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COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: PAKISTAN (PUNJAB)

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ACRONYMS

APC	Advancing Partners & Communities
BHU	basic health unit
CHS	community health system
C-IMNCI	community integrated case management of newborn and childhood illness
CMAM	community-based management of acute malnutrition
CMW	community midwife
CSG	community support group
DGHS	Directorate General of Health Services
DHIS	district health information system
DHO	district health office
DHQ	district headquarter hospital
DMU	district management unit
EDO-H	executive district officer of health
EPHS	Essential Package of Health Services for Primary Health Care
FP	family planning
I-RHPHCN	integrated program for reproductive health, primary health care, and nutrition
IUD	intrauterine device
LHS	lady health supervisor
LHW	lady health worker
MIS	management information system
MNCH	maternal, newborn, and child health
MOIC	medical officer in-charge
PC-I	planning commission – Performa I
PHC	primary health care
PHO	provincial health office
PKR	Pakistani rupees
PMU	program management unit
PSPU	Policy and Strategic Planning Unit
RHC	rural health center

TB	tuberculosis
THQ	tehsil headquarter hospital
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data extracted from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each country as appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

PAKISTAN COMMUNITY HEALTH OVERVIEW

Pakistan is the sixth most populous country in the world and home to approximately 200 million people. As such, it is governed under a decentralized system to ensure that the varying needs of its population are met by more tailored and appropriate policies, processes, and interventions. Pakistan underwent devolution in 2011, shifting public sector service planning from the national to the provincial level. As a result, the country no longer has a single health system but four—one in each of its provinces.[1]

This CHS Catalog profile focuses on the community health landscape of Pakistan's most populated province, Punjab, where approximately half of the country's population resides.[2] Given the country's decentralized health system, the information presented here serves as one example of how community health is organized in Pakistan and should not be generalized for the remaining provinces, Balochistan, Khyber Pakhtunkhwa, and Sindh. Table 1 provides a community health overview of Punjab, and Table 2 compares population and health data from both Pakistan (national) and Punjab (provincial).

Pakistan's government is decentralized; therefore, community health policy and implementation primarily occurs at the provincial level rather than at the national level.

At the national level, *Pakistan Vision 2025* is a broad development strategy that provides general direction to the provinces in the areas of social and economic growth, including the health sector. It emphasizes strengthening primary health care (PHC), particularly in rural areas, "where all health outlets will function as a focal point for control of communicable diseases and family planning services." The strategy emphasizes the health workforce, health emergency surveillance systems, and community health programs such as the lady health worker (LHW) program, which focuses on FP, immunizations, and other key PHC services.

Punjab has several complementary policies guiding health service delivery, including at the community level. *The Punjab Growth Strategy 2018* outlines its development and growth plan, with an emphasis on strengthening health service delivery in communities to improve health indicators and equity in health access. *The Health Sector Strategy, Punjab* details a phased approach to implementation between 2012 and 2020 that includes integrating community-based management information systems (MIS) to inform decision- making, emphasizing community engagement in service delivery, and strengthening maternal, newborn and child health (MNCH), FP, and nutrition services in communities. *The Health Sector Plan 2018: Building a Healthier Punjab* outlines medium-term activities and is guided by the first two documents.

Additionally, two policies focus on community health. *The Essential Package of Health Services for Primary Health Care in Punjab (EPHS)* outlines all PHC services, how they should be delivered, and the scope of practice of various health providers, including their respective relationships. Second, a Punjab government planning commission document, *Performa 1 (PC-1)*, outlines the province's integrated program for reproductive health, PHC, and nutrition (I-RHPHCN), a key community health program in Punjab that combines the following former programs and initiatives:

- The national LHW program, which provides FP and other PHC services in communities (established in 1994).
- The national MNCH program, which aims to reach poorer households with MNCH services, including skilled delivery by community midwives (CMWs) and emergency obstetric services at district- and community-level facilities (established in 2006).
- Community-based management of acute malnutrition (CMAM), an intervention package to address malnutrition and promote optimal child feeding (scaled up in Punjab in 2010 following the flood disaster).

