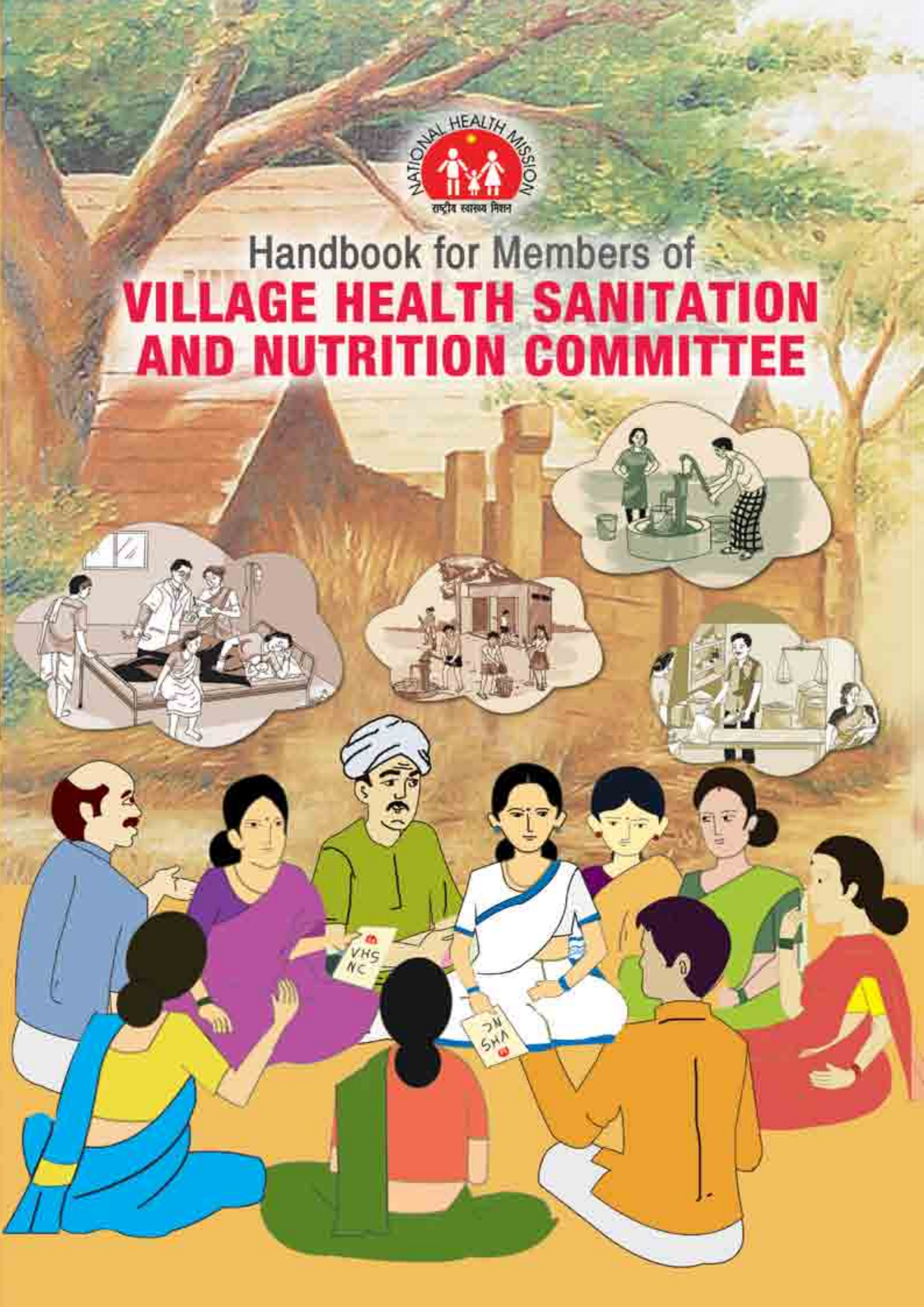
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
Handbook for Members of
VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE
VHSNC

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Handbook for Members of
VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE

Acknowledgements

The Handbook for members of Village Health Sanitation and Nutrition Committee was prepared in consultation with the members of the National ASHA Mentoring Group (NAMG), Advisory Group for Community Action (AGCA), CHETNA and Community Processes Nodal Officers from the States of Kerala, Chhattisgarh and Odisha. We are also especially thankful to Ms. Sulakhshana Nandi (Member National ASHA Mentoring Group) and Dr. T. Sundararaman (Executive Director, National Health Systems Resources Centre) who contributed substantially to preparing this Handbook.

CHAPTER

CONTENTS

CHAPTER 01

COMMUNITY PARTICIPATION AND NEED FOR VHSNCs

1.1 Need for Village Health Sanitation and Nutrition Committee (VHSNCs)

VHSNCs, one of the key interventions introduced by National Rural Health Mission, are an important mechanism to ensure community participation at all levels, which include participation as beneficiaries, in supporting health activities, in implementing, and even in monitoring and action based planning for health programmes.

1.2 Objective of VHSNCs is to

1. Inform the community about the health programmes and government initiatives.
2. Enable community to participate in the planning and implementation of the programmes, and take collective action for attainment of better health status in the village.
3. Take action on social determinants and all public services that directly or indirectly affect health and health outcomes.
4. Facilitate the community to voice health needs, experiences and issues related to- access of health services such that the institutions of local government and public health service providers can take note and undertake 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.

1.3 Understanding Health and its Determinants

1.3.a What is Commonly Understood by Health? What Constitutes Good Health?

People usually associate health with illness, doctor, and medicines. Actually good health does not simply mean the absence of disease, but is related to good physical, mental and social wellbeing.

A Healthy Family

1.3.b Important Determinants for Good Health are

- Adequate food (nutrition)
- Safe drinking water, sanitation, and housing
- Clean environment, healthy living conditions and health lifestyle
- Access to better health services
- Education
- Social security measures and proper and equal wages
- Freedom from exploitation and discrimination
- Women's rights
- Protected work environment
- Relaxation, recreation and healthy relationships

1.3.c ILL Health is Related to

- Malnutrition
- Unsafe water and lack of sanitation
- Unhealthy living conditions
- Unhealthy habits-alcohol/drug abuse
- Hard labour and difficult work conditions
- Mental tension
- Patriarchy
- Lack of access to health services
- Lack of health education

1. Malnutrition is the main cause of ill health

- Malnourished people fall ill very easily because they have reduced capacity to keep themselves free from diseases. That's why they fall ill very easily and stay ill for a long time.
- Diseases like diarrhoea, measles, malaria and pneumonia are often the cause for death of malnourished people.
- Around 50% of our population is very poor and they have to deal with a lot of difficult circumstances in their lives.
- Girls and women are often seen to be more malnourished

Malnutrition

Biggest reason for ill health is malnutrition

↓

Hunger is the main cause of malnutrition (lack of awareness is relatively a smaller problem)

↓

Poverty is the reason for hunger (availability of food is not the problem, the problem is that the poor do not have money to buy enough food)

↓

Malnutrition causes illness again and again

↓

Falling ill repeatedly leads to malnutrition

↓

Expenses on treatment further leads to poverty and more malnutrition

↓

Leading to more disease…more malnutrition

↓

This continuous process leads to ill health

2. Unsafe water and lack of sanitation


Unsafe Drinking Water

- Unsafe water is cause of many diseases.
- The lack of sanitation leads to contaminated and unsafe drinking water
- In both villages and cities, the non-availability of safe drinking water facilities for all residents also leads to more diseases
- Diarrhea, cholera, jaundice, typhoid spread due to unsafe drinking water
- Malaria, dengue Filaria, encephalitis spread due to mosquitoes breeding in stagnant water.

3. Unhealthy living conditions


Unhealthy living conditions

Crowded living spaces, damp rooms, smoke and dust filled environment, all these give rise to respiratory problems and lead to diseases like TB.

