Indira Gandhi National Open University
SCHOOL OF HEALTH SCIENCE

CHO-0001

Foundations of Community Health

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
राजस्थान



Communication Management and Supervision

5

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Indira Gandhi
National Open University
School of Health Sciences

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Block

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COMMUNICATION, MANAGEMENT AND SUPERVISION

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Appreciation of Collaborative Efforts

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BLOCK INTRODUCTION

As Mid level health care provider you are expected to provide comprehensive Primary health care at health and wellness centres. Therefore, you need to develop knowledge and skills in Social and behavior change communication which is the strategic use of communication to promote positive health outcomes, health systems management to ensure that a health facility runs smoothly and health workers know their responsibility ,health management information system (HMIS) which focuses on vital patient records, analysis of critical health related data ,financial management, accounts and computing, records and reports in peripheral health care setting, which is of utmost importance to manage the health and wellness centre effectively.

This block consist of six units as given below:

Unit 1 deals with Social and Behaviour Change Communication Skills and other Soft Skills. Unit 2 focuses on Work Management and Administration

Unit 3 explains Leadership, Supervision and Monitoring

Unit 4 discuses about Health Management Information System.

Unit 5 relates to Financial Management, Accounts and Computing at sub centre

Unit 6 explains Records and Reports

We hope that as you study these units, you will associate your new learning with your earlier experiences and knowledge .

UNIT 1 SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION SKILLS AND OTHER SOFT SKILLS

Structure

1.0 Introduction
1.1 Objectives
1.2 Communication
1.3 Human Behaviour
1.4 Socio-Ecological Mode (SEM)
1.5 Steps of Behaviour Change
1.6 Approaches to Social and Behaviour Change
1.6.1 Guiding Principles in Planning BCC Activity
1.7 Steps of Social and Behaviour Change Communication (SBCC)
1.8 Soft Skills
1.8.1 Soft Skill Attributes
1.8.2 Problem Solving
1.9 Let Sum Up
1.10 Key Words
1.11 Reference

1.0 INTRODUCTION

Behaviour is the range of actions and mannerisms made by humans or any organisms, systems, or artificial entities in conjunction with their environment, which includes the other systems or organisms around as well as the physical environment. It is controlled by a number of factors both internal and external. Change in behaviour is emerging as an important strategy of prevention and control of many diseases. Social and Behavior Change is a process that uses various methods to promote positive and measurable changes in people's environments, societies, and behaviors. It focuses on influencing attitudes, beliefs, and practices, both individually and collectively. aims to create lasting positive changes by addressing social norms, structural inequalities, and other factors that impact behavior. .

Previously known as behaviour change communication (BCC), SBCC is the strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviours. It refers to the coordination of messages and activities across a variety of channels to reach multiple levels of society, including the individual, the community, services and policy.

In this unit we will discuss the communication, how behaviour changes and behaviour change communications process, soft skills which involves interactions in the society would also be discussed.

1.1 OBJECTIVES

After completing this unit, you should be able to:

- explain communication;
- discuss human behaviour and how it can be changed;
- describe and strategies for Social and behaviour change communication (SBCC); and

- Understand and list the different steps involved in behaviour change.
- Relate real life examples for the steps in the change process
- List the barriers that could occur at each stage of change process.
- Articulate the role of health worker at each stage of the change process.

1.2 COMMUNICATION

Communication is the process of sending and receiving messages through various media. Messages are mainly related to health awareness so that healthy behaviour can be adopted.

Communication is necessary to pave way for desired changes in human behaviour and community participation to achieve predetermined goals. The ultimate goal of all communication is to bring change in the desired direction in one who receives it. These may be at-

a) Cognitive level - Knowledge
b) Affective level - Attitude
c) Psychomotor level - Practice

You must recall this communication process as shown in Fig. 1.1.

Communication process involves a source which can be called as sender or health worker in his/her capacity as a care giver decides to plan and prepare message keeping in mind target group. As shown in Fig.1.1 message is of prime importance from encoding to decoding (receiver), after that feedback from receiver to sender completes the process of communication. In this entire process, "listening" plays the most crucial role.

e) Effective communication is
   - Need based
   - Target group oriented
   - In simple and clear language and s
   - Meets the requirements of the people in need of health related messages.

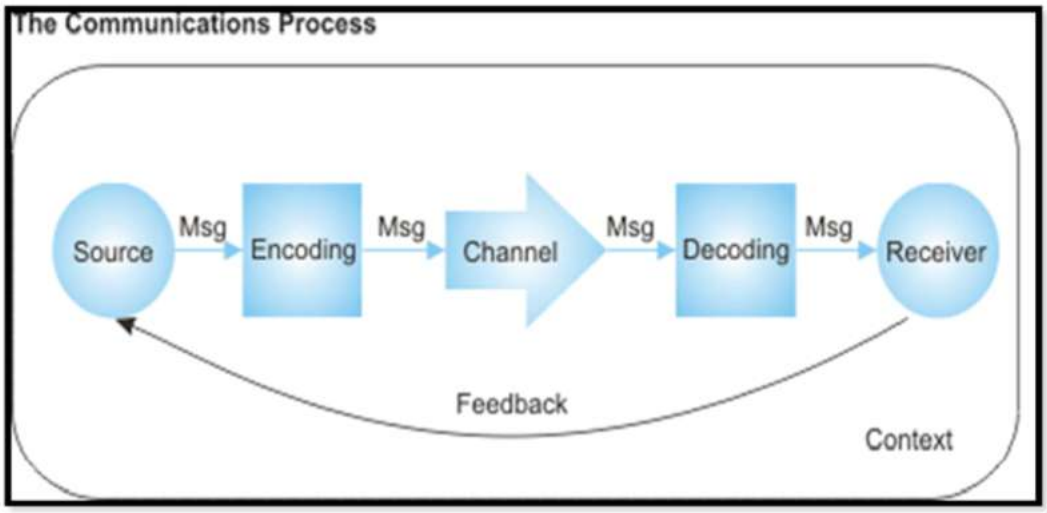


Fig. 1.1: The communication process

Msg – message

1.3 HUMAN BEHAVIOUR

Let us now read about human behaviour. It is not easy to change the behaviour of people. Behaviour is responsible for many health problems and at the same time solution to the health problem. It is not possible to change behaviour at once, or in one time conveying the messages, message has to be enforced many times such as importance of physical activities to prevent non-communicable diseases to be made people adopt this behaviour. (Fig.1.2)

Behaviour is an observable action of an individual often in reaction to specific circumstances or stimuli. It is acquired and liable to change. It is affected by a number of factors like genetic, social norms, culture, attitude, emotions, perceived risk and benefits etc.

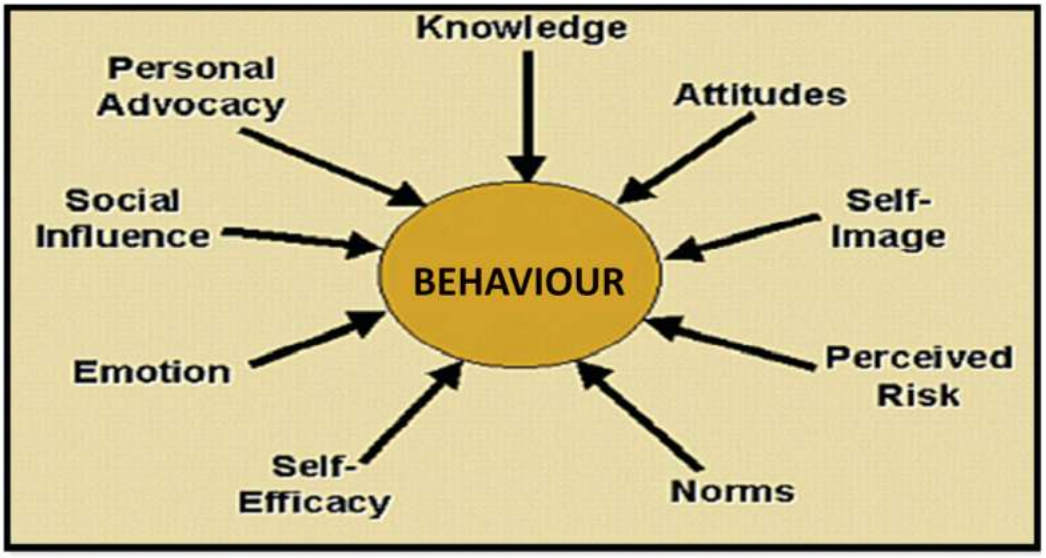


Fig. 1.2: Factors affecting behaviour

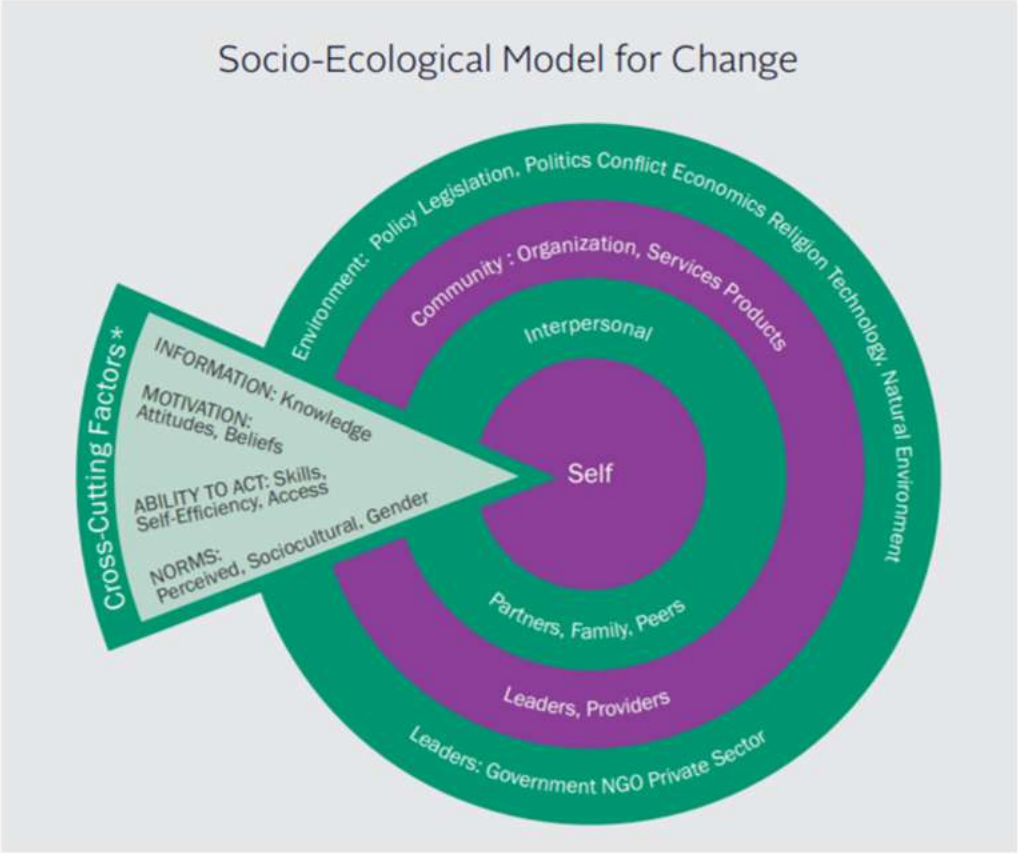
Human health behaviour and Behavioural insights

Conner and Norman define health behaviour as any activity undertaken for the purpose of preventing or detecting disease or for improving health and well-being. In simple words it relate to health maintenance, restoration and improvement. Behaviours within this definition include medical service usage (e.g., physician visits, vaccination, screening), compliance with medical regimens (e.g., dietary, diabetic, antihypertensive regimens), and self-directed health behaviours (e.g., diet, exercise, smoking, alcohol consumption). The initiation and maintenance of health behaviours result from an interaction of social, psychological, biological, and environmental factors. Behaviours can be harmful to health like smoking, alcohol, sedentary lifestyle or they can be health promoting like regular exercise, eating habits, compliance to treatment, safe sexual habits etc.

Behavioral insights are about understanding how people think and act to help them make better choices. It involves looking at why people do certain things, like habits or emotions, and using that knowledge to encourage positive changes. For example, making a task easier or more appealing can motivate people to try it. By greeting someone warmly, asking about their needs, explaining benefits clearly, and offering support, you can guide them toward better decisions. Small nudges, like reminders or simple instructions, can make a big difference in helping people change their behavior for the better.

1.4 SOCIO ECOLOGICAL MODEL (SEM)

Behaviour is a complex phenomenon, influenced by factors within the individual and beyond. The Social Ecological Model shown below, informed by Bronfenbrenner's 1979 seminal work, recognizes four levels of influence that interact to affect behaviour: individual, family and peer networks, community and social/ structural (Glanz & Rimer, 2005; Glanz & Bishop, 2010; HC3, 2014).



Self - Individual: At this level behaviour is affected by factors within the individual. Examples include knowledge, attitudes, skills, emotions and beliefs.

Example: During an disease outbreak, for individuals to practice the desired behaviours, they need to know the risks of transmission and how to prevent it, they need to feel that they are at risk of transmission, and they need the skills to practice protective behaviours.

Interpersonal - Family and peer networks: At this level, individual behaviour is affected by a person's close social and family circle. This includes influence from peers, spouse, partner, family and social support.

Example: for maternal health and infant and young child health related practices, Individuals will be more likely to practice desired behaviours if their family and friends believe these are important, are supportive of the desired behaviours and vulnerable populations, have knowledge and skills, and are already practicing them.

Community- Leaders, Providers: This refers to influences from the situational context in which the individual lives and in which social relationships are nested. The characteristics of the context are associated with risk and protective factors and include leadership, access to information, service provision, social capital and collective efficacy.

Example: during routine immunization, individuals are more likely to practice desired behaviours if leaders promote them, the whole community believes in their importance and if proper information and support are available and accessible.

Enabling Environment- Social/Structural: This refers to the larger, macro-level environment which can either promote or deter behaviours. Examples include leadership, health systems, resources and services, policies, guidance and protocols, religious and cultural values, media and technology, gender norms and income equity.

Example: in the prevention of teenage pregnancies, individuals are more likely to engage in desired behaviours if facilities exist that support those behaviours, if coordination mechanisms are in place, and if bylaws and policies are introduced to promote supportive norms around the desired behaviours.

As the field of BCC evolved, it placed greater emphasis on the socio-ecological context that grounds individual behaviours, and thus the preference for using SBCC as opposed to BCC. At each of these four levels of influence there are factors that affect behaviour in positive ways (facilitators) and factors that affect behaviour in negative ways (barriers). Effective SBCC interventions should aim to develop messages and activities that influence all four levels of the Social-Ecological Model, maximizing the facilitators and limiting the barriers.

1.5 STEPS OF BEHAVIOUR CHANGE



1) Knowledge

In this step, individual first learns about a new behaviour and recalls messages and understands meaning of the messages.

2) Approval

the individuals then approves of the new behaviour and responds favourably to messages. The person discusses the information with personal network (professional, colleagues, family and friends). Later he/She themselves approve of the practices.

3) Intention

the individuals believes this behaviour is beneficial to them and intends to consult the provider. The person recognises that the strategies can meet a personal need. The person intends to adopt these practices in future.

4) Practice

The person goes to provider of information/supplies/services.attempts new behaviour and continues to practice.

5) Advocacy

One can then promote the new behaviour through their social or professional networks as a satisfied practitioner. She/He experiences and acknowledges personal benefits of adopting behaviours and advocates it to others and supports the programme in the community. E.g. A diabetic person develops habit of regular monitoring of blood sugar which helped her in diabetes control for herself, will tell other diabetic persons to do so.

Roles To Be Performed By Health Workers At Each Step:

- **BUILDING KNOWLEDGE:** Role of Health Worker is to use IEC materials and other resources to communicate the relevant message to the community for spreading awareness about health services with all members of family. Health Worker can also remind/refer to the messages being given through TV, Radio and other communication mediums.
- **GAINING APPROVAL AND DESIRE:** To generate desire and approval, Health Worker must convey health messages repeatedly and discuss its benefits with the community and target families. Also, Health Worker needs to explain health risks associated with different reasons.
- **ENHANCING INTENTION:** Now the person is aware and has desire but still he may not be enthusiastic enough to try out new behaviour. This is the stage where role of Health Worker is very critical as a counsellor, She/he needs to provide necessary skill, and support to the prospective beneficiary by way of clarifying doubts, providing detailed information about services and their delivery process in a friendly way.
- **PROMOTING ACTION:** At this stage Health Worker provides a supportive environment and motivates the person to try out the new behaviour. Also, she/he needs to sort out possible barriers that may come from community and family against the new behaviour. Health Worker needs to keep in touch with the person, his family and community members who has just adopted a new behaviour so that problems, if any, post adoption of new behaviour, may be addressed to their satisfaction so that they repeat it. Health Worker needs to keep the person motivated and provide supportive environment so that the person maintains new behaviour.

  DEVELOPING ADVOCATES: Health Worker has followed above steps meticulously, the person will get convinced with the benefits of new behaviour and will accept it as standard habit. They not only sustains new behaviour but canvasses with others to adopt new behaviour. Health Worker should use these persons as their key influencers and advocates for the health behaviour.

  It is very clear from the chart that for moving from one step to the other, the Health Worker has a very important role to play in terms of counselling the prospective beneficiary, the family and community members otherwise the person can drop out after any step at any stage in the behaviour change process. Health Worker needs to keep in mind that if person drops out from the behaviour change process, getting her back on the process may be more challenging.

1.6 APPROACHES TO SOCIAL AND BEAHVIOUR CHANGE

key approaches in SBCC are:

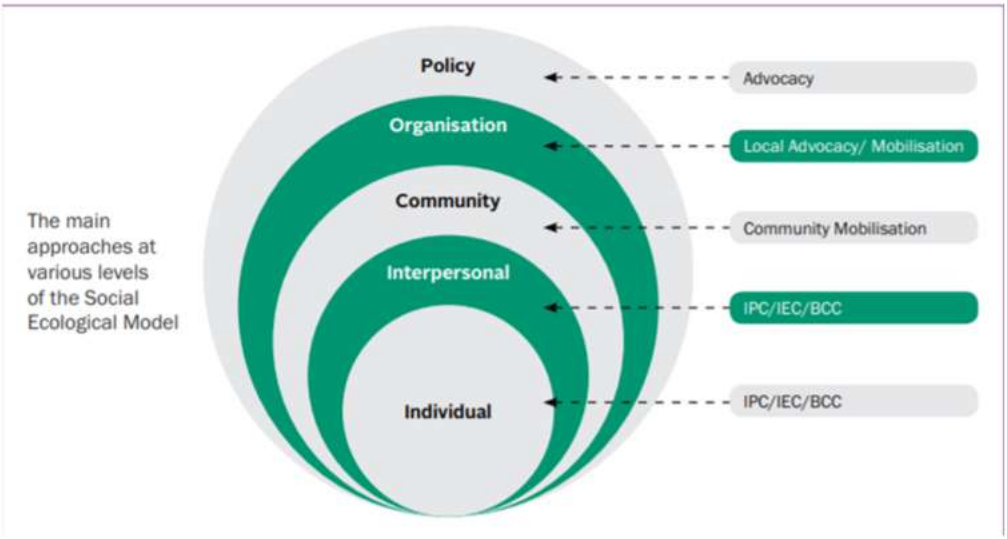
Advocacy: Advocacy is directed at different levels of decision makers - people who have the power to create policies, programmes and structures and to allocate resources. By persuading decision makers to decide in favour of a cause, advocacy seeks to develop, change or modify an existing law, policy and/ or administrative practice that would enhance the emergency response. It is a continuous and adaptive process of gathering, organising and transforming information into arguments. These arguments are then communicated to decision makers, to influence their choices to raising resources (human and financial), or demonstrate political or social leadership and commitment.

Social Mobilization: This is used to generate wider participation from the community, build sustainable local coalitions, strengthen local networks, create ownership. Community Mobilization is a part of Social Mobilization and includes Community Engagement Processes and Community Dialogues.

The purpose of social mobilization is to bring together relevant inter-sectoral partners to determine needs and raise awareness for a particular. It involves the identification of organizations, institutions, groups, networks and communities who can contribute their efforts and resources. It involves facilitating their participation. This approach should support actions and priorities identified by communities, especially the most vulnerable groups whose rights tend to be consistently denied.

Individualised Behaviour Change Communication: This is used for changes in specific knowledge, attitude and practices in a given community using Interpersonal Communication and Counselling to make the change. This approach addresses the knowledge, attitudes, practices and skills of individuals, families and communities as they relate to specific outcomes. Individuals and communities gain knowledge, appreciations and skills that motivate them to develop positive, healthy and protective practices.

Therefore, it requires a sound understanding of the audience(s) and the use of an appropriate mix of communication channels - interpersonal, group, community , media. It also recasts the role of the "communicator" as facilitator rather than "expert". It is more effective when complemented by well-planned advocacy and social mobilisation strategies.



1.6.1 Guiding Principles in Planning Behaviour Change Communications (BCC) Activity

1) BCC should be integrated with programme goals from the start. BCC is an essential element of disease prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives.

2) Formative BCC assessments must be conducted to improve understanding of the needs of target populations, as well as of the barriers to and supports for behaviour change that their members face (along with other populations, such as stakeholders, service providers and community).

3) The target population should participate in all phases of BCC development and in much of implementation.

4) Stakeholders need to be involved from the design stage.

5) Having a variety of linked communication channels is more effective than relying on one specific one.

6) Pre-testing is essential for developing effective BCC materials.

7) Planning for monitoring and evaluation should be part of the design of any BCC programme.

8) SBCC strategies should be positive and action-oriented.

Check Your Progress 1

Read the story and and answer the questions:

Sarla was pregnant for the first time. She was very happy, but she did not tell anyone about her pregnancy. After many days she confided in her mother-in-law about her pregnancy. When Sarla told about her pregnancy, her mother-in-law advised her not to speak about it to anyone and also not step out of the house alone. There were many evils, and Sarla could get caught in something like that which will affect her child. When the ASHA came on a routine visit, Sarla did not mention her pregnancy. ASHA didi heard about Sarla's pregnancy from her sister-in-law and went to inform Sarla about registering and coming in for her health check-ups. Sarla did not go for her first ANC and neither did she register her pregnancy.

ASHA didi visited Sarla at home. After speaking to Sarla, she gave her the Iron and Folic acid tablets and asked Sarla to take them regularly. She also advised her to rest for atleast two hours during the day. When ASHA didi returned after a week to check on Sarla, she found that Sarla had consumed only 2 or 3 of the IFA tablets.

On the next visit ASHA didi shared messages regarding rest, increased nutrition, IFA with Sarla. She told her that she will inform her when ANM behenji will be coming next and Sarla should go and get her weight checked. When the ASHA went out of the house, Sarla's mother in law told her that she should not eat too much food. She said that the ASHA herself is a young girl and did not know anything about child birth. The child will become too big and delivery will be a problem. Besides sleeping too much will make the baby's head flat on one side. So Sarla should not eat too much and also not lie down. Besides women of her generation gave birth to several children and worked all day in the house as well. They never had any problems.

ASHA didi was upset that she has been counseling Sarla but Sarla has not come and registered It had been three months and she was due for her first TT vaccine as well. ASHA didi spoke about her worries with the ANM and CHO and they decided to go to Sarla's house. In her conversation with Sarla, ANM behenji and CHO understood that Sarla was willing but her mother-in-law was not allowing her. ANM asked ASHA if she had spoken to Sarla's mother-in-law. When ASHA answered in the negative, ANM behenji immediately asked for permission to meet with Sarla's mother-in-law. She sat with her and explained why Sarla should eat and take rest. She also gave examples of families in the community who had taken good care of their daughter-in-laws and had registered their names at the Anganwadi Centre. She explained about the benefits that the government gave like free delivery at the hospital and transport facilities She told us why it was important to go to the hospital and also why regular check-ups were important for the health of the mother and the baby. Sarla's mother-in-law listened but said, "No, I think it is all right. Sarla will be all right"

CHO and ANM then decided to talk with to Rajwanti Chachi, who lived near Sarla's house. RajwantiChachi is a retired teacher. All the villagers hold her in high esteem and listen to her. Rajwanti chachi agreed to speak to Sarla's mother-in-law who heard her out and seemed to relent a bit. CHO also spoke with Sarla's husband who seemed very reluctant to discuss but grudgingly agreed that it must be important and that is why the government was laying so much stress on it. He kept hearing the advertisements of this on the radio and was grateful to the ASHA ANM that they were taking so much trouble. It was the reflection of Health workers' efforts that Sarla's mother-in-law accompanied Sarla to the MCHN and is now a doting grandmother.

FACILITATORS TO ASK:

1. Who are influencing the behaviour of Sarla. Put them in the various circles of SEM model:

2. What are the barriers at each circle ? and how should the health worker address these barriers.



1.7 STEPS OF SOCIAL AND BEHAVIOUR CHANGE COMMUNICATIONS (SBCC) FOR THE MOST VULNERABLE COMMUNITIES

Health inequities are often created by social conditions, and they can be changed with targeted efforts to promote fairness and improve access to healthcare for all . A vulnerable population consists of individuals at higher risk for health problems and disparities due to social, economic, or environmental disadvantages like socioeconomic status, age, gender, culture, religion, mental illness, disability, etc which create significant obstacles to accessing quality healthcare. In context of Rajasthan groups e.g. urban poor, resistant families, nomadic and denotified tribes, migrating families brick kiln laborers, construction laborers, persons with disabilities, and tribal families are particularly vulnerable because they often face limited access to resources, healthcare, and stable living conditions, necessitating targeted interventions to promote equity and improve well-being. Gender based norms across communities and wealth quintiles, put women at a greater disadvantage. Social norms and reliance on traditional practices often discourage these groups from seeking medical advice, leading them to favor home remedies or non-traditional healers. For example, the mobility of nomads and laborers disrupts consistent healthcare access, while tribal families in remote areas lack nearby medical facilities. Resistant families avoid health services due to social stigma or on the bases of their past AEFI experiences.

Social stigma and lack of sensitivity from healthcare providers can create an unwelcoming environment, leading to identity-related crises and reluctance to seek care. This avoidance exacerbates health disparities, as they miss out on essential medical services. Creating inclusive, gender-sensitive health functionaries and facilities is crucial to ensure equitable access and support for their well-being.

Prioritizing these groups in health program planning ensures equitable access to care, tackles their unique challenges, and promotes behavior change through tailored interventions, ultimately enhancing community health outcomes.

Let us go through the steps of addressing these social and behavioural challenges:

I. Identify the most vulnerable population

Identifying the most vulnerable populations for health programs involves a systematic approach to ensure resources and interventions reach those who need them most. Below is a concise guide on how to identify these groups, followed by a rationale and practical steps, tailored to the context of community health programs and incorporating insights from community influencers.

- **Analyse Demographic and Socioeconomic Data:** Use available data from government records, line PCTS data, National Family Health Survey (NFHS), Annual Health Surveys (AHS), Sample Registration Survey (SRS), District Level Household and Facility Survey (DLHS) or NGOs/CBS to identify groups with limited healthcare access, or high disease prevalence.
- **Map Health Disparities:** Examine health indicators like infant mortality, low routine immunisation, missed ANC, malnutrition, or chronic disease rates.

- **Consult Community Influencers:** Engage trusted local figures (e.g., teachers, ANMs, local influencers) to identify marginalised groups such as women, children, caste-based minorities, individuals of diverse gender identities, widows, single mothers, people with disabilities, who may not appear in formal data.
- **Assess Social and Environmental Risks:** Identify groups facing social exclusion (e.g., based on caste, gender, or religion) or environmental risks (e.g., living in tribal, forest, and flood-prone areas).
- **Conduct Community Surveys and Focus Groups:** Use participatory methods like rapid surveys, social listening, or focus groups to gather qualitative insights. Many reports showed that community feedback helped identify 15% more vulnerable households by addressing stigma-related barriers.
- **Leverage Local Networks:** Work with grassroots organisations, CBOs, NGOs, faith leaders, influencers or WhatsApp groups to uncover hidden populations, such as migrant workers (nomads), brick kiln and construction site labourers, and people living in temporary slum areas(urban poor) or elderly individuals who may lack formal documentation.

Identifying vulnerable populations requires a blend of data analysis, community engagement, and influencer collaboration to ensure accuracy and inclusivity.

II. Customise SBCC approach to address the chellenges of the most disadvantaged

To address the health challenges faced by identified vulnerable groups the health functionaries must implement targeted, inclusive, and culturally sensitive actions. Below is a concise outline of key actions, supported by evidence and integrated with strategies for engaging community influencers.

1. Promote Community Participation and Collective Action

a. Action: Engage community influencers (e.g., educated women, Faith leaders, influencers, women's collective) to promote health programs through WhatsApp groups and social events, encouraging participation in vaccinations or screenings.

b. Share digital content with influencers for amplification, to ensure broader reach.

2. Foster a Supportive and Inclusive Environment

a. Action: Develop inclusive health services, train healthcare workers in respectful, non-judgmental communication, and promote inclusivity to ensure that gender-diverse individuals, tribal families, and people from different castes, genders, or religions can access care without stigma.

b. Involve influencers in designing stigma-free campaigns, leveraging their role in shaping positive community culture, as seen in the MR campaign and the Polio Eradication Program.

c. Ensure inclusion of influencers and activities to engage them in microplanning at ASHA, Subcentre, Block and district level

3. Recognise and celebrate Influencers

a. Action: Non-financial recognition of influencers' contributions through public events, media features, or acknowledgement by local leaders to sustain their involvement

b. Invite influencers to block and district planning meetings, amplifying their role and motivating sustained participation.

