Innovations in "Communitization"
Under
National Rural Health Mission

Introduction:

National Rural Health Mission approved Rs. 30,000.00 for the project titled – *Innovations in "Communitization" under NRHM*. The first installment of Rs 15,00,000.00 out of the sanctioned Rs. 30 Lakhs was received on 16.12.2009, the second installment of Rs. 10,18,669.00 was received on 14.12 2010 and the final installment of Rs 4,81,331 was remitted to the IHMP account on 11 April 2011. During the year 2010, the NRHM grant was used towards the salary of PHC facilitators, transportation and incentive based reimbursement of AHSAs. After April 2011 the NRHM grant was used only towards the reimbursement of AHSAs. All other costs of salaries of facilitators, transportation, etc. during the financial year 2011 - 2012 were met through the MacArthur Foundation grant.

Specific Objectives:

1. To conduct a monthly comprehensive assessment of health needs of all households through ASHA in seven PHCs of Paithan Block to prepare monthly micro-plans, over a period of one year.

2. To increase demand for health services and modify key health utilization behaviour among all households in 7 PHCs of Paithan Block in one year.

3. To increase utilization of primary health care services in 7 PHCs of Paithan Block in one year – Establish linkages between ASHA, ANM, MPW, PHCs and CHCs.

4. To establish a community based monitoring system through Village Health, Nutrition, Water and Sanitation Committees in 7 PHCs, with a focus on the marginalized, for ensuring access and equity.

5. To create a enabling environment for the Community Based Monitoring process by conducting training for Capacity Building of NGO staff and all Health Providers (ANM, MPW (M), HA (M), LHV and MO, PHC) of Paithan Block.

Project Description

The five components of the SATHI intervention were scaled up to a block level through Government PHCs. The project was implemented in Paithan block through Government PHCs as model of "Communitization" wherein the village health committees; ASHA as a key functionary of civil society; the ANM, MPW and PHC staff as front line health providers; AWWs; and NGO staff as facilitators; functioned as a team to improve the management of the RCH program with a special focus on married adolescent girls. The 5

innovations of the SATHI project that were integrated with Reproductive and Child Health (RCH) through NRHM were:

1. Surveillance – ASHAs conducted a comprehensive assessment of health needs of all households on a monthly basis during household visits, in seven PHCs of Paithan Block
2. Monthly Micro-planning – On the basis of the needs assessed during monthly house visits ASHAs prepared a list of beneficiaries and clients that needed BCC and health services.
3. Primary Level Care – ASHAs actively linked clients to the ANM on the monthly Village Health and Nutrition Day (VHND) in the village, or at the SC and PHC.
4. Behavior Change Communication – ASHAs provided need specific BCC based on information needs identified and behavioral diagnosis made during household visits. BCC was implemented with the aim to increase demand for health services and modify key health utilization behaviors among all the households under 7 PHCs of Paithan block.
5. Village Health Nutrition Water Supply and Sanitation Committees – Monthly review meetings were held in the villages. In the meetings health needs identified by ASHAs were compared with the services provided by the ANM. The committees monitored service utilization and generated demand by motivating resistant families.

Details of the project site – Paithan block: *Paithan* block has a population of 322,734 (including the urban population of Paithan town) with a sex ratio of 925 females per thousand women as against the national average of 933. There are a total of 108 Panchayats in 196 villages of the block. The population is provided health services through 7 Primary Health Centers (PHCs) and 38 Sub- Centers (SCs). There are two CHCs or Rural Hospitals. The Crude Birth Rate is 23.39 and Infant Mortality Rate is 37.7.

The implementation process followed the sequential activities presented below:

- Recruitment and training of NGO staff
- Training of selected ASHAs
- Orientation of VHSC members
- Orientation of ANM, MPW, PHC staff - To strengthen institutional capacity
- Monthly surveillance of health needs
- Preparation of monthly micro-plans
- Demand generation through BCC
- Monthly monitoring of primary level health services by VHSCs
- Triangulation of data for preparing MPR for the village
- Regular monitoring of health facilities
- Strengthening the existing health care management system
- Providing support to the current administrative monitoring
- Opening space for dialogue between provider and beneficiaries

Capacity building:

The following trainings were conducted:

1. Training of trainers
2. Training of block and PHC facilitators
3. Training of ASHAs in the entire block
4. Orientation of health providers from 7 PHCs and 2 CHCs
5. Training of VHSC members at the PHC level in the respective PHCs.