4. Unhealthy habits like alcohol and drug abuse


Unhealthy habits like alcohol and drug abuse

Unhealthy habits related to life style like alcoholism and use of other intoxicants, drugs and norcotic substances are also a major cause of bad health in many families. They also lead to social problems at the family and community level.

5. Hard labour and difficult work conditions


Hard labour and difficult work conditions

- Having to do hard labour e.g. pulling cycle-rickshaws
- Working for long hours
- Conditions of work increase the possibilities for disease and illness. For example: working unprotected in stone quarries leads to severe respiratory problems, spraying pesticides without protection
- Unsafe equipment and work tools

6. Patriarchy

When we compare men and women, we find that more women fall ill than men. The core reason for this is patriarchy. It means that our society is dominated by men and accords a lower status to women. This causes ill-health for women in the following ways:


Patriarchy

- In the family, women eat last and also get lesser quantities of food to eat
- Women have to bear the burden of work both in the home and outside
- Women have lesser access to health services
- Women are giving lesser opportunities for education
- Women are taught to feel ashamed about their bodies
- Women are taught to tolerate everything in silence
- Women are made to give the least importance to their health
- They are subjected to violence, abuse and harassment
- They also face the constant fear that men can leave them or kick them out of the house
- Females are subjected to female feticide, girl infanticide, and dowry death

7. Mental tension


Mental Tension

- Many times the negative circumstances of life become too much to bear and leads to mental stress
- Breakdown of society or family, unemployment, social insecurity, no relaxation, these all are causes of mental tension
- People fall ill due to mental tension. Sometimes this also leads to the extreme step of committing suicide.

8. Lack of access to health services


Lack of access to health services

The government is responsible for providing healthcare services to all people. However, many a time people are not able to access these services. This may be due to many reasons, for example:

- Health facilities like HSC or PHC are non- functional due to lack of availability/vacant positions of ANMs, doctors, nurses and other staff.
- Overburdening of health facility staff may also limits their effectiveness in providing care to the patients.
- Provision of care is also adversely affected in cases where the staff of health facility lacks initiative or is negligent.
- People are unable to avail adequate health services due to limited availability of diagnostics and medicines in health centres in some places.
- Block and district hospitals sometimes also lack adequate services
- Lack of connectivity, unavailability of transport, geographic barriers limits the reach of the people to avail health services.
- In many places, people have to spend some money from their own pockets even if they go to Government hospitals. The cost of going to private hospitals is even higher. Therefore many poor people are not able to take treatment from proper hospitals.

9. Lack of health education


Lack of health education

- In order to increase the utilization of health services, people need to be given full information about this, like, what are the services available, what their importance is and how to utilize them. Many a times people are not given this information and this prevents them from utilizing the services.
- The lack of participation by the community in health and the lack of relationship between the community and health staff result in such problems.

1.3.d The two Principles on which our Health System is based

1. Health is our basic human right

Every human being, whether rich or poor, man or woman, young or old or of any religion or caste, has the right to be healthy and access health services.

2. The government is responsible for making health services available to all

It is the duty of the government to provide food, safe drinking water, employment, leisure and basic health services to all people. But this is not possible without collective action. People need to organize together in order to ensure 'health for all'. This is the right and duty of every person living in this country.

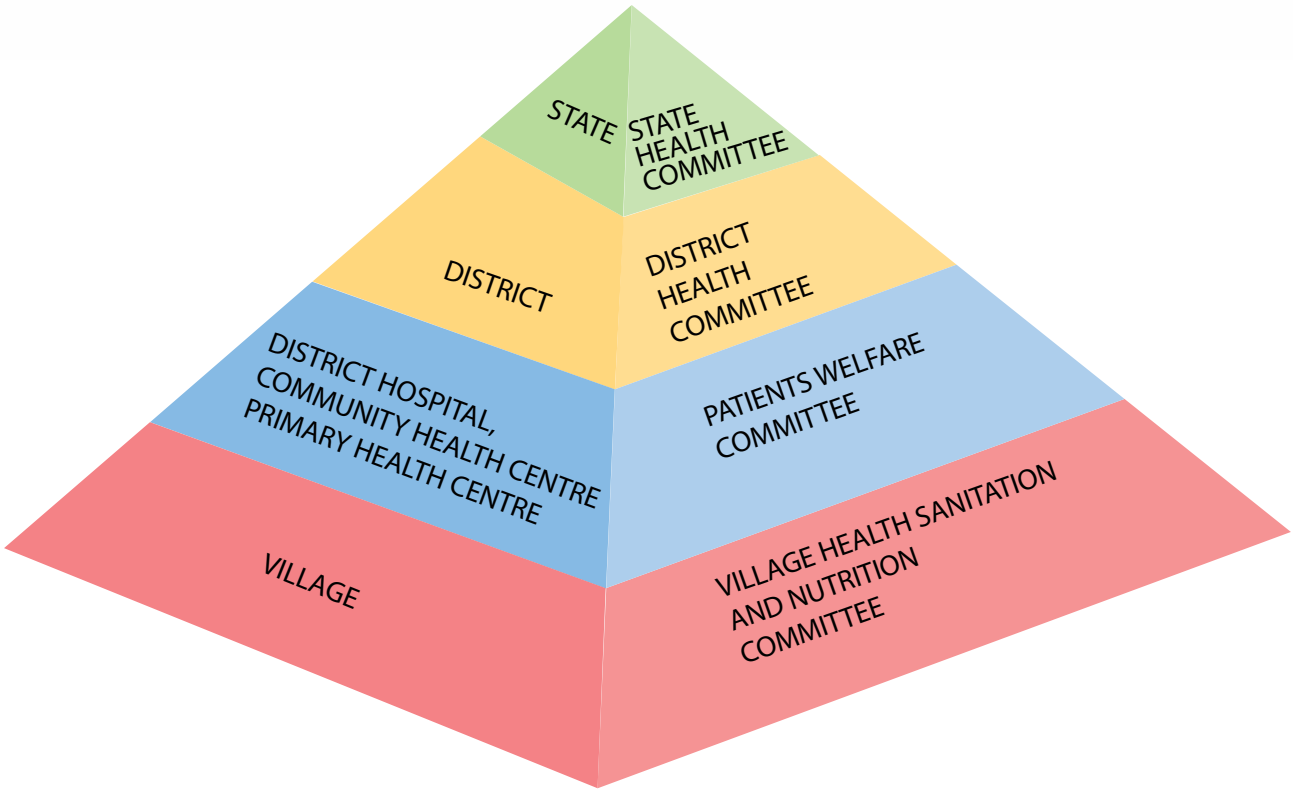
Our VHSNC is a vehicle for such collective action. The VHSNC can work along with the rest of the community to improve the health status of the village. We need to remember that in order to improve health we have to work on all social, economic and cultural determinants of health. Help the participants recall the various determinants of health once again.

1.4 The National Health Mission

In 2005 the Government of India launched the National Rural Health mission in order to provide accessible, affordable and quality health care to people living in rural areas of our country. The mission aimed to reduce maternal and child death and provide better access to health services especially for vulnerable section. In 2013, the NRHM was subsumed under the National Health Mission, which also addresses needs of people living in urban areas through the National Urban Health mission.

The National Health mission aims to ensure universal access to health care through strengthening health systems, institutions and capabilities under National Health Mission.

The various institutions which have been set up at different levels for effective health planning have been given in pyramid above. You can see that VHSNCs serve as village level institutions for health planning and action for the marginalized and poor sections.



1.5 Public Health Facilities

The table below shows the health facilities set up by the government.

NRHM support is being provided to strengthen these facilities through provision of adequate infrastructure, staff and supplies of drugs and equipment.