4. Document and Celebrate Stories of Change

a. Action: Record success stories of vulnerable individuals (e.g., a tribal woman, a nomadic construction and brick kiln female worker accessing healthcare, celebrate 100% routine immunization of children, and influencers' contributions, sharing them via media and community events.

b. Work with influencers to share these stories on platforms like X, WhatsApp groups, boosting visibility and participation.

5. Create and enabling environment

a. Action: engage with communities to counsel, and find collective solutions for transportation, and health education, and local challenges and creating enabling environment for accessing health services and entitlements

b. Health workers can align with community members and elders in various community meetings, mohalla baithaks, saas bahu samelans, youth networks. Self-help group meetings to discuss the importance of the health entitlement and need for community actions.

INTERPERSONAL COMMUNICATION SKILLS

Interpersonal communication (IPC) refers to face-to-face communication. IPC can either be one-to-one or in a small group. IPC makes it possible for people to exchange information, express their feelings and obtain immediate feedback, respond to questions and doubts, convince and motivate others to adopt certain behaviour practices. IPC requires listening skills, the ability to empathise and be supportive. IPC in a crisis situation is particularly useful in counselling approaches such as through hotlines, clinic consultations, in training service providers and community volunteers as peer educators, through pep talks by specialists, and for facilitating group meetings where the affected community can share and discuss the issues at hand.

GATHER is a simple way to remember the actions that make IPC effective:

G–GREET the caregivers (establish rapport): This step involves meeting people as equals and establishing or strengthening an existing relationship.Greeting is not only saying "Namaskar" or equivalent salutation, but having a small talk to establish the relationship and build rapport.

While Greeting remember:

- Greet people using local traditions and culture.
- Ask about people's well being.
- introduce yourself if you are new
- Talk positively
- Pay attention.
- Speak less, and use positive body language (havbhav)

A–ASK caregivers (gather information): to know what the persons requires so that you can give her information that is relevant to her needs. Asking should not be limited to mere medical history because other aspects of a person's life often impact an individual's behaviour. Asking open questions can help them share their problems.

While at ASK, remember:

- Listen patiently and fully to what the person is saying to you.
- Do not impose information which is not necessary to her at that moment.
- Keep your body language positive at all times
- Speak less, listen more

T–TELL (provide required information): filter the information that she is giving you to pick out on what is her immediate need and worry. She may or may not say it in so many words. And your "TELL", has to be based on what she has asked for on what has been her immediate, expressed need.

Avoid giving too much information overload because there is a limit to how much information a person can retain. Instead, package the information in smaller bytes and check for understanding after delivery of each byte. Specific information organized logically is retained longer and more completely, especially if the individuals are encouraged to ask questions.

While at 'TELL', remember:

- Do not give an overload of information
- Check if the person has understood what you have told her
- Take feedback
- Use communication materials to support you in your communication
- If you do not know something, say that you don't and that you will find and get back

H–HELP (provide required support to help the individual): This is the problem-solving moment. The provider is helping the person sort through the information and choices. Sorting through the issues they are facing, the health worker helps them to come up with various alternatives and discusses the advantages and disadvantages of each alternative. This is to finally help them in making an informed decision.

While at 'HELP', remember:

- Help the m to make decisions based on informed choices.
- Suggest the options giving advantages and disadvantages for each option.
- Check if any help is needed in speaking to other members of the family.

Two- way communication – giving the mother enough opportunity to speak.

E –EXPLAIN (support in informed decision making): Once the person has understood the various options available for her, she should be guided towards making a decision. Use IEC materials to help you in your communication. Once she had made a choice, use IEC material to help them remember key messages in the information. IEC materials reinforce key information, advantages and disadvantages.

While at 'EXPLAIN', remember:

- Use IEC material to support your communication.
- Use local example, simple language, fol k tales etc.
- Use local role models

R-RETURN/REFER/REALITY CHECK: When you have discussed and helped the person make a decision, she may want further help. This can be in the form of a referral that she requires or a follow up return visit that you may require to check if she has had any trouble in following the new behaviour. Return visits or referrals should be planned. If necessary, repeat the information given.

While at 'RETURN', remember:

- When you return check on the matter that you have discussed when you were there the last time.
- Keep your notes to refer to so that you do miss out any importantfollow-up
- Check if the behavi our has changed according decision taken

CHECK YOUR PROGRESS 2:

- Give a situation from the box 1: to three or four participants and ask them to do a role play on how they will communicate in the situation given to them.
- Give them two minutes to prepare what they will say. Then invite them to perform the role play. Tell all participants that they must listen carefully to the conversations and note down what was said, and how and what was the effect of what was said. This will be taken up for discussion later. (15 minutes)
- Once the groups have done the role play, ask them to check themselves on the parameters of IPC as you read the questions from the IPC checklist. The groups can also do this by themselves. Refer to Box 4. (15 minutes)
- Ask the groups to explain again what they would do and make a checklist for themselves based on the questions asked. As they call out what to do, write it down on a chart paper for everyone to see. Ask them to note it down in their handbooks.
- Thank the participants for their wonderful work on IPC and say that the focus will now be on what else is required other than IPC when communicating.

Situation 1

Salma has a two-month-old baby. She lives in Seohnar basti which is across the river. The river has been flooded for 6 months and the basti is cut-off as there is no direct road. Salma finds it difficult to come to the health centre. She worries about her baby's health, so she tries to keep him covered and out of the wind. She is not sure what she can do to protect her child except go to the loca I healer if he falls ill. She has not brought her baby for any vaccination till now.

Situation 2

Anandi brought her baby for immunization once. After the immunization, her baby got fever and the area where she was injected was swollen and red. Anandi does not want to hurt her baby, so she has decided that she will not go back again for immunization.

Situation 3

Parveena's friend had told her that her in-laws and husband did not allow her to take her baby for immunization as there were many new vaccines and they were not yet safe. They said many babies had died after vaccination as the government was still testing the vaccines. When the ASHA and AWW came to Parveena's house, she had already decided that she would flatly refuse to take the child for immunization.

Interpersonal communication(IPC)- Checklist



- Before an IPC session:
  1. Does health worker know the correct information on routine Immunization?
  2. Does she/he know the date and venue for the next round?
  3. Does she know what materials to carry with her?
  4. Will she carry the IEC material?
  5. Whom could she take along to approach/influence the family?
- While conducting the IPC session:
  1. Did health worker greet well?
  2. What did she do to develop rapport with the mother/family? Did she show concern for the child? How?
  3. Was she able to empathize and show respect through her body language and eye contact? Give an example.
  4. Did she understand the body language of the mother/family member? Give an example.
  5. Did she ask enough open-ended questions to give the mother an opportunity to speak?
  6. Did she listen effectively and repeat in her words what was told?
  7. Did she give the correct information based on what was asked?
  8. What were the key messages given by her?
  9. Did those messages help in addressing the problems that the mother had?
  10. Was the message understood? How did she check that?
  11. Was the mother/father/mother-in-law assured with her words? How did she check that?
  12. What was said by the mother/family which reassures that she/he will take the required action?
  13. What is the follow-up required? How has this been conveyed to the family?

1.8 SOFT SKILLS

Soft skills are a cluster of productive personality traits that characterise one's relationships in a social milieu with other people. These skills can include social graces, communication abilities, language skills, personal habits, cognitive or emotional empathy, time management, teamwork and leadership traits.

1.8.1 Soft Skill Attributes

Following is a list of soft skills important to effectively communicate with patients-

1) Communication – Oral, speaking capability, written, presenting, listening.
2) Courtesy – Manners, etiquette, gracious, says please and thank you, be respectful.
3) Flexibility – Adaptability, willing to change, lifelong learner, accepts new things, adjusts, teachable.
4) Integrity – Honesty, ethical, high morals, has personal values.
5) Interpersonal skills – Nice, polite, sense of humor, friendly, nurturing, empathetic, has self-control, patient, sociability, warmth, social skills.
6) Positive attitude – Optimistic, enthusiastic, encouraging, happy, confident.
7) Professionalism – Businesslike, well-dressed, appearance, poised.
8) Responsibility – Accountable, reliable, gets the job done, resourceful, self- disciplined, conscientious, common sense.
9) Teamwork – Cooperative, gets along with others, agreeable, supportive, helpful
10) Work ethic – Hard working, willing to work, loyal, initiative, self-motivated, on time, good attendance.

1.8.2 Problem Solving Skills

Problems are encountered every day in our work place. It can occur when a health worker is solving problems for a patient or their families, supporting those who are solving problems, or discovering new problems to solve. The problems can be large or small, simple or complex, and easy or difficult. A fundamental part of every health worker's role is finding ways to solve problems. Problem is a situation one want to change.

Problem-solving process

There are different stages of problem solving process. Every stage has different objectives and activities. Following are the stages of problem solving process:

Stage One

The objectives of stage one are as follows:

1) To analyse the facts
2) To define the problem Define the Problem

While defining a problem, various issues has to be kept in mind like:

1) What triggers the problem- It includes the precipitating factors which has contributed to the problem

2) State the problem
3) Question the constraints of the problem statement
4) Identify the essential elements that are needed to take into consideration while solving problem
5) Scope of the problem in terms of who all will be affected and what processes will be affected
6) Gain insights from others
7) Restate problem, if necessary

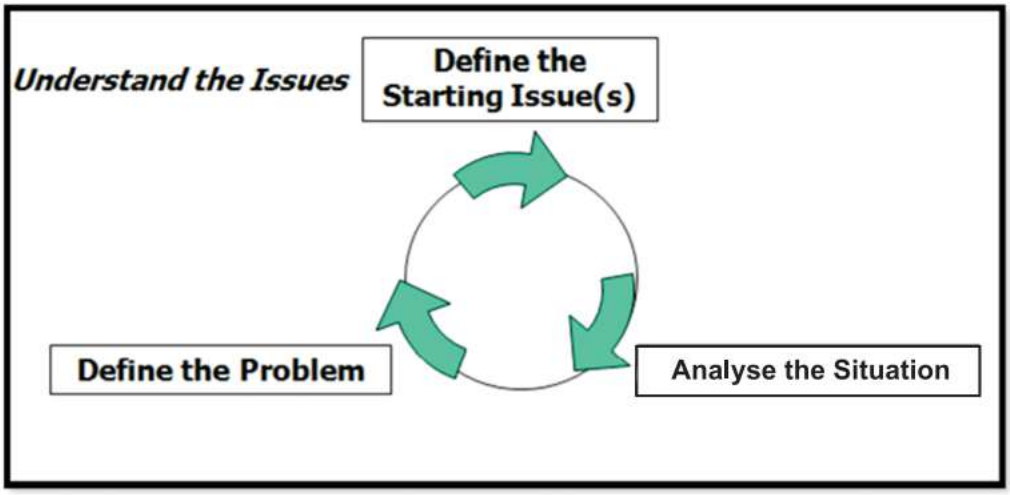


Fig. 1.5: Stage 1 of problem solving process

Stage Two

The objectives of this stage are:

1) To generate ideas
2) To evaluate ideas
3) To decide on the best possible solution Following are the activities to be done in this stage:
   a) Help determine what information to seek
   b) Explain your choices to others
   c) Determine the importance of time and effort devoted to the problem
   d) List the consequences of each alternative
   e) Assess the future consequences of each alternative
   f) Create a description of the consequences
   g) Eliminate any clearly inferior alternatives
   h) Organise descriptions of remaining alternatives into a table
   i) Try to develop a common scale to measure consequences
   j) Use qualitative and quantitative data
   k) Use experts if necessary
   l) Use scales that reflect appropriate levels of precision

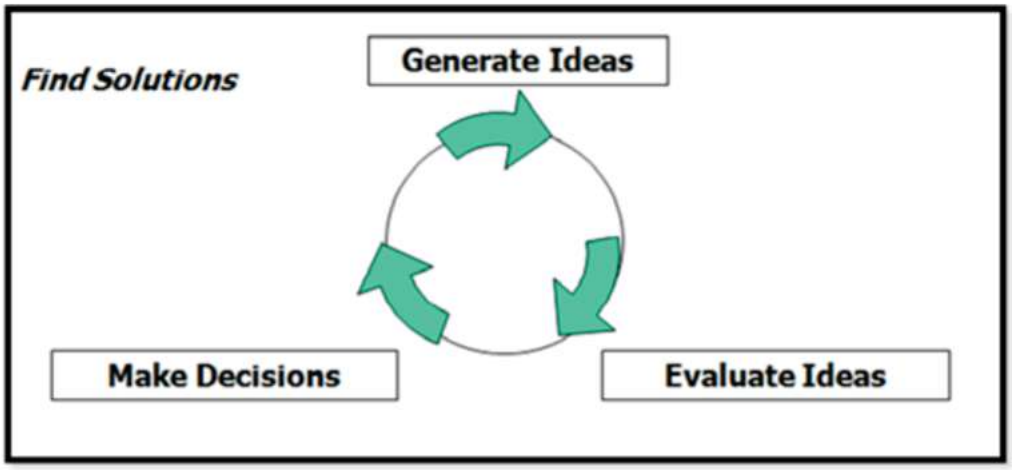


Fig. 1.6: Stage 2 of problem solving process

Stage Three

The objectives of this stage are as follows:

1) To determine the impact on people and systems
2) To build on action plan
3) To decide on follow-through

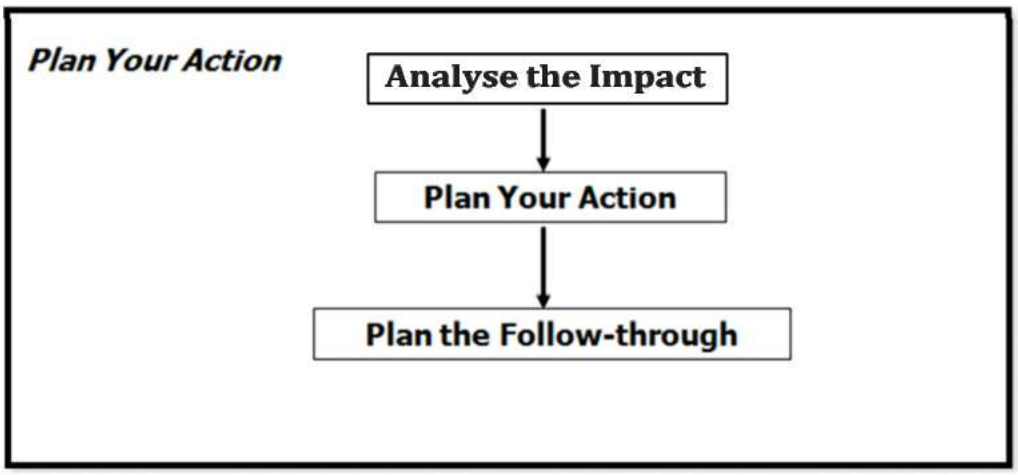


Fig. 1.7: Stage 3 of problem solving process

Steps of problem solving

1) State the problem carefully
   a) Acknowledge complexities
   b) Avoid assumptions and prejudices
2) Specify the objectives
3) Create imaginative alternatives
4) Understand the consequences of the alternative
5) Clarify uncertainties
6) Think about risk tolerance and the risks of each alternative
7) Consider linked decisions

1.9 LET US SUM UP

Behaviour is the range of actions and mannerisms made by individuals, systems, or artificial entities in conjunction with their environmentt. Change in individual and social behaviour is emerging as an important strategy of prevention and control of many diseases, especially non communicable diseases and addictions. Social and Behaviour change communication (SBCC) is an interactive process with an individual or communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours. Communication is necessary to pave way for desired changes in human behaviour and community participation to achieve predetermined goals. The ultimate goal of all communication is to bring change in the desired direction in one who receives it.. SBCC should be integrated with programme goals from the start. BCC is an essential element of disease prevention, care and support programmes, providing critical linkages to other programme components, including policy initiatives. Soft skills are a cluster of productive personality traits that characterise one's relationships in a social milieu with other people. These skills can include social graces, communication abilities, language skills, personal habits, cognitive or emotional empathy, time management, teamwork and leadership traits.

1.10 KEYWORDS

Behaviour : A behaviour is an observable action of an individual often in reaction to specific circumstances or stimuli.

Communication : Communication is a two way process of exchanging or shaping ideas, feelings, and information.

Behaviour Change : Behaviour change is the modification of an action by an individual in a direction that is intended to be an improvement.

Health education : An process aimed at encouraging people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help when needed.

Social and Behaviour change communication: An interactive process with an individual or communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours.

Interpersonal communication (IPC) : It is a two way communication process and forms an important part of counselling in BCC.

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UNIT 2 WORK MANAGEMENT AND ADMINISTRATION

Structure

2.0 Introduction

2.1 Objectives

2.2 Weekly Work Calendar

- 2.2.1 Steps for Preparing Weekly Work Calendar
- 2.2.2 Advantages of Weekly Work Calendar

2.3 Roles and Responsibilities of Grassroot Workers

- 2.3.1 Accredited Social Health Activists (ASHAs)
- 2.3.2 Multi-Purpose Workers (MPW) Male
- 2.3.3 Auxiliary Nurse Midwife (ANM)/ Multi-purpose Workers (MPW) Female

2.4 Village Health Sanitation and Nutrition Committee (VHSNC)

- 2.4.1 Objectives of VHSNC
- 2.4.2 Constitution of VHSNC Members
- 2.4.3 Roles and Responsibilities of VHSNC Members
- 2.4.4 Participatory Learning And Action (PLA)
- 2.4.5 Roles and Responsibilities of VHSNC Members

2.5 Team Management in Health Sector

2.6 Let Us Sum Up

2.7 Model Answers

2.0 INTRODUCTION

In the previous unit, you have read about behaviour change communication for healthy life style.

Universal coverage requires number of professionals trained in primary health care from multidisciplinary background with varying skills and knowledge. Doctors, paramedical staff including nurses, technicians, grassroot levels workers like MPWs and ASHAs all have significant defined role to play and can deliver quality health care services only if they work as a team. Since health has various social determinants; for attaining health, there is a need to collaborate with other sectors like education, public works, water and sanitation, environment, agriculture etc. The district has been identified as the organisational unit for the reorganisation and transformation of health care provision, thus planning for quality care provision has been decentralised up to the unit level like villages in rural areas through various platforms like Village Health Sanitation and Nutrition committees (VHSNCs).Thus with the decentralisation in health system, the PRIs, community groups and grass root levels workers have a significant role to play in planning, implementation and monitoring of various health and disease control programmes.

In this unit, you will learn about health planning and the role of community volunteers, PRIs and grass root level workers at village level. You will also understand the importance of effective team management for better delivery of services and ways to improve efficiency of staff.

2.1 OBJECTIVES

After going through this unit, you should be able to:

- prepare a weekly work calendar;
- enumerate the roles and responsibilities of Multi-purpose workers (male and female) and ASHA;
- describe objectives, composition and role of members of Village health, sanitation and nutrition committee (VHSNC); and
- explain importance of team management in health sector.

2.2 WEEKLY WORK CALENDAR

Before we discuss weekly work calendar, let us first of all know that Work Calendar is a systematic way to define and plan work for a specified period. These can be developed over varying periodicity like weekly, fortnightly, yearly schedule. These calendars helps to plan that which work will be carried out on what available dates in a week, fortnight, month or year. These are not only the tools of planning but also for monitoring and evaluation of the work done against the targets set. Weekly work calendars are better and feasible for health care workers since these are easy to plan and implement. Moreover, depending upon the achievement over one week's cycle, activities for subsequent weeks can be planned. A weekly work calendar should be prepared for each health worker and activities carried out in their areas accordingly. A weekly work calendar consists of days in a week in columns with working hours in first column.

2.2.1 Steps for Preparing Weekly Work Calendar

1) Make a blank table having rows and columns as per working hours and number of working days available in that week
2) First column is number of working hours in a day
3) Rows are prepared on hour wise basis starting from 9 am to 4 pm.
4) Next 6 columns are days in a week
5) The health worker then fill the table as per activities planned for the week like immunisation session, health talks, antenatal clinic, school health visit etc.

Weekly work calendar (Model for ANM)

Days Time (Hrs.)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday (Holiday)
9 am	Visit to families in Gali No. 14		Immunisation fixed centre activity		Immunisation fixed centre activity	ASHA meeting and diary checking	
10 am 11 am		MAS* meeting		Out reach session in AWC			
12 noon	Health Education Session					Preparing work calendar	

Days Time(Hrs.)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday (Holiday)
	with Adolescent girls					for next week	
1 pm							
2 pm		Record comple-tion at PHC		Monthly meeting			
3 pm							
4 pm							

*MAS (Mahila Arogya Smiti)

2.2.2 Advantages of Weekly Work Calender

1) Helps a worker to prepare his/her schedule in advance. This can also be shared with the supervising officer and can be used by them for monitoring and supportive supervision.
2) Planning activities in advance increases the efficiency of the worker.
3) Planning of activities on day to day basis results in wastage of health workers' precious time, thus planning in advance helps her/him to dedicate more productive hours to work with quality. S/He can also judiciously find time slots so that the pending work can be completed.

Note: Weekly work calender is a time management tool that increases the work efficiency of the health worker besides enabling the superiors to monitor and provide support to her/him in the day to day activities.

2.3 ROLES AND RESPONSIBILITIES OF GRASS-ROOT WORKERS

The workers that work within the community or at the sub-centre level are known as grass root level workers. Most important of these are Multipurpose Workers (MPWs)- Male and Female, Accredited Social Health Activists (ASHAs), Anganwadi workers (AWWs). MPWs are the health workers that are posted at the sub-centre for provision of services and also in the community to the population allocated to their sub-centre. Each sub-centre is located at a population of about 5000 in plains and 3000 in hilly and difficult areas. ASHAs are the community link workers and social health activist that are voluntary honorary workers under National Health Mission (NHM) and function as linkage between the community and the health system. Anganwadi Centres under Integrated Child Development Services Scheme (ICDS) are manned by Anganwad Workers (AWWs) and helpers, which serve as a point of service delivery for outreach health care services to the community.

2.3.1 Accredited Social Health Activist (ASHA)

Let us now read the roles of ASHA in detail:

Each ASHA has been made responsible for 1000 population under National Health Mission (NHM) in rural areas. The ASHAs are selected from the community where they are supposed to serve and trained to work as an interface between the

community and the public health system. ASHA is chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, Block Nodal officer, District Nodal officer, Village Health, Sanitation and Nnutrition Committee (VHSNC) and the Gram Sabha. ASHA must be a woman resident of the village married/widowed/divorced, preferably in the age group of 25 to 45 years and be able to spend at least two hours a day in the community work. She should be acceptable to all sections of the society and educated at least up to 10th standard. ASHAs should have effective communication skills, leadership qualities and be able to reach out to the community.

ASHA has to undergo a series of training sessions to acquire the necessary knowledge and skills for performing her roles. The modular training is for a period of 23 days in five episodes over one year and thereby refresher trainings are given on periodic bases. ASHA receives performance-based incentives for various activities like promoting universal immunisation, referral and escorting women for delivery and sick newborn to hospital and first referral unit, other healthcare programmes, and construction of household toilets.

Roles and responsibilities

1) **Awareness generation**- ASHA educates and generates awareness among the community on health and disease along with the determinants of health like nutrition, sanitation and hygienic practices, healthy lifestyle, existing health services and the need for timely utilisation of health and family welfare services.

2) **Home visits-** ASHA has to conduct home visits to provide Home Based Post Natal Care to mother and newborn and make adequate and timely referrals in case of need. They counsel pregnant women on:

   - birth preparedness
   - importance of institutional delivery
   - breastfeeding and complementary feeding
   - immunisation
   - contraception
   - prevention of common infections including Reproductive Tract Infection/ Sexually Transmitted Infection (RTIs/STIs) and
   - care of the young child.

3) **Community Mobilisation**- ASHA mobilises the community and facilitate them in accessing health care services available at the village/sub-centre and other public health facilities, such as immunisation, ante natal care, post natal check-ups, sanitation and other services provided by the government.

4) **Village Health Sanitation Nutrition Committee (VHSNC)** - ASHA has to work with the Village Health Sanitation Nutrition Committee of the Gram Panchayat to facilitate a comprehensive village health plan with ANM, AWWs and PRI members. ASHA have to mobilise targeted community once in a month for the celebration of Village Health and Nutrition Days (VHND) at their Aanganwadi Centre.

5) **Escort services-** ASHA have to arrange escort/accompany pregnant women and children requiring treatment/ admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit.

6) **Treatment of Minor ailments** - ASHA is given a drug kit to provide primary medical care for minor ailments such as diarrhoea, fever, and first aid for minor injuries. ASHA also acts as DOTS providers under Revised National Tuberculosis Control Programme (RNTCP). The drug kit of ASHA also contains oral and emergency contraceptives along with condoms to be given discretely to the users in the community at a nominal cost.

7) **Depot Holder-** ASHA act as a depot holder for ORS, Iron Folic Acid (IFA) tablets, Chloroquine tablets, contraceptives, etc. Provision of drug kit has been made for ASHA.

8) **Vital events-** ASHA are expected to provide first information about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the SC/PHC/CHC or directly to the District Authorities or even to the State HQ at the NRHM Help Line.

9) **Maintain records:** Maintaining records which help her in organising her work and help her to plan better for the health of the people.

10) **Coordination:** For efficient functioning, ASHA should coordinate with women self help groups, VHSNCs of the Gram Panchayat, AWW and ANMs and support them in data updating, organising community based services. She should also regularly meet the ANM for improvement in quality of work and guidance. She should also attend monthly meeting organised by PHC medical officer for periodic reviewing of her work, timely disbursement of incentives and replenishment of kits. The staff at PHC and other public health facilities should also be sensitised to honour the referrals made by ASHA to build her credibility in the community.

2.3.2 Multi-Purpose Worker (MPW) – Male

The concept of Multipurpose Health Workers (Male and Female) was introduced in 1974 as per the recommendation of Kartar Singh Committee for the delivery of preventive and promotive health care services to the community through Sub-Centres (SCs) located at the population of 5000 in plains and 3000 in hilly and tribal areas.

The minimum qualification for MPW male is class XII pass with biology which can be relaxed in the notified tribal areas where the minimum educational qualification may be relaxed to Class X pass. The applicants should be below 25 years age. Relaxation in age limit has been provided to SC, ST, OBC and other categories. The applicant should preferably be resident of any of the villages within the Gram Panchayat, or in the event of no availability from any of the villages in adjoining Gram Panchayats/Blocks. The selection committee is constituted at the Block PHC level by the State government with a representation from the panchayat members.

Roles and responsibilities : Let us now read the roles and responsibilities in details:

MPW Male should make visit to the families allocated to him at least once in a month. His work should mainly focus on:

Prevention and control of following Communicable diseases and Epidemic

1) **Malaria** - During his home visit, he has to enquire about fever cases in each family and verify the cases diagnosed positive after the last visit. He Should
   - collect blood smears and performs rapid diagnostic test (RDT) from suspected fever cases
   - ensure immediate dispatch of collected blood smears for laboratory investigations
   - provide treatment to positive cases
   - refer seriously ill cases to visit PHC for immediate treatment
   - take necessary measures to contain the spread of disease as advised by PHC Medical officer.
   - work in coordination with ASHA / ANM/ Anganwadi worker for early detection of malaria
   - replenish the stocks of microscopy slides, drugs etc.
   - supervise the spraying operations and ensure the quality of spraying operations
   - maintain records for domiciliary visits, blood smears collected, patients given anti-malarial, details of spraying operations etc.
2) **Tuberculosis** - He Should be able to:
   - identify all cases of fever for over two weeks with cough with sputum and refer them to PHC along with verification of self reporting of the TB patients at health facilities
   - function as DOTS provider to ensure that all confirmed cases are on regular treatment
   - motivate defaulters for regular treatment
   - raise community awareness about tuberculosis and guide suspected TB cases for referral to the designated microscopy centres.
   - ensure that follow up sputum smear examinations are carried out as per the schedules
   - maintain the treatment cards
   - transmit the data weekly to the PHC.
3) **Leprosy** - He is trained to:
   - identify the suspected cases of skin patches with loss of sensation and refer them to PHC
   - ensure that the confirmed patients are put on adequate treatment and follow up for completion of treatment
   - refer leprosy patients with deformities for management at appropriate health facilities
   - coordinate with and supervise the ASHAs / Anganwadi Workers for early detection and management of leprosy
   - generate the awareness of the community on signs and symptoms of Leprosy for early detection

- maintain the records of domiciliary visits and treatment cards and transmit the data to the PHC.

As Community Health Officer, you are going to play major role above the staff working under you as a team leader. Hence, you must know other responsibilities of Multipurpose male worker which are given below:

- **Preventive Health Care** - He is responsible for surveillance for cases of diarrhoea, dysentery, fever, jaundice, diphtheria, whooping cough, tetanus, polio and other communicable disease and notify them to PHC. He should ensures availability of clean drinking water including by regular chlorination of all the drinking water sources. Therefore, he should periodically collect water samples for testing and undertake appropriate actions for provision of safe drinking water supplies. He should also be actively involved in generating awareness in the community regarding safe drinking water, sanitation, waste disposal and personal hygiene.
- **School Health -** He should regularly visit all the schools in the assigned area and promote health by educating the students on personal hygiene, nutrition, safe drinking water, sanitation etc. He assists ophthalmic assistant for eye screening of children for detection of visual defects. He identifies cases of malnutrition in school children and refers cases to PHC Medical Officer. He also guides teachers and parents on nutrition and anaemia. He also educates the community about nutritious diet for mothers and children from locally available foods.
- **Maternal Health and Family Planning** - He assists in ensuring timely referral, transport for pregnant women for emergency obstetric care. He motivates men for spacing methods and sterilisation methods and provides follow-up services for the acceptors.He also supports the ANMs and ASHAs in distribution of conventional contraceptives to eligible couples.