1 In addition to the four provinces, Pakistan comprises Azad Jammu and Kashmir, a separate, autonomous state, as well as Gilgit Baptist, a former federal territory for which provincial status is in process. These areas have their own community health systems.
2 Punjab was selected due to its population size and the availability of its policies.

In 2013, the provincial government launched the I-RHPHCN program, which it planned to roll out in all of Punjab's 36 districts by 2016. The respective program management unit (PMU) within the Department of Health (DOH) leads and finances the program, with support from international donors. The program links to many other departments, including education, agriculture, and food, and operates in rural, urban, and peri-urban areas.

These Punjab-specific policies, along with several others that are focused on specific health areas like immunization and tuberculosis (TB), provide guidance across a spectrum of health areas and specify the roles of community health providers including information about their scope, selection, training, supervision, monitoring and evaluation, and integration into the provincial health system. While health-related policies are for the most part available, comprehensive, and clear, some information across multiple policy documents is fragmented and contradictory.

Punjab's policies define the roles of civil society and community groups. For instance, community support groups (CSGs), comprising community members and health facility staff, bridge communities and health facilities to ensure that service delivery responds appropriately to the needs of local populations. The policies also address gender issues, discussing the CMW role in providing services related to gender-based violence. The Punjab Health Sector Plan also briefly acknowledges that female health providers may be reluctant to go to rural areas for safety concerns. To compensate, the document suggests providing them a specialized (financial and non-financial) incentives package.

Table 1. Community Health Quick Stats—Punjab

Main community health policies/ strategies	*Essential Package of Health Services for Primary Health Care in Punjab*	*Health Sector Strategy, Punjab*	*Pakistan Growth Strategy 2018*	*Pakistan Vision 2025*	*PC-1: I-RHPHCN program*	*Punjab Health Sector Plan 2018: Building a Healthier Punjab*
Last updated	2013	2013	2015	2014	2013	2015
Number of community health provider cadres	2 main cadres					
	Community midwives (CMWs)			Lady health workers (LHWs)		
Recommended number of community health providers	9,000 CMWs			51,500 LHWs[1]		
Estimated number of community health providers	4,200 CMWs[2]			48,500 LHWs		
Recommended ratio of community health providers to beneficiaries	1 CMW : 5,000–10,000 people[3]			1 LHW : 1,200–,300 people[4]		
Community-level data collection	Yes					
Levels of management of community-level service delivery	Provincial, district, community					
Key community health program	Integrated Reproductive Health, Primary Health Care, and Nutrition (I-RHPHCN) Program (formerly the MNCH Program and the LHW Program)					

[1] By 2020.
[2] As of 2012, an additional 500 CMWs were awaiting deployment, 950 were in training, and there were plans to recruit and train 3,000 between 2012 and 2015.
[3] The target ratio for CMWs under the MNCH program was first set to 1: 10,000, with plans to add more CMWs to achieve a ratio of 1 CMW : 5,000 people by 2015. 1 CMW : 5,000 people is the ratio in districts with 'scattered' populations' and urban slums.
[4] It is unclear in policy if this ratio is an ideal ratio or the actual ratio of LHWs to people.

Punjab has two main cadres of community health providers, CMWs and LHWs, who currently work under the I-RHPHCN program. These cadres also work in other provinces of Pakistan, though their scopes of work may vary based on different priorities. The Human Resources for Health section provides more information about LHWs and CMWs in Punjab.