Name of the Facility	Population Coverage	Providers	Available Services
Health Sub-Centres are of two types. Type A and Type B. The latter provides all recommended services also facilities for conducting deliveries) 	3000 population in tribal hilly areas and up to 5000 population in plain areas	▪ One ANM* ▪ Multipurpose health worker in some places *A second ANM (has been placed in certain states)	▪ Conducts VHND and other outreach services ▪ Here, ANM provides the following services: ▪ Family Planning services like provision of OCPs, condoms, IUCD insertion and related counselling ▪ Complete package of ANC including pregnancy registration, PNC and immunization ▪ Growth Monitoring and Nutritional Counselling ▪ Treatment of minor illnesses and childhood diseases including prompt referral when required. ▪ Treatment for TB leprosy, malaria and also facilitates activities for control of vector borne diseases. ▪ Delivery services only if she is trained as SBA
Primary Health Centre 4-6 bedded and acts as a referral unit for 6 Sub-Centres 	20,000 in hilly, tribal, or difficult areas and 30,000 population in plain areas	▪ One or two MBBS Medical Officer ▪ One AYUSH Doctor ▪ One Staff nurse ▪ One Sanitary Staff (Many PHCs have two Medical Officers)	Provides all the services mentioned under HSC plus: ▪ 24 Hours institutional delivery services both normal and assisted (if designated as 24X7 PHC) ▪ Out-patient care for all ailments is possible through skills of medical officer. ▪ Essential New born care(with provision of New born corner in labour room) ▪ Abortion services with linkage for timely referral to the facility approved for 2ndtrimester of MTP (where trained personnel and facility exist) ▪ Male/ female Sterilization services where trained personnel and facility exists ▪ Health check- up and treatment of school children and adolescent friendly clinic for 2 hours once a week on a fixed day addressing adolescent health concerns ▪ Screening of general health, assessment of Anaemia/Nutritional status, visual acuity, hearing problems, dental check-up, common skin conditions, Heart defects, physical disabilities, learning disorders, behaviour problems, etc.

Name of the Facility	Population Coverage	Providers	Available Services
Community Health Centre 30-bedded hospital and acts as referral for 4 PHCs	80,000 in tribal/ hilly/desert areas and 1,20,000 In plain areas.	5-6 doctors including specialists for different types of health care. Nurses and Paramedical staff more than PHC	Apart from all services that a PHC is meant to provide as detailed above, each CHC also provides clinical care services in some of the specialist areas and institutional delivery services. Some CHCs are designated and equipped to provide services of Caesarean Delivery.
			
District Hospital-. 75 to 500 beds depending on the size, terrain and population of the district.	One per district	Specialist for different types of health care with adequate number of nurses and paramedic staff.	▪ It is a hospital at the secondary referral level ▪ Generally provides all basic speciality services and also certain kinds of highly specialized services ▪ It has Specialized New-born Care Unit for sick and high risk new borns, blood bank, specialized labs, and provides services for caesarean sections, post- partum care, safe abortion and all kinds of family planning procedures. ▪ It also provides most of the surgical services and has a well- equipped Operation Theatre. ▪ It has provisions for dealing with accident and emergency referrals, rehabilitation, mental illnesses and other forms of communicable and non- communicable diseases
			

CHAPTER 02

FORMATION OF VHSNCs

A. Level of Formation of VHSNCs

The VHSNC is to be formed at the level of revenue village. Where the population of a revenue village is over 4000 the VHSNC can be at the level of a Ward Panchayat (as in Kerala).

Relationship of VHSNC with Gram Panchayat

The VHSNC functions under the ambit of the Panchayat Raj Institutions (PRI). It would be a sub-committee or a standing committee of the panchayat.

B. Process of Formation of VHSNCs

- The ASHA, and ASHA Facilitator (or Block Mobilizer) will hold meetings in the village to discuss the role of the VHSNC and its composition.
- The Gram Panchayat members, ASHA, ASHA facilitator (or Block Mobilizer) and ANMs will then select members through a consultative process with the community at village level. The principles for selection are given ahead.
- This list will have to be ratified with inclusion of further suggestions, at the next Gram Sabha meeting.
- The term of a committee shall be co-terminus with that of the Gram Panchayat where it is located. Therefore the VHSNC will be re-constituted after a new panchayat is elected.
- There is no bar on reselecting those who have proved active and effective as VHSNC members, or dropping those who have not been active.
- VHSNC can select new members to replace non-active members or add a new member within the norms, by two thirds majority.

C. Composition of the VHSNC

i. Number of Members

The VHSNC should have a minimum of 15 members. It may have more members.

ii. Key principles Governing the Composition of the VHSNC

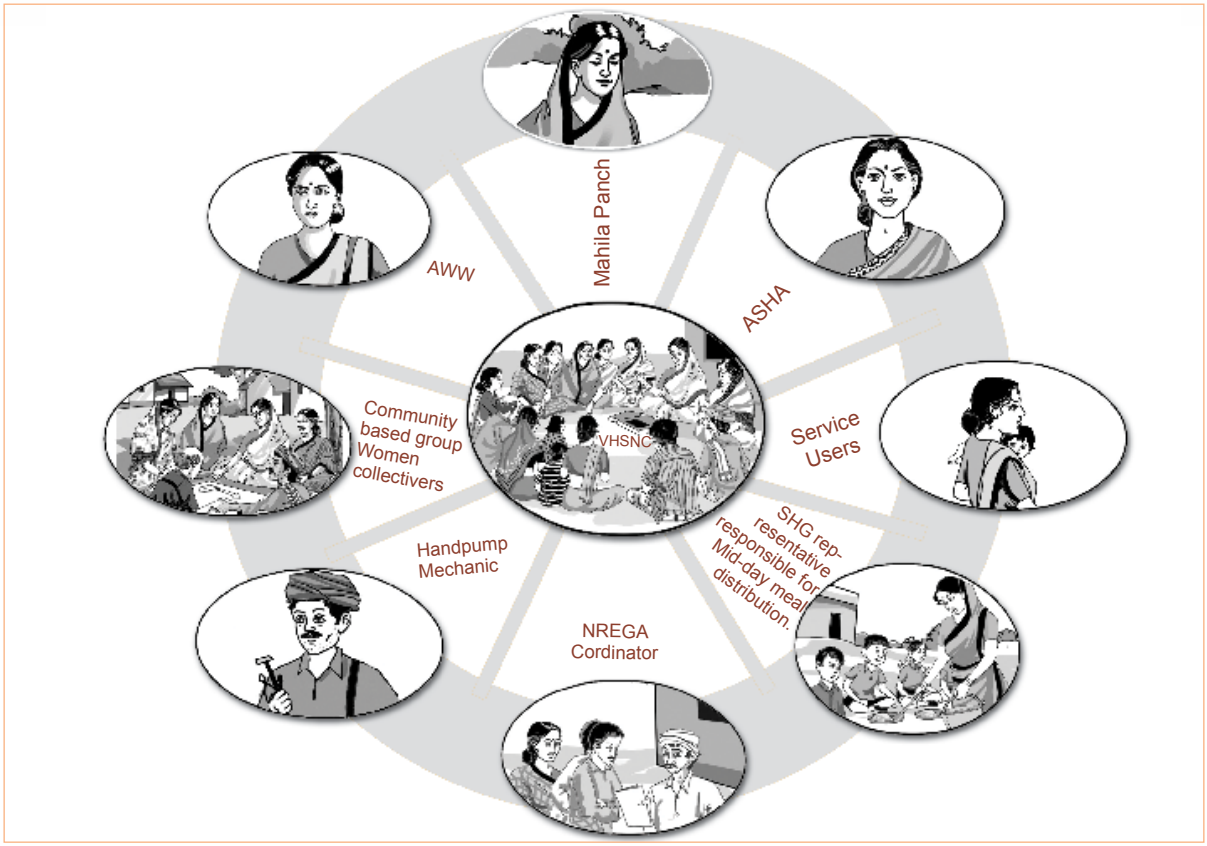
1. Elected members, especially women members of the panchayat resident in the village should be enabled to lead.
2. All those working for health or health related services should be able to participate.
3. The voices of service users of health services- especially of mothers should find place.
4. There should be representation from all community sub-groups, especially from poorer and more vulnerable sections.
5. All habitations/hamlets should have representation.

