भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Department of Health and Family Welfare
Nirman Bhavan, New Delhi - 110011

वन्दना गुरनानी, भा.प्र.से.
Vandana Gurnani, I.A.S.
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Additional Secretary & Mission Director (NHM)

D.O. No. Z.28015/44/2020-NHM-I
Dated 9th October, 2020

Dear Colleague,

Please refer to this Ministry's DO letter of even no. dated 7th July, 2020 seeking your inputs/ comments on the draft of the revised Community Based Assessment Checklist (CBAC) reflecting the expanded range of services to be provided at Health & Wellness Centres.

As you are aware, CBAC introduced in 2016, originally for Population based screening of NCDs was revised in 2018 to include questions related to Leprosy and Tuberculosis. Now, with expanded range of services being implemented at the Health and Wellness Centres under Comprehensive Primary Health Care, it has been further revised to include questions related to these services.

The use of the CBAC is expected to increase community awareness on the benefits of regular screening, serve as a memory trigger and job aid for the ASHA to enable her to undertake activities pertaining to community mobilization and health promotion in her community.On the basis of the inputs/ comments received from the States/UTs, the revised CBAC Form has been finalized and a copy of the same is attached herewith, for information and necessary action.

Efforts are on to convert this revised version of CBAC into a digital format, so that this can facilitate collection and compilation of information derived from CBAC to ensure continuum of care. To bring the activity of CBAC administration to a logical conclusion, States/UTs are requested to ensure that the respective HWC team leader analyse the captured information on a periodic basis to enable positive health outcomes.

Hence, you are requested to ensure communication of revised CBAC form to all concerned stakeholders and utilization henceforth. Further, I request you to orient the Primary Health Care team across Health and Wellness Centres including ASHA, MPW – F/M and CHO to this version during regular monthly PHC meetings.

Pl feel free to approach NHSRC for any support.

with warm regards

Yours sincerely,

Encl: As above.

(Vandana Gurnani)

Additional Chief Secretary (Health)/Principle Secretary (Health)/Secretary (Health) – All States and UTs

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Copy to:

1. Mission Director, NHM – All States and UTs
2. ED, NHSRC
3. JSs/EAs under NHM
4. DSs/Directors of NHM
5. PPS to AS&MD

(**Vandana Gurnani**)

Community based assessment checklist (CBAC)

Date: DD/MM/YYYY

General Information	
Name of ASHA:	Village/Ward:
Name of MPW/ANM:	Sub Centre:
	PHC/UPHC:
Personal Details	
Name:	Any Identifier (Aadhar Card/ any other UID – Voter ID etc.):
Age:	State Health Insurance Schemes: Yes/No If yes, specify:
Sex:	Telephone No. (self/family member /other - *specify details*):
Address:	
Does this person have any of the following: visible defect /known disability/Bed ridden/ require support for Activities of Daily Living	If yes, Please specify

Part A: Risk Assessment				
Question	***Range***		***Circle Any***	***Write Score***
1.What is your age? (in complete years)	0 – 29 years		0	
	30 – 39 years		1	
	40 – 49 years		2	
	50 – 59 years		3	
	≥ 60 years		4	
2. Do you smoke or consume smokeless products such as gutka or khaini?	Never		0	
	Used to consume in the past/ Sometimes now		1	
	Daily		2	
3.Do you consume alcohol daily	No		0	
	Yes		1	
4. Measurement of waist (in cm)	Female	Male		
	80 cm or less	90 cm or less	0	
	81-90 cm	91-100 cm	1	
	More than 90 cm	More than 100 cm	2	
5. Do you undertake any physical activities for minimum of 150 minutes in a week? (*Daily minimum 30 minutes per day – Five days a week)*	At least 150 minutes in a week		0	
	Less than 150 minutes in a week		1	
6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?	No		0	
	Yes		2	
Total Score				

Every individual needs to be screened irrespective of their scores.
A score above 4 indicates that the person may be at higher risk of NCDs and needs to be prioritized for attending the weekly screening day

Part B: Early Detection: Ask if Patient has any of these Symptoms			
B1: Women and Men	**Y/N**		**Y/N**
Shortness of breath (*difficulty in breathing*)		History of fits	
Coughing more than 2 weeks*		Difficulty in opening mouth	
Blood in sputum*		Any ulcers in mouth that has not healed in two weeks	
Fever for > 2 weeks*		Any growth in mouth that has not healed in two weeks	
Loss of weight*		Any white or red patch in mouth that has not healed in two weeks	
Night Sweats*		Pain while chewing	
Are you currently taking anti-TB drugs**		Any change in the tone of your voice	
Anyone in family currently suffering from TB**		Any hypopigmented patch(es) or discolored lesion(s) with loss of sensation	
History of TB *		Any thickened skin	
Recurrent ulceration on palm or sole		Any nodules on skin	
Recurrent tingling on palm(s) or sole(s)		Recurrent numbness on palm(s) or sole(s)	
Cloudy or blurred vision		Clawing of fingers in hands and/or feet	
Difficulty in reading		Tingling and numbness in hands and/or feet	
Pain in eyes lasting for more than a week		Inability to close eyelid	
Redness in eyes lasting for more than a week		Difficulty in holding objects with hands/ fingers	
Difficulty in hearing		Weakness in feet that causes difficulty in walking	
B2: Women only	**Y/N**		**Y/N**
Lump in the breast		Bleeding after menopause	
Blood stained discharge from the nipple		Bleeding after intercourse	
Change in shape and size of breast		Foul smelling vaginal discharge	
Bleeding between periods			
B3: Elderly Specific ***(60 years and above)***	**Y/N**		**Y/N**
Feeling unsteady while standing or walking		Needing help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet	
Suffering from any physical disability that restricts movement		Forgetting names of your near ones or your own home address	
In case of individual answers Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available			
**If the response is Yes- action suggested: Sputum sample collection and transport to nearest TB testing center*			
*** If the answer is yes, tracing of all family members to be done by ANM/MPW*			

Part C: Risk factors for COPD
Circle all that Apply
Type of Fuel used for cooking – Firewood / Crop Residue / Cow dung cake / Coal / Kerosene / LPG
Occupational exposure – Crop residue burning/burning of garbage – leaves/working in industries with smoke, gas and dust exposure such as brick kilns and glass factories etc.

Part D: PHQ 2					
Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things?	0	+1	+2	+3
2.	Feeling down, depressed or hopeless?	0	+1	+2	+3
Total Score					
Anyone with total score greater than 3 should be referred to CHO/ MO (PHC/UPHC)					