Table 2. Key Health Indicators, Pakistan and Punjab

	Pakistan	Punjab
Total population	203.4 m[1]	101.4 m[2]
Rural population	61%[1]	68%[2]
Total expenditure on health per capita (current US$)	$36[3]	N/A
Total fertility rate[4]	3.8	3.8
Unmet need for contraception[4]	20.1%	17.7%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[4]	26.1%	29.0%
Maternal mortality ratio	178[5]	189[6]
Neonatal, infant, and under 5 mortality rates[4]	55 / 74 / 89	63 / 88 / 105
Percentage of births delivered by a skilled provider[4]	52.1%	52.5%
Percentage of children under 5 years moderately or severely stunted[4]	44.8%	39.8%
HIV prevalence rate	<0.1%[7]	<0.1%[8]

[1] PRB 2016; [2] Bureau of Statistics, Government of the Punjab 2015; [3] World Bank 2016; [4] National Institute of Population Studies (NIPS) [Pakistan] and ICF International 2013; Figures for Punjab were calculated from the last ten years preceding the Demographic and Health Survey, whereas overall country figures were calculated from the last five years before the survey. Data for the last five years for Punjab are unavailable; [5] World Health Organization 2015; [6] Population Council 2015; [7] UNAIDS 2015; [8] Punjab Health Department 2012.

LEADERSHIP AND GOVERNANCE

The national level plays a small but important role in defining the general health direction of the country, such as striving toward the Sustainable Development Goals and improving access to health care through community health providers like LHWs. Community health in Punjab is managed and coordinated across the provincial, district, and community levels. Each level has a distinct role in supporting policy and program efforts, described below and shown in Figure 1.

- **Provincial level:**
  - The Policy and Strategic Planning Unit (PSPU) within the DOH creates and disseminates policy guidance for the province, provides funding for programs, and conducts monitoring and evaluation. Within the PSPU, the Directorate General of Health Services (DGHS) is responsible for implementing the primary and secondary care service delivery components of the *EPHS*, including at the community level.
  - The PMU for the I-RHPHCN program, which also falls within the purview of the DHGS, manages all program functions, including but not limited to providing input to the PSPU in policy development, training, health workforce management, monitoring and evaluation, and budgeting.
- **District level:**
  - The executive district officer of health (EDO-H) and other district-level health officials are responsible for implementation of the *EPHS* at district- and community-level service delivery points, which include rural health centers (RHCs), basic health units (BHUs), CMWs, and LHWs.[3] The district health office (DHO) provides management oversight, supervision, supplies and medicines, training, and monitoring and evaluation of health services.
  - The district program management unit (DMU) coordinates with the EDO-H and other district health officials, manages the I-RHPHCN program at the district level (e.g., supervision of health providers, accounting, program reporting, data collection), and submits monitoring information and annual work plans to the PMU.

3 Tehsil headquarter hospitals (THQs) and district headquarter hospitals (DHQs) offer secondary care but are not largely mentioned in policy documents related tocommunity health.

– District-level health facility staff, such as the medical officer in-charge (MOIC) and the lady health supervisor (LHS), manage and train community health providers, collate MIS data from reports, and replenish supplies. Facility staff report through the district health information system (DHIS) to the DHO and send program data to the DMU.