At least 50% should be women members and SCs, STs and minorities should be well represented.

There is considerable over-lap between these categories- thus a woman with a small child given membership on the committee could be also representative of a distant hamlet and belonging to a marginalized community etc.

iii. Constitution of the VHSNC

1. **Elected Gram Panchayat Members:** Those members who are residents of the village are to be preferred, like the women Ward Panch. In areas where there are no elected panchayats, members of tribal councils, could be considered. Though more than one elected member of a panchayat can be included in the VHSNC, their numbers should be limited to one third of the total number of members, and preference should be given to women panchayat members. Members of the permanent standing committees of the gram panchayat who are usually elected members should also be preferably included.



2. **ASHAs:** All ASHAs of the village should be on the committee. In small villages there would be only one ASHA per VHSNC.
3. **Frontline staff of government health related services:** The ANM of the health department, the anganwadi worker of the ICDS, and the school teacher should be included as regular members only if they are resident in that particular village. Otherwise they qualify to be special invitees. Volunteers/ village level workers of other government departments- eg. The hand pump mechanic of Public Health and Engineering Department (PHED) or the field coordinators of the MNREGA programme, should also be considered if they are resident in the village.
4. **Community Based Organizations:** Representatives of existing community based organisations like Self Help Groups, Forest Management Committees, Youth Committees, etc.
5. **Pre-Existing Committees:** If there are separate committees on School Education, Water and Sanitation or Nutrition, the first effort should be to integrate these committees with VHSNC. If that is not possible or till the time it has not been done, key functionaries of each of these bodies should be included as a member in the VHSNC and chairperson of the VHSNC should also become a member of these committees.
6. **Service-Users:** Pregnant women, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using the public services should also find place.

D. Mechansim of Selection

All the selections are done by the community keeping in view the above principles as guidelines. The ANM, AWW and ASHA along with the Panchayat members are expected to ensure that every section is represented. 50% of total members of VHSNC must be women and SC, ST & Minorities should be adequately represented as per their population in village.

E. Who are the Special Invitees?

Other than members a more general category of special invitees can be included. They can attend the meeting and indeed their presence and interaction with the committee is essential. They are generally not residents of the village. This includes 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.

Ideally the medical officer and block development officer should participate in every VHSNC meeting at least once or twice a year. ASHA Facilitators who are also facilitators for other community processes including the VHSNC itself should attend the VHSNC meetings more regularly.

F. Who is the Chairperson?

The Chairperson of the VHSNC is a woman elected member of the gram panchayat (panch) 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 should be given to any panch from the SC/ST. But this is a decision arrived at between the gram panchayat and VHSNC with the ANM & ASHA playing a facilitating role.

G. Who is the Member-Secretary and Convener?

The ASHA will be the Member-Secretary and Convener of VHSNC.

H. Importance of ASHA as the Member-Secretary and Convener of VHSNC

This is important because of the following reasons:

1. It has been found that ASHA, if put in the leadership role, can play a very important role in providing a more organized support mechanism and more sustained building of capacity of the VHSNC.
2. She also has better community ownership and acceptance. She is person who belongs to the community and is knowledgeable about health.
3. She has been involved in health related issues over the past few years.
4. For successful achievement of her objectives especially as related to health promotion, prevention and community mobilization, the ASHA also requires an active VHSNC.

I. How to Select if there are More than one ASHAs in the Village?

If there is more than one ASHA in the VHSNC village, then 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 but that is a local decision.

ASHA Facilitator (or Block Mobilizer) should organize a meeting of all ASHAs of the village in the presence of the Panch. Selection of the ASHA who would become the Member Secretary would be as per consensus in the meeting.

Joint Bank Account

Once the VHSNC has been constituted, an account in the nearest bank should be opened. It is to this bank that the untied fund of the VHSNC shall be credited.

The joint signatories of the VHSNC account would be the Chairperson of the VHSNC (female panchayat member) and the Member Secretary (ASHA).

If any other persons, for example ANM, AWW are amongst the joint signatories of the account they should be replaced as per the above guideline.

All withdrawals from VHSNC account must be done by signature of both the signatories (if the account is operated by two signatories) or by two of the three signatories (if the account is operated by three signatories). The decision on expenditure of untied fund will only be done through a written approved proposal of the VHSNC with signatures of its members.

J. Importance of Having two Joint Signatories in VHSNC

Having two joint signatories reduces the possibility of any wrong doings. It also ensures more transparency.

Roles and Responsibilities of key VHSNC Members

1. Chairperson of the Committee

The Chairperson will:

a. Be responsible for ensuring that meetings are held on monthly basis.

b. Lead the monthly meetings of the committee and ensure smooth coordination amongst members for effective decision making.

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

d. Helps the VHSNC to undertake village health planning and take responsibilities for necessary actions and follow ups.

e. Help the VHSNC to formulate annual plan.

f. Ensure that the issues/plans emerging from village health monitoring and planning are reflected in the Gram Sabha and Gram Panchayat proceedings.

g. Ensure that the records are adequately maintained.

2. Member Secretary and Convener of the Meeting

ASHA acts as the member secretary and convener of the committee.

She will:

a. Fix the schedule and venue for monthly meetings of the committee.

b. Ensure that meetings are conducted regularly with 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-related to total population of the village, number of maternal and infant deaths, JSY/JSSK beneficiaries, children immunized, malnourished children and those referred to Nutrition Rehabilitation Centre (NRC), number of households and details of families falling under marginalized 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, This includes identifying the cause of the gap, recording the decision on collective action as needed by the village to address the gap, and designating the persons responsible for leading the collective action, the specified timeframe to undertake the action, and recording follow up action.

f. Ensure utilization of the un-tied fund as per the decisions taken by the committee through regular disbursal of funds jointly with the Chairperson and other signatories, if any, and undertake regular update of the cashbook and maintain other necessary records related to the funds.

g. Provide information on activity wise fund utilization 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 expenditures in the annual Gram Sabha, its social audit and getting the approval of the Statement of Expenditure (SOE) by the Gram Panchayat, and timely submission of the SOE to the ASHA Facilitators or at the block level.

3. The Anganwadi Worker

She is an important member of the VHSNC. She has a critical role in enabling VHSNC to take action on addressing malnutrition.

She will:

a. Provide information on hamlet wise malnutrition status of children (less than six years of age) and presenting before the committee any specific challenges related to the functioning of AWC or help she needs for improving her effectiveness.

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

c. Be accountable for ensuring the provision of take Home ration for children of less than three age group, 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. Be held accountable by the VHSNC for providing hot cooked meals in accordance with norms.

4. ANM

She will:

a. Provide information to VHSNC regarding available services, schemes, and services for maternity 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 or support 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. Be made 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

The mandate of the VHSNC encompasses health, sanitation, drinking water and nutrition as well as the Education, particularly in the context of the programmes like Mid-Day Meal, and other programmes implemented by Department of Woman and Child Development. Accordingly the VHSNC has the role of providing 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. This will ensure action on improving social determinants of health. This also allows VHSNC to ensure local level accountability in delivery of social sector programmes.

6. ASHA Facilitator

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

CHAPTER 03

ACTIVITIES AND OUTCOMES OF VHSNC

The activities of VHSNC can be classified into nine categories

Some activities relate to the essential processes involved in the functioning of VHSNC and include - Monthly Meetings, Management of Untied Village Health Fund, Accounting for the Untied Village Fund and Record Maintenance. The other set of activities include - Monitoring and Facilitating Access to Essential Public Services, Organizing Local Collective Action for Health Promotion, Facilitating Service Delivery in the village, Village Health Planning and Community Monitoring of Health Care Facilities.