2.3.3 Auxillary Nurse Midwife (ANM)/ Multi-Purpose Worker (MPW) – Female

ANM also works at sub-centre level. She should pay at least one visit, once in two months to each household in the area. They report to the concerned medical officer through their supervisors (Lady Health Visitors). In the case of Block PHCs and CHCs, the reports are routed through Lady Health Supervisors.

Roles and responsibilities

1) **Maintenance of Records and Registers**- Comprehensive survey of all households under their sub-centre area is conducted by them during specified period. All households that qualify to be "beneficiary households" in her area are duly listed. This data should have separate details about migrant or nomadic population present in the area, houseless dwellers and individuals on visit to the area. Family and Village Records are also maintained by her. Separate record of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA) Services like immunisation, eligible couples, antenatal women is also maintained by her.

2) **Maternal and Child health**- Render care to pregnant women throughout pregnancy which includes counselling on nutrition, institutional delivery, distribution of Iron and Folic acid tablets, TT injection, identify high-risk cases and refer them. They are also trained to conduct deliveries and provide

family planning services including IUD insertion in the sub-centre and refer the women, in case required. They also pay postnatal visits to oversee health of mother and baby and educate mothers regarding family planning, nutrition, immunisation, personal hygiene, baby care etc. During the outreach session and in the sub-centre, while providing ante-natal care to mothers, she should conduct routine examination, weight recording, checking the blood pressure, urine examination, haemoglobin estimation and per abdominal examination in all pregnant women.

For promoting child health, they immunise the children and distribute Vitamin A syrup in the sub-centre and in the outreach sessions. They also assess growth and development of children and take necessary actions.

3) **Family welfare services-** She is responsible to contact eligible couples, educate and motivate them for accepting family planning methods. She distributes contraceptives, setup depot holders for contraceptive distribution and provide follow-up services to acceptors and timely identify complications and failures and advice the couple accordingly. She has to identify local leaders and educate them and utilise their services for raising community support. She organises and conduct meetings of Mahila Swasthya Sanghs (MSS) and provides guidance and supervision to these voluntary workers in health activities.

4) **Adolescent health-** Line listing and monitor adolescent girls for anaemia, malnutrition and take corrective steps by distribution of Iron Folic Acid (IFA) tablets in coordination with schools and Anagnwadis. They also arrange sessions to provide sex education, counselling and family life education to adolescent girls.

5) **Providing health services** - Arrange and assist the Medical officer in clinics during Antenatal and Immunisation clinics in the PHC and independently provide these services in the sub-centre.

6) **Nutritional Services** - Identify cases of malnutrition among children and refer them to nearest health facility or anganwadi centre for hospital or community based rehabilitation, whichever required. She should make regular visits to anganwadis for support and supervision. She should also educate families about nutritious diets and conduct nutrition education sessions and provide Iron Folic Acid(IFA) tablets for the anemic children and mothers.

7) **Immunisation**- After headcount, she maintains a list of all the beneficiaries for immunisation in her area. She conducts immunisation sessions for all children listed in the area. She helps supervisor in maintaining stock register, maintenance of cold chain and in distribution of vaccines. She educates the community about the importance of immunisation and encourages community participation.She organises and conducts special immunisation sessions also like National Immunisation Days (NIDs) as in "Pulse Polio" immunisation, "Mop up rounds" etc.

8) **Implementation of National Health Programmes**- She assists in implementation of various national health programmes like RNTCP, NVBDCP, NHM, JSY, NPCB, JSSK etc. by raising awareness, mobilising communities, participating as DOTS provider etc.

9) **Health education-** Educate community about health and diseases, personal hygiene, prevention of diseases and promotion of health by organising health talks, group discussions etc.

10) **Prevention and Control of communicable diseases-** Notify notifiable diseases and other diseases of public health importance to PHC medical officer. In case of outbreaks, she should actively carry out control measures like chlorination of water, distribution of ORS, DDT spraying, conducting mass survey etc.

11) **Curative Services-** Render first aid services and preliminary management of sick persons.

12) **Vital Events-** She educates the community about the importance of registration of births and deaths, and also records births and deaths in her area and gives information about deaths to the supervisor. Provide information about births/deliveries as well.

13) **School Health-** She assist in organising and conducting medical examination, immunisation session, nutrition and health education talks for school children.

14) **Medical Termination of Pregnancy-** Render assistance and guidance to females requiring Medical Termination of Pregnancy (MTP) ensuring safe abortion services and educating women about PCPNDT Act.

15) **Others-** To identify cases of hypertension and diabetes mellitus in the community and provide health education about prevention, detection, timely and proper management and complications. Assist in follow up and community rehabilitation of the mentally ill patients. She should attend staff meetings at PHCs, Block Offices or Panchayat Offices or at any other places or occasions as and when required or instructed. Attend sectoral and project level meetings of the ICDS. She is a member of VHSNC.

Check Your Progress 1

1) Fill in the blanks.
   a) One ASHA works for a population of .....
   b) IUD insertion at sub-centre level is done by .....
   c) The preferable age eligibility for MPW male is by.....

2) State true and false
   a) ASHA must be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
   b) ASHA is a permanent workers in health system at village level
   c) MPW male works mainly for control of communicable diseases at SC level.

3) List the steps for preparing weekly calendar.

   .....

   .....

4) List the advantages of weekly calendar.

   .....

   .....

2.4 VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE (VHSNC)

Village Health, Sanitation and Nutrition Committee (VHSNC) as shown in Fig. 2.1 has been constituted under National Health Mission (NHM) in rural areas to plan and implement activities at village level related to health and social determinants of health. The main purpose to set up VHSNC is to promote community involvement at local level so as to promote decentralisation in planning. This committee provides leadership and platform for addressing issues related to health services, raising community awareness and promoting community involvement.

VHSNC acts as a sub-committee of the Gram Panchayat having members from all stakeholders like panchayat members, community representatives, community health workers etc. Local ASHA residing in the village is member secretary and convener of the committee.

To ensure universal access to health care through strengthening health systems, various institutions and capabilities have been set up under National Health Mission.

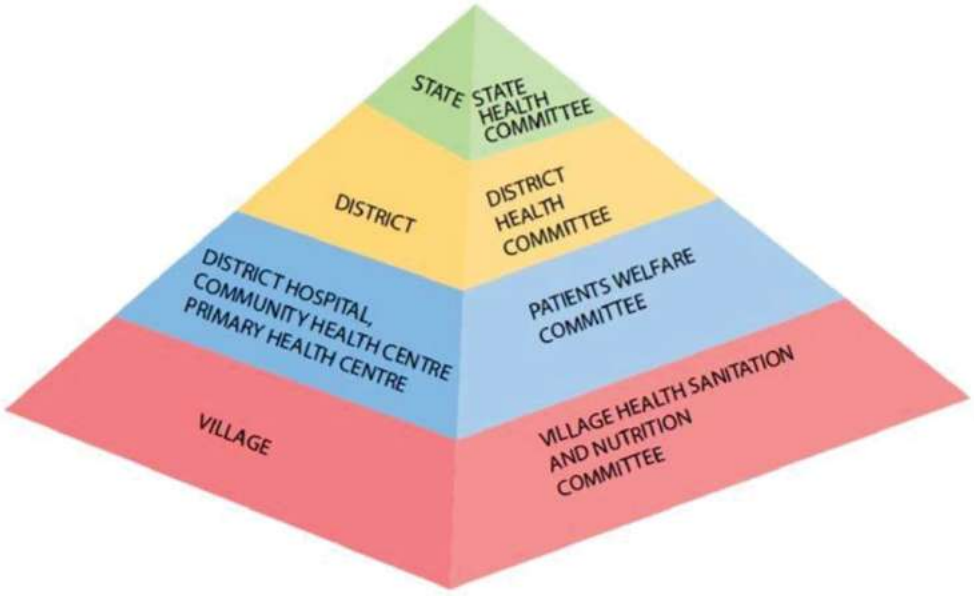


Fig. 2.1: VHSNC sub committee

These institutions aim for effective health planning at various levels. The VHSNCs serve as village level institutions for health planning and action for the marginalised and poor sections.

2.4.1 Objectives of VHSNC

Objectives of Village Health Sanitation and Nutrition Committee are to:

1) inform the community about the health programmes and government initiatives.
2) enable local community to participate in the planning and implementation of the programmes, and to take collective action for attainment of better health status in the village.

3) take action on social determinants of health.

4) facilitate the community to voice health needs, experiences and issues related to accessibility of health services such that the institutions of local government and public health service providers can take appropriate action.

5) equip Panchayats with the understanding and mechanisms required for them to play their role in governance of health and other public services and provide leadership to the community for collective action to improve health status.

6) provide support and facilitate the work of community health workers like ASHA and other frontline health care providers, who form a crucial interface between the community and health institutions.

7) monitor issues, status and action pertaining to nutrition in the community.

2.4.2 Constitution of VHSNC Members

Constitution of VHSNC Members includes the VHSNC is to be formed at the level of revenue village. Where the population of a revenue village is more than 4000, the VHSNC can be at the level of a Ward Panchayat. The Gram Panchayat members, ASHA, ASHA facilitator (or Block Mobiliser) and ANMs select members through a consultative process with the community at village level. The VHSNC functions under the ambit of the Panchayat Raj Institutions (PRI) as a subcommittee or a standing committee of the panchayat. In other words, VHSNC is co-terminus with Gram Panchayat of the village. Thus, it has to be re-constituted after a new panchayat is elected.

The VHSNC should have a minimum of 15 members and the members can be increased if needed. At least 50% should be women members and SCs, STs and minorities should be well represented. VHSNC can select new members to replace previous members or add a new member within the norms, by two thirds majority.

Following are members of VHSNC:

1) **Elected Gram Panchayat Members**: Those members who are residents of the village are preferred. In areas where there are no elected panchayats, members of tribal councils can be considered. The number of panchayat members is limited to one third of the total number of members, and preference is given to women panchayat members. Members of the permanent standing committees of the gram panchayat are preferred. The members of VHSNC are shown in Fig. 2.2.

2) **ASHAs:** All ASHAs of the village are members.

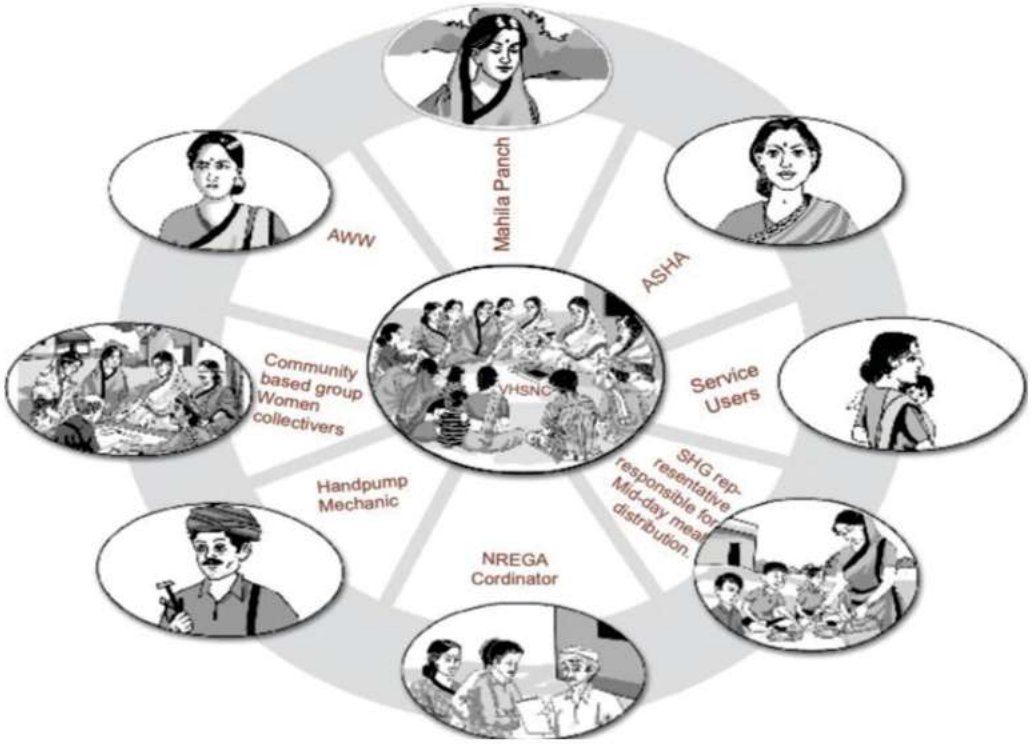


Fig. 2.2: Members of VHSNC

3) **Staff of government health related services:** The local ANM, the anganwadi worker, and the school teacher are members (if they are resident in that particular village). If not, they can be special invitees. Volunteers/village level workers of other government departments like hand pump mechanic of Public Health and Engineering Department (PHED) or the field coordinators of the MNREGA programme can be members if they are resident of the village.

4) **Community Based Organisations:** Representatives of community based organisations like self help groups, youth groups, etc. are also members.

5) **Pre-Existing Committees:** If there are separate committees on school education, water and sanitation or nutrition, they are integrated with VHSNC.

6) **Service-Users:** Pregnant females, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using the public services are also members.

Medical Officer of the local PHC, Facilitator of the ASHA Programme, Supervisors in health and ICDS departments, Panchayat secretary and Block Development Officer, Zilla and block panchayat member are special invitees. The Chairperson of the VHSNC is a woman elected member of the gram panchayat preferably from among the SC/ST communities, who is a resident of that village. If there is no woman panch from that village, then preference is given to any panch from the SC/ST. The ASHA is the Member-Secretary and Convener of VHSNC. If there are more than one ASHAs in the village, one of them is to be selected by consensus as Member-Secretary and convener. This could also be by rotation amongst the ASHAs after a two or three year period.

Once the VHSNC has been constituted, a bank account is opened in the nearest bank, in which the untied fund of the VHSNC is credited.The joint signatories of the VHSNC account are Chairperson of the VHSNC (female panchayat member) and the Member Secretary (ASHA). The decision on expenditure of united fund will only be done through a written approved proposal of the VHSNC with signatures of its members.

2.3 Activities of the committee



2.4.4 Participatory Learning And Action (PLA)

Heterogeneous nature of the community in the context of Rajasthan due to rigid caste and socio economic background of the population makes mobilization and community action difficult. So year 2020-21, Rajasthan initiated a pilot program in 10 districts of Rajasthan i. e. Ajmer, Jahalawar, Pali, Chittorarh, Udaipur, Baran, Banswara, Dungarpur, Rajsamand and Pratapgarah with the name of PLA. Participatory Learning and Action (PLA) approach and its tool can bring community together for a common goal beyond such inequities.

Participatory Learning and Action (PLA) approach is proposed to strengthen the existing platform of VHSNC. This will help in improvement of health indicators and uptake of responsibilities by the action committee of the village. Capacity building of ASHAs on ways and methodologies to impart their learning to the community to empower them can bring the desired result.



3 Participatory Learning and action (PLA) approach is based on principles of adult learning methods, where the learner is treated as a co-creator of knowledge. It is a problem solving approach that includes a combination of role play, story-telling, picture cards, demonstration and participatory tools. Each meeting builds on the previous meeting in such a way that the issues and discussions remain entwined.

This capacity building process helps community members to identify, understand and find feasible solutions and strategies to address common health problems in the community. It helps to build solidarity to work together cohesively, to plan to improve health in a way where community is at the centre and is done in a respectful way.

PLA is designed as an intervention that would empower groups and are likely to be more cost-effective and scalable than individually targeted health education programmes. The idea of PLA is to understand if peer groups could influence key behaviours in home care and care seeking to avert many preventable deaths and improve other health indicators.

2.4.5 Roles and Responsibilities of VHSNC Members

Let us now go through roles and responsibilities of various members.

1) **Chairperson of the Committee**

   a) The Chairperson is responsible for ensuring that meetings are held on monthly basis.

   b) She leads the monthly meetings of the committee and ensure smooth coordination amongst members.

   c) Represent the VHSNC in the Standing Committee of the Panchayat on health and share details of work undertaken by VHSNC.

   d) Guide the VHSNC to undertake village health planning (annual plan) and take responsibilities for actions and follow ups.

   e) Ensure that the issues emerging from village health monitoring and planning are reflected in the Gram Sabha and Gram Panchayat proceedings.

   f) To ensure adequate records maintenance.

2) **Member Secretary and Convener of the Meeting**

   a) To fix the schedule and venue for monthly meetings of the committee.

   b) Ensure that meetings are conducted regularly with active participation of all members.

   c) Draw attention of the committee on specific constraints and achievements related to health status of the village community and enable appropriate planning.

   d) Facilitate collection of information for village level planning like total population of the village, number of maternal and infant deaths, JSY/ JSSK beneficiaries, number of children immunised, malnourished children and those referred to Nutrition Rehabilitation Centre (NRC), number of households and details of families falling under marginalised groups such as- those below poverty line, SC/ST category, women headed households, landless families working as daily wage labourers, families living in distant hamlets, migrant labours and individuals with disability.

   e) Maintain records on gaps identified in health or other related sectors like cause of the gap, recording the decision on collective action required, and designating the persons responsible for leading the collective action, the specified timeframe to undertake the action, and recording follow up action.

   f) Ensure utilisation of the un-tied fund as per the decisions taken by the committee through regular disbursal of funds jointly with the Chairperson.

g) Provide information on activity wise fund utilisation to the committee every month and with bills and vouchers / documents on a quarterly basis.

h) Work with Chairperson for the annual presentation of the activities and

3) **The Anganwadi Worker**

a) Provide information on distribution of malnutrition status of children and presenting any specific challenges related to the functioning or any help she needs for improving effectiveness.

b) Help in mapping the marginalised households needing nutrition services and extends support in forming and implementing nutrition component of the village health plan.

c) Accountable for ensuring the provision of take home ration for children of less than three years, pregnant/lactating mothers, and supplementary food for children 3–6 years, and bringing the issues related to non-availability of supplementary nutrition before the committee.

d) Inform VHSNC of any difficulties she faces in providing Anganwadi services.

e) Accountable by the VHSNC for providing hot cooked meals.

4) **Auxiliary Nurse Midwife (ANM)**

a) Provide information to VHSNC regarding available services, schemes, and services for maternal and child health.

b) Share details on marginalized groups or those unreached through health services and seek the support of the VHSNC to reach these populations.

c) Inform the VHSNC on the deaths in the village, especially maternal and child death and their probable causes.

d) Facilitate the committee in preparing a village action plan to address the issue of reaching the marginalized and unreached groups with health services.

e) Inform VHSNC of any difficulties she faces in providing health services.

f) Accountable by the committee for smooth functioning of sub-centre and provision of quality services and regular conduct of VHND.

5) **Role of Representatives from other Departments Like Education, Water and Sanitation, and Department of Woman and Child Development**

VHSNC provides oversight and monitoring of their services to ensure convergent action on wider determinants of health such as drinking water, sanitation, female literacy, nutrition and women and child health. These representatives will inform VHSNC on various developments, enable VHSNC to monitor and take action on challenges faced in implementing the respective programmes.

6) **ASHA Facilitator**

The ASHA Facilitator helps in facilitating the VHSNC meeting. She is also responsible for collecting utilization certificates and other records for submitting to the BMO.

Roles and Responsibilities of VHSNC

VHSNC has following important functions to promote health status at village level-

1) **Village health planning** to plan, implement and monitor activities for health promotion in village.
2) **Monitoring of health care services**- Health care services in primary and secondary health care facilities.
3) **Organising local action for health promotion**- Motivating for community mobilization and utilising their support for improving health status like village sanitation, efforts for vector control etc.
4) **Nutrition**- To raise awareness about significance of nutrition and related nutritional issues as an important determinant of health. It also plan and undertake a community level survey on nutritional status of people and prevalent nutritional deficiencies among them especially women and children. It also identifies and disseminates information about locally available food stuffs of high nutrient value. The committee also conduct an in-depth analysis of causes of malnutrition at the community level by involving the ANM, AWW, ASHA and ICDS Supervisors. It facilitates early detection of malnourished children in the community and tie up referral to the nearest Nutritional Rehabilitation Centre (NRC).
5) **Monitoring and Supervision of Village Health and Nutrition Day**- To ensure that it is organised every month in the village with the active participation of the whole village.
6) **Supervise the functioning of Anganwadi**- In the village and facilitate its working in improving nutritional status of women and children.
7) **Grievances redressal forum on Health and Nutrition issues**- Organise Jan Samvads which are forum for dialogue between the community and the authorities.
8) **Management and Accounting of Untied Fund-** An untied fund of Rs. 10,000 is given annually to the VHSNC which can be used for nutrition, education, sanitation, environmental protection, public health measures.
9) **Record maintenance**- Monthly meetings, death register, birth register, village health register are to be maintained.

Role of Community health officer

This low-cost intervention can help build greater confidence among workers and committee members, enabling them to effectively present themselves and represent their committees on various platforms.

VHSNCs have specific roles and responsibilities to fulfill in their respective villages. Therefore, the performance of Community Health Officers (CHOs) can be assessed based on how well they support VHSNCs in carrying out these duties. The following indicators can be improved through the efforts of the CHOs:

1. Whether the VHSNC account is functional.
2. Whether VHSNC meetings are conducted monthly.

3. Percentage of utilization of untied funds.
4. Average number of VHSNC members attending monthly meetings.
5. Average number of community members attending monthly meetings.
6. Whether regular payments for VHSNC meetings are made to ASHAs.
7. Whether the Village Health Plan has been prepared.
8. Whether the mapping of all VHSNCs has been completed in the ASHA software.
9. Whether meeting minutes are properly recorded.

2.5 TEAM MANAGEMENT IN HEALTH SECTOR

A health team comprises of health workers who work together to deliver health care services for which they are mutually accountable. A team shares goals, are interdependent in their accomplishment, and they affect the results through their interactions with one another. Because whole team is held collectively accountable for goals, the work of integrating with one another is included among the responsibilities of each member. Teamwork in health care employs the practices of collaboration and good communication to help all health workers who are part of the team to make decisions as a unit that works toward a common goal.

Composition of health team

Health team is a multidisciplinary composition which consists of doctors (medical officer), Pharmacist, PHNs, LHVs, ANM, MPW (male), ASHA, Anganwadi worker (AWW), members of panchayat etc. Each member has specialised knowledge and skills, defined roles and responsibilities for various tasks. Targets can be set for each member as per the goal to be achieved.

Importance of team work

1) Team work enhance quality and efficiency of workers.
2) More chances of innovation as different team members has different expertise. For example, a community health worker who is well aware of local resources available and prevalent beliefs or level of awareness of a community can give valuable insight about acceptance of a particular health intervention in community.
3) Decision making becomes easier since all members can contribute.
4) When the responsibilities are shared among team members, team members experience lower levels of stress.
5) Members of team are much clearer about what their jobs entail because team working enables good communication and detailed negotiation of effective work roles.

Check Your Progress 2

1) Fill in the blanks.
   a) VHSNC plan and implement activities at village level related to health and .....
   b) The VHSNC should have a minimum of..... members)
      An untied fund of Rs. ..... is given annually to the VHSNC

2) State true and false.
   a) VHSNC acts as a sub-committee of the Gram Panchayat
   b) ASHA is a member of VHSNC
   c) Team management has limited role in health sector

3) List members of VHSNC.

   .....

   .....

4) Explain importance of team work.

   .....

   .....

2.6 LET US SUM UP

We have discussed about weekly work calendar, steps and advantages. Roles and responsibilities of various grassroot level health worker in detail.

Decentralisation is bottom up approach in health sector where health planning starts from village level. ASHA workers are considered as important intervention under NRHM who works at village level with MPW male and female. Important roles of theses grass root level workers are promotion of maternal and child health, vital registration, community survey, adolescent health and promoting sanitation and hygiene. VHSNC is village level institution for planning for health and its social determinants. It is composed of members from PRI, ASHA, MPWs and AWW with representation from disadvantageous sections of society.

Health team consists of doctor, ANM, ASHA and other staff. Effective team management is a important for achievement of health goals.

2.7 MODEL ANSWERS

Check Your Progress 1

1) a) 1000 b) MPW female c) less than 25 years

2) a) True b) False c) False

3) **Steps for preparing weekly work calendar**

- Make a blank table having rows and columns as per working hours and number of working days available in that week
- First column is number of working hours in a day
- Rows are prepared on hour wise basis starting from 9 am to 4 pm.
- Next 6 columns are days in a week
- The health worker then fill the table as per activities planned for the week like immunisation session, health talks, antenatal clinic, school health visit etc.

4) **Advantages of weekly work calender**

- Helps a worker to prepare his/her schedule in advance. This can also be shared with the supervising officer and can be used by them for monitoring and supportive supervision.
- Planning activities in advance increases the efficiency of the worker.
- Planning of activities on day to day basis results in wastage of health workers' precious time, thus planning in advance helps her/him to dedicate more productive hours to work with quality. S/He can also judiciously find time slots so that the pending work can be completed.

Check Your Progress 2

1) a) social determinants of health b) 15 c) 10,000

2) a) True b) True c) True

3) Elected Gram Panchayat Members, ASHAs, Government Staff, Representatives of community, members form school education, water, sanitation and service users such as Pregnant and lactating mothers etc.

4) Importance of team work

- Team work enhance quality and efficiency of workers.
- More chances of innovation as different team members has different expertise. For example, a community health worker who is well aware of local resources available and prevalent beliefs or level of awareness of a community can give valuable insight about acceptance of a particular health intervention in community.
- Decision making becomes easier since all members can contribute.
- When the responsibilities are shared among team members, team members experience lower levels of stress.
- Members of team are much clearer about what their jobs entail because team working enables good communication and detailed negotiation of effective work roles

UNIT 3 LEADERSHIP, SUPERVISION AND MONITORING

Structure

3.0 Introduction

3.1 Objectives

3.2 Leadership

- 3.2.1 Qualities of a Good Leader
- 3.2.2 Creating A Leadership Style For Transformational Change
- 3.2.3 How is a Leader Different from a Manager

3.3 Leadership in Health

- 3.3.1 Taking Control of Health of Community
- 3.3.2 Organising Health Camp

3.4 Supervision

- 3.4.1 Qualities of a Supervisor
- 3.4.2 Things Required for Supportive Supervision
- 3.4.3 Areas Covered During Supportive Supervision
- 3.4.4 Key Elements of Effective Supervision
- 3.4.5 Advantages of Supervision
- 3.4.6 Challenges in Providing Supportive Supervision

3.5 Monitoring

- 3.5.1 Concept and Process of Monitoring
- 3.5.2 Difference between Monitoring and Supervision

3.6 How to De-stress Yourself

- 3.6.1 Importance of De-stressing
- 3.6.2 Techniques of De-stressing

3.7 Let Us Sum Up

3.8 Key Words

3.9 References

3.0 INTRODUCTION

We operate in a knowledge worker economy, where the team is the competitive advantage, through the competency, ingenuity and agility of the team. A group of great individuals poorly led will be outperformed by an average team well led. Leadership matters just as much as the team matters. It is important to appreciate, understand and apply the concepts of transformational leadership in Leading others, through creating, and leading high performing teams.

As a mid- level health care provider your job involves observing the work of the ground level staff and collaborating with them for solutions. They are the most vital link between the community and health care system. It is very important to monitor performance and results on the ground. Supportive Supervision is a step ahead of monitoring. In this unit we will learn about the nuances of monitoring and supervision

3.1 OBJECTIVES

At the end of the unit, you will be able to:

- explain the meaning of leadership;
- list the types of leader;
- describe the qualities of a good leader;
- enumerate the differences between a leader and a manager;
- organise a health camp or other health related activities in your community;
- explain the meaning of monitoring and supervision;
- differentiate between the monitoring and supervision;
- discuss the various techniques of monitoring; and
- describe the methods of de-stressing yourself.

3.2 LEADERSHIP

"To lead people, walk behind them." - Lao Tzu'

A leader is a person who creates an inspiring vision of the future, motivates and inspires people to engage with that vision, manages delivery of the vision and coaches and builds a team, so that it is more effective at achieving the vision. Bernard M. Bass, a widely cited leadership expert, states that a leader is measured by the degree of influence s/he has on the followers or the team. Leadership brings together the skills needed to do these things. Good leadership is important for the success of any organisation.

3.2.1 Qualities of a Good Leader

A team is as good as the leader. A leader is as good as their team.

Leadership is an ecosystem of interdependence between the leader and the team.

An effective leader has following personalities traits:

- **High energy level and stress tolerance:** They have high levels of energy and can work effectively for long periods. They are also less affected by conflicts, crisis events and pressure. They are able to think relatively calmly in crisis situations and communicate that calmness and confidence to others.
- **Self-confidence:** They are optimistic and confident in the face of difficulties.They are more likely to deal with difficult situations rather than deny or avoid them. However, excessive self-confidence or self-esteem can make leaders prone to making risky or wrong decisions.
- **Internal locus of control:** They believe what happens around them is more under their control than the control of external forces and are motivated to take action to influence and control events. This is associated with a tendency to be proactive rather than passive.
- **Emotional maturity:** They have emotional maturity and intelligence in the sense that they are less prone to moodiness, irritability and angry outbursts. They are positive and optimistic, communicating their positivity to others. They are aware of their own strengths, weaknesses and typical reactions to situations.

- **Personal integrity:** High levels of personal integrity, along with honesty, transparency and trustworthiness are key characteristics of a good leader.
- **Achievement orientation:** High achievement orientation is associated with leadership effectiveness.
- **Low needs for affiliation:** This refers to the need to be liked and accepted by others, which effective leaders do not have.