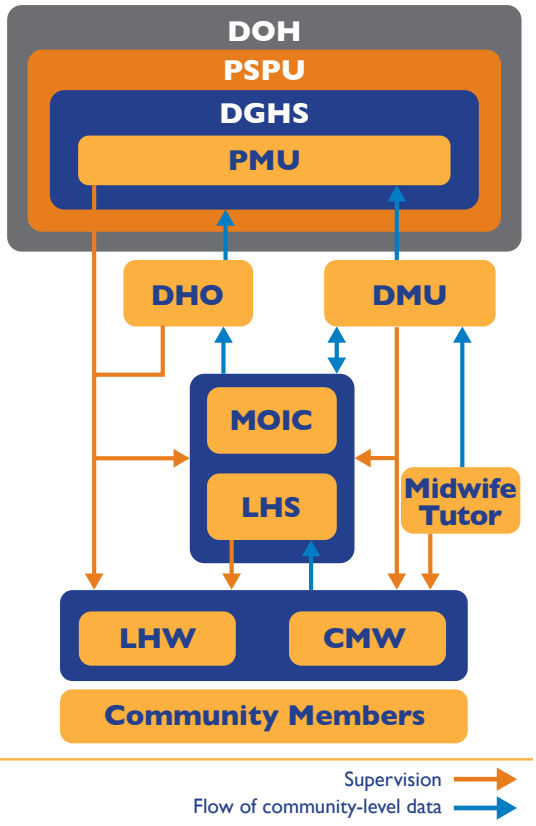
- **Community level:**

  – LHSs provide administrative supervision to CMWs and technical supervision to both CMWs and LHWs. They report to the MOIC at the facility and compile and send reports to the DMU. CMWs receive technical supervision from midwife tutors (MTs) and monitoring visits from officials at the DMU and PMU. CMWs and LHWs deliver health services in communities from work stations (WSs) and health houses (HHs), respectively, in accordance with the *EPHS* and the I-RHPHCN program.

Figure 1 summarizes Punjab's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	DOH PSPU DGHS PMU	Teaching and tertiary care hospitals	
District	DHO DMU Helath facility staff (MOIC, LHS)	DHQ THQ RHC BHU	
Community	LHW CMW	Work Station Health House	



HUMAN RESOURCES FOR HEALTH

Since the mid-1990s, LHWs have provided FP and PHC services throughout Pakistan, including Punjab. Under the new I-RHPHCN program in Punjab, LHWs also conduct tasks related to MNCH, CMAM, and community integrated case management of newborn and childhood illness (C-IMNCI). LHWs are linked to a specific BHU or RHC but deliver community health services at health houses, also known as vaccination posts, in communities.

Lady health workers deliver services primarily from posts known as health houses, while community midwives provide services from sections of their homes called work stations, which are designated and equipped for deliveries.

CMWs are responsible for basic MNCH health interventions, FP services, and uncomplicated deliveries, though they may also be trained to provide IMCI and other PHC services. They primarily work from work stations, which are in sections of their homes and designated and equipped for deliveries. CMWs refer high-risk pregnancies and complicated deliveries to BHUs and RHCs that have the necessary emergency obstetric equipment and personnel.

LHWs and CMWs have complementary roles. LHWs support CMWs, particularly in providing and following up antenatal and postnatal care and assisting during delivery. LHWs may refer patients to CMWs (or BHUs or RHCs) for services too complicated for them to manage. CSGs are expected to support LHWs, CMWs, and facility-based health providers under the I-RHPHCN program through advocacy and health promotion.

Table 3. Community Health Provider Overview

	CMWs	LHWs
Number in Punjab	4,200, with 500 awaiting deployment, 950 under training, and plans to recruit and train an additional 3,000 between 2012 and 2015	48,500
Target number	9,000	51,500 by 2020
Coverage ratios and areas	1 CMW : 5,000–10,000 people The target ratio for CMWs under the MNCH program was first set to 1 CMW : 10,000 people, with plans to add more CMWs to achieve a ratio of 1 CMW : 5,000 people by 2015. 1 CMW : 5,000 people is the ratio in districts with 'scattered' populations' and urban slums Operate in mostly rural and peri-urban areas, but sometimes in urban slums	1 LHW : 1,2000–1,300 people[1] Operate in mostly rural and peri-urban areas, but sometimes in urban slums
Health system linkage	CMWs are part of the formal health system, originally linked through a national government MNCH program, and currently through the provincial government's I-RHPHCN program.	LHWs are part of the formal health system. They are linked through the provincial government's I-RHPHCN program. The services they provide are regulated following a decision by the Supreme Court of Pakistan.
Supervision	LHSs provide administrative supervision to CMWs.[2] They review monthly reports and support CMW logistical and supply needs. They also are expected to provide on-the-job training to CMWs and written and verbal feedback. Each LHS supervises a maximum of three CMWs and is required to ensure support to each CMW at least once a month for an entire day. CMWs receive technical supervision from midwife tutors, who assess their skills, observe their interactions with patients, assist during deliveries, and submit monitoring reports to the PMU. Representatives from the PMU and DMU also may conduct regular supervision and monitoring during visits to CMWs. CMWs and other facility staff are also monitored by a DHO on a weekly basis to validate progress and provide guidance.	LHWs are supervised on a day-to-day basis by LHSs. The LHS supervises a maximum of 24 LHWs and is required to ensure support to each LHW at least once a month for the entire day. They are expected to provide follow-up training and supportive supervision; evaluate LHW knowledge and skills; and validate LHW records, progress, and monthly reports. LHWs and other facility staff are also monitored by a DHO on a weekly basis to validate progress and provide guidance.
Accessing clients	On foot Provide services from their homes	On foot At health houses