3.1 VHSNC Monthly Meetings

The VHSNC functions through its meetings. Therefore regular meetings are a hallmark of a functioning VHSNC. It is in the meeting that the VHSNC monitors and plan for health. It is a platform for taking and initiating action, to identify, discuss the problems and plan for ways to mitigate them.

The meeting also serves as an important platform for service providers to learn about the gaps from the community feedback and for the community to learn about the gaps from provider feedback. For example if toilet construction is not being undertaken, the frontline worker of the government may have her/his understanding of why people do not opt for it; but people may have another set of reasons. In this case the VHSNC becomes a platform for dialogue and action.

How regularly should the VHSNC Meet?

Meetings of VHSNC should be held at least once every month. A day should be fixed every moth for the meeting, for example 10th of every month or third Saturday of every month. This will ensure that the members are aware beforehand of when the meeting is to be held so that they can plan to participate.

Who is Responsible for Organizing the Meeting?

The ASHA (Member Secretary) and the Panch (Chairperson) will be responsible for organizing the meeting. They would, in most circumstances need to remind the members of the meeting, and mobilize them toattend.

Who should help in Facilitating the Meeting?

The ASHA and the ASHA Facilitatorshould help to facilitate the meeting.

Where should the Meetings be Held?

The meeting can be held in one fixed venue. It may be in a public facility like AWC, Panchayat Bhawan or School which is easy to reach and accessible to all members. The venue may be changed as per need. For example, in order to understand and formulate an action plan for the problems faced by families in the farthest hamlet, in bringing their children for immunization, it may be necessary to hold the meeting in that particular hamlet. Or in order to deal with a case of domestic violence it may be necessary for the VHSNC to hold their meeting in/near the house of the victim. However, any change in venue needs to be discussed in the previous meeting and all members and community informed in time.

Who should Attend the Meetings?

All VHSNC members need to attend the meeting along with the special invitees like the Block Medical Officer, Block or District Panchayat member etc. Other people from the community should also be encouraged to participate in the meeting.

It should be doubly ensured that members of marginalized and vulnerable sections of the village participate in the meeting.

Who will Provide support and Monitoring to VHSNCs?

The ASHA Facilitator and the Block Mobilizer will provide support and monitoring to the VHSNC.

3.2 Untied Fund and Principles of Utilization

An untied fund of Rs. 10,000 is given annually to the VHSNC.

Why is the Untied fund Given to the VHSNC?

The main purpose of the untied fund is to use it as a catalyst for health planning and for executing the plan. It is expected that the VHSNC should leverage funds from other sources too.

Every village is encouraged to contribute additional funds to the Village Health, Sanitation and Nutrition Committee. This may be in terms of money or labour.

What can the Untied Fund be used for?

The VHSNC can use these funds for any purpose aimed at improving the health of the village. Nutrition, education, sanitation, environmental protection, public health measures are key areas where this fund could be utilized.Decision on the utilization of funds should be taken during the VHSNC meetings and should be based on the following principles:

- The fund shall be used for activities that benefit the community and not just one or two individuals.
- However in some cases such as that of a destitute women or very poor household, the untied grants could be used to meet their health care needs and facilitate access to care. For example, one VHSNC identified a suspected pneumonia patient who did not have money to go to the CHC for treatment. The VHSNC provided funds for her treatment at the CHC and one of the members also accompanied her and her family to the CHC for support. In another village, one village a woman had died soon after giving birth. The family was too poor to buy milk for the child and could only fed her rice water. The child was getting more and more malnourished. Seeing this, the VHSNC decided to provide milk for the child daily for six months.
- The fund shall not be used for works or activities for which an allocation of funds is available through PRI or other departments and duplication of activities on which funds

are used should be avoided. For example, the fund should not be used in activities like construction of roads or drainage system in the village as these activities are already budgeted in their respective departments like Rural development, PHED or Forest Department.

- In special circumstances the district could give a direction or a suggestion to all VHSNCs to spend on a particular activity- but even then it should be approved first by the VHSNC.
- VHSNCs will not be directed to contract with specific service providers for specific activities, regardless of the nature of the activity. If the VHSNC wants to engage someone for providing emergency transport, neither health department staff nor anyone else can direct it to buy the machine from any particular shop or give the contract for referral transport to any particular service provider.
- All payments from the untied grant must be done through the VHSNCs directly to the service provider. This means that no one, not even the health department staff can collect money from the VHSNC for payment to a service provider. The VHSNC should make any payments directly.

3.3 Managing the Untied Fund

- The management of funds is completely in the hands of the VHSNC.
- The utilization of the funds has to be transparent and should involve a participatory decision making process.
- Decisions taken on expenditure should be documented in the minutes during meetings. It is preferably adopted as a written resolution that is read out and then incorporated into the minutes in a meeting where there was adequate quorum.
- The member secretary should be allowed to spend small amounts on necessary and urgent activities, of up to Rs. 1000, for which details of activity, bills and vouchers should be submitted in the next VHSNC meeting and a post facto approval of the committee should be taken. This is important for emergency cases.

Accounting for the Untied Village Fund

- VHSNC has to present an account of its activities and expenditures in the bi-annual meeting of Gram Sabha and the quarterly meeting of the Gram Panchayat in which the plan and budget of the gram panchayat is discussed.
- The annual Statement of Expenditure, prepared by VHSNC, will be forwarded by the Gram Panchayat to the appropriate block level functionaries of NRHM.
- All vouchers related to expenditures will be maintained for upto three years, by the VHSNC and should be made available to Gram Sabha, or audit or inspection team appointed by district authorities. After that the Statement of Expenditure (SOE) should be maintained for 10 years.
- The VHSNC should be allowed a period of 12 months after transfer of the untied funds, to spend the funds. In case of delayed fund receipts VHSNCs need to be given a six month period to spend funds beyond financial year end. When final accounts are presented unspent funds are to be regarded as unsettled advances and district will top-up VHSNC funds on the unsettled advances.

3.4 Maintaining Records

Maintaining records enables VHSNC to be more organized and function systematically. The records that are to be maintained are as follows:

1. Record of meetings with attendance signatures – This includes VHSNC monthly meeting attendance records and the record of minutes of the monthly meetings. (Annexure 1). Key financial decisions adopted for withdrawal and expenditure should be recorded here with signatures of all the members who have attended the meeting. If there are any changes made by VHSNC in its membership or any other critical decisions taken, they should also be written in this register.
2. Cash Book -To record details of all expenditures: Since it is relatively more difficult for ASHA to learn how to maintain a proper Cash book, a simpler format for recording expenditures is given at (Annexure-2).
3. Bank Pass Book
4. VHSNC Statement of Expenditure- Along with the cash book, this record would help the VHSNC to present an account of its activities and expenditures when asked for. It could be useful in the bi-annual meetings of the gram sabha and will also be used by Gram Panchayat to forward annual Statement of Expenditure to the appropriate block level functionaries of NRHM. (Annexure-3)

Along with the above records, the VHSNC should maintain the following that are discussed in detail in the next chapter:

1. Village Health Register(Annexure- 4)
2. Public Services Monitoring Tool and Register(Annexure:5 and 5a)
3. Death Register(Annexure- 6)
4. Birth Register(Annexure-7)