Expected outcomes of the project:

- Integration of ARSH with RCH
- Special focus on married adolescent girls / young women less than 19 years
- Increase in contraceptive use and sterilization
- Increase in utilization of services delivered by the public health institutions
- Increase in antenatal service coverage
- Increase in institutional deliveries
- Increase in post natal service coverage
- Increase in immunization coverage
- Increase in treatment of childhood illnesses
- Reduction in RTI/STI
- Increase in utilization of ICTC services

Outputs and Outcomes of Scaling up at the Block Level:

The data from the monthly surveillance and monitoring system was used for assessing the outcome of the project. External investigators were hired to validate the information collected through the management information system. Thereafter the data were utilized to do a trend analysis through a time series research design comparing the situation prior to the intervention (July 2010) with the situation after the intervention; in March 2011 and March 2012.

Table 1: Description of the Paithan Block

Sr. No.	Details	July 2010	March 2011	March 2012
1.	No. of PHCs	7	7	7
2.	No. of ASHAs	152	169	138
3.	Population covered	154,070	175,847	139,989

Table 1 presents number of PHCs, ASHAs functioning and population covered in Paithan Block.

Table 2: Monthly Surveillance

Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
Surveillance done during Household Visits	<=19 years	90.5	87.4	90.0
	>=20 years	95.2	92.3	92.0

Table 2 indicates that about 90 percent households were covered by ASHAs through surveillance and monitoring undertaken during monthly house visits. The coverage of households for surveillance and monitoring is marginally higher for women over 20 years of age as compared to married adolescent girls less than 19 years.

Table 3: Maternal Health Services

Sr. No.	Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
1.	New registration in the Month	<=19 years	49.5	94.0	100
		>=20 years	40.4	62.4	63.0
2.	Registration Within 12 week of Pregnancy	<=19 years	75.8	85.6	86.1
		>=20 years	61.0	75.8	77.5
3.	Three or more Antenatal checkups	<=19 years	65.5	84.3	87.3
		>=20 years	82.9	84.7	85.4
4.	Two TT injections	<=19 years	89.9	97.5	97.2
		>=20 years	87.6	96.4	95.6
5.	100 IFA Tablets	<=19 years	67.1	88.4	87.3
		>=20 years	64.0	87.4	85.4
6.	Minimum Standard Antenatal Care	<=19 years	67.1	84.3	86.0
		>=20 years	64.0	84.7	85.0
7.	Hospital Delivery	<=19 years	93.9	96.5	97.2
		>=20 years	90.0	94.8	97.0

Table 3 above presents indicators for maternal health services. There is a significant increase in all the 7 maternal health care service related indicators. For each of the 7 indicators the increase is greater for married adolescent girls <= 19 years as compared to women > 20 years.

Table 4: Neonatal Care

Sr. No.	Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
1.	Newborns weighed within 24 hours of birth	<=19 years	85.4	94.3	100
		>=20 years	81.8	96.4	100
2.	Low Birth Weight babies (weight < 2.5kg)	<=19 years	21.9	15.1	11.7
		>=20 years	15.5	09.3	12.9

Table 4 indicates the proportion of newborn babies, delivered in the project area, weighed within 24 hours of birth. Both for women over 20 and married adolescent girls less than 19 years the proportion of children weighed immediately after birth increased from 82 and 85 per cent to 100 percent. There is a significant reduction in the proportion of low birth weight babies which is more among married adolescent girls less than 19 years as compared to women over 20 years.

Table 5: Information about Births and Deaths

Sr. No.	Variable	Category	Total - 2010	Total - 2011	Total - 2012
1.	Live Births	<=19 years	225	195	206
		>=20 years	583	466	406
2.	Neonatal Deaths (0 - 28 days)	<=19 years	11	7	5
		>=20 years	24	14	7
3.	Post Neonatal Deaths (29 days - 12months)	<=19 years	1	1	1
		>=20 years	4	6	0
4.	Infant Deaths	<=19 years	12	8	6
		>=20 years	28	20	7
5.	Maternal Deaths	<=19 years	0	0	0
		>=20 years	2	0	0