Table 3. Community Health Provider Overview

	CMWs	LHWs
Selection criteria	18–35 years old Female Preferably married Selected from rural areas or urban slums Permanent resident of the area for which she is applying Experience working in the community, preferably as a LHW Willing to regularly attend residential training at the institution Must pass an exam following training Minimum qualification of matriculation[3] preferably with science subjects obtaining at least 45% marks Selection criteria may be relaxed if there is difficulty identifying someone from the harder-to-reach or mountainous areas	At least 18 years old Female Preferably married Local resident Middle school pass Recommended and accepted by the community[4]
Selection process	An advertisement is placed in the local newspaper, electronic media, and/or through local announcements. At the district level, a selection committee (comprising the EDO-H, principal of the midwifery school responsible for training, district coordinator, medical superintendent of concerned hospital, and members of community health councils) consults with CSGs or community members to shortlist candidates, invites them for interviews, and selects applicants according to the criteria and the number of positions available in the local midwifery schools. Candidates then undergo training to provide basic obstetric care and must pass an exam. Finally, they register with the Pakistan Nursing Council.	Areas or health facilities in need of an LHW are identified, and then an advertisement is placed in the local newspaper. Candidates submit applications to the health facility, undergo an assessment or interview, and are selected by a committee chaired by the medical officer in-charge in conjunction with a community representative. The DHO, district coordinator, female police officer, and/or female supervisor then verify selected candidates. The DHO issues an appointment letter.[4]
Training	Basic CMW training lasts one year and has theoretical and practical components. There is an additional 6-month practicum at a training site where CMWs must log 25 deliveries: 15 in a hospital and 10 at home. She must also pass an exam at the end of training. Under the I-RHPHCN program, CMWs may also undergo a 4-day training on nutrition and infant and young child feeding. Some CMWs may be trained in a 6-day structured training for C-IMNCI.	Basic LHW training comprises a 15-month initial training. Refresher trainings occur 1 day per month after deployment.[4] Under the I-RHPHCN program, LHWs may also undergo a 4-day training on nutrition and infant and young child feeding. LHWs may receive refresher trainings and opportunities for capacity building as determined by programs. Some may be trained in a 6-day structured training for C-IMNCI.

Table 3. Community Health Provider Overview

	CMWs	LHWs
Curriculum	The *Community Midwifery Curriculum*, approved by the Pakistan Nursing Council, (no publication year) comprises 7 modules, including information on the background of the community midwifery education program; maternal and newborn health and the community midwife; the foundation of midwifery (e.g., physiology, midwifery drugs, infection prevention, individual and community health assessment, first aid, health education and communication); pregnancy, complications, and antenatal care; labor and child birth, complications and skilled care during labor; newborn and infant care; puerperium and postnatal care; and preparing for professional practice.	*Training Manual for LHWs*. Details from this manual, which was developed at the national level, are unavailable.[5]
Incentives and remuneration	CMWs receive monthly payments of 5,000 Pakistani *rupees* (PKR) (about $48 US) from the DOH and international donors for completed monthly reports. During the training period, CMWs receive a stipend of PKR 3,500 and a training allowance of PKR 1,500. CMWs also charge fees for their services (PKR 500 per delivery and PKR 150 per referral and according to a fee structure depending on several factors: rural/urban, economic status of family, newborn sex, and parity). They are expected to use these fees to replenish their supply of commodities and supplies. On an annual basis, the three CMWs with the best performance according to 7 pre-selected indicators (e.g., deliveries conducted at home, children dewormed), receive public acknowledgement, a cash reward of PKR 10,000, and a certificate signed by the DGHS of Punjab. CMWs do not receive non-financial incentives.	LHWs receive monthly stipends of PKR 8,000 (about $76 US) from the DOH. They do not receive non-financial incentives.