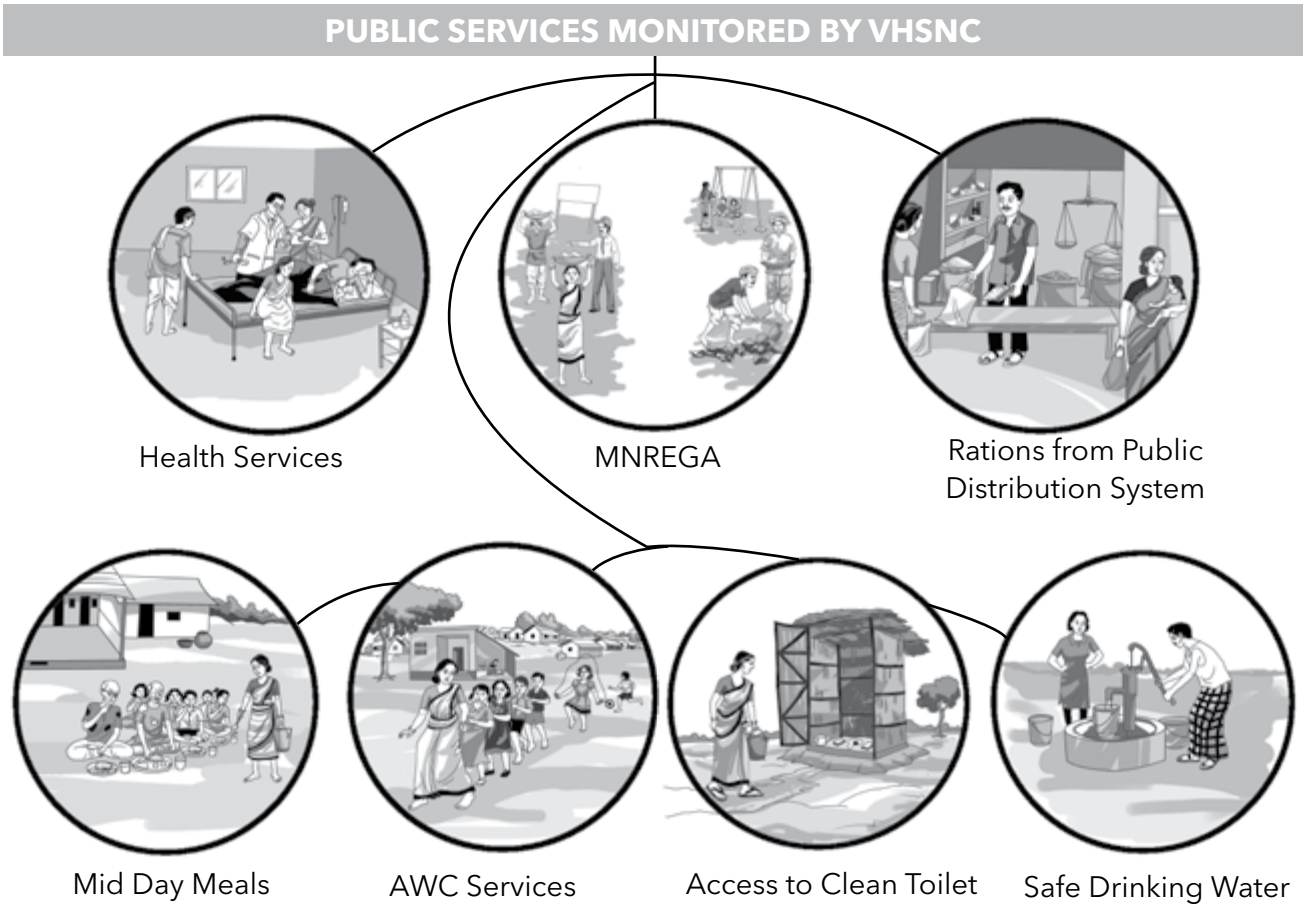
3.5 Monitoring and Facilitating Access to Essential Public Services and Correlating such Access to Health Outcomes

- **Use a Village health register:** Records data on total population of the village, number of households, BPL families (with information on their religion, caste, language), list of current beneficiaries of services related to health, water and sanitation and nutrition, to ensure access of all sections, particularly the marginalized groups including the disabled.

  By using this register VHSNC can easily identify who are being excluded from receiving various services.

  Once this is identified the corrective action provides for greater focus or different approaches to ensuring utilization by this excluded group. In this way the VHSNC becomes one of the most important ways of addressing social determinants.

- **Use Public Service Monitoring tool:** it is simple tool to assess the situation of public service in the village and helps ascertaining whether key services were available in the previous



month and what is the status of some critical indicators for the wellbeing of the village. Based on this tool fill Public Services Monitoring Register during the VHSNC meeting every month and plan for appropriate action.

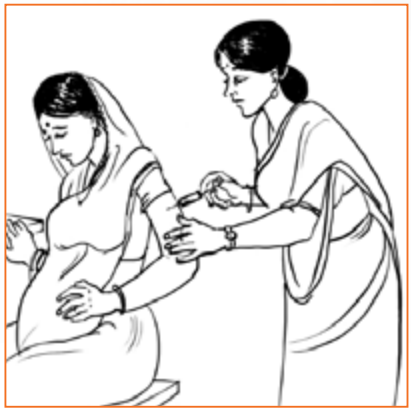
3.6 Organizing Local Collective Action for Health Promotion

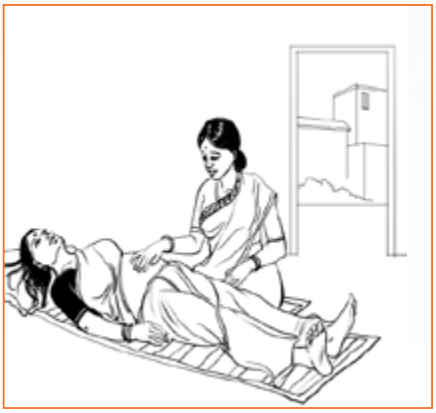
VHSNC serves as an inspiring village organization and bring the community together for collective action on health. This could be done by motivating voluntarism for community mobilization and utilizing their support for organizing cleaning drives, improving village sanitation, or in synergized efforts for vector control.

3.7 Facilitating Service Delivery and Service Providers in the Village

- Organizing the Village Health and Nutrition Day and support to the organization of immunization sessions. VHSNC members should facilitate mobilization of pregnant women and children, particularly from marginalized families, facilitate the organization of and support the ANM, AWW and ASHA in conducting the VHND.

- Act as a medium to allow outreach workers and community service providers to articulate their problems and provide support in overcoming their challenges. The meetings identify who the ANM, Anganwadi worker, the school teacher and the ASHA are unable to reach and help these providers to reach these sections. In cases where providers are facing personal taunts or even harassment, support from the VHSNC members may make a difference.

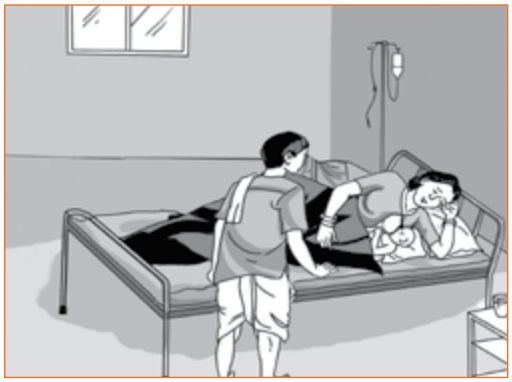




- Help in providing important amenities missing in the Anganwadi Center or Sub-Center or School. The VHSNC can help provide these amenities, so as to make it more comfortable and healthy for both user and provider.

- Learn about the gaps in services from the community feedback and possible gaps from the provider feedback and act as platform for dialogue and action. For example if toilet construction is not being undertaken, the frontline worker of the government may have her/his understanding of why people do not opt for it; but people may have another set of reasons.
- Support service delivery by organizing local tie-ups with vehicle owners to transport a patient to the hospital in time of need.

- Undertake registration of births and deaths and ensure that a birth certificate is issued by the appropriate authority and reaches the family within the given time standard. All deaths too should be followed by the issuance of a death certificate, including for still births.
- The VHSNC should focus on cause of death and good quality reporting of such causes, as this is likely to form the basis for village planning. Information on any maternal death , child death and any outbreak should be immediately provided to the Sub center ANM/PHC Medical officer.