Table 6: Death Rates

Sr. No.	Death Rate	Category	2010	2011	2012
1.	Neonatal Death Rate (0 - 28 days)	<=19 years	48.9	35.9	24.3
		>=20 years	41.2	30.0	17.2
2.	Post Neonatal Death Rate (29 days – 12 months)	<=19 years	4.5	5.1	4.9
		>=20 years	7.0	12.9	-
3.	Infant Death Rate	<=19 years	53.4	41.0	29.1
		>=20 years	48.1	42.9	17.2

** (Rates have been calculated only to indicate the trends in neonatal and infant mortality)

Table 5 and 6 present the trend in births and deaths over the three points of assessment. The data indicate a reduction in neonatal, peri-natal and infant deaths among women over 20 years as well as married adolescent girls less than 19 years.

Table 7: Current Use of Temporary Family Planning Methods

Sr. No.	Variable	Category	Average 2010 (%)	Average 2011 (%)	Average 2012 (%)
1.	Temporary Methods	<=19 years	13.0	16.9	18.5
		>=20 years	36.0	41.0	41.0
2.	Oral Pills	<=19 years	03.6	03.1	03.6
		>=20 years	10.9	12.9	13.0
3.	Condoms	<=19 years	08.8	13.0	14.1
		>=20 years	20.7	24.2	23.5
4.	Copper T	<=19 years	00.9	00.8	00.7
		>=20 years	04.1	03.9	04.1

Table 7: above indicates that the current use of temporary contraceptives increased significantly among married adolescent girls as well as women over 20 years. Whereas, there is a preference for condoms among married adolescent girls, women over 20 years prefer oral pills. The increase in contraceptive use can be attributed to demand generation through BCC, better monitoring of unmet need and behavior tracking. The study period is too short to assess the impact of the intervention on birth interval or birth rate.

Table: 8 Vaccination Coverage of Children 12-23 months:

Sr. No.	Vaccine	July 2010 %	March 2011 %	March 2012 %
1.	BCG	90.4	95.0	97.4
2.	Three - DPT	82.5	90.4	98.0
3.	Three - Polio	82.6	90.5	98.0
4.	Three Hepatitis - B	71.8	88.1	96.8
5.	Measles	78.5	88.4	89.4
6.	Completed Vaccination	66.2	83.9	87.5

Table 8 presents the vaccination coverage of children 12-23 months of age. Data indicate that coverage of each vaccine has gone up. The greatest increase is seen for Hepatitis B and measles. Proportion of children completing primary vaccination on time increased significantly from 66.2 percent to 87.5 percent.

Project – Inputs:

Project implementation was initiated in January 2010. In the first six months, ASHAs were trained in batches. The induction training of 200 ASHAs, PHC staff and IHMP coordinators was reported in the previous annual report. Implementation started from July 2010.

One-day Training of ASHAs on Surveillance:

One-day training of ASHAs from Nander PHC was organized on 4th July 2011. For the ASHAs of remaining six PHCs, it was organized from 7th September to 9th September 2011. ASHAs transferred information about married women 15-45 years and children under two years to the new registers. In-service training was conducted on how to do surveillance and how to record information in the register. A household visit plan for monthly surveillance was prepared for each ASHA.

Table 9: One-day Training of ASHAs on Surveillance:

Sr. No.	PHC	Date of Training	No. of ASHAs Expected for the Training	Actual No. of ASHAs Attended Training
1	Nander	4th July 2011	28	24
2	Pimpalwadi	7th Sept. 2011	17	12
3	Dhakephal	7th Sept. 2011	20	15
4	Vihamandawa	8th Sept. 2011	19	18
5	Nilajgaon	8th Sept. 2011	28	25
6	Adul	9th Sept. 2011	25	21
7	Balanagar	9th Sept. 2011	14	12

ASHAs who could not attend training for personal reasons were trained at the village level. A total of 24 ASHAs from 7 PHCs were trained at the village level. (Nander -4, Balanagar -2, Vihamandawa -1, Pimpalwadi -5, Adul -4, Dhakephal -5 and Nilajgaon -3)

Surveillance: ASHAs do household visits as per the monthly visit plan given to them. During house visit the ASHA assesses health needs of married women 15-45 years and children under two years. She records this information in the surveillance register. ASHA also records information on the vital events (Births, Deaths and Marriages) in her village.