3.2.2 Creating A Leadership Style For Transformational Change

"There are only two ways to influence human behavior: you can manipulate it or you can inspire it." - Simon Sinek

Transformational leaders inspire behavior change in their followers. the 4 Is of transformational leadership include:

1. **Inspirational motivation:** Inspirational motivation is when leaders inspire their followers to achieve. They inspire hope and courage. They give their team a vision of what is possible, and a sense of achievement.
2. **Idealized influence:** Idealized influence is when leaders act as strong role models for their team and lead by example, they are admired due to how they lead and conduct themselves. They give their followers a sense of aspiration.
3. **Intellectual stimulation :** Intellectual stimulation happens when leaders encourage their teams and stimulate creativity, innovation finding solutions. They create a learning environment and abandon outdated practices.
4. **Individualized consideration:** Individualized consideration is when leaders establish a strong relationship with their team. They are genuinely interested in each member of the team. They lead the individual and also lead the team collectively. They act as a supportive resource for the team.

3.2.3 How a Leader is Different from a Manager

"None of us is as smart as all of us." - Ken Blanchard

A team is as good as the leader. A leader is as good as their team. Leadership is an ecosystem of interdependence between the leader and the team.
Every team member brings who she/he is to work. The whole person means - head, heart and hands. However, many leaders, while wearing their managers' hat, only focus on the work i.e. the hands part of the individual, but they neglect the other parts that make a whole person, the heart and the head.

They miss to tap into the individual cognitive abilities, thinking, reasoning and information gathering skills and they also miss to tap and leverage the passions, commitment and interests of the individuals to drive inspiration, innovation and creativity.

Hence to be a good leader rather than a manager, we need to practice empathy and active social skills

Empathy : Empathy is the ability to understand and share the needs, feelings and thinking of another. Empathy is key to a leader ability to inspire, motivate and

influence the team.

Social skills – Hand in hand with empathy: Leadership happens in a social space. A leader utilizes empathy and social skills to foster healthy relations among the team members. A healthy team environment is critical to team performance and well being.

Practices to be a good leader:

Be Proactive	• See alternatives, no roadblocks • Be responsible for your own choices
Have a Vision	• Begin with clarity of result you want to achieve in the end, before you begin
Practice integrity in execution	• Focus on what is important, not just urgent • Plan weekly , act daily
Plan for WIN/WIN results	• Effective relationships require mutual respect and mutual benefit • Build trust with co-workers
Seek first to understand then to be understood	• To communicate effectively, start with listening • Be empathetic • Give and take honest feedback
Seek synergy through cooperation	• Collaborate to arrive at better solutions • Give due credit
Sharpen the Saw	• Continue to invest in constant learning • To maintain effectiveness, we must renew ourselves in body, heart, mind and soul

3.3 LEADERSHIP IN HEALTH

In health care setting leadership is central to improving the quality of health care and the improvement of organisational processes. In health care organisations the quality and safety of care is of paramount importance. For this to be achieved the leader who have the resources, influence, and control must provide these:

- A culture that fosters safety and quality
- Planning and provision of services that meet the needs of clients
- Human, financial, physical, and information resources for providing care
- Ongoing evaluation and improvement of performance

3.3.1 Taking Control of Health of Community

Healthcare systems is very large and complex. It is composed of numerous professional groups, departments, and specialties with intricate, nonlinear interactions between them.. Your leadership needs to capitalise on the diversity within the organisation.

3.3.2 Organising Health Camp

Health camps means that a team of health professionals 'camp' in an area to carry out a limited health intervention. This is one of the strategies adopted by both government and non-government organisations to provide health care services to the doorstep of the population. Following points should be kept in mind while organising a health camp in the community.

a) **Choosing the date and timing for the camp:** The success of the health camp depends upon the number of persons turning up for it. Choosing a day which is suitable for most of the local residents is vital for the effectiveness of the camp. The health camp should preferably take place on a holiday

42when most of the residents are expected to be in home. Preferably summer months should be avoided. The health camp should run for the entire day.

b) **Target population:** The health camp can be thematic. The target population may be female of reproductive age group, children, adolescents, geriatric population etc. Special efforts should be made to mobilise youth and women groups in the community for camps focusing on reproductive issues.

c) **Site of the camp:** The venue of health camp should ideally be situated in the center of the village or town. It should be readily accessible by public transport. There has been instances where despite the publicity the health camps had poor attendance just because it was located at some ground which was far from the center of the village where villagers had difficulty in commuting.

d) **Publicity of the health camp:** Much of the success of the health camp depends upon the number of individuals knowing about the camp. A good pre-planned publicity campaign will draw good attendance to the camp. All effort should be made to involve the local level media tools such as folk media, miking, announcements through village health and nutrition days (VHNDs,) Gram Sabhas etc. to publicise the health camp. The publicity should begin atleast 2 days before the scheduled health camp. The publicity activity should cover the entire catchment area of the camp adequately.

e) **Services at the health camp:** The services at the health camp should essentially include but not be limited to:

- General health checkup facilities and provision of medicines
- Antenatal checkups, immunisation can also be provided
- Information, Education and Communication Activities
- Health exhibitions

f) **Sensitisation of the key stakeholders:** The key and influential persons of the area should be told about the health camp. They may help in mobilising the population and help in conducting the camp smoothly. The plan of the health camp should be shared with them.

Check Your Progress 1

1) List common leadership approach in health care setting.

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2) Explain points to be kept in mind while organising a health camp in the community

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3.4 SUPERVISION

Supervision is the process of guiding, helping and encouraging staff to improve their performance so that they meet the defined standards of their organisation. Supervision can be either traditional or supportive. The traditional way of doing supervisory visits has several shortcomings. Thus performance improvement of the staff is not the objective of traditional supervision. Supportive supervision, on

the other hand promote sustainable and efficient programme management through interactive communication, as well as performance planning and monitoring. Table 3.2 shows some of the differences between traditional supervision and supportive supervision.

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimising the allocation of resources, promoting high standards, teamwork and better two-way communication. Supportive supervision involves directing and supporting healthcare workers in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the population they manage. It is an ongoing relationship between health care workers and their supervisors. Supportive supervision is recognised as critical part of human resource management for the delivery of quality health care services.

Table 3.4: Comparison of Traditional and Supportive Supervision

Action	Traditional Supervision	Supportive Supervision
Who performs supervision	External supervisors	External supervisors Staff from other facilities Colleagues from the same facility (Internal supervision) Community health committees Staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	**Continuously:** During routine work Team meetings Visits by external supervisors
How do supervisors prepare	Little or no preparation	Supervisors review previous supervisory reports Supervisors review reported achievements Supervisors decide before the supervision visit on what they need to focus on
What happens during supervision	Inspection of facility Review of records and supplies Supervisor makes most of the decisions Reactive problem-solving by Supervisor Little feedback or discussion of supervisor observations	Observation of performance and comparison to standards Provision of corrective and supportive feedback on performance Discussion with clients Provision of technical updates or guidelines On site training Use of data and client input to identify opportunities for

Action	Traditional Supervision	Supportive Supervision
		improvement Joint problem solving Follow-up on previously identified problems
What happens after supervision	No or irregular follow-up	Actions and decisions recorded Ongoing monitoring of weak areas and improvements Follow -up on prior visits and problems

3.4.1 Qualities of a Supervisor

A supervisor should possess these qualities in order to do his/her job well:

- She/He should be very familiar with health care system prevailing in his area
- She/He should have ability to address both administrative and programmatic issues of the health problems
- She/He should be committed, responsible and have strong interpersonal skills
- She/He should have the ability to train, motivate and support staff
- She/He must be flexible, respectful and should have hard working attitude
- She/He should have patience to listen carefully
- She/He should probe into the problems, analyse the situations and formulate solutions to overcome it
- She/He should have ability to provide and receive feedbacks after each visit and write reports

3.4.2 Things Required for Supportive Supervision

The main resources required for an effective supportive supervision are:

- Transport which should be reliable and should be available whenever required
- Sufficient time for preparation, travel, field visit, reporting and follow-up activities
- Supportive supervision tools (like checklist, standard operating procedures and guidelines) and stationery
- Support for periodic review meetings

3.4.3 Areas Covered During Supportive Supervision

Supporting supervision includes looking after the entire aspect of the programme. These can be covered under following headings:

A) Patient care:

- Coverage of health services in a given region
- Referral system and linkages
- Availability of policies, guidelines, standard operating procedures, Job aids, manuals and IEC materials at the health centre

*B) **Health infrastructure:***

- Facility and equipment
- Utilities such as water, electricity and communication facilities
- Privacy to patient as and when required

*C) **Human resources for health:***

- Staff adequacy, availability of trained staff
- Training and staff needs
- Short- and long-term plan

*D) **Logistics and resource management:***

- Availability and adequacy of medicines, lab reagents and other commodities
- Availability of reliable transport
- Sources and management of funds
- Implementation status of different health programmes

*E) **Monitoring and Evaluation:***

- Records and documentation system
- Patient records, registers/forms
- Data management

3.4.4 Key Elements of Effective Supervision

For a supervision system to be effective, there are a number of elements that needto be present:

1) **Management Commitment:** Supportive supervision is an integral part of any health programme. It should be given equal importance and separate resources should be allotted for this activity.

2) **Standards of Performance:** For supervision to be effective, the supervisor should have knowledge about the work profile of the staff. Unless he has the knowledge about the work of the ground staff he cannot supervise and comment on the performance of the staff.

3) **Planning for Supervision:** Proper planning prevents poor performance. Just like any activity supervision should start only when there is a planning in place. Planning should be practical and include resources available to the supervisor.

4) **Preparation for Supervision:** All the tools required for supervision should be made available beforehand. This involves availability of transport, check lists, documents amongst other things.

5) **Stakeholder Involvement:** All the relevant persons involved in the programme should be informed about the impending supervision prior to the activity. They should be involved in the activity on as and when required basis. This helps in conducting the supervision smoothly. The stakeholders become accountable also and has a sense of belonging to the programme.

6) **Supervisory Tools:** The supervisory tools help to ensure that all key areas are covered.

7) **Documentation of Supervisory Findings:** All the steps involved in supervision should be recorded meticulously. The results and findings should be recorded in detail. Any on-site training given should also be recorded. It is important that only those information and data which are important for programme purpose should be collected and recorded. Unnecessary data collection just lengthens the report and serve no purpose. The vital information may be lost in that case.

8) **Preparation of an Action Plan:** Follow-up activities after the supervision is as important as supervision process. Process of supervision is shown in Fig.3.1 given ahead. The supervisor should prepare an action plan following the field work. This plan include work to be done at later stage and should be prepared in consultation with the ground staff.

9) **Sharing of Supervision Findings:** The findings should be shared with supervisors and relevant officials. This ensures that all staff are aware of results, including actions to be taken.

10) **Self-Assessment:** Periodic self-assessment should be done by the staff himself to prepare for the supervisory visit by external assessor. This will help them in facing the supervision process by external team more efficiently and confidently.

3.4.5 Advantages of Supervision

There are many proven advantages of supportive supervision. Some of these are:

- Supportive supervision helps service providers to achieve work objectives by improving their performance
- It ensures uniformity to set standards
- It helps in identifying problems and solving them in a timely manner
- It helps in making a follow-up on decisions reached during previous supervision visit
- It also identifies staff needs and provides opportunities for personal development
- It reinforces administrative and technical link between high and lower levels

Box: Effective behaviours for encouraging performance improvement

Behaviours that are helpful in gaining the commitment of the supervisees to make efforts in order to improve performance are:

1) Supervision should be facilitative, not fault-finding.
2) Always praise work well done before raising problems.
3) If you see a problem, check to see if the supervisee sees the same problem.
4) Analyse problems with the supervisee to gain a good understanding of the underlying causes.
5) Let the supervisee suggest possible solutions. This facilitates ownership and acceptance of the solutions.

3.4.6 Challenges in Providing Supportive Supervision

Some of the challenges in providing supportive supervision of health programmes in our country are:

- Lack of a standardised approach to supportive supervision
- Lack of adequate and reliable financial resources
- Shortage of human, financial and time resources
- Lack of technical skills and work overload among health care workers
- Vertical, uncoordinated intervention-specific supervisory activities

Setting up a supportive supervision system

- Training a core set of supervisors
- Creating checklists and recording forms
- Ensuring appropriate resources are available – vehicles, per diem, areas for collaboration with other programmes

Planning regular supervisory visits

- Where: using data to decide priority supervision sites
- When: schedule supervision visits using a work plan
- What subjects to train: identify training needs and skills that need updating

Conducting supportive supervision visits

- Observation
- Use of data
- Problem-solving
- On-the-job training
- Recording observations and feedback

Follow-up

- Follow up on agreed actions by supervisors and supervised staff
- Regular data analysis
- Feedback to all stakeholders

Fig. 3.1: Process of supervision

3.5 MONITORING

Let us discuss concept and process of monitoring.

3.5.1 Concept and Process of Monitoring

Monitoring is a process of measuring, recording, collecting and analysing data on actual implementation of the programme and communicating it to programme

managers so that any deviation from the planned operations are detected, diagnosis for causes of deviations are made and suitable corrective actions are taken. For any monitoring to be effective, first a plan for the district health programme needs to be prepared. Such a plan would specify what needs to be done, who is going to do it and when. During the course of implementation, monitoring can help identify whether activities are being implemented as planned and if not then reasons for such deviation.

The word monitoring instils fear in the staff. There is opposition to monitoring due to the fear that it can expose the deficiencies in working both at worker and supervisor level. But monitoring is essential in running a programme efficiently. Timely submission of appropriate amount of data to higher authority is essential for effective monitoring. The staff should be given feedback after the monitoring. Workers are motivated if they receive the feedback.

The monitoring process comprises of:

- **Detecting deviation from the plan:** The monitor should compare the activities with the standard of procedure, if there is one or the micro plan. He should know what should be measured. It is important to measure major input, activities and outputs. Everything need not be measured frequently. Some crucial points need daily monitoring, for some other activities yearly monitoring is enough.
- **Diagnosing causes of deviations:** After finding out the deviations look for the reasons of it. In-depth analysis of the deviation should be done. The staff may not always be at fault all the time. At the same time staff may put blame on someone else or find some excuse for the deviation. The problem areas should be investigated thoroughly so that it is not repeated.
- **Taking corrective actions:** Corrective actions depend upon the level of the deviations. The mid-level health provider can take corrective action at the spot without informing his superior if the deviation is small and does not harm the programme in a major way. But he should inform the authority during reporting if the deviation is major one or repetitive in nature.

3.5.2 Difference between Monitoring and Supervision

The difference between monitoring and supervision is that monitoring is usually concerned with aspects of the programme that can be counted, whereas supervision deals with the performance of the people working within the programme including giving them support and assessing conditions in the health facility.

Some aspects of monitoring are closely connected to supervision. During the supervisory visit, the supervisor can monitor by taking notes and recording data, such as how many trained healthworkers at the session are giving injections according to the protocols, and the vaccines and supplies available. However, a person who monitors does not always come in contact with the staff, for example, when reviewing reports to count the number of health workers who attended training.Thus, supervision must involve interaction with staff, and usually also has an element of monitoring. Monitoring does not often or automatically have a supervisory element.

Table 3.5 : Differences between monitoring and supervision

Monitoring	Supervision
Episodic in nature	Continuous process
Narrow meaning	Wider (includes monitoring)
May not involves interaction with humans	Always involves interaction with staff

Check Your Progress 2

Choose the best option:

1) The attitude of supervisor towards the health workers should be
   a) Strict and controlling
   b) Submissive and requesting
   c) Polite and listening
   d) Based on situations

2) Monitoring means
   a) Regular observation and recording of activities taking place in a project or a programme so as to facilitate feedback and improved performance
   b) Process of helping staff to improve their own work performance
   c) Controlling all processes related to the delivery of services and not just the final activities
   d) A systematic approach for compiling the information

3) What are the features of 'Supportive Supervision'?
   a) More like a teacher, coach, mentor
   b) Focus on improving performance
   c) Follow up regularly
   d) All of the above

4) As a manager, your role is to provide constant oversight to ensure that health workers and service providers deliver programme objectives. This can be provided by
   a) Supervision
   b) Episodic problem solving
   c) Authoritarian inspection
   d) Supportive Supervision

5) Differentiate between a leader and a manager.

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3.6 HOW TO DE-STRESS YOURSELF

Working hard has its disadvantages too. Sometimes we get involved so much in our work that we forget to relax and it shows physically and mentally. Work can be demanding and if we do not maintain a proper balance between the professional and personal life our health will deteriorate.

3.6.1 Importance of De-stressing

Stress can develop through many ways at the work place. The most common cause of stress is not meeting the expectations of the superiors. This can be in the form of not meeting the target, not able to visit a place, staff not listening to you etc. Sometimes personal problems can have bearing on your work. Stress produces a hormone in our body which causes physiological changes inside. Recurrent or chronic stress produces changes which may become irreversible. Physical ailments following stress are hypertension, peptic ulcer diseases and headaches. Stress can lead to some mental conditions like depression and anxiety disorders. It has been proven that stress makes some diseases like bronchial asthma, irritable bowel syndromeworse. Stress can also lead to insomnia which has a cascading effect on health. Thus it becomes very important to de-stress ourselves on regular basis and maintain good health.

3.6.2 Techniques of De-stressing

Here are some ways to de-stress yourself. Each of these is backed by sound scientific evidences.

1) ***Deep breathing exercise:*** Breathing exercise or *pranayama* helps us to relax. Taking a few deep breaths helps in reducing the tension and relieves stress due to an extra boost of oxygen entering the lungs. Clinical research has shown that deep breathing exercise reduces the high blood pressure.
2) ***Listen to some music:*** Your favourite music slows heart rate, lowers blood pressure and decreases levels of stress hormones.
3) ***Have a good laugh:*** It may sound cliché but it is true that 'laughter is best medicine'. Find time in between the work schedule to laugh for a while.
4) ***Alternative contracting and relaxing muscles:*** Tighten your foot muscles as much as you can, then relax them. Then go up and do this exercise for all the voluntary muscles of your body.
5) ***Meditation:*** Performing different *asanas* specific for stress is stress buster and has been found effecting in different trials. Meditation is a great way to calm the mind.
6) ***Have a walk:*** Just ten minute of brisk walk and not thinking about the work has positive impact on our body. Monitor own time and work hours; take responsibility for personal rest and renewal.

These are the methods to improve yourself:

1) Set personal growth goals and follow plan to attain them
2) Get and use a mentor or coach. Ask for help
3) Learn to delegate work
4) Understand your own style of learning, approach to power and to problems, dealing with criticism and conflict

3.7 LET US SUM UP

In this unit you have learned about the three important aspects of your work: leadership, monitoring and supervision. As a mid-level health care provider you play an important part in connecting the ground level health care worker with your superiors. We cannot work in isolation. Providing health care to community is a team work. Again, in a team not all players do same things. Each player has different role to do. Here comes the role of hierarchy in a team. You have to play a leader role while leading your team. Basic qualities of effective leader are mentioned in the unit. Though we live in a target free era, we have to work towards achieving some goals for which there are targets and indicators. You have to monitor the performance of the staff and see their performance level. Supervision should be supportive one and not a fault finding exercise. You may have to find immediate solutions to problems faced by staff and train them on spot. All these work can have bad effects on your health. Thus it is important to de-stress yourself on daily basis by doing deep breathing exercise. There are other proven techniques too de-stress yourself. Doing yoga is one of them. During counselling it is important to keep yourself in client's shoes but remember to put it off at the end of your work. In this way you will be an effective health care provider and will definitely become an asset for your organisation.

3.8 KEY WORDS

IEC : Information education and communication. A public health approach aiming at changing or reinforcing health-related behaviours in a target audience, concerning a specific problem and within a pre-defined period of time, through communication methods and principles.

Job aids : An external device that provides just-in-time knowledge and information to help individuals with tasks by directing, guiding, and enhancing performance.

Leadership : Process of influencing the activities of an organised group in its efforts towards goal setting and goal achievement.

Mentoring : System of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes.

Monitoring : A management function which uses a methodical collection of data to determine whether the material and financial resources are sufficient, whether the people in charge have the necessary technical and personal qualifications, whether activities conform to work plans, and whether the work plan has been achieved and had produced the original objectives.

Motivation : An individual's degree of willingness to exert and maintain an effort towards organisational goals.

Performance management : A continuous process of identifying, measuring and developing the performance of individuals or teams and

aligning that performance to the strategic goals of the organisation.

Supportive supervision : A process that uses dialogue and constructive feedback to help staff to improve their performance in pursuit of the organisation's mission, while also setting goals for growth and development.

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UNIT 4 HEALTH MANAGEMENT INFORMATION SYSTEM

Structure

4.0 Introduction

4.1 Objectives

4.2 Uses of Health Management Information System (HMIS)

4.3 Components of HMIS

- 4.3.1 Data Elements
- 4.3.2 Recording and Reporting Formats
- 4.3.3 Data Compilation
- 4.3.4 Data Flow
- 4.3.5 Logistics and Technology
- 4.3.6 Analysis of Data and Indicators
- 4.3.7 Feedback

4.4 Data Quality

4.5 Let Us Sum Up

4.6 Model Answers

4.7 References

4.0 INTRODUCTION

Health Management Information System is an essential component of health caresystem. It forms a base upon which the health services can be moulded and improved upon. It deals with data related to health, their generation, transmission, output and finally the dissemination and feedback, to make full utilisation of such a system. It can range from a collection of data in a paper form and passing it on to the next level or in a modern world, a complex network of data collection, entry, software, internet, data analysis and reporting. For a health manager, understanding the importance of health information and ability to manage it becomes a vital function to bring about positive changes in health care.

4.1 OBJECTIVES

By the end of this unit, the learner should be able to:

- explain the concept of HMIS;
- enumerate the uses of HMIS;
- describe on the components of HMIS; and
- describe data errors and ways to ensure quality of data;

4.2 USES OF HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

HMIS has many purposes, depending upon the level at which it is analysed and utilized. It helps to:

1) Make sense of the data that is collected for various programmes

2) Monitor and evaluate health services and programmes
3) Provide feedback to the health facilities about their own performance individually
4) Compare performance of neighbouring blocks, regions, states, etc.
5) Prepare reports for the block, district, state and country regarding health status and give a clear picture of progress
6) Implement corrective measures in the services and programmes to improve efficiency
7) Reveal the areas that are weak and focus on them for intervention and research.

4.3 COMPONENTS OF HMIS

After going through the uses of HMIS, let us now read in details about various components of HMIS as follows:

4.3.1 Data Elements

Data elements: The basic unit in HMIS is data, and data element is a record of a health event or a health related event. The number and nature of data elements collected at each level will vary. It depends upon the services provided by that level.

Each of these data elements will represent one aspect of health care e.g. institutional delivery, and a collection of these will represent one component of a health programme e.g. maternal health will be represented by place of delivery, antenatal care, postnatal care, complications after childbirth, etc. These data elements will be the ones that will feature in the facility's reports.

Table 4.1: Number of data elements at facility level formats

Facility Code	Name of data item	No. of data item at SC level	No. of data item at PHC level
Part A	REPRODUCTIVE AND CHILD HEALTH		
M1	Ante Natal Care (ANC) Services & High Risk Pregnancies	8	9
M2	Deliveries	6	6
M3	Number of Caesarean (C-Section) deliveries	-	1
M4	Pregnancy outcome & details of new-born/children	5	5
M5	Anaemia Mukt Bharat	2	2
M6	Post Natal Care (PNC)	6	6
M7	Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI) Cases	1	1
M8	Family Planning	15	19
M9	CHILD IMMUNISATION	8	8
M10	Number of cases of Childhood Diseases	1	2
Part B	National Programmes		
M11	National Vector Borne Disease Control Programme(NVBDCP)	2	3
M12	Adolescent Health	2	3
Part C	Health facility Services		
M13	Patient Services	13	18
M14	Diagnostics	4	6
Part D	Mortality Details		
M15	Details of deaths reported	9	9
Part E	Quality Control		
M16	QA (Quality Assurance) & BEMMP (Biomedical Equipment Management & Maintenance Program)	1	2

Data element need to be specific and well defined, or else it can lead to inaccurate data and wrong reporting. Following are the data elements and their brief details contained in the reporting format of a sub-centre shown in Table 4.1. It has five parts:

Part A Reproductive and Child Health (M1-M10)
Part B National Programmes (M11-M12)
Part C Health facility Services (M13-M14)
Part D Mortality Details (M15)
Part E Quality Control (M16)

Table 4.2: Data elements in the reporting format of sub-centre

Facility Code	Data Item	Numbers reported during the month (In-facility)	Numbers reported during the month (Outreach)
Part A	**REPRODUCTIVE AND CHILD HEALTH**		
M1	**Ante Natal Care (ANC) Services & High Risk Pregnancies**		
1.1.	Total number of NEW Pregnant Women registered for ANC		
1.1.a	Out of total number of NEW pregnant women registered with age less than <15 years		
1.1.b	Out of total number of NEW pregnant women registered with age 15-19 years		
1.1.c	Out of total number of NEW pregnant women registered with age more than >19 to 49 years		
1.1.d	Out of total number of NEW pregnant women registered with age more than >49 years		
1.1.1.	Out of the total NEW ANC registered, number registered within 1st trimester (within 12 weeks)		
1.1.2	Total ANC footfall/cases (Old cases + New Registration) attended		
1.2	**ANC services**		
1.2.1.	Number of PW given Td1 (Tetanus Diptheria dose 1)		
1.2.2.	Number of PW given Td2 (Tetanus Diptheria dose 2)		
1.2.3.	Number of PW given Td Booster (Tetanus Diptheria dose booster)		
1.2.4.	Number of PW provided full course 180 Iron Folic Acid (IFA) tablets		
1.2.5.	Number of PW provided full course 360 Calcium tablets		
1.2.6.	Number of PW given one Albendazole tablet after 1st trimester		
1.2.7.	Number of PW received 4 or more ANC check ups		
1.2.8.	Number of PW given ANC Corticosteroids in Pre-Term Labour		
1.3	**Pregnant Women (PW) with Hypertension (BP>140/90)**		
1.3.1.	New cases of PW with hypertension detected		
1.3.2.	Number of New Pre-Eclampsia/Eclampsia cases identified		
1.4	**Pregnant Women (PW) with Anaemia**		
1.4.1.	Number of PW tested for Haemoglobin (Hb) 4 or more than 4 times for respective ANCs		
1.4.2.	Number of PW tested for Haemoglobin (Hb)		
1.4.3.	Number of PW having Hb level<11(7.1 to 10.9 g/dl) (Out of total tested cases)		
1.4.4.	Number of PW having Hb level<=7 g/dl (Out of total tested cases)		
1.5	**Pregnant Women (PW) with Gestational Diabetes Mellitus (GDM)**		
1.5.1.	Number of PW tested for Blood Sugar using OGTT(Oral Glucose Tolerance Test)		
1.5.2.	Number of PW tested positive for GDM out of total OGTT(Oral Glucose Tolerance Test) conducted		
1.6.	**Pregnant Women (PW) with Syphilis**		
1.6.1	**Syphilis test conducted for Pregnant Women**		
1.6.1.a	Number of pregnant/Direct-In-Labor (DIL) women screened/tested (with VDRL/RPR/TPHA/RDT/PoC) for Syphilis		

1.6.1.b	Number of pregnant/DIL women found seropositive for Syphilis by VDRL/RPR/TPHA/RDT/PoC test		
1.6.1.c	Number of pregnant/DIL women found Syphilis-Seropositive and given treatment with injection Benzathine Penicillin (IM)		
1.6.1.d	Number of live births among Syphilis seropositive Pregnant Women		
1.6.1.e	Number of babies born to Syphilis-Seropositive Pregnant Women tested positive/ clinically diagnosed for congenital Syphilis		
1.6.1.f	Out of above, babies with congenital Syphilis received curative treatment		
1.7.	**Tuberculosis test conducted for Pregnant Women**		
1.7.1.	Number of Pregnant Women screened for TB		
1.7.2.	Number of Pregnant Women identified with Presumptive TB symptoms		
1.7.3.	Number of Pregnant Women referred out of those identified with Presumptive TB symptoms		
1.8.	**High Risk /Complicated Pregnancies**		
1.8.1.	Total High Risk Pregnancy (HRP) Intrapartum including following:		
1.8.1.a.	Number of Pregnant Women only with Post-Partum Haemorrhage (Immediately after delivery) in the facility		
1.8.1.b.	Number of Pregnant Women only with Sepsis in the facility		
1.8.1.c.	Number of Pregnant Women identified only with Eclampsia in the facility		
1.8.1.d.	Number of Pregnant Women identified only with obstructed labour in the facility		
1.8.1.e.	Number of Pregnant Women identified with more than 1 complication listed above		
1.8.2.	Total High Risk Pregnancy (HRP) Antepartum (Only New Cases are to be reported)		
1.8.3.	Total no. of highrisk ANC cases referred to Higher/ any other facility (Referred out)		
1.8.3.a	Total no. of Intrapartum/PNC High Risk Pregnancy cases referred to Higher/ any other facility (Referred out)		
M2	**Deliveries**		
2.1.	**Deliveries conducted at Home**		
2.1.1.	Number of Home Deliveries attended by		
2.1.1.a	Number of Home Deliveries attended by Skill Birth Attendant(SBA) (Doctor/Nurse/ANM)		
2.1.1.b	Number of Home Deliveries attended by Non SBA		
2.1.2.	Number of PW given Tablet Misoprostol during home delivery		
2.2.	Number of Institutional Deliveries conducted (Including C-Sections)		
2.2.1.	Out of total institutional deliveries(excluding C-section), number of women stayed for 48 hours or more after delivery		
2.2.2.	Out of total Institutional deliveries, number of Institutional Deliveries (Excluding C-Sections) conducted at night (8 PM- 8 AM)		
2.3.	**Age wise total number of delivery (Home +Institutional) reported (2.3.1+2.3.2+2.3.3+2.3.4)**		
2.3.1.	Out of total number of delivery, PW with age less than <15 years		
2.3.2.	Out of total number of delivery, PW with age 15-19 years		
2.3.3.	Out of total number of delivery, PW with age more than >19-49 years		
2.3.4.	Out of total number of delivery, PW with age more than > 49 years		
2.4.	Number of newborns received 6/7 HBNC visits after Delivery (Home+ Institutional)		
2.5.	No. of identified Sick new-borns referred by ASHA to facility under HBNC Programme		
2.6.	Total number of Children received all scheduled 5 Home visits under HBYC		
M3	**Pregnancy outcome & details of new-born/children**		
3.1.	**Pregnancy Outcome (in number)**		
3.1.1.	**Live Birth**		
3.1.1.a	Live Birth - Male		
3.1.1.b	Live Birth - Female		
3.1.2.	Number of Pre-term newborns (< 37 weeks of pregnancy)		
3.1.3.	**Still Birth**		
3.1.3.a	Intrapartum (Fresh) Still Birth		