3.8 Community Monitoring of Healthcare Facilities

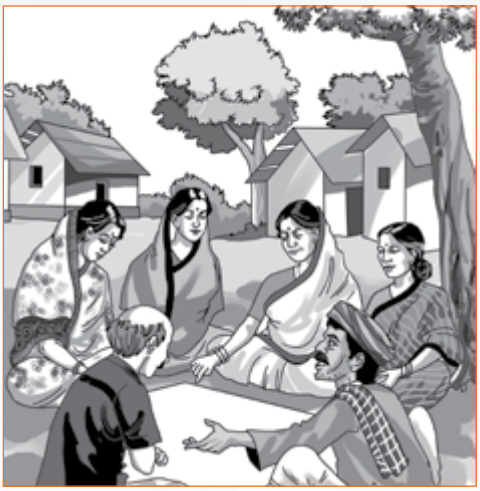
- Monitor health care services in primary and secondary health care facilities.
- Fill scorecard for health facilities and visit PHCs and HSC for monitoring and dialogue with service users to understand key issues and gaps related in service delivery and quality of care.
- Organize Jan Samvads- which are forum for dialogue between the community and the authorities and also perform the task of grievance redressal. In the Jan Sanwad the PHCs which do well as per the scorecard will be felicitated and those which are faring poorly in the scoring are singled out for appropriate action.

- Monitor Programmes such as Rashtriya Swasthya Bima Yojana and private sector partnerships and highlight their problems.

3.9 Village Health Planning

Village Health Action Planning is a continuous process and is to be done in each monthly VHSNC meeting. It includes discussion and decision in VHSNC on:

- Identifying a gap with help of monitoring registers and other methods.
- Identifying the habitation where the gap is.
- Identifying the cause of the gap.
- Deciding the collective action needed by the village to get the gap addressed.
- Deciding the responsible persons to lead the collective action.
- Fixing the time frame for attempting the action.



A second mechanism to develop a village plan is to identify health care priorities and to take appropriate action at various levels: health education action at the level of the community and asking for government action or services at the level of health systems.

To understand the health care priorities the VHSNC could:

1. Maintain a record of deaths and their causes as perceived. All deaths of pregnant woman and children less than one year of age should be reported and followed by an enquiry with family members.
2. Use the record of deaths to estimate the disease loads. For example- If there is one maternal death; it would indicate that at least 30 women would suffer from really troubling complications that can be avoided.
3. Use the record of deaths to conduct verbal autopsies. This involves identifying causes, extent of suffering from causes that do not lead to death and economic loss. This also involves ascertaining how all these situations can be prevented.
4. Maintain records of disability.
5. Focused group discussion to identify frequent causes of care seeking by patients in a hospital.

CHAPTER 04

ANNUAL VILLAGE HEALTH PLAN

In addition to the monthly village health planning which looks at specific gaps, the VHSNC should also make an annual plan on issues that affect the health of the community. This annual plan can be made during a specific month each year and reviewed every month.

4.1 Difference Between Annual Village Health Plan and the Monthly Plan

The difference lies in the fact that the monthly plan addresses the immediate and short term interventions. For example: monitoring gaps such as availability of bed nets or chloroquine tablets for control of malaria. However, the annual plan would look at the factors to prevent the spread of malaria in the village. Thus an annual malaria plan will focus on vector control activities and other preventive measures.

The important steps to be followed for making an annual village health plan are as follows:

Step 1: Gather the following Data and Information taken from the Village Health Register

1. Total population of the village.
2. Number of Households.
3. Number of BPL families, with information on their religion, caste.
4. Current beneficiary / target lists of services related to health, water and sanitation and nutrition to ensure access of all sections, particularly the marginalized groups. For example, list of pregnant women, list of people with disability, list of children under the age of six years etc.

Step 2: Prepare an annual calendar of activities or issues that can guide the VHSNC in taking up various issues every month. This calendar should be formulated, taking into account the seasonality of diseases, availability of community for various activities etc.

An example of the Annual Calendar is as follows:

Month	Suggested issue/activity
January	
February	Measles
March	

Month	Suggested issue/activity
April	Awareness campaign on diarrhea
May	Monitoring Diarrhea
June	Awareness campaign on malaria
July	Monitoring malaria/school enrolment drive
August	
September	
October	
November	Newborn Health
December	

4.2 Making an Annual Malaria Plan

All members divide into groups and go into different directions of the village with the task to count and write down the number of places with stagnant water and discuss action to be taken to correct it. Once everyone returns, present what they saw, describing the area of stagnant water (whether it was a pond, rock pool, broken matka/pot in a courtyard, area around the hand pump) and mark the observations in a map of the village. They discuss what corrective measures could be taken to reduce mosquitoes in that area.

After all the members, summarize and discuss how to make a village level malaria plan. They discuss the role of ASHA, VHSNC members, Panchayat, home visits and counseling, village meetings, awareness about malaria, information about drugs with ASHA etc.

Note: The plan should include:

- Identification of all possible breeding sites in the vicinity of the village- All places should be marked on a village map.
- Action on controlling breeding of mosquitoes like i) pouring oil (usually waste machine oil) on stagnant pools, closing up hollows and depressions where water accumulates, ii) de-grassing the edges of ponds and tanks with a vertical cut iii) ensuring that septic tanks are closed with no cracks and are fitted with a netting on the gas vent and iv) ensuring overhead tanks are well closed and not breeding mosquitoes v) Insecticide spraying and introduction of larvivorous fish.
- Action on personal protection, including making available bed nets, mosquito repellant and monitoring its use.
- Availability of medicines and materials for diagnosis for malaria with ASHA – the VHSNC can plan to write to the BMO/CMHO/Collector regarding need for these items before the malaria season. VHSNC will also monthly monitor their availability.

- Availability of referral transport for severe cases- The VHSNC can fix a service provider for referral transport so that time is not wasted in making arrangements for referral.
- Person/s responsible for each activity need to be identified.
- Timelines for all these activities have to be fixed.

4.3 Making an Annual Plan for Referral Transport

In order to make an annual plan for arranging referral transport, the VHSNC members have to first make an estimate of the number of referrals that would need to be made. This would include cases of institution deliveries, and serious cases requiring hospitalization. The VHSNC will then have to develop the terms and conditions of the contract, like how would the payment be determined, how soon should the vehicle be available for transporting a patient etc. They will then have to identify the possible service providers and discuss with them the terms and conditions of the contract. They would then select the provider with the lowest rate. The VHSNC would have to create a system through which the service provider can be called, maybe through the panch or the ASHA or directly by the family. Then they have to plan to disseminate this information along with the phone number of the service provider/ASHA and details of the service being provided. They may do this through wall writing, or share this information in gram sabha and other village meetings. The VHSNC will also have to develop a system to document the number of trips and monitor the functioning of the service provider.

ANNEXURES

Annexure 1: VHSNC Monthly Meeting Attendance Record

Village Health and Sanitation Committee, Village:_____ GP:_____

Block:_____ Meeting Date: _____Meeting Time:_____

Meeting Chaired by: _____

Sl. No.	Name*	Hamlet/ Post	Signature

*Mention details of special invitee if any.

Annexure 1b: VHSNC Monthly Meeting Minutes Record

Agenda Item	Key discussions**	Decisions Taken	Name of individuals assigned responsibilities	Financial allocations, if any with stated details

**Specify issues in objection or support of the Agenda item.

Sign of Member Secretary: **Sign of Chairperson:**

Annexure 2: Cash Book for VHSNC

- The cash book of the VHSNC is to be maintained for recording of income & expenditure of the VHSNC.
- This cash book is totally maintained by the VHSNC Member Secretary cum Convener (ASHA) with the help of AWW/ANM/Chairperson of VHSNC.
- One part (PART 1) of the cash book comprises income of the VHSNC (untied fund, donation, other source) and other part (PART 2) of the cash book comprises expenditure.