Details of the surveillance done during the period June 2011 – March 2012 is given in Table: 10. ASHAs prepare a Monthly Progress Report at the end of the month and submit the report at the monthly review meeting at the Primary Health Centre.

Average number of ASHAs who were expected to do the surveillance was 181, out of which 140 ASHAs actually did the surveillance during the reporting period.

Table 10: Monthly Surveillance Done by ASHAs at the Village Level:

Sr. No.	Month	Total Number of ASHAs	Expected Number of ASHAs for Doing Surveillance	Actual Number of ASHAs Who Completed Surveillance
1.	June 2011	181	150	147
2.	Aug. 2011	181	150	130
3.	Sept. 2011	181	147	139
4.	Oct. 2011	181	147	134
5.	Nov. 2011	181	150	140
6.	Dec. 2011	181	150	145
7.	Jan. 2012	181	151	142
8.	Feb. 2012	181	151	143
9.	Mar. 2012	181	151	138
Average		**181**	**140**	**140**

Micro-planning: Every month the ASHAs prepare micro planners based on the surveillance register for pregnant women and children. This micro-planner is given to the ANM when she visits the village for conducting the Village Health and Nutrition Day (VHND). The ASHA also uses the planner to remind and collect her clients on the Village Health and Nutrition Day.

There were no PHC facilitators after June 2011, since there was no NRHM budget for their salaries. In the reporting period each ASHA was visited once in two months by the IHMP staff. They check the surveillance register and micro-planners prepared by ASHAs and facilitate review meetings with the Village Health Nutrition Water Supply and Sanitation Committees. Details of the supervision visit are given below in the Table 11.

Table 11: Supervision of ASHA's Work:

Sr. No.	Month	No.of Villages Under PHCs	No. of Visits during Reporting Period		No. of Visits Given to ASHAs	
			1st visit	2nd visit	1st visit	2nd visit
1.	Aug.2011-Sept.2011	188	129	42	149	56
2.	Oct. 2011-Nov. 2011	188	128	71	147	88
3.	Dec. 2011 – Jan. 2012	188	130	33	145	43
4.	Feb. 2012 – Mar. 2012	188	130	22	146	26
Average		**188**	**129**	**42**	**147**	**53**

On an average 129 villages were visited once and 42 villages were visited twice every two months. On an average 147 ASHAs were visited once in two months and given feedback on surveillance and micro-planning.

Primary Level Care: ANMs from primary health centers conduct Village Health and Nutrition Days (VHND) on a fixed day in the villages under their sub-centre. Based on the micro-planner prepared by the ASHA, she informs pregnant women and mothers of children less than two years to come to the clinic. The ANM also checks whether all the clients as per the micro-planner availed services or not. This has helped to improve both coverage and quality of services.

Need Based Behavior Change Communication: During household visits, ASHAs assess information needs of every client and make a behavioral diagnosis. Based on their diagnoses the ASHAs give specific messages to the households using BCC cards and undertake counseling where necessary. Each ASHA was given two sets of BCC cards (Maternal & Newborn Health and Family Planning) designed and developed by IHMP.

Simultaneously, other BCC inputs were given at the community level to establish an environment which is conducive for the project and for introducing new social norms like age at first conception, birth interval, institutional delivery, etc.

Information Centre: A total of 225 information centers were established in the villages of Paithan Block. BCC materials for the centers were made available by the IEC Bureau, Pune. During the reporting period, community based male and female volunteers, on separate fixed days in the week, continued to have the information center open in their village. Posters on different topics were displayed and reading material was made available to the people. Community members could borrow and take the materials home to read. Record of the people visiting the centre was kept by the volunteers.

Review Meetings of the Village Health, Nutrition, Water Supply and Sanitation Committees (VHNWSC): Once in two months, a meeting of VHNWSC was facilitated by the program coordinators. In this meeting, health needs assessed by the ASHA's and services provided by the ANM were reviewed by the VHNWSC. The committee certified the work of the ASHA on the basis of whether she had completed surveillance for the month; prepared micro-planners for maternal and child health services and immunization, given need specific BCC, was present for the Village Health and Nutrition Day (VHND) and prepared her monthly progress report. After taking the review of ASHA's work the VHNWSC President or Secretary would sign on the stipulated format recommending her to be paid her remuneration for these activities. The ASHAs were given their monthly honorarium by a cheque during the monthly meeting held at the PHC only if they brought the stipulated format signed by the VHNWSC President or Secretary. Once every two months the VHNWSC members were visited at home.