[1] It is unclear in policy if this ratio is an ideal ratio or the actual ratio of LHWs to people.
[2] The *EPHS (2013)* indicates that lady health visitors provide technical supervision and LHSs provide only administrative supervision to CMWs. This information contradicts information in the I-RHPHCN *PC-1*.
[3] Matriculation refers to the final examinations in 9th and 10th grades, resulting in a Secondary School Certificate or Technical School Certificate.
[4] Available Punjab policy documents do not provide details about LHW selection criteria, the selection process, training details, or stipend amount. This information comes from general guidance on LHWs provided by the National Programme for Family Planning & Primary Health Care, Punjab website: http://lhwp.punjab.gov.pk/website/Introduction.aspx?id=12
[5] The main details about scope of work and training specifically for LHWs in the province of Punjab are outlined in the *EPHS* and in the *PC-1* describing the I- RHPHCN program.

HEALTH INFORMATION SYSTEMS

CMWs and LHWs are responsible for data collection at the community level. LHWs use forms and registers to collect and report data, such as a *khandan* or family register, which contains records relating to the household visits they perform and services they deliver, including FP, immunization, and administration of medicines. CMWs use MNCH reporting forms and maintain a registry for tracking antenatal care, postnatal care, and deliveries.

On a monthly basis, CMWs and LHWs submit reports to the LHS for validation. The LHS may confer with the MOIC and other health workers at the facility. The LHS then:

- Sends data to health officials at the DHO, where it is entered into the DHIS. Then, provincial-level officials review and use it, but available policy does not specify how or for what.
- Sends I-RHPHCN program data to the DMU, which transmits data to the PMU through a separate MIS. The DMU also reviews CMW performance data to identify where additional training to reinforce skills might be needed.

The I-RHPHCN program plans to align the DHIS with various program-specific MIS, such as the former MNCH program MIS, but it is unclear if that has been established.

LHSs are expected to share performance feedback with CMWs and LHWs at least once a month, both verbally and in writing. BHUs and RHCs are also meeting points for LHWs, CMWs, and LHSs to review reports and discuss outstanding issues.

Figure 1 shows the flow of community-level data through Punjab's health system.

HEALTH SUPPLY MANAGEMENT

LHWs receive equipment for their health houses, as well as LHW kits, which include the commodities, supplies, and products they need, during monthly meetings with the LHS or as needed at the facility to which they are linked. They maintain a record of the commodities they need in their khandan registers.

CMWs are provided with a one-time supply of the equipment needed for basic skilled delivery from the DMU, such as delivery tables, office furniture, and an instrument kit. LHSs are expected to inspect the condition of the equipment regularly. CMWs also receive an initial disbursement of the commodities and medicines they need for other MNCH-related tasks, and thus, they are expected to replenish their stock themselves using the fees they charge for deliveries.

There is no policy that specifies how community health providers access back-up supplies for emergencies like stockouts.

Waste management is part of training for both CMWs and LHWs, who are expected to follow specific protocols. CMWs, for instance, are provided with syringe cutters and containers for disposal of sharps and other hazardous materials. They must empty or send the container[4] for incineration when it is three-quarters full. CMWs must bury or burn contaminated solid waste and pour liquid waste down a drain or flushable toilet.