3.1.3.b	Antepartum (Macerated) Still Birth		
3.2.	Abortion (spontaneous)		
3.3.	**Post-abortion/MTP Complications**		
3.3.1	Total Post-abortion/MTP Complications Identified		
3.3.2.	Post-abortion/MTP complications identified (where abortions were carried out in facilities other than public and accredited private health facilities)		
3.4.	**Details of Newborn children**		
3.4.1.	Number of Newborns weighed at birth		
3.4.2.	Number of Newborns having weight less than 2500 gms		
3.4.2.a	Out of the above, number of Newborns having weight less than 1800 gms		
3.4.3.	Number of Newborns breast fed within 1 hour of birth		
3.4.4.	No. of Newborns discharged from the facility were exclusively breastfed till discharge		
3.5.	**Rashtriya Bal Swasthya Karyakram (RBSK)**		
3.5.1	Number of Newborns screened for defects at birth (as per Comprehensive Newborn Screening, RBSK)		
3.5.1.a	Number of Newborns identified with visible birth defects (including Neural tube defect, Down's Syndrome, Cleft Lip & Palate, Club foot and Developmental dysplasia of the hip)		
M4	**Anaemia Mukt Bharat**		
4.1.	**IFA Coverage**		
4.1.1.	Number of women of reproductive age (WRA) 20-49 years (non-pregnant, non-lactating), provided 4 Red Iron and folic acid (IFA) tablets in a month		
4.1.2.	Number of children (6-59 months old) provided 8-10 doses (1ml) of IFA syrup (Bi weekly)		
4.1.3.	**Number of children 5-9 years provided Weekly Iron Folic Acid (IFA Pink) tablets in a month**		
4.1.3.a	Number of out of school children (5 -9 years) given 4-5 IFA Pink tablets at Anganwadi Centres		
4.2.	**Anaemia- Identified & Treated**		
4.2.1	**Beneficiaries identified with Mild and Moderate Anaemia**		
4.2.1.a	Number of out of school adolescent girls (10-19 years) having anaemia (Hb 8.1-11.9 g/dl)		
4.2.1.b	Number of lactating mothers (of 0-6 months old child) having anaemia (Hb 8.1-11.9 g/dl)		
4.2.1.c	Number of women of reproductive age (non-pregnant, non-lactating) (20-49 years) having anaemia (Hb 8.1-11.9 g/dl)		
4.2.2.	**Beneficiaries identified with Severe Anaemia**		
4.2.2.a	Number of out of school adolescent girls (10-19 years) having severe anaemia (Hb <8 g/dl)		
4.2.2.b	Number of lactating mothers (of 0-6 months old child) having severe anaemia (Hb <8 g/dl)		
4.2.2.c	Number of women of reproductive age (non-pregnant, non-lactating) (20-49 years) having severe anaemia (Hb <8 g/dl)		
4.2.3.	**Beneficiaries diagnosed with mild and moderate Anaemia, put on treatment**		
4.2.3.a	Number of anaemic in-school Children (5-9 years) put on treatment		
4.2.3.b	Number of anaemic in-school adolescent girls (10-19 years) put on treatment		
4.2.3.c	Number of anaemic out of school adolescent girls (10-19 years) put on treatment		
4.2.3.d	Number of anaemic in-school adolescent boys (10-19 years) put on treatment		
4.2.3.e	Number of anaemic lactating mothers (of 0-6 months old child) put on treatment		
4.2.3.f	Number of anaemic women of reproductive age (non-pregnant, non-lactating) (20-49 years) put on treatment		
M5	**Post Natal Care (PNC)**		
5.1.	In case of home delivery, number of women receiving 1st Postpartum checkups within 48 hours		
5.2.	Number of women receiving Postpartum checkup between 48 hours and 14 days after Institutional delivery		
5.3.	Number of mothers provided full course of 180 IFA tablets after delivery		
5.4.	Number of mothers provided full course 360 Calcium tablets after delivery		
5.5.	Total No of High Risk Mothers identified during Post Natal Period		
5.6.	Out of above identified number of High Risk Mothers managed (including referred in cases)		

M6	Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI) Cases		
6.1.	**Number of new STI/RTI cases identified**		
6.1.1.	Number of males assessed for STI/RTI		
6.1.1.a	Out of the above, number of males diagnosed with STI/RTI		
6.1.1.b	Out of the above, number of males treated for STI/RTI		
6.1.2.	Number of females (all females) assessed for STI/RTI		
6.1.2.a	Out of the above, number of females (all females) diagnosed with STI/RTI		
6.1.2.b	Out of the above, number of females (all females) treated for STI/RTI		
6.1.3.	Number of H/TG assessed for STI/RTI		
6.1.3.a	Out of the above, number of H/TG people diagnosed with STI/RTI		
6.1.3.b	Out of the above, number of H/TG people treated for STI/RTI		
M7	**Family Planning**		
7.1.	Number of Interval IUCD Insertions (excluding PPIUCD and PAIUCD)		
7.2.	Number of Postpartum (within 48 hours of delivery) IUCD insertions		
7.3.	Number of IUCD Removals		
7.4.	Number of complications following IUCD Insertion		
7.5.	**Injectable Contraceptive MPA- First Dose**		
7.5.1.	Injectable Contraceptive MPA (Intra Muscular) - First Dose		
7.5.2.	Injectable Contraceptive MPA (Sub Cutaneous) - First Dose		
7.6.	**Injectable Contraceptive MPA- Second Dose**		
7.6.1.	Injectable Contraceptive MPA (Intra Muscular) - Second Dose		
7.6.2.	Injectable Contraceptive MPA (Sub Cutaneous)- Second Dose		
7.7.	**Injectable Contraceptive MPA- Third Dose**		
7.7.1.	Injectable Contraceptive MPA (Intra Muscular) - Third Dose		
7.7.2.	Injectable Contraceptive MPA (Sub Cutaneous)- Third Dose		
7.8.	**Injectable Contraceptive MPA- Fourth and above Dose**		
7.8.1.	Injectable Contraceptive MPA (Intra Muscular) - Fourth and above Dose		
7.8.2.	Injectable Contraceptive MPA (Sub Cutaneous)- Fourth and above Dose		
7.9.	Number of Combined Oral Pill cycles distributed to the beneficiary		
7.10.	Number of Condom pieces distributed to the beneficiary		
7.11.	Number of Centchroman (weekly) pill strips distributed to the beneficiary		
7.12.	Number of Emergency Contraceptive Pills (ECP) given to the beneficiary		
7.13.	Number of Pregnancy Test Kits (PTK) utilized		
7.14.	**No. of Subdermal Contraceptive Implant**		
7.14.1.	No. of Subdermal Contraceptive Implant inserted		
7.14.2.	No. of Subdermal Contraceptive Implant removed		
7.15.	**Quality in sterilization services**		
7.15.1.	Complications following male sterilization		
7.15.2.	Complications following female sterilization		
M8	**CHILD IMMUNISATION**		
8.1.	**Number of Infants 0 to 11 months old who received:**		
8.1.1.	Child immunisation - Vitamin K (Birth Dose)		
8.1.2.	Child immunisation - BCG		
8.1.3.	Child immunisation - Pentavalent 1		
8.1.4.	Child immunisation - Pentavalent 2		
8.1.5.	Child immunisation - Pentavalent 3		
8.1.6.	Child immunisation - OPV 0 (Birth Dose)		
8.1.7.	Child immunisation - OPV1		

8.1.8.	Child immunisation - OPV2		
8.1.9.	Child immunisation - OPV3		
8.1.10.	Child immunisation - Hepatitis-B0 (Birth Dose)		
8.1.11.	Child immunisation - Inactivated Injectable Polio Vaccine 1 (IPV 1)		
8.1.12.	Child immunisation - Inactivated Injectable Polio Vaccine 2 (IPV 2)		
8.1.13.	Child immunisation - Rotavirus 1		
8.1.14.	Child immunisation - Rotavirus 2		
8.1.15.	Child immunisation - Rotavirus 3		
8.1.16.	Child immunisation - PCV1		
8.1.17.	Child immunisation - PCV2		
8.2	**Number of Children 9-11 months who received:**		
8.2.1.	Child immunisation(9 - 11 months) - Inactivated Injectable Polio Vaccine 3 (IPV 3)		
8.2.2.	Child immunisation (9-11months) - Measles & Rubella (MR)/Measles containing vaccine(MCV) - 1st Dose		
8.2.3.	Child immunisation (9-11months) - JE 1st dose		
8.2.4.	Child immunisation - PCV Booster		
8.2.5.	**Number of children aged between 9 and <12 months FULLY IMMUNIZED {BCG +OPV123+ Pentavalent123+ MR/ Measles Containing Vaccine (MCV)-1st Dose}**		
8.2.5.a	FULLY IMMUNIZED children aged between 9 and <12 months- Male		
8.2.5.b	FULLY IMMUNIZED children aged between 9 and <12 months- Female		
8.3.	**Children given following vaccination after 12 months (delayed vaccinations)**		
8.3.1.	Child immunisation(after 12 months-delayed vaccination) - Measles & Rubella (MR)/Measles containing vaccine(MCV)- 1st Dose		
8.3.2.	Child immunisation (after 12 months-delayed vaccination) - JE 1st dose		
8.3.3.	Child immunisation - DPT 1 after 12 months of age (delayed vaccination)		
8.3.4.	Child immunisation - DPT 2 after 12 months of age (delayed vaccination)		
8.3.5.	Child immunisation - DPT 3 after 12 months of age (delayed vaccination)		
8.3.6.	Child immunisation - DPT Booster after 24 months of age (delayed vaccination)		
8.3.7.	Child immunisation - OPV Booster after 24 months of age (delayed vaccination)		
8.3.8.	Child immunisation - JE Booster after 24 months of age (delayed vaccination)		
8.4.	**Number of Children more than 12 months who received:**		
8.4.1.	Child immunisation - Measles & Rubella (MR)/ Measles containing vaccine(MCV)- 2nd Dose (16-24 months)		
8.4.2.	Child immunisation - DPT 1st Booster		
8.4.3.	Child immunisation - OPV Booster		
8.4.4.	Number of children more than 16 months of age who received Japanese Encephalitis (JE) vaccine- 2nd dose (16-24 months)		
8.5.	**Number of Children more than 23 months who received:**		
8.5.1.	Child Immunization- Typhoid		
8.5.2.	Children more than 5 years received DPT5 (2nd Booster)		
8.5.3.	Children more than 10 years received Td10 (Tetanus Diptheria10)		
8.5.4.	Children more than 16 years received Td16 (Tetanus Diptheria16)		
8.6.	**Adverse Event Following Immunisation (AEFI)**		
8.6.1.	Number of cases of AEFI -Minor (eg.- fever, rash, pain etc)		
8.6.2.	Number of cases of AEFI - Severe (eg.- anaphylaxis, fever>102 degrees, not requiring hospitalization etc.)		
8.6.3.	Number of cases of AEFI - Serious (eg.- hospitalization, death, disability , cluster etc.)		
8.6.3.a	Out of Number of cases of AEFI - Serious , total number of AEFI deaths		
8.7	**Number of Immunisation sessions**		
8.7.1.	Immunisation sessions planned		
8.7.2.	Immunisation sessions held		
8.8.	**Children received Vitamin A Doses between 9 months and 5 years**		

8.8.1.	Child immunisation - Vitamin A Dose - 1		
8.8.2.	Child immunisation - Vitamin A Dose - 5		
8.8.3.	Child immunisation - Vitamin A Dose - 9		
M9	**Number of cases of Childhood Diseases**		
9.1.	**New Cases of Childhood Diseases (0-5 years) & Leprosy (0-14 years) Include new cases of OPD/IPD/Emergency**		
9.1.1.	Childhood Diseases - Malaria		
9.1.2.	Childhood Diseases - Diarrhoea		
9.1.3.	Childhood Diseases - Diarrhoea treated with ORS		
9.1.4.	Childhood Diseases - Diarrhoea treated with Zinc for 14 days		
Part B	**National Programmes**		
M10	**National Vector Borne Disease Control Programme(NVBDCP)**		
10.1.	**Malaria**		
10.1.1.	**Rapid Diagnostic Test (RDT)**		
10.1.1.a	RDT conducted for Malaria		
10.1.1.b	Malaria (RDT) - Plasmodium Vivax test positive		
10.1.1.c	Malaria (RDT) - Plasmodium Falciparum test positive		
10.1.1.d	Malaria (RDT) - Mixed test positive		
10.2.	**Lymphatic Filariasis**		
10.2.1.	Number of persons that consumed MDA (Mass Drug Administration) drugs during the MDA round		
10.2.2.	Number of Lymphatic Filarisis lymphoedema patients received MMDP(Morbidity Management And Disability Prevention) kits		
M11	**Adolescent Health**		
11.1.	**Coverage under MHS- Menstrual Hygiene Scheme (GOI supported)**		
11.1.1.	Number of adolescent girls provided sanitary napkin packs by ASHA		
11.1.2.	Number of sanitary napkin packs distributed free to ASHA (for her personal use)		
11.1.3.	Number of adolescent girls attended monthly meeting		
11.1.4.	Number of adolescent girls provided sanitary napkin packs by State/UT supported Menstrual Hygiene Scheme (MHS)		
11.2.	**Peer Educator Programme**		
11.2.1.	Number of Peer Educators selected		
11.2.2.	Out of the selected Peer Educators, numbers trained		
11.2.3.	Number of Adolescent Health & Wellness Days organized		
11.2.4.	Number of Adolescent Friendly Club Meetings organized		
Part C.	**Health Facility Services**		
M12	**Patient Services**		
12.1.	**Services provided**		
12.1.1.	**Geriatric/Elderly**		
12.1.1.a	Total number of geriatric/elderly patients (age>=65 yrs) Registered		
12.1.1.b	Geriatric (age>=65 yrs) patients footfall		
12.1.1.c	Number of geriatric/elderly persons who underwent Comprehensive Geriatric Assessment by CHO		
12.1.1.d	Number of geriatric/elderly persons managed for any elderly conditions		
12.1.1.e	Number of geriatric/elderly persons followed-up for any elderly conditions		
12.1.1.f	Number of geriatric/elderly patients (age>=65 yrs) provided physiotherapy services		
12.1.1.g	Number of home bound (bed bound & restricted mobility) elderly and single elderly visited by ASHA & ANM/MPW-M during the month		
12.1.1.h	Number of elderly support groups-'Sanjeevini' created during the month		
12.1.1.i	Number of weekly geriatric clinics organized during the month		
12.1.1.j	Number of fixed day rehabilitation services provided during the month		
12.1.2.	**Other Services**		
12.1.2.a	Number of Palliative Patients visited at home		
12.1.2.b	Number of weekly palliative care OPD conducted at AAM-PHC		

12.1.2.c	Number of cases reported for Self Harm		
12.1.3.	**Services provided in outreach camps during the month**		
12.1.3.a.	Total number of footfall in outreach camps/sessions		
12.1.3.b.	Total number cases examined in outreach camps for Mental illness		
12.1.4.	Number of psychoeducation sessions conducted at the Ayushman Arogya Mandir during the month		
12.2.	**Outpatient attendance (All) (excluding teleconsultation)**		
12.2.1.	Allopathic- Outpatient attendance		
12.2.1.a	Out of above, number of specialist Allopathic OPD services provided		
12.2.2.	Ayush - Outpatient attendance		
12.2.2.a	Out of above, number of specialist AYUSH OPD services provided		
12.3.	**Total Number of cases Referred out (OPD+Emergency)**		
12.3.1.	Total cases Referred out (OPD+Emergency)-During Day		
12.4.	Day Care Admissions		
12.5.	Total number of telemedicine consultation provided		
12.6.	**Emergency**		
12.6.1.	Total Number of Emergency cases managed		
12.6.2.	Total Number of CPR performed in the emergency		
12.7.	**Janani Shishu Suraksha Karyakram (JSSK)**		
12.7.1	**Number of Pregnant Women(PW) and Post Natal Care (PNC) Beneficiaries**		
12.7.1.a.	**Number of PW and PNC beneficiaries provided - Free Medicines under JSSK**		
12.7.1.a.i	Number of pregnant women provided free medicines during ANC period under JSSK		
12.7.1.a.ii	Number of Pregnant women provided free medicines during delivery under JSSK		
12.7.1.a.iii	Number of PNC mothers provided free medicines under JSSK		
12.7.1.b.	Number of women provided - Free Diet under JSSK		
12.7.1.c.	**Number of PW and PNC beneficiaries provided - Free Diagnostics under JSSK**		
12.7.1.c.i	Number of pregnant women provided free diagnostics during ANC period under JSSK		
12.7.1.c.ii	Number of Pregnant women provided free diagnostics during delivery under JSSK		
12.7.1.c.iii	Number of PNC mothers provided free diagnostics under JSSK		
12.7.1.d	Number of-pregnant women provided - Free Home to facility transport for conducting delivery under JSSK		
12.7.1.e	Number of pregnant women provided - Interfacility transfers when needed during delivery under JSSK(in case of referral)		
12.7.1.f	Number of PNC mothers provided - Free Drop Back home after delivery under JSSK		
12.7.2.	**Number of sick infants provided**		
12.7.2.a	Number of infants admitted at facility due to any sickness- JSSK Beneficiaries		
12.7.2.b	Number of sick infants provided - Free Medicines under JSSK		
12.7.2.c	Number of sick infants provided - Free Home to facility transport under JSSK		
12.7.2.d	Number of infants received free referral transport under JSSK		
12.8.	Number of Jan Arogya Samiti (JAS) meetings held		
12.9.	Number of Anganwadi centres reported to have conducted atleast one Village Health & Nutrition Day (VHNDs)/UHND/ Outreach / Special Outreach sessions		
12.10.	Total number of UHND/VHND sessions conducted in the reporting month		
12.11.	Total number of Outreach/Special Outreach camps conducted in the reporting month		
12.11.1.	Total number of outreach visits conducted by staff		
12.12	Patient Satisfaction Score of the facility in percentage (from Mera Aspatal)		
12.13.	**National Viral Hepatitis Control Program (Diagnosis and Management of viral hepatitis)**		
12.13.1	**Total number of blood samples screened by ELISA/Rapid tests for viral hepatitis**		
12.13.1.a	Total number of blood samples screened by ELISA/Rapid tests for viral hepatitis B i.e. HBsAg (excluding pregnant women)		

12.13.1.b	Total number of blood samples screened by ELISA/Rapid tests for viral hepatitis C (Anti- HCV)		
12.13.2.	**Total number of blood samples tested positive by ELISA/ Rapid tests for viral hepatitis & its management**		
12.13.2.a	Total number of blood samples tested positive by ELISA/ Rapid tests for Hepatitis B (out of those tested for HBsAg excluding pregnant women)		
12.13.2.b	Total number of blood samples tested positive by ELISA/ Rapid tests for Hepatitis C (out of those tested for Anti-HCV)		
12.13.3.	**Hepatitis B in pregnancy**		
12.13.3.a	Number of Pregnant Women tested for HBsAg		
12.13.3.b	Number of Pregnant Women who are HBsAg positive (out of those tested for Hepatitis B i.e. HBsAg)		
12.13.3.c	Number of Pregnant Women found positive for HBsAg referred out to higher centre for institutional delivery		
12.13.3.d	Number of newborn who received birth dose of Hepatitis B vaccine born to HBsAg positive pregnant women		
M13	**Diagnostics**		
13.1.	**Total Number of Lab Tests & Kit Tests**		
13.1.1.	Total Number of Lab Tests done- Inhouse (including kits tests conducted in Laboratory)		
13.1.2.	Total Number of Lab Tests done- Outsourced (including kits tests conducted in Laboratory)		
13.1.3.	Total Number of Kit Tests conducted in Outreach areas/Camps/in-facility (outside lab)		
13.2.	**Hb Tests Conducted**		
13.2.1.	Number of Hb tests conducted including kit tests		
13.2.2.	Out of the total number of Hb tests done, Number having Hb < 7 mg		
13.3.	**HIV tests**		
13.3.1.a	Number of males screened for HIV by Whole Blood Finger Prick/RDT test/POC test		
13.3.1.b	Out of the above, No. of males found reactive for HIV		
13.3.1.c	No. of males subjected to HIV test at Confirmatory Centre/Stand Alone-ICTC		
13.3.1.d	Out of the above, No. of males confirmed as HIV Positive		
13.3.2.a	Number of females (non-ANC) screened for HIV by Whole Blood Finger Prick/RDT test/POC test		
13.3.2.b	Out of the above, No. of females (non-ANC) found reactive for HIV		
13.3.2.c	No. of females (non-ANC) subjected to HIV test at Confirmatory Centre/Stand Alone-ICTC		
13.3.2.d	Out of the above, No. of females (non-ANC) confirmed as HIV Positive		
13.3.3.a	Number of Pregnant Women (PW-ANC) screened for HIV by Whole Blood Finger Prick/RDT test/POC test		
13.3.3.b	Out of the above, No. of PW(ANC) found reactive for HIV		
13.3.3.c	No. of PW(ANC) subjected to HIV test at Confirmatory Centre /Stand Alone-ICTC		
13.3.3.d	Out of the above, No. of PW(ANC) confirmed as HIV Positive		
13.3.3.e	Number of Pregnant Women (ANC&DIL) screened for HIV more than once(Repeated testing)		
13.3.4.a	Number of H/TG people screened for HIV by Whole Blood Finger Prick/RDT test/POC test		
13.3.4.b	Out of the above, No. of H/TG people found reactive for HIV		
13.3.4.c	No. of H/TG people subjected to HIV test at Confirmatory Centre/Stand Alone-ICTC		
13.3.4.d	Out of the above, No. of H/TG people confirmed as HIV Positive		
13.4.	**STI/RTI attendees Tested for Syphilis**		
13.4.1.a	Total number of males tested for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		
13.4.1.b	Out of the above, number of males tested reactive for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		
13.4.1.c	Out of the above, number of males treated for Syphilis		
13.4.2.a	Total number of female (non-ANC) tested for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		
13.4.2.b	Out of the above, number of females (non-ANC) tested reactive for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		
13.4.2.c	Out of the above, number of females (non-ANC) treated for Syphilis		
13.4.3.a	Total number of H/TG people tested for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		
13.4.3.b	Out of the above, number of H/TG people tested reactive for Syphilis (RPR/VDRL/PoC/ RDT/TPHA)		

13.4.3.c	Out of the above, number of H/TG people treated for Syphilis		
Part D.	**Mortality Details**		
M14	**Details of deaths reported:**		
14.1.1.a	New born deaths within 24 hrs(1 to 23 Hrs 59 minutes) of birth at Facility/Facility to facility in transit		(Outreach)
14.1.1.b	New born deaths within 24 hrs(1 to 23 Hrs 59 minutes) of birth in Community (at home or home to facility transit)		
14.1.2.a	New born deaths within 1 week (1 to 7 days) at Facility/Facility to facility in transit		
14.1.2.b	New born deaths within 1 week (1 to 7 days) At Community (at home or home to facility transit)		
14.1.3.a	New born deaths within 8 to 28 days at Facility/Facility to facility in transit		
14.1.3.b	New born deaths within 8 to 28 days At Community (at home or home to facility transit)		
14.1.4.a	Infant Deaths (>28 days to below 12 months) at Facility/Facility to facility in transit		
14.1.4.b	Infant Deaths (>28 days to below 12 months) At Community (at home or home to facility transit)		
14.2.	**Neonatal Deaths up to 4 weeks (0 to 28 days) due to**		
14.2.1.	Neonatal Deaths up to 4 weeks (0 to 28 days) due to Sepsis		
14.2.2.	Neonatal Deaths up to 4 weeks (0 to 28 days) due to Asphyxia		
14.2.3.	Neonatal Deaths up to 4 weeks (0 to 28 days) due to complications of Prematurity		
14.2.4.	Neonatal Deaths up to 4 weeks (0 to 28 days) due to Other causes		
14.3.	**Infant Deaths Between more than 28 days and below 12 months due to**		
14.3.1.	Number of Infant Deaths (>28 days - below 12 months) due to Pneumonia		
14.3.2.	Number of Infant Deaths (>28 days -below 12 months) due to Diarrhoea		
14.3.3.	Number of Infant Deaths (>28 days -below 12 months) due to Fever related		
14.3.4.	Number of Infant Deaths (>28 days -below 12 months) due to Measles		
14.3.5.	Number of Infant Deaths (>28 days -below 12 months) due to Others		
14.4.	**Child Deaths between 1 - below 5 years due to**		
14.4.1.	Number of Child Deaths (1 -below 5 years) due to Pneumonia		
14.4.2.	Number of Child Deaths (1 -below 5 years) due to Diarrhoea		
14.4.3.	Number of Child Deaths (1 -below 5 years) due to Fever related		
14.4.4.	Number of Child Deaths (1 -below 5 years) due to Measles		
14.4.5.	Number of Child Deaths (1 -below 5 years) due to Others		
14.5.	**Maternal Deaths at facility due to**		
14.5.1.	Number of Maternal Deaths at facility due to APH (Antepartum Haemmorhage)		
14.5.2.	Number of Maternal Deaths at facility due to PPH (Post-Partum Haemmorhage)		
14.5.3.	Number of Maternal Deaths at facility due to Pregnancy related infection and sepsis, Fever		
14.5.4.	Number of Maternal Deaths at facility due to Abortion and/ or its complication		
14.5.5.	Number of Maternal Deaths at facility due to Obstructed/prolonged labour		
14.5.6.	Number of Maternal Deaths at facility due to Severe hypertension/fits/Pre Eclampsia/Eclampsia & in pregnancy, during delivery and puerperium		
14.5.7.	Number of Maternal Deaths at facility due to Other/Unknown Causes		
14.5.8.	**Age wise total Maternal Deaths, occurred at Facility**		
14.5.8.a	Out of total number of maternal deaths at facility, deaths with age less than <15 years		
14.5.8.b	Out of total number of maternal deaths at facility, deaths with age 15-19 years		
14.5.8.c	Out of total number maternal deaths at facility, deaths with age more than >19-49 years		
14.5.8.d	Out of total number maternal deaths at facility, deaths with age more than >49 years		
14.6.	**Other Deaths (except Infant, Child & Maternal Deaths) 5 years and above due to**		
14.6.1.	Number of deaths due to Diarrhoeal diseases		
14.6.2.	Number of deaths due to Tuberculosis		
14.6.3.	Number of deaths due to Respiratory diseases including infections (other than TB)		

14.6.4.	Number of deaths due to Other Fever Related		
14.6.5.	Number of deaths due to Heart disease/Hypertension related		
14.6.6.	Number of deaths due to Cancer		
14.6.7.	Number of deaths due to Neurological disease including strokes		
14.6.8.	Number of deaths due to Accidents/Burn cases		
14.6.9.	Number of deaths due to Animal bites and stings		
14.6.10.	Number of deaths due to Known Acute Disease		
14.6.11.	Number of deaths due to Known Chronic Disease		
14.6.12.	Number of deaths due to Other Causes		
14.7.	**Deaths due to Vector Borne Diseases (all age groups)**		
14.7.1.	Number of Deaths due to Malaria- Plasmodium Vivax		
14.7.2.	Number of Deaths due to Malaria- Plasmodium Falciparum		
14.8.	**Total Deaths (5 years and above of age): Excluding in-transit & maternal deaths**		
14.8.1.	5 years and above to below 10 years		
14.8.2.	10 year and above to below 19 years		
14.8.3.	Adult 19 years and above		
14.9.	**Total In-transit Deaths :Excluding infant & maternal deaths**		
14.9.1.	In-transit Deaths: 1 year and below 5 years		
14.9.2.	In-transit Deaths: 5 years and above to below 10 years		
14.9.3.	In-transit Deaths: 10 year and above to below 19 years		
14.9.4.	In-transit Deaths: Adult 19 years and above		
Part E	**Quality Control**		
M15	**QA (Quality Assurance) & BEMMP (Biomedical Equipment Management & Maintenance Program)**		
15.1.	**EQAS Compliance**		
15.1.1.	Total Quantity of Bio medical waste generated in Kg for the month - (All Yellow, Red, white & Blue)		
15.1.2.	Total Quantity of General waste generated in Kg for the month		

In addition to the above, PHCs/CHCs/SDH/DH will have data elements related to more components according to the services provided at those facilities. Data elements related to these components will be available in their reporting formats:

- Number of cesarean sections done at the facility
- Number of spontaneous and Induced abortion
- Number of cases of pregnant women with Obstetric Complications and attended at Public facilities
- Complicated pregnancies treated at thefacility, IVantibiotics, IVanti-hypertensive's and IV oxytocis
- Postnatal care maternal complications
- Medical termination of pregnancy performed
- RTI/STD treated
- Sterilisations done; male and female
- In laboratory, more investigations will feature like Widal's, HIV, etc
- Availability of sick newborn and child care unit
- Presence of Rogi Kalyan Samitis, Ambulance, patient transportation, etc.