Table 12: provides details about the VHNWSC meetings conducted during the reporting period. On an average 69 percent of the committee meetings were conducted once every two months.

Table: 12 Monthly Meetings of Village Health, Nutrition, Water & Sanitation Committees:

Sr. No.	Month	No. of VHNWS Committees	No. of VHNWSC meetings conducted	No. of Committee Members Attended Meeting	No. of Committee Members Visited
1.	Aug.2011-Sept.2011	160	110	98	484
2.	Oct. 2011-Nov. 2011	160	109	99	466
3.	Dec. 2011-Jan. 2012	160	110	103	472
4.	Feb. 2012 – Mar. 2012	160	110	97	435
Average		**160**	**110**	**99**	**464**

Examples of people's participation and ASHA's role have been presented as case studies.

Table 13: gives births and deaths during the period August 2011 to March 2012. During this period 37 neonatal deaths, 55 infant deaths and 0 maternal deaths were recorded.

Table 13: Births and Deaths during the period August 2011 to March 2012

Month	Population	Live Births	Neonatal Deaths*	Post- Neonatal Deaths**	Maternal Deaths
Aug. 2011	130892	204	4	4	0
Sept. 2011	142841	192	3	1	0
Oct. 2011	137108	205	6	4	0
Nov. 2011	141691	216	7	4	0
Dec. 2011	145932	240	7	2	0
Jan. 2012	145823	220	2	1	0
Feb. 2012	144303	191	5	1	0
Mar. 2012	139989	201	3	1	0
Total		**1669**	**37**	**18**	**0**

The project outputs and outcomes are encouraging and indicate that systems like monthly surveillance and micro-planning are efficacious. These systems have contributed towards improving performance. These innovations have helped ASHAs to identify clients and assess their health needs, provide need based BCC, link clients to primary level and referral services.

Case Studies:

Case Study 1:
Tuljapur village is under Vihamandawa PHC. Munni Shahanoor Sheikh works as ASHA in this village. Rijavana Raju Sheikh is 28 years old and she has two sons and one daughter. Her youngest child is 3 years old. For almost a year the ASHA, during her monthly surveillance visit, has been trying to motivate Rijavana and her family to adopt a family planning method. Rijavana and her family expressed a desire for a family planning operation on several occasions but never went to a hospital.

ASHA kept on motivating Rijavana. One day, ASHA asked Rijavana why they were not going for a family planning operation. Rijavana said “I have a doubt, I have heard that several women conceive even after a family planning operation”. ASHA used BCC cards to explain to Rijavana and her family about male and female sterilization operations. She cleared all their doubts. ASHA advised her to go to the block hospital in Paithan when her youngest child had completed 3 years. Finally, in February 2012, Rijavana got her family planning operation done.

Case Study 2:
Ranjani village is under Nilajgaon PHC and has a population of about 1000 persons. There are two anganwadi centers and one ASHA in the village. Shobha Sahebrao Ganaraj lives in Ranjani and has a 9 month old daughter. Shobha had two abortions prior to this girl. Therefore, Shobha is very protective of her girl. She did not listen to the ASHA and ANM when they asked her to bring her daughter for vaccination. Shobha was scared that vaccination would harm her daughter.

ASHA discussed this case in the monthly review meeting with Dr. Parasiwar, Medical Officer of Nilajgaon PHC. During the next Village Health and Nutrition Day (VHND), Dr. Parasiwar was present. He explained to Shobha and her husband about advantages of taking vaccination. Since last two months, Shobha is bringing her daughter to the anganwadi for vaccination because of the efforts of ASHA, nurse and doctor.