Table 4 lists selected essential medicines and products listed in the *National Essential Medicines List of Pakistan* (2007) (PK) and available in Punjab (PJ) according to the *EPHS* (2013). The full list of commodities that CMWs and LHWs provide is included in the *EPHS*.

Table 4. Selected Medicines and Products Included in the *National Essential Medicines List of Pakistan* (2007) and the *Essential Package of Health Services for PHC*, Punjab (2013)

Category	PK	PJ	Medicine / Product
FP	☐	☐	CycleBeads®
	☑	☑	Condoms
	☑	☑	Emergency contraceptive pills
	☑	☐	Implants
	☑	☑	Injectable contraceptives
	☑	☑	IUDs
	☑	☑	Oral contraceptive pills
Maternal health	☐	☑	Calcium supplements
	☑	☑	Iron/folate
	☐	☑	Misoprostol
	☑	☑	Oxytocin
	☑	☑	Tetanus toxoid
Newborn and child health	☑	☑	Chlorhexidine
	☐	☐	Cotrimoxazole
	☑	☑	Injectable gentamicin
	☑	☑	Injectable penicillin
	☑	☑	Oral amoxicillin
	☑	☐	Tetanus immunoglobulin
	☑	☑	Vitamin K
HIV and TB	☑	☐	Antiretrovirals
	☑	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	☑	Oral rehydration salts
	☑	☑	Zinc
Malaria	☑	☑	Artemisinin combination therapy
	☐	☐	Insecticide-treated nets
	☑	☑	Paracetamol
	☐	☐	Rapid diagnostic tests
Nutrition	☑	☐	Albendazole
	☑	☑	Mebendazole
	☐	☐	Ready-to-use supplementary food
	☐	☐	Ready-to-use therapeutic food
	☑	☑	Vitamin A

4 Policy does not specify where they send the containers.

SERVICE DELIVERY

The main service delivery package in Punjab is outlined in the *EPHS*, which includes primary and secondary health care services, with an emphasis on the services delivered under the I- RHPHCN program, including FP, MNCH, nutrition, and, particularly, emergency obstetric care. The *EPHS* outlines the services delivered by various cadres of health workers, including CMWs and LHWs, and where services may be provided.

Table 5 outlines the modes of service delivery CMWs and LHWs take to provide health education, deliver selected preventive and curative services, and mobilize communities.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Punjab has four levels of referral, from households to tertiary care hospitals. The community is the first referral level, where LHWs refer households to CMWs or BHUs. CMWs and health workers at BHUs are required to provide feedback[5] to the LHW on the referral form she submits. CMWs may also refer patients to BHUs. Policy, training, and job aids guide CMWs and LHWs on where and when to refer patients.

Using FP as an example, LHWs may provide condoms, oral contraceptive pills, emergency contraceptive pills, and injectable contraceptives. They may also refer clients to CMWs, BHUs, and RHCs for the methods they may provide, as well as intrauterine devices (IUDs). LHWs do not refer patients directly to hospitals, where permanent methods are offered; BHU or RHC staff must make the referral.

There is no guidance on where implants or information on fertility awareness methods, such as the Standard Days Method, may be obtained.

Table 6 provides more information about selected interventions that CMWs and LHWs deliver in FP, MNCH, nutrition, TB, HIV and AIDS, malaria, and WASH.