4.3.2 Recording and Reporting Formats Recording

Data is recorded at the health facilities in various registers and data formats. At sub-centre level, an ANM and male health worker maintain a number of registers:

Registers in sub-centre:

1) Eligible Couple Register including Contraception
2) Maternal and Child Health Register:
   a) Antenatal, intra-natal, postnatal
   b) Under-five register:
      i) Immunisation
      ii) Growth monitoring
3) Births and Deaths Register
4) Drug Register
5) Equipment Furniture and other accessories Register
6) Communicable diseases/ Epidemic Register
7) Passive surveillance register for malaria cases
8) Register for records pertaining to Janani Suraksha Yojana
9) Register for maintenance of accounts including untied funds
10) Register for water quality and sanitation
11) Minor ailments Register
12) Records/registers as per various National Health Programme guidelines (NLEP, N T E P, NVBDCP, etc.)

At PHC and above, there will be more registers, according to the services they provide and the facilities they have like MTP register, Operation theatre register, In patient register, etc.

Recording of cases is done as line list in standard formats shown in Fig.4.1. This will have the details of each individual case. It can be reported as such from lower level facility as they will have limited number of cases. Information for the reporting formats will be derived from the line lists.



Fig. 4.1: Line list of delivery cases



Fig.4.2: Line list of Infant death cases

Reporting formats

The reporting formats of different facilities will contain data elements relevant to that level. The number and nature of data elements will vary depending upon the facility. Fig. 4.3 shows monthly reporting format for the health facility.

Monthly Service Delivery Reporting format

Sub Centre (SC) FORMAT

State : _____ **District :** _____

Sub district/Block / Health Block : _____

Name of Health Facility: _____

Facility Type: AAM-SHC (R): _____ **UAAM-SHC:** _____ **Non-functional as AAM-SHC:** _____

Ownership: _____Public_____

Reporting month: _____ **Financial Year:** _____

Name & Designation of the person reported Data: _____

Date of reporting Data: _____

Facility Code	Data Item	Numbers reported during the month (In-facility)	Numbers reported during the month (Outreach)
Part A	REPRODUCTIVE AND CHILD HEALTH		
M1	Ante Natal Care (ANC) Services & High Risk Pregnancies		
1.1.	Total number of NEW Pregnant Women registered for ANC		
1.1.a	Out of total number of NEW pregnant women registered with age less than <15 years		
1.1.b	Out of total number of NEW pregnant women registered with age 15-19 years		
1.1.c	Out of total number of NEW pregnant women registered with age more than >19 to 49 years		
1.1.d	Out of total number of NEW pregnant women registered with age more than >49 years		
1.1.1.	Out of the total NEW ANC registered, number registered within 1st trimester (within 12 weeks)		

Fig. 4.3: Monthly reporting format for the health facility

Other reporting formats

- Infrastructure and HR Format
- Health Condition Matrix

Monthly Infra & HR Reporting format

HWC-Sub Centre (HWC-SC)/SC FORMAT

State : _____

District : _____

Block / Health Block : _____

Name of Health Institution : _____

Facility Sub Type: _____ Ownership: Public / Private

Number of Beds : _____ Reporting month: _____ Financial Year _____

Name & Designation of the person reported Data _____

Date of reporting Data

Facility Item Code	Name of the Data Items	Numbers/Status reported during the month
I	Physical Infrastructure ®	
1.1.	Other then 24x7 beds (these beds are beyond sanctioned beds)	
1.1.1	Total other then 24x7 beds (these beds are beyond sanctioned beds)	
1.2.	Category-wise bed distributions	
1.2.1	Other then 24x7 beds (these beds are beyond sanctioned beds)	
1.2.1.a	No. of labour Beds	
1.2.1.b	No. of day care beds	
1.3.2.c	No. of beds available other then above mentioned non 24X7 beds (if any)	
1.3	Other Infrastructural services	
1.3.1	Is there a designated government building (Yes / No).	
1.3.1.a	If there is no designated government building, then where is facility located?	
1.3.1.a.i	Rented Buildings(Yes / No)	

Fig. 4.4: Monthly reporting format for the health facility

HEALTH CONDITION MATRIX: SUB CENTRE FORMAT

S.NO.	Name of health conditions/diseases	Screening		Pre existing conditions		New cases detected		Management/Treatment provided		Counselling provided		Followed-up		Refer out		Refer in		OPD Footfall/Cases	
		Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility	Outreach	Infacility
D1	Oral Health Conditions																		
1.1.	Total no. of patients attended for Dental Care services																		
1.1.1.	Total no. of patients attended for oral potentially malignant disorders																		
1.1.2.	Total no. of patients attended for Tobacco Cessation Services at Dental Care Unit																		
D2	Diseases/Health Conditions																		
2.1.	MNS																		
2.1.1.	Total No. of Patients attended for Neurological condition																		
2.1.2.	Total No. of Patients attended for Substance Abuse																		
2.1.3.	Total number of patients of Tobacco Cessation																		
2.1.4.	Total No. of Patients attended for Dementia																		
2.2.	Mental Health																		
2.2.1.	Total No. of Patients attended for Mental illness/condition																		
2.2.2.	Total No. of Patients attended for Epilepsy																		
2.3	Non-Communicable Diseases																		
2.3.1	Total No. of Patients attended for Ophthalmic Related (Eye) Conditions																		
2.3.2	Total No. of Patients attended for Ear related conditions																		
2.3.3	Total No. of Patients attended for Diabetes																		
2.3.4	Total No. of Patients attended for Hypertension																		
2.3.5	Total No. of Patients attended for Stroke (Paralysis)																		
2.3.6	Total No. of Patients attended for Cardiovascular Disease																		
2.3.7	Total No. of Patients attended for Asthma																		
2.3.8.	Cancer																		
2.3.8.a	Total No. of Patients attended for Oral Cancer																		
2.3.8.b	Total No. of Patients attended for Breast Cancer																		
2.3.8.c	Total No. of Patients attended for Cervical Cancer																		
2.3.8.d	Total No. of Patients attended for Primary Hepatocellular carcinoma																		
2.3.8.e	Total No. of Patients attended for Other Type of Cancers																		
2.3.9.	Total No. of Patients attended for Chronic Liver Disease																		
2.3.10.	Total No. of Patients with refrective index problem																		
2.4.	Anemia																		
2.4.1	Number of beneficiaries attended T3 camps/ facilities/ VHND for Anaemia																		
2.5.	Total No. of Patients of Palliative Care																		
2.6.	Total No. of Patients attended for Elderly care																		

Updated as on 06-03-2025

Fig. 4.5 : Health Condition Matrix

4.3.3 Data Compilation

Compilation of data happens at three levels: you have read in Block 1, Unit 2 about healthcare delivery system in detail.

First level Compilation is at Block PHC where the Block Data Manager makes the "Block Monthly Consolidated Report" from data obtained from its own PHC as well as other PHCs and Sub-centres.

Second level Compilation is at District level where the District Data Manager will make the "District Monthly Consolidated Report" after data from all institutions within its limits, both private and public send their respective reports. This report will be electronically uploaded on the central Web Portal. Where ever State HMIS application is functional one copy of the entire database will be stored in the State HMIS application.

Third level Compilation will be at State level where monthly, quarterly and annual reports of the state will be prepared. Aggregation will be carried out by accessing all District consolidated reports and all State specific data entry that was done at the State level (quarterly, FMR, annually). 'State Aggregated Report'will be uploaded on the Web Portal, and a copy of the same will be available in the State specific HMIS application running on the State server.

4.3.4 Data Flow

Data is transmitted either in line list format, if there is limited number to report, or more commonly in a reporting format, where it is aggregated. At sub-centre level, reporting format is filled and sent to the PHC. At the PHC, data from all the sub-centres under them are collated and added to their own PHC data. This report is then sent to Block PHC, where they receive and combine reports of all the PHCs and their own. Block PHC will have a Block Data Manager (BDM) who will be responsible for collecting,

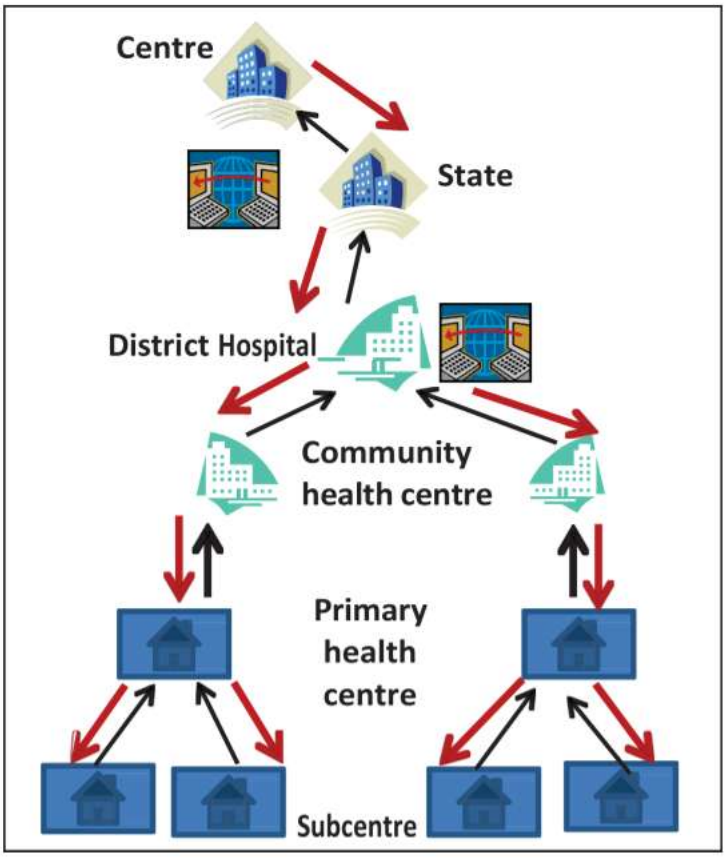


Fig. 4.6: Transmission of information from sub-centre to central level

checking data quality and preparation of the block report. The block will send their report to District headquarter, which will also receive reports from sub-district hospitals, private practitioners and nursing homes, public and private sector hospitals present in the district. District will have District Data Manager (DDM), who will ensure the collation, quality and transmission of data of the whole district including the district hospital.

The report will be sent as hard copy from the sub-centre level and at most PHC level. However, most of the blocks will have online data entering and reporting system, which will be operated by the BDM and they will send the signed hard copy of the report as well as enter the data in the system, which can be accessed by the district.

This flow of data from the lowest level of health care institution to the central level is done through specific formats developed for the purpose as shown in Table 4.3.

Table 4.3: Reporting formats for different levels

A	Reporting forms from State & UTs to GOI (These forms are to be sent to GOI)			
1)	**NRHM/GOI/1/A**	Annual Consolidated	30th April	
2)	**NRHM/GOI/2/Q**	Quarterly Consolidated	20th of month following the quarter	State Govt to GOI
3)	**NRHM/GOI/3/M**	Monthly consolidated	20th of following month	
B	Reporting forms within State Govt. (These are not to be sent to GOI)			
4)	**NRHM/SG/1/A**	Annual	15th April	Internal for state govt.
5)	**NRHM/SG/2/Q**	Quarterly	20th of month following the quarter	
C	Reporting forms within Districts (these are to be sent to the state govt.)			
6)	**NRHM/DHQ/1/A**	Annual	5th April	District to state govt.
7)	**NRHM/DHQ/2/Q**	Quarterly	10th of month following the quarter	
8)	**NRHM/DHQ/3/M**	Monthly	10th of following month	
D	Facility reporting forms within Districts (These forms are to be sent to district headquarter)			
9)	**NRHM/DH-SDH-CHC/3/M** (The forms are the same for DH, SDH, CHC and can be used interchangeably)	Monthly	5th of the following month	District hospital to district headquarter
10)	**NRHM/PHC/3/M**	Monthly	5th of the following month	PHC to district headquarter
11)	**NRHM/HSC/3/M**	Monthly	5th of the following month	Health sub-centre to district headquarter

4.3.5 Logistics and Technology

In India, till few years back, all data were being exclusively dealt with as only hard copies in the form of reporting formats and written reports. However, Government of India in the last has now established an electronic HMIS Portal in 2008 under National Health Mission (NHM), which manages data related to maternal and child health.

Health Management Information System (HMIS) Portal

The HMIS portal is envisaged as a "Single Window" for all public health data for the Ministry of Health and Family Welfare. The MOHFW initially rolled out the HMIS up to the District Level and now being expanded to the Sub District/Block level facility wise data entry. Over 630 Districts are reporting their monthly performance on a regular basis. eHMIS is most efficient for data transfer because it is network based and without physical movement, data is easily transmitted. However, it requires both hardware, software and network for it to function efficiently.

Hardware- Computers are needed at all levels with eHMIS with minimum specifications i.e. intel Pentium, 254 MB RAM, 20 GB hard disk space, explorer 6 and above. Along with computers, its peripherals like printers and UPS and modem will be needed.

Software- MOHFW has developed a software, which has two domains. One is public domain and anybody can access it. Other is the secured domain, which can be accessed only by authorised health workers/personnel with log in ID and password. User operability depends upon the extent of access each level requires. At every level, the operator can access the formats that need to be filled at their level. So long as entered data is in draft mode, the operator can edit the entry. Once the form is submitted, then it will no longer be accessible for editing, though they can see what they had submitted. Only their facility data will be available to them. In District level, they will be able to see and extract data of all the CHCs under them as well as enter their own facility data. The principle of editing and access remains the same; after submission, it won't be editable.

4.3.6 Analysis of Data and Indicators

Data analysis can be done at every stage. An ANM can analyse the data in her area and use it to bring about changes in her activities. Medical officer in the PHC and other staff including supervisors can use data from their areas, provide feedback and amend their own activities to be more efficient or effective.

Example of data analysis:

If there are 16 deliveries in an ANM's area in the past year and if the delivery register shows that, three of them were home deliveries; then institutional delivery in her area is only 81.3%, which should be actually 100%.

$$\textit{Institutional delivery (\%)} = \frac{\textit{No of deliveries in institutions x 100}}{\textit{Total no of deliveries 16}} = 13*100/16 = 81.3\%$$

She can go back to those cases and inquire into reasons for home delivery, and try to tackle those reasons either at her own level or have it brought to the attention of the PHC/CHC depending upon the reasons.

This measure of percentage of institutional delivery is called an '**Indicator'**. When data are compiled, like number of pregnant women registered for antenatal care, it has limited meaning unless, it's accompanied by a denominator. If an ANM says she has 16 pregnant women registered with her, it will have limited value because, there is no idea of how many pregnant women are there and of them how many have registered. Even though, this number will be useful in planning her activities and stock supply, as for its representativeness about health and service for pregnant women, it does not convey much. Hence, this data needs to be converted to an indicator.

An indicator is a measure which denotes the health status, service deliveryor efficiency of operations according to how it is calculated. Indicators helps one to know :

- how healthy a population group is,
- what is the quality of service provided, and
- how efficient an activity is
- finding the vulnerable groups which are affected, place that are most affected as well as time when certain health problems occur.

These can help in planning of services and allocation of resources.

Example of indicators:

Antenatal coverage

1) **Percentage of pregnant women registered** = $\frac{\text{no of pregnancies registered}}{\text{Total no of pregnancies}}$ x100

2) **Percentage of pregnant women registered in first trimester = no of pregnancies registered in 1st trimester / Total no of pregnancies x100**

Indicators can be calculated for TT dose, IFA tablet, place of delivery (institutional), postnatal care, etc.

Immunisation coverage

3) **Immunisation coverage= no of 9–11 months old children fully immunised total no of children in the same age group x 100**

Coverage for each individual vaccine can be calculated and also percentage of children getting adverse effects following immunisation.

Services

4) **Percentage of children with diarrhoea treated with ORS= no of children with diarrhoea treated with ORS/total no of children with diarrhoea x 100**

5) **Percentage of children with pneumonia treated with antibiotic= no of children with pneumonia treated with antibiotic/total no of children with pneumonia x 100**

Mortality rates

6) **Maternal Mortality Ratio= no of women dying during pregnancy, delivery and postpartum/total no of live births x 100,000**

7) **Infant mortality rate = no of children dying within one year of birth/total no of livebirths x 1000**

These are some of the indicators that health workers can use in their own areas too. Indicators can be used to compare performances and health status of different sub-centres and PHC areas or blocks. State will use it to compare different Districts and at national level, they will compare different states.

These indicators should be the driving points for providing feedbacks and planning ahead by strengthening the weak areas and services.

4.3.7 Feedback

Feedback should be an integral part of HMIS, inbuilt and robust. Without feedback, data collection, aggregation, flow and analysis will be in vain except for few uses. It is essential that feedback of HMIS information flows in the opposite direction of data flow from every level.

Primary health centres should give feedback to their sub-centres. Clock PHCs should give feedback to all other PHCs and District should give feedback to all blocks, CHCs and hospitals. State should give feedback to the Districts and centre should give feedback to the states.

Feedback can be given in the form of

- Written reports
- In monthly/quarterly meetings
- In annual review meetings

Everyyear, Ministryof Health and Family Welfare, Govt of India as well as the States publish their annual report from 1st April of previous year to 31st March. This can also be utilised as also a form of feedback.

4.4 DATAQUALITY

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

A) **Completeness**

For data to be of good quality, it has to be complete. Completion can be seen in two ways:

1) Facility wise completion: Of the total facilities both private and public existing in an area, what percentage are sending their reports and they are included in the District report?

2) Number of data elements reported among total data elements in a reporting format.

The forms have to be assessed for zeros and blanks. If there is repeated omission of certain elements, reason has to be as certained and if needed, amended.

B) **Timeliness**

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

reporting and will affect functioning and status of District.

C) **Accuracy**

Data should measure what it is supposed to measure and if it does that, then it is said to be accurate. It means that accurate data will be correct and useful. If data is incorrect for any reason, it will lead to false interpretation and actions that might be harmful for population/facility health and service provision.

Error in data could arise due to:

1) Gaps in understanding of data definitions and data collection methods
2) Data recording and data entry errors
3) Systemic errors- Logical errors embedded in the system due to which these errors remain unless underlying systemic issues are corrected
4) Misreporting

Data entry errors can be reduced by

1) **Visual scanning or eye balling:** This is just scanning of the document for any major deviation from the normal. It maybe in the form of missing values, abnormal figure or calculation mistakes. For e.g. age of an antenatal mother written as 60 years.

	PHC A	PHC B	PHC C	PHC D
Total ANC registration	281	328	491	267
Early ANC registration	90	100	214	95
ANC Third visits	211	309	425	186
ANC given TT1	247	295	424	250
ANC given TT2 or Booster	277	305	425	231
ANC given 100 IFA	276	296	438	253
ANC moderately anemic < 11 gm	68	67	114	51
ANC having Hypertension -New cases	20	76	15	4711

Very high

One can easily see from the above Table that 4711 is an exceptionally large figure, which is not appropriate for a PHC.

2) **Performing validation checks:** Validation is performed by comparing values of 2 (or more) data elements that are related . One (or more) data elements are placed on left side and other data element(s) are placed on right side with an operator separating both sides e.g. 'Early ANC registration' is a part of 'ANC registration' and it can equal to 'ANC registration' or it will be less than or equal to 'ANC registration' but it cannot be greater than 'ANC registration'. This rule can be expressed as:

Validation rule	Left side	Operator	Right side
Early ANC registration is less than or equal to total ANC registration	Early ANC registration	≤ (less than or equal to)	Total ANC registration

It is important to note that violation of a validation rule does not always indicate error. Sometimes inconsistent/unexpected values may be due to management issues like availability of vaccines or medicines in stock, disease outbreak, etc. Violation of validation rule indicates that one has to enquire and check/verifydata until satisfactory answer is not found.

Validation tools that can be used regularly in these aspects:

a) Number of low birth weights cannot be more than number of deliveries

b) Number of BCG given cannot be more than number of live births; unless there are children born outside the area who have come only for immunisation

c) Number of family planning users should be less than total eligible couples

d) Number of women receiving postnatal care should not be more than total deliveries

3) **Identification of statistical outliers:** Outliers are those values that in statistical terms live above or below 2 standard deviations. If any such figures stand out, they need to be checked for their accuracy. It need not be an error always. Figures may exceed 2 SD if there is an outbreak and large number of cases are reported.

Systemic errors can arise due to many reasons and unless the system fault leading to the error is corrected, it will continue. Some of the reasons for such systemic errors are:

Problem 1: Errors due to multiple registers or poorly designed registers

Sometimes, when there are too many registers to handle, ANMs may record certain data in their personal diaries and when they eventually have to fill the register format, they realise that they missed something out and that element will be missing. This can be corrected by discouraging personal diaries for official use.

Problem 2: Misinterpretation of Data Elements

In ANC care, instead of number of women given 100 IFA tablets, some health workers may write number of tablets given. Some may visit a woman who has delivered the baby after 6 weeks and still write postnatal visit done. This can only be achieved by proper training in data elements and supportive supervision.

Problem 3: Consistency of terms used

This means the same terms being used in more than one form or in the recording register/format as well as the reporting format. Newborns being breastfed within first hour of birth needs tobe reported in the reporting format but it is missing element from the records. In such cases, the health workers have to compare and add or amend the element in question.

Problem 4: Computation problem

At times, there might be problem compilation. For e.g.in order to calculate the number of children fully immunised the health worker will add up all the children receiving vaccine in the previous month irrespective of their actual immunisation status. Instead she should have taken only those 9–11 months old children who have received all vaccines till measles vaccine. This should be corrected by proper training and supportive supervision.

Problem 5: Problem in data aggregation/ Compilation

At times, simple errors of calculation like addition can lead to such situations where it becomes unreliable. One can clearly see in the table below that there is gross discrepancy between the block total and district total when they should be same as district total is addition of all blocks. Visual scanning can spot such errors.

REPRODUCTIVE AND CHILD HEALTH							
Antenatal Care Services	**Block A**	**Block B**	**Block C**	**Block D**	**Block E**	**Block Total**	**District Report**
Total number of pregnant women registered for ANC	387	457	2114	2076	2586	7620	11110
Of which number registered within first trimester	20	288	2142	1636	1202	5288	5288
New women registered under J5Y	0	401	169	1765	1588	3923	5445
Number of pregnant women received 3 ANC check ups	2984	239	1357	1679	124	6383	6383

Check Your Progress 1

1) What do you mean by data element?

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2) List Five parts of data element.

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3) What are data elements involved in assessing immunisation coverage?

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4) List the registers maintained at sub-centres.

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5) What are the aspects of data quality? What methods can be used to detect data entry errors?

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4.5 LET US SUM UP

HMIS is an important component of a health system. It is vital that all the health functionaries at various levels have a clear understanding of the data management in terms of recording, aggregation, reporting flow and feedback. This module dwells heavily on data elements, which is the building block for HMIS. If data elements have error, this will be passed on to every level. The unit also focuses on identification of errors in data and how to ensure quality of data. Understanding of indicators and their use will help to identify the areas of strength and weaknesses, and the area's own performance vis-á-vis others in their vicinity and beyond. How data flows, in which format its reported, how the MCTS works, etc will all aid in improving efficiency and planning of health activities.

4.6 MODEL ANSWERS

Check Your Progress 1

1) Data element is a record of a health event or a health related event.

2) The Five parts of data element are:

   Part A Reproductive And Child Health (M1-M10)

   Part B National Programmes (M11-M12)

   Part C Health facility Services (M13-M14)

   Part D Mortality Details (M15)

   Part E Quality Control (M16)

3) Data elements involved in assessing immunisation coverage are:

   Child Immunisation

   Number of Infants 0 to 11 months old who received the following:

   Data Source – Immunisation Register

   Data Element: BCG

   Data Element: Pentavalent 1

   Data Element: Pentavalent 2

   Data Element: Pentavalent 3

   Data Element: OPV 0 (Birth Dose)

   Data Element : OPV 1

   Data Element : OPV 2

   Data Element : OPV 3

   Data Element : Hepatitis - B 1

   Data Element: Hepatitis - B 2

   Data Element : Hepatitis - B 3

   Data Element : Measles

   New data element: Measles 2nd dose and Hepatitis B0

   Data Element : Total number of children aged between 9 and 11 months who have been fully immunised (Child given one dose of BCG, three dosages of

DPT i.e., DPT 1,2,3; three dosages of polio i.e,. OPV 1,2,3 and a dosage of Measles)

Data Source – Immunisation Register

4) ***Registers in sub-centre:***

1) Eligible Couple Register including Contraception
2) Maternal and Child Health Register
   a) Antenatal, intra-natal, postnatal
   b) Under-five register:
      i) Immunisation
      ii) Growth monitoring
3) Births and Deaths Register
4) Drug Register
5) Equipment Furniture and other accessories Register
6) Communicable diseases/ Epidemic Register
7) Passive surveillance register for malaria cases
8) Register for records pertaining to Janani Suraksha Yojana
9) Register for maintenance of accounts including untied funds
10) Register for water quality and sanitation
11) Minor ailments Register
12) Records/registers as per various National Health Programme guidelines (NLEP, RNTCP, NVBDCP, etc.)

5) ***The aspects of data quality are:***

A) **Completeness**

For data to be of good quality, it has to be complete. Completion can be seen in two ways:

a) Facilitywise completion: Of the total facilities both private and public existing in an area, what percentage are sending their reports and they are included in the district report?

b) Number of data elements reported among total data elements in a reporting format.

The forms have to be assessed for zeros and blanks. If there is repeated omission of certain elements, reason has to be as certained and if needed, amended.

B) **Timeliness**

For data to be useful, it has to be reported timely. Delayed reports will hinder accurate assessment and action. There is enough time given for the facilities to submit data after the month ends i.e. earliest being 5th of next month or 20th in case of quarterly report. They should be sent on time. Assessment of the district will also include timeliness of reporting and will affect functioning and status of district.

C) **Accuracy**

Data should measure what it is supposed to measure and if it does that, then it is said to be accurate. It means that accurate data will be correct and useful. If data is incorrect for any reason, it will lead to false interpretation and actions that might be harmful for population/facility health and service provision.

Error in data could arise due to

- Gaps in understanding of data definitions and data collection methods
- Data recording and data entry errors
- Systemic errors- Logical errors embedded in the system due to which these errors remain unless underlying systemic issues are corrected
- Misreporting

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UNIT 5 FINANCIAL MANAGEMENT AND ACCOUNTS AND COMPUTING AT SUB-CENTRE

Structure

5.0 Introduction

5.1 Objectives

5.2 Activities for which Funds are Received and Spent

- 5.2.1 Janani Suraksha Yojana
- 5.2.2 Untied Funds for Sub-centre
- 5.2.3 Untied Funds for Village Health and Sanitation Committees (VHSC) under the Sub-Centre

5.3 Accounting and Book Keeping Requirements

- 5.3.1 Important Accounting Principles and Policies to be Followed
- 5.3.2 Books of Accounts to be Maintained
- 5.3.3 Basic Accounting Entries
- 5.3.4 Accounting Process and Internal Controls
- 5.3.5 Payments and Expenditure
- 5.3.6 Fixed Asset
- 5.3.7 SoE Reporting Format
- 5.3.8 Utilisation Certificate (UC) Reporting

5.4 Preparing a Budget

5.5 Audit

5.6 Let Us Sum Up

5.7 Model Answers

5.8 References

5.9 Annexure (I – VIII)

5.0 INTRODUCTION

The Government of India has launched the National Health Mission (NHM) to carry out the necessary architectural correction in the basic health care delivery system. The Plan of Action includes increasing public expenditure on health, decentralisation and district management of health programmes, as well as induction of management and financial personnel into district health system.

As a result of decentralisation, most of the NHM funds are flowing down to the blocks and units below it, like CHCs/ PCHs, Sub-centres and VHSCs. The success of decentralisation experiment would depend on the strength of the management capacities built at each level.

In many states the sub-centre is also maintaining the books of accounts for the VHSCs under its jurisdiction (like in Rajasthan), hence the unit also includes guidelines for such situations. In other states the funds for VHSCs are transferred directly to the VHSC bank accounts and not routed through the sub-centre. In such cases the sub-centre only collects expense information and consolidates the same along with its SoE.

Sub-centre receives funds from blocks to carry out specified activities. They are supposed to report their activities to their supervisory unit which could be Block/ CHC / PHC. In case they are also maintaining books of accounts for VHSC's within their jurisdiction, they are supposed to consolidate the activities of the VHSC in their monthly SoE and accordingly report to the block.

This unit is aimed at building capacity your capacity in maintaining proper accounting records of the funds received at the sub-centre.

5.1 OBJECTIVES

After going through the unit, you should able to describe:

- the activities for which funds are received and spent at the sub-centre under the National Health Mission (NHM);
- the mechanism for accounting; and book keeping requirements as per the Important Accounting Principles and Policies under the National Health Mission (NHM) such as–Books of Accounts to be maintained, BasicAccounting Entries,Accounting Process and Internal Controls, Payments and Expenditure, Fixed Asset, SoE reporting format and Utilisation Certificate (UC) reporting format; and
- basics tools for financial management such as the budget and audit.

5.2 ACTIVITIES FOR WHICH FUNDS ARE RECEIVED AND SPENT

The following table summarises the activities under which the sub-centre receives money from the blocks/ supervisory unit.