Case Study 3:
Chittegaon village under Nilajgaon PHC has population of 15,000. This village has 12 anganwadi centers and three ASHAs. This case study is from Ranjana Tingote's area. A 20 year old girl has been married to a 40 year old man. This is his second marriage and he has two daughters from the first marriage. The first daughter is 17 years old and second daughter is 12 years old. ASHA during her monthly surveillance visits realized that this woman had two induced abortions in the last one and half years. She tried to find out the reasons for her abortions. ASHA learnt that the family had told her that till the older daughter gets married, she should not have a child. ASHA discussed the risks of getting repeated abortions with this woman, her husband and in-laws. ASHA also mentioned that every woman has a dream of becoming mother. She advised them that it might be better to have one child and then consider undergoing a family planning operation. At present, this woman is 4 month pregnant and everyone in the household has welcomed her pregnancy.

Case Study 4:
Ektuni is a sub-center village under Adul PHC. Meera Devidas Bansode is the ASHA of this village. Vandana Chatare was pregnant for the third time. ASHA was called when Vandana went into labour. She went to the sub-center to call the nurse. But the nurse as per her fixed visit schedule, had gone to another village to conduct the Village Health and Nutrition Day (VHND). ASHA took the decision to take Vandana to Adul PHC for the delivery. There was no vehicle available at the village level, so Vandana's family requested ASHA to make some arrangement. ASHA called Adul PHC and requested them to send an ambulance. She accompanied Vandana to Adul PHC. Vandana delivered a 2.8 kg baby. Vandana had to have an episiotomy which was stitched after her delivery. Vandana's family praised and thanked the ASHA in front of the medical officer.

Case Study 5:
Gadhegaon village is under Dhakephal PHC. This village with 1000 population, has one anganwadi center and one ASHA. The sub-center nurse of this village went on maternity leave. Therefore, the Village Health and Nutrition Day (VHND) were not conducted for two months. IHMP Project Coordinator brought it to their notice and it was discussed by the Village Health Nutrition and Sanitation Committee. It was decided in the meeting that the ASHA and three committee members will request the Medical Officer, PHC to send another nurse. Three committee members and the ASHA met the Medical Officer, PHC on 27th February 2012. He deputed another ANM and the Village Health and Nutrition Day (VHND) has been restarted in this village since March.

Conclusion and Recommendations:

1. The five innovations introduced by IHMP resulted in a **measurable increase in coverage** with maternal, neonatal and child health services over a short period of time and they can be efficaciously used in ensuring universal health coverage.

2. The first innovation is **'Monthly Surveillance'** undertaken by the ASHAs though home visits. Each ASHA has been allotted 1000 population or 200 households. By visiting 10 household a day she easily covers 200 households in 20 days. During her household visits, which do not take more than one hour she is able to assess the health needs of every woman and child living in her 200 houses. This becomes the basis for ensuring "universal health coverage".

3. The second innovation is monthly micro-planning. The **Village Health and Nutrition Day (VHND) guidelines, issued by MOHFW, GoI in 2007,** clearly state that ASHAs should visit the households under her jurisdiction every month and prepare 7 different lists of beneficiaries that are in need of various health services. These lists are referred to as **"Monthly Work-plans" or "Due Lists".** However, the ASHAs are not undertaking this responsibility as they have not been provided with necessary protocols and systems. The micro-planning system introduced by IHMP in Paithan Taluka was especially successful as PHC ANMs said that their work was facilitated as a result of the micro-planning undertaken by the ASHAs. The monthly micro-planning also facilitated the need specific BCC provided by the ASHAs during their household visits.

4. The third innovation that was implemented in the Paithan project was **'Need Specific Behavior Change Communication (BCC)**. The monthly surveillance of health needs by ASHAs results in the identification of health service and BCC needs of each household. The ASHAs were provided with tools for providing information, counseling and motivation specific to the needs of each household. Need Specific BCC has resulted in a rapid increase in demand for services, especially family planning, maternal and child health services.

5. Active linkage of beneficiaries with health providers and facilities. Once the ASHAs have prepared monthly "Work-plans or Due Lists" they use these to remind, and accompany their beneficiaries thereby ensuring that they utilize services at the VHND, Sub-centre, PHC or FRU.

6. The Village Health Nutrition and Sanitation Committee **review the work-plans prepared by the ASHAs and MPR prepared by the ANM** to ensure that those who required services as identified by the ASHAs actually received the services from the ANM. This concept of Community Based monitoring (CBM) is an alternative to the red, yellow and green dots that have been used in the past by NGOs and it can be implemented by MO PHCs. This system of CBM provides the basis for the monthly review that MO PHCs are mandated to do.