5 Policy does not specify what type of feedback is provided, but it likely refers to a counter referral.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CMW, LHW	CMW, LHW	CMW, LHW	Unspecified
	CycleBeads®	Unspecified	Unspecified	Unspecified	Unspecified
	Emergency contraceptive pills[1]	CMW, LHW	CMW, LHW	CMW, LHW	Unspecified
	Implants[2]	CMW, LHW	No	CMW	Unspecified
	Injectable contraceptives	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	IUDs	CMW, LHW	CMW[3]	CMW, LHW	CMW, LHW
	Lactational amenorrhea method	Unspecified		Unspecified	Unspecified
	Oral contraceptive pills	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	CMW, LHW	No	CMW, LHW[4]	Unspecified
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	Iron/folate for pregnant women	CMW, LHW	CMW, LHW[5]	CMW, LHW	CMW, LHW
	Nutrition/dietary practices during pregnancy	CMW, LHW		CMW, LHW	CMW, LHW
	Oxytocin or misoprostol for postpartum hemorrhage	CMW	CMW	CMW	CMW
	Recognition of danger signs during pregnancy	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	Recognition of danger signs in mothers during postnatal period	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
Newborn care	Care seeking based on signs of illness	CMW, LHW			CMW, LHW
	Chlorhexidine use	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CMW, LHW		CMW, LHW	CMW, LHW
	Nutrition/dietary practices during lactation	CMW, LHW		CMW, LHW	CMW, LHW
	Postnatal care	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	Recognition of danger signs in newborns	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	CMW, LHW	CMW[6], LHW	CMW, LHW	CMW, LHW
	Exclusive breastfeeding for first 6 months	CMW, LHW		CMW, LHW	CMW, LHW
	Immunization of children	CMW, LHW	CMW[7], LHW[8]	CMW, LHW	CMW, LHW
	Vitamin A supplementation for children 6–59 months	CMW, LHW	CMW[9], LHW	CMW, LHW	CMW, LHW
HIV and TB	Community treatment adherence support, including directly observed therapy	LHW	LHW	LHW	LHW
	Contact tracing of people suspected of being exposed to TB	CMW, LHW	LHW	LHW	Unspecified
	HIV testing	CMW, LHW	No	CMW, LHW	Unspecified
	HIV treatment support	No	No	No	No
Malaria	Artemisinin combination therapy[10]	Unspecified	Unspecified	Unspecified	Unspecified
	Long-lasting insecticide-treated nets	CMW, LHW	Unspecified	Unspecified	Unspecified
	Rapid diagnostic testing for malaria[11]	Unspecified	Unspecified	Unspecified	Unspecified
WASH	Community-led total sanitation	Unspecified	Unspecified		
	Hand washing with soap	CMW, LHW			
	Household point-of-use water treatment	CMW, LHW[12]			
	Oral rehydration salts[13]	CMW, LHW	CMW, LHW	CMW, LHW	CMW, LHW

[1] The *EPHS* contains contradictory information on whether CMWs and LHWs may deliver emergency contraception.
[2] Information about implants is inconsistent and unclear throughout Punjab policies. Some documents do not specify implants at all as an offered FP method. The CMW curriculum indicates that CMWs should refer patients for implants, but it does not specify where. The *EPHS* permits both LHWs and CMWs to provide information on implants, but it does not indicate that LHWs and CMWs may refer patients to health facilities for implants (as it does for other methods).
[3] The *EPHS* contains contradictory information on whether or not CMWs can administer this method. However, the IUD is included in the CMW kit.
[4] Referrals are mentioned only for tubal ligation, not vasectomy.
[5] CMWs and LHWs may also give iron/folate to women who are anemic, lactating, or of childbearing age.
[6] CMWs may administer deworming medication to the general population; LHWs may distribute to children under five years only.
[7] There is conflicting information about whether CMWs may provide routine immunizations.
[8] Includes BCG, pentavalent I-III, polio, hepatitis, and measles.
[9] Policy does not explicitly say that CMWs can provide vitamin A, but it is included in their CMW kits.
[10] CMWs and LHWs may provide treatment for uncomplicated cases of malaria in children, but policy does not mention artemisinin combination therapy explicitly.
[11] The *EPHS* stipulates that CMWs and LHWs may do a clinical (though not a laboratory) diagnosis of malaria.
[12] CMWs and LHWs may give "advice on safe water techniques, storage, and consumption" but unclear if this includes household point of use water treatment.
[13] CMWs only provide ORS to children under five years of age.

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