Sl. No.	Activities for which funds are received by the Sub-centre from the Block /Supervisory unit	Purpose
A.	RCH Flexipool	
1.	JSY Payments to Mothers &ASHAs	Received from blocks for disbursement to JSY beneficiaries and ASHAs.
2.	Any Other (to be specified)	
B	NRHM Additionalities	
1.	Untied Funds at Sub-centres	Received from blocks
2.	Untied fund for VHSC	Received from blocks for all the VHSCs under its jurisdiction
3.	Annual Maintenance Grants (AMG) at Sub-centres	Received from blocks
4.	Any Other (to be specified) Others	

5.2.1 Janani Suraksha Yojana (JSY)

The guidelines as provided by MoHFW is available at the following link http://mohfw.nic. in/janani suraksha_yojana.htm

Purpose

The purpose of this scheme is to provide cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health worker (ASHAs).

Under this scheme cash assistance is provided to women from below BPL families, for enabling them to deliver in health institutions. The purpose of the scheme is to encourage institutional deliveries which would in turn help to bring down MMR and IMR.

Eligible Amounts

Several States have come out with their own variations of the JSY keeping in mind the contextual requirements for their State.

E.g in the state of Rajasthan

Payment to beneficiary

At CHC/ PHC — Rs. 1000

At Sub-centre — Rs. 1400 + 300 (for transportation)

Payment to ASHAs

Rs. 200 (100 and 100 after 2 days)

Fund Flow

Funds are received from the Block for the said activity.

5.2.2 Untied Funds for Sub-Centre

The guidelines as provided by MoHFW is available at the following link http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

Purpose and Eligible Amounts

As a part of the NHM programme untied fund to the tune of Rs. 10000 is provided to each sub-centre annually. The purpose of the fund is to provide for urgent yet discrete requirements at the sub-centre so as to increase their workability and at the same time ensure their functionality.

Besides the usual recurring cost support to the sub-centres, they also would be given an Annual Maintenance Grant (AMG) of Rs. 10,000 per annum (applicable only to those sub-centers which are functioning in Government buildings). The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch.

Guidelines for use of sub-centre (SC) funds under NHM

- As part of the National Health Mission, it is proposed to provide each sub-centre with Rs.10,000 as an untied fund to facilitate meeting urgent yet discrete activities that need relatively small sums of money.
- The fund shall be kept in a joint bank account of the ANM and the Sarpanch.
- Decisions on activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and be administered by the ANM. In areas where the sub-centre is not co-terminus with the Gram Panchayat (GP) and the sub-centre covers more than one GP, the VHC of the Gram Panchayat where the

SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub-centre.

- Untied Funds will be used only for the common good and not for individual needs, except in the case of referral and transport in emergency situations.

Suggested areas where Untied Funds may be used include:

- Minor modifications to sub-centre – curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level.
- Ad hoc payments for cleaning up sub-centre, especially after childbirth.
- Transport of emergencies to appropriate referral centres Transport of samples during epidemics.
- Representation to women's self-help group etc. on these committees etc. will enable the Committee to undertake women's health activities more effectively.
- Notwithstanding the above, the overall composition and nomenclature of the Village Health and Sanitation Committees is left to the State Government as long as these committees were within the umbrella of PRIs.
- Purchase of consumables such as bandages in sub-centre.
- Purchase of bleaching powder and disinfectants for use in common areas of the village.
- Labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
- Payment/reward to ASHA for certain identified activities.

Untied funds shall not be used for any salaries, vehicle purchase, and recurring expenditures or to meet the expenses of the Gram Panchayat.

5.2.3 Untied Funds for Village Health and Sanitation Committees (VHSC) under the Sub-Centre

The guidelines as provided by MoHFW are available at the following link http://mohfw.nic.in/NRHM/Documents/Guidelines of untied funds NRH M.pdf

Every VHSC to get Rs 10000 per year as untied funds.

Guidelines regarding constitution of Village Health and Sanitation Committees and utilisation of untied grants to these committees.

The NRHM implementation has been planned within the framework of Panchayati Raj Institutions [PRIs] at various levels. The Village Health and Sanitation Committee envisaged under NRHM is also within the overall umbrella of PRI.

Composition of the Village Health and Sanitation Committee

To enable the Village Health and Sanitation Committee to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

- At least 50% members on the Village Health and Sanitation Committee should be women.
- Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker

sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.

- A provision of at least 30% representation from the Non-governmental sector.
- Representation of women self help groups

Orientation and Training

Every Village Health and Sanitation Committee after being duly constituted by the State Governments needs to be oriented and trained to carry out the activities expected of them.

Village Health Fund

Every such committee duly constituted and oriented would be entitled to an annual untied grant of Rs.10,000/-, which could be used for any of the following activities:

- As a revolving fund from which households could draw in times of need to be returned in installments thereafter.
- For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.
- In extraordinary case of a destitute women or very poor household, the Village Health and Sanitation Committee untied grants could even be used for health care need of the poor household.
- The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education and Sanitation, Environmental Protection and Public Health Measures shall be key areas where these funds could be utilised.
- Every village is free to contribute additional grant towards the Village Health & Sanitation Committee. In villages where the community contributes financial resources to the Village Health and Sanitation Committee untied grant of Rs.10,000/-, additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention.

Maintenance of Bank Account

The Village Health and Sanitation Committee fund shall be credited to a bank account, which will be operated with the joint signature of ASHA/Health Link Worker/ Anganwadi Worker along with the President of the Village Health and Sanitation Committee/Pradhan of the Gram Panchayat. The account maintenance of this joint account shall be the responsibility of the Village Health and Sanitation Committee especially the ASHA/AWW [wherever no ASHA]. The Village Health and Sanitation Committee, theASHA/AWW shall maintain a register of funds received and expenditure incurred. The register shall be available for public scrutiny and shall be inspected from time to time by the ANM/MPW/Gram Panchayat.

Accountability

- Every Village Health and Sanitation Committee needs to maintain updated Household Survey data to enable need based interventions.
- Maintain a register where complete details of activities undertaken, expenditure incurred etc will be maintained for public scrutiny. This should be periodically reviewed by the ANM/Sarpanch.

- The Block level Panchayat Samiti will review the functioning and progress of activities undertaken by the VHSC.
- The District Mission in its meeting also through its members/block facilitators supporting ASHA [wherever ASHA's are in position] elicit information on the functioning of the VHSC.
- A data base may be maintained on VHCSs by the DPMUs.

Check Your Progress 1

1) List the activities under which the sub-centre receives money from the blocks/ supervisory unit.

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2) List the guidelines for use of the untied funds for sub-centre.

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3) List the guidelines for the use of untied funds for Village Health and Sanitation Committee.

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5.3 ACCOUNTING AND BOOK KEEPING REQUIREMENTS

Let us now read about accounting and book keeping requirements.

5.3.1 Important Accounting Principles and Policies to be Followed

- Accounting shall be done on cash basis i.e. a transaction shall be accounted for at the time of receipt or payment only.
- The books of accounts of the sub-centre shall be maintained on double entry book keeping principles.
- Period –Accounting period followed shall be the financial year of the Government of India i.e. 1st April to 31st March.

5.3.2 Books of Accounts to be Maintained

Following books should be manually maintained by the accountant:

- Columnar Petty Cash book

- Bank Register
- Ledger book (Units currently maintaining ledgers may continue maintaining it as a good practice.)
- Fixed Asset/ Stock register
- JSY Register

Columnar Petty Cash Book (Format Provided in Annexure I)

- The sub-centre should maintain a columnar petty cash book.
- Petty Cash book to be updated weekly and duly signed by the ANM 4.2.3. Bank Register (Format Provided in Annexure II).
- Sub-centre should maintain a bank register to record receipt and payment of funds through cheque respectively.
- It is to be closed monthly and duly signed by the ANM.

Ledgers (Format Provided in Annexure III)

Following points should be taken care of while maintaining ledger book:

Ledger accounts in the prescribed format are to be maintained. Accounting should be done and ledgers prepared under the following account heads (heads may be added / deleted based on state specific customisation):

- Grant in aid for JSY
- Grant in aid for untied fund for Sub-centre
- Grant in aid for untied fund for the respective VHSC under the sub-centre (One ledger account for each VHSC)
- Expenditure incurred out of JSY (Payment to beneficiaries)
- Expenditure incurred out of untied fund for Sub-centre
- Expenditure incurred out of untied fund for VHSC (One ledger account for each VHSC)
- Interest Earned

Once the vouchers are entered in cash / bank book, they should be immediately entered in the appropriate ledger folios (along with referencing to cash book serial number and voucher serial number)

All the ledger accounts shall be closed at the end of the month. Totals would be done for each ledger head and a SoE prepared. Discrepancies, if any, will be rectified and reconciled.

Fixed Asset and Stock Register (Format Provided in Annexure IV)

A fixed asset/ stock register is to be maintained to include the following items. It may be broken into three parts:

- Consumables purchased out of untied funds – like stationery, etc.
- Items of fixed nature purchased out of untied fund (like furniture, almirah, etc for the sub-centre). Assets transferred from the block are also to be recorded.
- Stock of free supplies (medicines or consumables, etc.) received from blocks

JSY Register

A register to keep the record of JSY beneficiaries is to be maintained. Register should capture all relevant information with respect to the beneficiary. (Information like Name, Age, Complete address, No of children, Finger print column, Name of husband, etc are required to be captured)

5.3.3 Basic Accounting Entries

At the time of receipt of funds from the Block for advance against a particular activity, the following entry is to be passed:

Bank A/c Dr

To, Grant-in-Aid for (Activity for Which Fund has been received)

(Three activities under which grants-in-aid is received are-JSY, Untied fund for Sub-centre and Untied fund for various VHSCs under it)

At the time of withdrawing money from the bank the following entry is to be passed

Cash A/c Dr

To, Bank A/c

At the time of incurring of expenditure the following entry is to be passed:

Expenditure Head A/c Dr

To, Bank/ Cash A/c

(The three categories of expenditure include payments for – JSY, from Untied fund for Sub-centre and Untied fund for various VHSCs under it)

For Interest earned on bank account the following entry is to be passed:

Bank A/c Dr

To, Interest Earned on Bank A/c

For unspent grant against a particular activity returned to the supervising Block/ BCHC

Grant-in-Aid for

(Activity for Which Fund has been received) A/c Dr

To, Bank A/c

(Three categories of grant-in-aid may be returned – JSY, Untied fund for Sub-centre and Untied fund for various VHSCs under it)

5.3.4 Accounting Process and Internal Controls

Cash/ Bank Book

- Sub-centre should withdraw cash as required and not have heavy cash in hand
- Cash book is to be updated on a weekly basis
- Physical cash should tally with the figure of cash as per books
- Bank pass book / bank statement to be updated regularly (monthly inspection by BAM during the monthly meeting may be conducted)

- Bank Account to be opened and operated under joint signature of the ANM and Sarpanch in any scheduled commercial bank / Grameen Bank/ Post office. Following points to be noted w.r.t the same:Private bank accounts should not be allowed to be maintained; In areas where bank availability is a problem, account should be maintained in post office.
- Interest income should be clearly identified and reported in the SoE/ UC on timely basis.
- All cheques shall be signed by the two signatories as authorised by the Governing/ Executive body of the Society in line with defined guidelines.
- Cheque books, new, used or currently under use shall be kept in the personal custody of ANM who is the authorised signatory on the cheques.
- Acknowledgement of a cheque issued and received shall be obtained from the payee.
- While making payments through cheque, its number should invariably be noted in the cash book for cross checking.
- All cash/cheques/Demand Drafts etc. received should be deposited into bank as far as possible on the same day itself, otherwise on the next working day positively.
- Bank reconciliation statement should be prepared as per the Format (appended under Annexure V). Following points should be followed in this regard:

BRS should be prepared on a monthly basis (by the 10th of the following month)

Separate BRS should be prepared for each bank account

BRS should be reviewed and signed by the Supervisory Medical Officer

Outstanding entries should be followed up

Proper explanation by the ANM to be given in case of any unreconciled entries

5.3.5 Payments and Expenditure

- All vouchers/ bills/ invoices to be scrutinised thoroughly before making payments
- All vouchers to be filled properly and should be complete in all respects
- All vouchers / bills / invoices to be scrolled (serial numbered) and entered in cash / bank book with appropriate referencing
- All vouchers to be supported with appropriate documentary evidence (vouchers to be prepared only when adequate supporting are in place)
- All supporting documents in originals should be defaced as 'PAID & CANCELLED' with details of cheque number and date
- All expenditure made should be in accordance with the approval of the sanctioning authority in line with delegation of power as prescribed by the State
- Expenditures to be debited to the correct account head
- The sub-centre should endeavour to make all payments only by crossed account payee cheque. Bearer cheque can be given to JSY beneficiaries if it is not practical/ time consuming to open their bank accounts. Normally payments by cash should be discouraged, however if that is not practical, payment by cash may be made, subject to directives / limits prescribed by the State.
- Any payment above Rs. 2500/- must necessarily be made through crossed Account payee cheques only.

5.3.6 Fixed Asset

Annual physical verification of fixed assets, if any, purchased out of untied grants should be conducted by block accountant with major discrepancies in physical verification, if any, reported to the BMO.

5.3.7 SoE Reporting*

Format of SoE Reporting and Provided in Annexure VI

- The sub-centre should ensure that by the 25th of the month it collects the monthly SoE from the VHSCs under its jurisdiction, if applicable to the sub-centre. (The ANM should review the SoE along with books of the VHSC to ensure correct reporting).
- However, it was observed in many cases, that the ANM of the supervising sub-centre was examining the books and preparing a quarterly / six-monthly SoE for the VHSCs under its jurisdiction. So the states may appropriately customise the reporting frequency from the VHSC based on their requirements.
- Further by the 26th of the month it should submit its monthly SoE (along with monthly SoEs received / collected from the VHSCs) to the block/ supervisory units.
- Even if in a particular month there is no expense at the sub-centre, a nil SoE report should be submitted to the block/ supervisory units.

In case any funds are also received under National Disease Control Programmes (NDCPs) at Sub-centre level, SoE reporting for the same also needs to be made by the sub-centre. Format similar to the SoE format (appended as Annexure V) can be used to report expenditure under them.

***Note:** In case of untied funds given to Sub-centre as advance, only funds reported by sub-centre as 'actually spent' under SoE shall be booked as expenditure. Hence, timely and accurate SoE reporting by sub-centre is very important.

5.3.8 Utilisation Certificate (UC) Reporting

Format Utilisation Certificate is Provided in Annexure VII.

- The sub-centre is required to submit the UC annually (Duly signed by the AN M of the sub-centre) along with the vouchers.
- The ANM should review the UC (along with books of accounts) prepared by the ASHA of the VHSCs under its jurisdiction for correctness and counter sign the same before submitting / forwarding it to the block / supervisory unit.
- As per GFR requirements, Utilisation Certificate also needs to be submitted for any funds received under NDCPs. Above format can also be used for the same.

Summary of Reporting Requirements for Sub-centre.

S. No.	Activity	Frequency	Cut-off Date
1	Collection of SoEs from the VHSCs*	Monthly	25th of the Month
2	Submission of monthly SoE (including all vouchers) to the supervisory unit	Monthly	26th of the Month
3	Submission of UCs (including the vouchers)	Annually	30th April of the following year

* Wherever Sub-centres are controlling the VHSCs.

Check Your Progress 2

1) List the Important Accounting Principles and Policies to be followed at the sub-centre.

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2) List the names of the Books of Accounts to be maintained at the sub-centre.

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3) List any five guidelines for operating Cash/ Bank Book at the sub-centre.

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4) List any five guidelines for Payments and Expenditure at the sub-centre.

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5.4 PREPARING A BUDGET

Let us now discuss the budget in detail:

Definition of budget

- A financial statement or plan for future activities in your health centre.
- It is frequently used to help control future activities.

Characteristics of budget

- It is prepared in advance.
- It focuses on the future i.e., it is future oriented.
- It is expressed in quantitative forms, physical or monetary unit or both.

Uses of budget

- It brings about the efficiency.
- It serves as a benchmark for controlling ongoing activites.
- It helps in reducing wastages and losses by revealing them in time for corrective actions.

Steps in preparing budget

- List out the activities you wish to carry out in your sub-centre for the next year.
- For each of the activity, mention number and money etc required.
- Add the total costs and this is your budget for the sub-centre in the next year.

Preparing for the budget of the sub-centre

Name of the Activity	Number of the Activity (A)	Estimated Money Required per Activity (B)	Total Money for the Activities (AXB)	Remarks

Check Your Progress 3

1) What is a budget?

.....

.....

.....

2) What are the steps in preparing budget?

.....

.....

.....

5.5 AUDIT

Auditing is a systematic examination of the books and records related to finances.

Scope of Audit

- To check the arithmetical accuracy of the accounts
- To check the books of accounts with the help of all the relevant vouchers, invoices, correspondences, minute books, etc.
- To verify the assets and liabilities shown in the balance sheet.
- To report to the client on the basis of his findings.

Objectives of Audit

- Ensuring the correctness and completeness of accounts.

- Ensuring regulations of expenditure by examination of accounts.
- Looking into the honesty of financial transactions to detect errors and frauds.
- Ensuring that the funds expended by institution have produced the desired results.

Audit Process

- Audit is done by the auditors identified.
- They will visit you and ask for various records and documents related to the activities you have carried our in the given financial year.
- The various records and vouchers related to the account as you have maintained at your sub-centre (mentioned above) will be examined by them.
- The suggestion for the improvement in future will be given by them.

Check Your Progress 4

1) What is audit?

.....

.....

.....

2) What is the scope of audit?

.....

.....

.....

5.6 LET US SUM UP

The Government of India has launched the National Rural Health Mission to carry out the necessary architectural correction in the basic health care delivery system. As a result of decentralisation, most of the NRHM funds are flowing down to Sub-centres and VHSCs.

The success of decentralisation experiment would depend on the strength of the management capacities built at this level.

The activities under which the sub-centre receives money from the blocks/ supervisory unit are – Janani Suraksha Yojana, Untied Funds for Village Health and Sanitation Committees (VHSC) under the sub-centre, Untied Funds for Sub-centre.

The guidelines for use of the untied funds for sub-centre are :

- As part of the National Health Mission, it is proposed to provide each sub-centre with Rs.10,000 as an untied fund to facilitate meeting urgent yet discrete activities that need relatively small sums of money.
- The fund shall be kept in a joint bank account of the ANM and the Sarpanch.
- Decisions on activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and be administered by the ANM. In areas where the sub-centre is not co-terminus with the Gram Panchayat (GP) and the

sub-centre covers more than one GP, the VHC of the Gram Panchayat where the SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub-centre.

- Untied Funds will be used only for the common good and not for individual needs, except in the case of referral and transport in emergency situations.

The guidelines for the use of untied funds for Village Health and Sanitation Committee.

- As a revolving fund from which households could draw in times of need to be returned in installments thereafter.
- For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.
- In extraordinary case of a destitute women or very poor household, the Village Health and Sanitation Committee untied grants could even be used for health care need of the poor household.
- The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education and Sanitation, Environmental Protection and Public Health Measures shall be key areas where these funds could be utilised.

The Important Accounting Principles and Policies to be followed at the sub-centre.

- Accounting shall be done on cash basis i.e. a transaction shall be accounted for at the time of receipt or payment only.
- The books of accounts of the sub-centre shall be maintained on double entry book keeping principles.
- Period –Accounting period followed shall be the financial year of the Government of India i.e. 1st April to 31st March.

The Books of Accounts to be maintained at the sub-centre:

- Columnar Petty Cash book
- Bank Register
- Ledger book (Units currently maintaining ledgers may continue maintaining it as a good practice.)
- Fixed Asset/ Stock register
- JSY Register

The guidelines for operating Cash/ Bank Book at the sub-centre:

- Sub-centre should withdraw cash as required and not have heavy cash in hand
- Cash book is to be updated on a weekly basis
- Physical cash should tally with the figure of cash as per books
- Bank pass book / bank statement to be updated regularly (monthly inspection by BAM during the monthly meeting may be conducted)
- Bank Account to be opened and operated under joint signature of the ANM and Sarpanch in any scheduled commercial bank / Grameen Bank/ Post office. Following points to be noted w.r.t the same:Private bank accounts should not be allowed to be maintained; In areas where bank availability is a problem, account should be maintained in post office

The guidelines for Payments and Expenditure at the sub-centre

- All vouchers/ bills/ invoices to be scrutinised thoroughly before making payments
- All vouchers to be filled properly and should be complete in all respects
- All vouchers / bills / invoices to be scrolled (serial numbered) and entered in cash / bank book with appropriate referencing
- All vouchers to be supported with appropriate documentary evidence (vouchers to be prepared only when adequate supporting are in place)
- Any payment above Rs. 2500/- must necessarily be made through crossed Account payee cheques only.

The budget is a financial statement or plan for future activities in your health centre. It is frequently used to help control future activities . The steps in preparing budget are:

- List out the activities you wish to carry out in your sub-centre for the next year.
- For each of the activity, mention number and money etc required.
- Add the total costs and this is your budget for the sub-centre in the next year.

The Audit is a systematic examination of the books and records related to finances. The scope of audit is:

- To check the arithmetical accuracy of the accounts
- To check the books of accounts with the help of all the relevant vouchers, invoices, correspondences, minute books, etc.
- To verify the assets and liabilities shown in the balance sheet.
- To report to the client on the basis of his findings

5.7 MODELANSWERS

Check Your Progress 1

1) Janani Suraksha Yojana

   Untied Funds for Village Health and Sanitation Committees (VHSC) under the sub-centre

   Untied Funds for Sub-centre

2) The guidelines for use of the untied funds for sub-centre are :
   - As part of the National Health Mission, it is proposed to provide each sub centre with Rs.10,000 as an untied fund to facilitate meeting urgent yet discrete activities that need relatively small sums of money.
   - The fund shall be kept in a joint bank account of the ANM and the Sarpanch.
   - Decisions on activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and be administered by the ANM. In areas where the sub-centre is not co-terminus with the Gram Panchayat (GP) and the sub-centre covers more than one GP, the VHC of the Gram Panchayat where the SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub-centre.
   - Untied Funds will be used only for the common good and not for individual needs, except in the case of referral and transport in emergency situations.

3) The guidelines for the use of untied funds for Village Health and Sanitation Committee are:

- As a revolving fund from which households could draw in times of need to be returned in installments thereafter.
- For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.
- In extraordinary case of a destitute women or very poor household, the Village Health and Sanitation Committee untied grants could even be used for health care need of the poor household.
- The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education and Sanitation, Environmental Protection and Public Health Measures shall be key areas where these funds could be utilised.

Check Your Progress 2

1) The important Accounting Principles and Policies to be followed at the sub-centre are:

- Accounting shall be done on cash basis i.e. a transaction shall be accounted for at the time of receipt or payment only.
- The books of accounts of the sub-centre shall be maintained on double entry book keeping principles.
- Period - Accounting period followed shall be the financial year of the Government of India i.e. 1st April to 31st March.

2) The names of the Books of Accounts to be maintained at the sub-centre are:

- Columnar Petty Cash book
- Bank Register
- Ledger book (Units currently maintaining ledgers may continue maintaining it as a good practice.)
- Fixed Asset/ Stock register
- JSY Register

3) The five guidelines for operating Cash/ Bank Book at the sub-centre are:

- Sub-centre should withdraw cash as required and not have heavy cash in hand
- Cash book is to be updated on a weekly basis
- Physical cash should tally with the figure of cash as per books
- Bank pass book / bank statement to be updated regularly (monthly inspection by BAM during the monthly meeting may be conducted)
- Bank Account to be opened and operated under joint signature of the ANM and Sarpanch in any scheduled commercial bank / Grameen Bank/ Post office. Following points to be noted w.r.t the same:Private bank accounts should not be allowed to be maintained; In areas where bank availability is a problem, account should be maintained in post office

4) The five guidelines for Payments and Expenditure at the sub-centre are:

- All vouchers/ bills/ invoices to be scrutinised thoroughly before making payments

- All vouchers to be filled properly and should be complete in all respects
- All vouchers / bills / invoices to be scrolled (serial numbered) and entered in cash / bank book with appropriate referencing
- All vouchers to be supported with appropriate documentary evidence (vouchers to be prepared only when adequate supporting are in place)
- Any payment above Rs.2500/- must necessarily be made through crossed Account payee cheques only.

Check Your Progress 3

1) Budget is :
   - A financial statement or plan for future activities in your health centre.
   - It is frequently used to help control future activities

2) The steps in preparing budget are:
   - List out the activities you wish to carry out in your sub-centre for the next year.
   - For each of the activity, mention number and money etc required
   - Add the total costs and this is your budget for the sub centre in the next year.

Check Your Progress 4

1) Audit is :

Auditing is a systematic examination of the books and records related to finances

2) The scope of audit is:
   - To check the arithmetical accuracy of the accounts.
   - To check the books of accounts with the help of all the relevant vouchers, invoices, correspondences, minute books, etc.
   - To verify the assets and liabilities shown in the balance sheet.
   - To report to the client on the basis of his findings

5.8 REFERENCES

1) The guidelines for the Janani Suraksha Yojana, MoHFW, Government of India, New Delhi, It is available at the following link :

   http://mohfw. nic. in/janani suraksha_yojana.htm

2) The guidelines for NHRM, MoHFW , Government of India, New Delhi, it is available at the following link:

   http://mohfw.nic.in/NRHM/Documents/Guidelines of untied funds NRH M.pdf

3) Model accounting handbook for sub centres, MoHFW , Government of India, 2011, New Delhi , it is available at the following link

   http://www.mohfw.nic.in/showfile.php?lid=868

4) The framework for implementation of NHM, MoHFW, Government of India, New Delhi, it is available at the following link:

   http://nrhm.gov.in/images/pdf/NHM/NHM_Framework_for_Implementation_08-01-2014_.pdf

5.9 ANNEXURE (I – VIII)

Refer the following eight Annexures pertaining to the various records maintained and prepared at sub-centre as given below:

Annexure-1, Format of Columnar Petty Cash Book

Annexure-II, Format of Bank Register

Annexure-III, Format of Ledger Account (for those sub-centres already preparing ledger books)

Annexure IV, Format of Asset Register

Annexure- V, Format of Bank Reconciliation statement

Annexure VI, Format of SoE Reporting from Sub-centres

Annexure VII, Format for Utilisation Certificate (UC) Reporting

Annexure-VIII, ASHA incentives under various National Health Programmes

Annexure-1, Format of Columnar Petty Cash Book

Sr. No.	Date	Particulars (Including party name, activity head, etc.)	Receipts (A)	Total Cleaning Expenditure of the sub centre(B)	Minor modifications and repair	Transport of emergencies	Payment/ Reward to ASHA	Other Expense	Daily Balance (C= A-B)

Note: Note: Cash book should be serially page numbered and authenticated by the supervisor

* Illustrative expense heads have been mentioned here, however, additional heads can be added as per requirement

Annexure-II, Format of Bank Register

Receipts				Payments			
Date	Particulars (Details of the source)	Amount (Rs.)	Sr. No.	Date	Particulars (Details of the activity for which amount is spent)	S. No.	Amount (Rs.)
	Grant-in-aid for VHSC untied fund				Cash Withdrawal		
	Cash Deposit				Payment for (Explanation of the activity for which payment has been made)		
	Interest Received						
	Monthly Total (A)				Monthly Total (B)		
Balance (A–B)							

S.No. Serial Number of the Invoice / voucher

Annexure-III, Format of Ledger Account (for those sub-centres already preparing ledger books)

Name of the Ledger Account (Name of the Expense / Activity and Name of the Pool)

Date	Particular	Voucher Serial Number	Cash Book Folio Number	Amount (Dr.)	Amount (Cr.)	Balance (Dr. / Cr.)

Dr-debited , Cr-credited

Annexure-IV, Format of Asset Register

Date	Voucher Sr. No.	Particular	Location	Assets Quantity (Number)				Assets Cost (Rupees)			
				Beginning of year	Addition	Deletion/transfer	End of year	Beginning of year	Addition	Deletion/transfer	End of year

Annexure- V, Format of Bank Reconciliation Statement

Bank Reconciliation statement for the month of_____

Name of Sub-centre :
Bank Account No.
Name of Bank

Balance as per the cash book (as on the date)

Add:

i. Cheques issued but not yet presented for payment

ii. Credit entered made in the bank pass book but not yet shown as cash

Total

Less:

i. Amount sent to bank but not yet credited in the saving account of the unit

ii. Bank charges debited in the bank account but not yet accounted for in the cash book

Total

Balance as per the pass book

Prepared by

Examined by

Date

Annexure-VI, Format of SoE Reporting from Sub-centres

Sr. No.	Activity	A	B	C	D= (B+C)	E	F	G= (E+F)	H=(A+D–G)
		Opening balance (Begging of Financial year)	Amount received (In current financial year) till the previous month	Amount received during the month	Total amount received (in current financial year) till date	Expenditure (in current financial year) Ttiillll the previous month	Expenditure during the month	Total expenditure (In current Financial year) Ttiillll date	Unspent balance
1.	JSY								
a	Paid to beneficiaries								
b	Paid to ASHA								
2.	Untied fund of Sub-centre							*Please fill note-1	
3.	Untied fund for VHSC								
a	VHSC-1								
b	VHSC-2								
c	VHSC-3								
4.	Annual maintenance grant for sub-centre							**Please fill note-2	

Note 1: Out of the amount of Rs.10, 000 sanctioned for the year (Reporting Year) towards Untied Fund for Sub-centre, only Rs. _____, has been utilised and the remaining utilisation of Rs._____ relates to the previous years.

****Note 2:** of the amount of Rs.10, 000 sanctioned for the year (Reporting Year) towards Annual Maintenance Grant for Sub-centre, only Rs._____ has been utilised and the remaining utilization of Rs._____ relates to the previous years.

Annexure-VII, Format for Utilisation Certificate (UC) Reporting (Form No. GFR-19A)

Name of the sub-centre

Reproductive Helth Programme Phase-II

Utilisation certificate for the year

Dated

Sanction Letter No. and Date	Opening Balance	Funds Received in Current Year	Expenditure in Current Year	Balance if Any

Further certified that I have satisfied myself that the conditions, on which the grant-in-aid was sanctioned, have been duly filled and that I have exercised the following checks to see that the money actually utilised for the purpose for which it was sanctioned.

1.

2.

3.

Signature of ANM

Supervisory Medical Officer in charge

Annexure-VIII, ASHA incentives under various National Health Programmes

Sl. No.	Heads of Compensation Maternal Health	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
1	JSY financial package (NEW uniform package)			MOHFW Order No. Z 14018/1 2012/-JSY JSY section Ministry of Health and Family Welfare-6th. Feb. 2013
	a. For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health- RCH Flexi pool	
	b.For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
2	Reporting death of women (15-49 years age group) by ASHA to Block PHC Medical Officer. (New Revised incentive)	200 for reporting within 24 hours of occurrence of death by phone	Health Sub-Centre Un-tied Fund	MOHFW-OM - 120151/148/2011/ MCH; Maternal Health Division; 14th Feb. 2013
II	Child Health Undertaking six (in case of institutional deliveries) and seven (for home deliveries) home- visits for the care of the new born and post-partum mother	250	Child Health-RCH Flexi pool	HBNC Guidelines –August 2011
III	Immunisation			
1	Social mobilisation of children for immunisation during VHND	150/session	Routine Immunisation Pool	Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
2	Complete immunisation for a child under one year	75.00		
3	Full immunisation per child upto two years age (all vaccination received between 1st and second year age after completing full immunisation after one year	Rs. 100	Routine Immunisation Pool	Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
4	DPT booster ii	Rs. 50		

IV	Family Planning			
1	Ensuring spacing of 2 years after marriage	500	Family Planning Compensat-ion Funds	Minutes Mission Steering Group meeting- April 2012
2	Ensuring spacing of 3 years after birth of 1st child	500		
3	Ensuring a couple to opt for permanent limiting method On 1 or 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	Sterlization post partam 400 Sterilization female 300	Family Planning Sterilisation Compensation Funds	Revised Compensation package for Family Planning- September 2007- No-N 11019/2/ 2006-TO-Ply
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	400		
V	Adolescent Health			
	Organising monthly meeting with adolescent girls pertaining to Menstrual Hygiene		VHSNC Funds	
VI	Nirmal Gram Panchayat Programme			
	Motivating households to construct and use a toilet	constructed	Funds for IEC activities under District Project Outlay under TSC	Minutes MSG-Meeting April 2012; DO No. W-11042/7/2007/-CSRP-Part
VII	Village Health Sanitation and Nutrition Committee			
	Facilitating monthly meetings of VHSNC followed by meeting with women and adolescent girls	150/ meeting	VHSNC Untied Fund	MOHFW Order Z-18015/12/2012-NRHM-II
VIII	Revised National Tuberculosis Control Programme			

	Being DOTS Provider (only after completion of treatment or cure)	Type of TB and incentive DS-TB 1000 DR-TB H MONO 1000 Dr-TB SHORTER IP 2000 Dr-TB SHORTER CP 3000 Dr-TB LONGER IP 2000 Dr-TB LONGER CP 3000	RNTCP Funds	Revised Norms and Basis of Costing under RNTCP
IX	National Leprosy Eradication Programme			
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	400	NLEP Funds	Guidelines for involving ASHAs under NLEP
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	600		
X	National Vector Borne Disease Control Programme			
1	Preparing blood slides	slide 15	NVDCP Funds for Malaria Control	NVDCP Guidelines for involvement of ASHAs in Vector Borne Diseases-2009
2	Maleria cases full	RT 75 rs.		

UNIT 6 RECORDS AND REPORTS

Structure

6.0 Introduction

6.1 Objectives

6.2 Concept of Records and Reports

- 6.2.1 Importance of Records and Reports
- 6.2.2 Legal Implications of Record and Reports
- 6.2.3 Purposes of Records
- 6.2.4 Value and Uses of Records
- 6.2.5 Principles of Record Writing
- 6.2.6 Filing of Records

6.3 Types of Records

- 6.3.1 Records Related to Community
- 6.3.2 Registers
- 6.3.3 Guidelines for Maintaining Records

6.4 Report Writing and Documentation of Activities Carried out During Field/ Home Visits

- 6.4.1 Purposes of Writing Reports
- 6.4.2 Types of Report
- 6.4.3 Criteria of Good Report

6.5 Medical Record Department

- 6.5.1 Filing of Medical Records
- 6.5.2 Retention of Medical Records
- 6.5.3 Functions of Medical Records Department

6.6 Electronic Medical Records (EMR)

- 6.6.1 Capabilities and Components of an Electronic Medical Record
- 6.6.2 Electronic Health Record
- 6.6.3 Levels of Automation
- 6.6.4 Attributes of Electronic Health Record (EHR)
- 6.6.5 Benefits of Electronic Health Record
- 6.6.6 Advantages and Disadvantages of Electronic Health Record

6.7 Nurses Responsibility in Record Keeping and Reporting

6.8 Let Us Sum Up

6.9 Key Words

6.10 Model Answers

6.11 References

6.0 INTRODUCTION

In the previous unit you have learnt financial management and accounts. In continuation this unit deals with records and reports. As you know that records are a source from which data can be collected, it becomes basis for assessment of needs and future planning. You will also learn about various reports to be submitted at the place of work, information provided in monthly reports. Records evaluate previous performance with current status.

6.1 OBJECTIVES

After completing this unit, you should be able to:

- list the records to be maintained at sub-centre/ FRU level;
- explain the importance of records to be maintained and reports to be prepared at sub-centre /FRU level;
- identify the official records to be maintained and reports to be submitted under the provision of community health nursing practice;
- discuss the guidelines to be used for maintaining the up to date records. And sending the reports to appropriate authority;
- explain about the surveillance and role of Nurse health practitioner in the surveillance;
- describe the information to be provided in monthly reports and prepare the reports in the prescribed formats under the current health programme; and
- evaluate your own performance by assessing the reports prepared by you.

6.2 CONCEPTS OF RECORDS AND REPORTS

A record is a permanent written communication that documents information relevant to a client's health care management, e.g. a client chart is a continuing account of client's health care status and need. –Potter and Perry

An effective health record shows the extent of the health problems' needs and other factors that affect individuals their ability to provide care and what the family believes. What has been done and what to be done now also can be shown in the records. It also indicates the plans for future visits in order to help the family member to meet the needs.

All documents information, regardless its characteristics, media, physical form and the manner it is recorded or stored. Records function as evidence of activities. Express or presenting facts, data, figures or other information in writing is called records means written information. Health records refers to the forms on which information about an individual or family is recorded.

The performance or output of services rendered by the staff are reported on the formats prescribed. This information is communicated from the lowest to highest level of health services, They are also used as important management tools for assessment of quality and quantity of services provided, which further helps in decision making process for future action plans. These reports also help to understand if planned services are provided or not.

6.2.1 Importance of Records and Reports

- Assess health level of the community
- Helps in collecting data
- Assessment and evaluation of work
- Basis for formulating plans
- Tool or medium for health education.

- Determine needs of resources
- Legal documentation
- Means of communication
- Provide information of good nursing
- Conduct training and research work
- Assess health problems

6.2.2 Legal Implication of Records and Reports

There are three approaches to legal implications of records and reports:

1) **Individual approach:** Records of importance are birth records, death records etc. They are valuable documents not only from health department also from other departments.
2) **Community approach:** Health records provide conformation and protection of rights related to health. It presents charges through which charges can be taken against medical administration and political system. It could lead to proper implementation of services.
3) **Nursing approach:** It is important preserving individual records of health. Confidentiality and privacy has to be maintained. These documents should be shown to authorised person. The value of the record when they are presented at the right time. Legally accepted process should be followed for destroying obsolete records. Records of medico legal cases should be handled carefully.

6.2.3 Purposes of Records

1) Supply data that are essential for programme planning and evaluation.
2) To provide the practitioner with data required for the application of professional services for the improvement of family's health.
3) Records are tools of communication between health workers, the family, and other development personnel.
4) Effective health records shows the health problem in the family and other factors that affect health.
5) A record indicates plans for future.
6) It provides baseline data to estimate the long-term changes related to services.
7) Legal documents: poisoning, assault, rape, LAMA, burn etc.
8) Research or statistics: rates
9) Audit and nursing audit
10) Quality of care
11) Continuity of care
12) Informative purposes: census
13) Teaching purpose of students
14) Diagnostic purposes: test reports

6.2.4 Value and Uses of Records

Let us go through the value of records for the nurses, doctors, and for the Community and Organisation as discussed below:

For the Nurse:

- Provides basic facts for service.
- Provides a basis of analysing needs.
- Provides a basis for short term and long term planning.
- Prevents duplication of service.
- Helps evaluate care and teaching given.
- Helps follow-up services effectively.
- Helps to organise work.
- Serves as a guide to professional growth.
- Enables to judge the quality and quantity of the work done.

For the Family and Individual:

- Creates awareness.
- Helps to recognise health needs.
- Can be used as teaching tool.

For the Doctor:

- Serves as a guide for diagnosis, treatment and evaluation of services.
- Indicates progress.
- May be used in research.

For the Sanitarian:

- Identify families needing service.
- Draw nurses attention to any pertinent observation made.

For the Community and Organisation:

- Evaluate services rendered, teaching done and persons action and reactions.
- Helps in the guidance of students.
- Helps administrator to assess the health needs and needs of village/area.
- Helps in making studies for research, for legislative action and for planning budget.
- Is a legal evidence of service rendered.
- Provides justification for expenditure of funds.

6.2.5 Principles of Record Writing

1) Nurses should develop their own method of expression and form in record writing.
2) Records should be written clearly, legibly and appropriately.
3) Records should contain facts based on observation, conversation and action.

4) Select relevant facts and the recording should be neat, complete and uniform
5) Records should be written immediately after an interview.
6) Records are confidential documents.
7) Records are valuable legal documents and so it should be handled carefully, and accounted for.
8) Records systems are essential for efficiency and uniformity of services.
9) Records should provide for periodic summary to determine progress and to make future plans.

6.2.6 Filling of Records

Different systems may be adopted depending on the purposes of the records and on the merits of a system. The records could be arranged:

- Alphabetically
- Numerically
- Geographically and
- With index cards

Records should be Permanent, Secure, Traceable

- Permanent,
- Secure: Maintain confidentiality
  Limit access
  Protect from environmental hazards
- Traceable: Sign and date every
  Keep books bound record
  Number pages
  Use permanent ink
  Control storage

6.3 TYPES OF RECORDS

There are different ways to know the type of records. Let us discuss each one by one:

1) **Cumulative or continuing records**
   - This is found to be time saving, economical and also it is helpful to review the total history of an individual and evaluate the progress of a long period. (e.g.) child's record should provide space for newborn, infant and preschool data.
   - The system of using one record for home and clinic services in which home visits are recorded in blue and clinic visit in red ink helps coordinate the services and saves the time.

2) **Family records**
   - The basic unit of service is the family. All records, which relate to members of family, should be placed in a single family folder. This gives

the picture of the total services and helps to give effective, economic service to the family as a whole.

- Separate record forms may be needed for different types of service such as TB, maternity etc. all such individual records which relate to members of one family should be placed in a single family folder.

Some scholars have classified records under four headings. They are as follows:

1) **Periodical:**
   a) Permanent records (cumulative)
   b) Temporary records (casual/daily records)
2) **Unit Based Records:**
   a) Individual (individual health cards)
   b) Related to family (family folders)
   c) Related to community (community folders)
   d) National (national health programms records)
3) **Subject Based:**
   a) Economical (financial structure of family, village)
   b) Social (records of social structure)
   c) Political
   d) Medical and nursing (treatment and medicine records)
4) **Collection Place Based:**
   a) Collected at institutions (records of hospitals/ health Centres)
   b) Records to be kept with the individual (immunisation cards, disease cards)

6.3.1 Records Related to Community

These are of two categories:

a) Records to be kept under health centres
b) Records to be kept with the patient

a) **Records to be kept under health centres**

Family folders: MCH cards

Antenatal card/ postnatal cards

Infant card

Pre-school child card

Medicine distribution card include records of iron and folic acid distribution cards

Family welfare records: Eligible couple,

MTP,

Family planning.

Treatment and referral records

Vital event records: birth and death records

General information records: Individual records
Family
Village
Map of community

Other records: antenatal records
Medicine records
Monthly/ yearly records
Consumable stock register
Stationary stock register
Daily diary
Cumulative records

b) **Records to be kept with the Patient (Kept under supervision of community health nurse)**

These are:

- Health record of school going children
- Infant health card
- Maternal card
- TB patient card
- Individual health card
- Birth and death record
- Inpatient and outpatient record
- Eligible couple records

6.3.2 Registers

It provides indication of the total volume of service and type of cases seen. Clerical assistance may be needed for this. Registers needed to be maintained at FRU are:

- MCH Register and Immunisation card- Maternal care, Birth, Newborn and child care.
- Registers for recording Contraceptives:
  - Condom distribution register
  - Oral pill register
  - CU 'T'/IUD register
  - Sterilization register – Male and female
- FRU clinic register/OPD register
- Admission and Discharge register
- Death register

* Stock register

* Referral register

* Duplicate copy of the monthly report submitted for each month.

6.3.3 General Guidelines for Maintaining Records

1) Enter information in the proper place.
2) Write down information immediately as soon as possible. Delay results in incomplete and inaccurate records.
3) Maintain records up-to-date daily and avoid letting records being piled up.
4) Write clearly and neatly. It should be legible.
5) Keep records in order either alphabetically/numerically/geographically and with index card.
6) Keep all the registers in cupboard, dust regularly and protect from rats, cockroaches and termites.
7) Treat records confidential and do not allow unauthorised person to read the records.
8) Maintain an adequate stock of stationary, registers and all forms needed to ve filled and submitted.
9) Destroy all old records (i.e. more than 5 years old).

Maintenance of Health Record at Facility Level

a) **Village Register**

The register is maintained to store the information regarding an overall picture of each village covered under the sub-centre area.

b) **Household Survey Register**

The information regarding each and every household is collected during household survey. After the initial survey, it should be revised after three years. The details of information, need to be collected and entered in the survey register

c) **Eligible Couple Register**

Identify the number of couples where the wife's age is between 15–45 years from household survey register and enter in this register with address. The family status with parity and age of the youngest child should also be mentioned. The couples if using any contraceptives also need to be recorded along with the details of contraceptives methods being used.

d) **Maternal and Child Health Register cum Contraception Register**

Is just like the family folder with maternal data (antenatal, natal and postnatal) record and under five records of the child, adolescent card and eligible couples use of contraceptives methods.

e) **Sub-centre/FRU Clinic Register**

This register is maintained for keeping records of patients attending the sub-centre clinics. The attendance in antenatal, immunisation, family planning clinics should not be registered in this record.

f) **Death Register**

All deaths occurring in the area are covered by the sub-centre are entered in this register.

g) **Stock Register**

Records of particulars related to all items provided and utilised at sub-centre should be maintained.

h) **Register for Recording Consultative Process**

As an important member of the health team you have to conduct meetings with village working team constituted for each village and with other members of the group of that village. The details of the meetings are recorded of each meeting in the register.

i) **Referral Register**

The details of the referred cases should be entered in the register. This will also help to undertake follow-up of the referrals made.

j) **Daily Diary**

The daily diary is maintained by the Health Team Members in which the daily activities are performed in the field as well as the clinic with regard to immunisation, antenatal checkup and follow-up, distribution of contraceptives, follow-up of IUD and OP cases, identification of PID. RTI/ STI cases, birth and death reported, malaria cases etc. The meetings conducted with the village working team and the group of village representatives should also be mentioned in the diary.

The daily diary will enable to update all the register to be maintained and will also be helpful in preparation of the monthly report. It is easy to carry one daily diary instead of all the registers when one goes on home visits/meetings.

Check Your Progress 1

1) List the purposes of record keeping.

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2) List the types of records to be kept at the health centre.

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3) Explain the legal implication of records.

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4) List the principles of record writing.

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5) List the patient records to be kept at health centre and with the patient.

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6) List the registers to be maintained at the health centre.

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7) Describe the guidelines for maintaining records.

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6.4 REPORT WRITING AND DOCUMENTATION OF ACTIVITIES CARRIED OUT DURING FIELD/HOME VISITS

Let us now learn about reports, purpose of writing reports in details:

Reports

Potter and Perry stated that "a report is a summary of activities or observations seen, performed or heard". These are account or statement describing in detail an event, situation, or like, usually as the result of observation, inquiry, etc. a formal or official presentation of facts. Some important aspects to be considered are :

- Reports can be compiled daily, weekly, monthly, quarterly and annually.
- Report summarises the services of the nurse and/or the agency.
- Reports may be in the form of an analysis of some aspect of a service.
- These are based on records and registers and so it is relevant for the nurses to maintain the records regarding their daily case load, service load and activities.
- Thus the data can be obtained continuously and for a long period.

6.4.1 Purposes of Writing Reports

- To show the kind and quantity of service rendered over to a specific period.
- To show the progress in reaching goals.
- As an aid in studying health conditions.
- As an aid in planning.
- To interpret the services to the public and to other interested agencies.

6.4.2 Type of Reports

1) Performance in corresponding month of last year
2) Performance in the reporting month
3) Cumulative performance till corresponding month of last year
4) Cumulative performance till current month
5) Planed performance in current year

6.4.3 Criteria of Good Report

- Can be made promptly
- Clear, concise and complete
- All pertinent, identifying data included
- Mention all people concerned, situation and signature of person making report
- Easily understood
- Important points are emphasised

Key Messages

- Written policies and procedures are the backbone of the quality system
- Complete quality assurance records make quality management possible
- Keeping records facilitates meeting programme reporting requirement
- Records and reports reveals the essential aspects of service in such logical order so that the new staff may be able to maintain continuity of service to individuals, families and communities.

6.5 MEDICAL RECORD DEPARTMENT

Medical Record of the patient stores the knowledge concerning the patient and his care. It contains sufficient data written in sequence of occurrence of events to justify the diagnosis, treatment and outcome. In the modern age, Medical Record has its utility and usefulness and is a very broad based indicator of patients care.

6.5.1 Filing of Medical Records

- The inpatients Medical Record is filed by the serial numbers assigned at central Admitting Office.
- The Record is bound in bundles 100 each and are kept year wise according to the serial number.

6.5.2 Retention of Medical Record

- The policy is to keep indoor patient Records for 10 years
- The OPD registers for 5 years
- The record which is register for legal purposes in Maintained for 10 years or till final decision at the court of Law

6.5.3 Functions of Medical Record Department

1) Daily receipt of case sheets pertaining to discharge and expired patients from various wards, there checking and assembly.
2) Daily compilation of Hospital census report.
3) Maintains and retrieval of records for patient care and research study.
4) Completion and Procession of Hospital statistics and preparation on different periodical reports on morbidity and mortality.

5) Online registration of vital events of Birth and Death.
6) Issuing Birth and Death certificated up to one year.
7) Dealing with Medico Legal records and attending the courts on summary.
8) Arrangement and Supervision of enquiry and admission office.

6.6 ELECTRONIC MEDICAL RECORDS (EMR)

Let us now learn electronic medical records.

The IOM 2003 Patient Safety Report describes an EMR as encompassing:

- "a longitudinal collection of electronic health information for and about persons
- Immediate electronic access to person and population-level information by authorized users;
- Provision of knowledge and decision-support systems that enhance the quality, safety, and efficiency of patient care and
- Support for efficient processes for health care delivery."

The 1997 IOM report "The Computer-Based Patient Record: An Essential Technology for Health Care" defines an EMR as: "A patient record system is a type of clinical information system, which is dedicated to collecting, storing, manipulating, and making available clinical information important to the delivery of patient care. The central focus of such systems is clinical data and not financial or billing information."

6.6.1 Capabilities and Components of an Electronic Media Record (EMR)

There are three essential capabilities of an EMR. They are:

1) To capture data at the point of care,
2) To integrate data from multiple internal and external sources, and
3) To support caregiver decision making.

Components of an EMR

- Results reporting
- Data repository
- Decision support
- Clinical messaging and e-mail
- Documentation
- Order entry

6.6.2 Electronic Health Record (EHR)

It is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. There are interoperability standards to exchange information outside a single healthcare delivery system. It supports other care-related activities directly or indirectly– evidence-based decision support, quality management, and outcomes reporting.

6.6.3 Levels of Automation

- Stage 0: Not all ancillary systems (Lab, X-ray, Pharmacy) are operational
- Stage 1: Major ancillary clinical systems installed
- Stage 2: A clinical data repository (CDR) stores information from major ancillary clinical systems
- Stage 3: Basic clinical documentation required, CDR storage retrieval (picture archiving communication systems-PACS)
- Stage 4: Computerised provider order entry(CPOE), support for evidence-based practice
- Stage 5: Barcode medication administration (BCMA), radio frequency identification (RFID) integrated with CPOE and pharmacy
- Stage 6: Full physician documentation, decision support, alerts, full PACS
- Stage 7: Fully electronic paperless environment

6.6.4 Attributes of Electronic Health Record (EHR)

The attributes of Electronic Health Record are listed below:

- Secure, reliable access where and when needed
- Records and manages episodic and longitudinal information
- Primary information source during care
- Assists with planning and delivery of evidence-based care
- Captures data for:
  - Quality improvement
  - Utilization review
  - Risk management
  - Resource planning
  - Performance management
- Captures information needed for medical record and reimbursement purposes
- Longitudinal, masked information supports clinical research, public health reporting, and population health initiatives
- Supports clinical trials and evidence-based research

6.6.5 Benefits of Electronic Health Record

The benefits of Electronic Health Record are tabulated and listed below:

S.No	Areas	Benefits
1.	General	Improved data integrity: readable, better organised, accurate, complete Improved productivity: access data whenever, wherever for timely decision Increased quality of care: tailored views, "dash-board" Increased satisfaction for caregivers: easy access to client data and related services

S.No	Areas	Benefits
2.	Nursing	Decreased redundant data collection Allowed data comparison from prior visits Ongoing access, update record at bedside Improved documentation and quality of care Supported timely decision
3.	Health provider	Better/faster/simultaneous data access Improved documentation, reporting Prompted to ensure administration of treatments and medications Supported automation of critical pathways / workflows Improved efficiency: eligibility, early warning of status changes
4.	Healthcare Enterprise	Better record security Fewer lost records Instant notice of eligibility/procedure authorisation Decreased need and cost for record storage, x-ray film, filing Decreased length of stay due to waiting Faster turnaround for accounts Increased compliance with regulatory requirements
5.	Patient	Decreased wait time for treatment Increased access/control over health information Increased use of best practices/decision support Increased ability to ask informed questions Quicker turnaround time for ordered treatments Greater clarity to discharge instruction Increased responsibility for own care Alerts and reminders for appointments and scheduled tests Increased satisfaction and understanding of choices

6.6.6 Advantages and Disadvantages of Electronic Health Record

The advantages of an EHR are listed below:

a) EHRs are easily accessible.

b) Easier to send a digital file from one office to another.

c) Time is saved in transferring files.

d) Accuracy of data are readily available for further decision making.

e) Readily available to patients when stored electronically.

f) Occupies less space in the office/file rooms.

g) Easier to store them for long term.

h) Reduces errors which arises from misinterpretation of bad handwritings.

Disadvantages of Electronic Health Record

The disadvantages of an EHR are listed below:

a) Compromise on privacy of the health records of patients as it can be accessed by many.

b) To have error free maintenance, skilled technicians are required.

c) Details of the health records can be hacked.

d) Minimal error can lead to bigger loss as retrieval of data may be difficult if lost.

e) Is costly to set up the infrastructure.

f) Requires compatible system on board for all users.

g) Need to have a backup plan.

6.7 NURSES RESPONSIBILITY IN RECORD KEEPING AND REPORTING

Let us now discuss the nurses responsibility for records and reports as given below:

- Keep under safe custody of nurses.
- No individual sheet should be separated.
- Not accessible to patients and visitors.
- Strangers is not permitted to read records.
- Records are not handed over to the legal advisors without written permission of the administration.
- Handed carefully, not destroyed.
- Identified with bio-data of the patients such as name, age, admission number, diagnosis, etc. (Legal Issues)
- Never sent outside of the hospital without the written administrative permission.
- Patient Verification: Two identifiers: patient name and date of birth
- Compare to ID band, consents, diagnostic images, and all other patient documentation related to the procedure

Check Your Progress 2

1) What are the purposes of report writing?

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2) List the types of reports.

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3) List the benefits of electronic health records for nursing department.

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6.8 LET US SUM UP

One of the foremost and important role of the nursing professionals is to accurately document their work so that it can be useful to all members of the health team in the interest of the client. A number of records and reports are maintained in the

health centre. These are essential to check the progress of the clients, and the need to make accurate decisions when need arises.

6.9 KEY WORDS

BCMA : Barcode medication administration
CPOE : Computerised Provider Order Entry
CDR : Clinical Data Repository
EHR : Electronic Health Record
EMR : Electronic Medical Record
FRU : First Referral Unit
IOM : Institute of Medicine
IUD : Intra Uterine Device
LAMA : Left Against Medical Advice
MCH : Maternal and Child Health
MTP : Medical Termination of Pregnancy
OP : Oral Pills
OPD : Out Patient Department
PACS : Picture Archiving Communication Systems
PID : Pelvic Inflammatory Disease
RFID : Radio Frequency Identification
RTI : Reproductive Tract Infection
STI : Sexually Transmitted Infection

6.10 MODEL ANSWERS

Check Your Progress 1

1) **Purposes of record writing**
   - Supply data that are essential for programme planning and evaluation.
   - Provide the practitioner with data required for the application of professional services for the improvement of family's health.
   - Records are tools of communication between health workers, the family, and other development personnel.
   - Health records shows the health problem in the family and other factors that affect health.
   - A record indicates plans for future.
   - Provides baseline data to estimate the long-term changes related to services.

2) **Types of Records**
   a) Cumulative or continuing records
   b) Family records

3) **Legal Implication of Records and Reports :**

   There are three approaches to legal implications of records and reports:
   - Individual approach : Records of importance are birth records, death records etc. They are valuable documents not only from health department also from other departments.
   - Community approach: Health records provide conformation and protection of rights related to health. It presents charges through which

charges can be taken against medical administration and political system. It could lead to proper implementation of services.

- Nursing approach : It is important preserving individual records of health. Confidentiality and privacy has to be maintained. These documents should be shown to authorised person. The value of the record when they are presented at the right time. Legally accepted process should be followed for destroying obsolete records. Records of medico legal cases should be handled carefully.

4) **Principles of record writing**

1) Nurses should develop their own method of expression and form in record writing.
2) Records should be written clearly, legibly and appropriately.
3) Records should contain facts based on observation, conversation and action.
4) Select relevant facts and the recording should be neat, complete and uniform.
5) Records should be written immediately after an interview.
6) Records are confidential documents.
7) Records are valuable legal documents and so it should be handled carefully, and accounted for.
8) Records systems are essential for efficiency and uniformity of services.
9) Records should provide for periodic summary to determine progress and to make future plans.

5) **Records to be kept under health centres**

Family folders: MCH cards; Antenatal card/ postnatal cards; Infant card; Pre-school child card; Medicine distribution card include records of iron and folic acid distribution cards

Family welfare records: Eligible couple, MTP, Family planning. Treatment and referral records, Vital event records: birth and death records

General information records: Individual records; Family records; Village records; Map of community

Other records: Antenatal records; medicine records; monthly/ yearly records; consumable stock register; stationary stock register; daily diary and cumulative records

Records to be kept with the Patient (Kept under supervision of CHN):

health record of school going children; infant health card; maternal card; TB patient card; individual health card; birth and death record; inpatient and outpatient record and eligible couple records

6) **Register to be maintained in Health Centre**

Village register; household survey register; eligible couple register; maternal and child health register and contraception register; sub-centre/FRU clinic register; death register; stock register; register for recording consultative process; referral register; daily diary.

7) **General guidelines for maintaining records**
   1) Enter information in the proper place.
   2) Write down information immediately as soon as possible. Delay results in incomplete and inaccurate records.
   3) Maintain records up-to-date daily and avoid letting records being piled up.
   4) Write clearly and neatly. It should be legible.
   5) Keep records in order either alphabetically/numerically/geographically and with index card.
   6) Keep all the registers in cupboard, dust regularly and protect from rats, cockroaches and termites.
   7) Treat records confidential and do not allow unauthorized person to read the records.
   8) Maintain an adequate stock of stationary, registers and all forms needed to be filled and submitted.
   9) Destroy all old records (i.e. more than 5 years old).

Check Your Progress 2

1) Purposes of writing reports
   - To show the kind and quantity of service rendered over to a specific period.
   - To show the progress in reaching goals.
   - As an aid in studying health conditions.
   - As an aid in planning.
   - To interpret the services to the public and to other interested agencies.
2) Types of Reports
   1) Performance in corresponding month of last year
   2) Performance in the reporting month
   3) Cumulative performance till corresponding month of last year
   4) Cumulative performance till current month
   5) Planed performance in current year
3) List the benefits of electronic health records for nursing department.
   1) Decreased redundant data collection
   2) Allowed data comparison from prior visits
   3) Ongoing access, update record at bedside
   4) Improved documentation and quality of care
   5) Supported timely decision

6.11 REFERENCES

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Certificate in Community Health for Nurses (BPCCHN)
Theory Course

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Unit 4 : Introduction to Epidemiology, Epidemiological Approaches and Processes
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Unit 3 : Communicable Diseases -2 Infectious Diseases
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Unit 4 : Health Management Information System
Unit 5 : Financial Management, Accounts and Computing at Sub-Centre
Unit 6 : Records and Reports