PART 1- Income Details – (To be Maintained on Left Side of the Cash Book)

Sl. No.	Opening Balance	VHSNC Untied Fund Received- Donation or Untied (Amount)	Details of Funds Received by the VHSNC-Donation or Untied - (Cheque no./Draft no./Cash)	Date of the details donation/ income (To be written red ink)	Source of donation/ income	Sign of Member Secretary

PART 2- Expenditure Details – (To be Maintained on Right Side of the Cash Book)

Sl. No.	Amount of Fund Spent by VHSNC	Details of Funds Spent by the VHSNC- (Voucher No. Bill No.)	Date of the expenditure (To be written red ink)	Activity on which funds were spent	Signature of Member Secretary

Annexure 3: VHSNC Statement of Expenditure

Sl. No.	Period of Activity (Date/Month)	Name of Activity	Purpose (including details on beneficiaries and location of activity)	Details of expenditure (rates of items, break-up of expenses)	Total expenditure on Activity
Total expenditure (All Activities)					
Total amount received					
Total unspent amount					
(a) Total amount at hand/cash					
(b) Total amount in bank					

Annexure 4: Village Health Register

The village health register should contain information on the following:

a. Total Population of the village.

b. Total Number of Households in the village.

c. Total Number of BPL Families; with details of their religion, caste and language.

d. Current beneficiaries/target lists for services related to health, water and sanitation, and nutrition to ensure access of all sections, particularly the marginalized groups.

e. Details of Individuals with Disability.

Annexure 5: Public Services Monitoring Tool

	Indicators	Jan.	Feb.	March
	Anganwadi Centre			
1	Did all Anganwadicentres open regularly during the month?			
2	Number of children aged 3 - 6 years?			
3	Number of children aged 3 - 6 years who came regularly to Anganwadicentre ?			
4	No. of 0-3 year children in village			
5	No. of 0-3 year children who are in malnourished or severe malnourished grade			
6	Was the weight measurement of children done in all centres last month?			
7	Were pulse and vegetables served all days in cooked meal last week in all the centres?			
8	Was Ready to Eat food distributed in all centres on each Tuesday during the last month?			
	Complementary Feeding			
9	Number of children aged 6-9 months whose complementary feeding has not started yet ?			
	Health Services			
10	Did the ANM come last month for the Immunization/ VHND?			
11	Whether all children of all hamlets are being vaccinated in appropriate age ?			
12	Whether the BP measurement of pregnant woman was done in the VHND ?			
13	Did the ANM provide medicines to the patients free of cost?			
14	Did all the ASHAs have more than 10 chloroquine tablets with them ?			
15	Did all the ASHAs of the village had more than 10 Cotrimaxazole tablets with them ?			
16	Whether the transportation facility was available to take the serious patients, delivery cases, sick newborn cases, etc to health facilities ?			
17	Number of families not using mosquito net ?			
18	Number of deliveries that took place in the home during the last month ?			
19	Number of diarrhoea cases during the last month ?			
20	Number of fever cases during the last month ?			
	Food Security			
21	Whether the ration shop provided all ration items during the last month ?			
22	Did the old age pensioners get pension in time ?			
23	Was the MNREGA payment made in time ?			

	Indicators	Jan.	Feb.	March
	Education			
24	Number of girls under the age group of 6-16 not attending the school ?			
25	Did all the schools teachers come to the schools regularly during the last month ?			
	Mid- Day Meal			
26	Were pulse and vegetables served all days in cooked meal last week in all the schools (upto 8th)?			
	Handpump			
27	How many hand pumps are non-functional as on today?			
28	Number of hand pumps with stagnant water around -today?			
	Individual Household Latrines			
29	Number of households with individual household latrines constructed and used?			
	Others			
30	Number of cases of violence against women during the last month?			
31	Number of cases of early childhood marriages reported?			

The above table is based on the experience of Chhattisgarh VHSNCs. Exact details of each row can change according to the state or district. VHSNC too can add on aspects which it wants to monitor.

(Based on above table- the following notes are kept- which is a monthly action plan)

Annexure 5a: Public Services Register

Sl. No.	Gap Identified in table above	Date on which identified	Action to be taken	Person responsible	What happenned next

Annexure 6: Death Register

Name of Village: _____

Name of Panchayat: _____

Sl. No.	Name of Deceased individual	Age and Sex	Name of Father/ Spouse	Name of hamlet	Date of death	Place of death	Cause of death

VHSNC should use this information to facilitate death registration for issuance of death certificate by appropriate authority. All deaths should be recorded, including still births if any. This list is used for discussion in VHSNC meetings on how to prevent such deaths in future as record of causes of death is important and will form the basis for village planning.

Annexure 7: Birth Register

Name of Village: _____

Name of Panchayat: _____

Sl. No.	Name of infant	Sex of infant	Name of mother and father	Name of mamlet	Date of birth	Time of birth	Place of birth	Birth weight

VHSNC can use this information:

- To facilitate birth registration for issuance of birth certificate by appropriate authority.
- In monitoring institutional delivery, birth weight.
- In improving home visits by ASHA for HBNC, monitoring of neonatal deaths.

Annexure 8: Checklist for Village Health Nutrition Day

Name of Block: _____

Name of PHC: _____

Name of Subcentre: _____

Name of Village: _____

Sl. No.	Parameters	Assessment Yes/ No/Partial/NA- Not Applicable	Remarks
Presence of Health Workers during VHND			
1	Was ANM present during VHND?		
2	Was ASHA present during VHND?		
3	Was AWW present during VHND?		
Services delivery during VHNDs by ANM			
1	Was ANM doing ANC check- up of pregnant women?		
2	What components of ANC were being provided?		
i	Tetanus toxoid injections		
ii	Blood pressure measurement		
iii	Weighing of pregnant women		
iv	Blood test for anaemia using Haemoglobinometer		
v	Examination of abdomen		
vi	Counselling of appropriate diet and rest		

Sl. No.	Parameters	Assessment Yes/ No/Partial/NA- Not Applicable	Remarks
vii	Inquiring about any danger signs like – selling in whole body, blurring of vision and severe headache or fever with chills etc.		
viii	Counselling for institutional delivery		
3	Was ANM providing vaccination to children?		
4	Did she also provide medicine or referral in case of any sickness of any child below 2 years of age ?		
Services provided by AWW during VHND			
1	Was AWW weighing all the children of 0-6 years of age?		
2	Was AWW weighing the children correctly?		
3	Did AWW record the weight on the growth monitoring card correctly?		
4	Did AWW give take home rations to children 6 months –3 years of age?		
5	Did AWW give take home rations to adolescent girls?		
6	Did AWW give take home rations to pregnant women?		
7	Did AWW give take home rations to lactating mothers?		
Quality of services delivered during VHND			
1	Weighing machine of ANM was in order		
2	Weighing machine of AWW was in order		
3	Thermometer was working accurately		
4	BP apparatus was working accurately		
5	Supplementary food was available		
6	Quality of supplementary food was good		
Roles played by ASHA			
1	Did ASHA make a list of potential beneficiaries who need either ANM or AWW services?		
2	Was ASHA able to motivate most (>75%) of the beneficiaries to attend VHND?		
3	Did she inform the beneficiariesatleast a day before about the date of VHND?		
4	Did she help ANM or AWW in organizing the VHND?		
General questions			
1	What was the venue of the VHND		
i	Anganwadicentre		
ii	Sub centre		
iii	Panchayat hall		
iv	Some other – open venue		
2	Was VHND held on a fixed date every month?		

Annexure 9: Checklist for Assessing Quality of Services at Health Facilities

a. Observation Checklist for Health Sub-centre

General Information

Name of the sub-centres village: _____

Total population covered by the sub-centre: _____

Distance from the PHC: _____

Availability of Staff at the Sub-centre

- Is there an ANM available/appointed at the centre? Yes/No
- Is there health worker-male (MPW) available/appointed? Yes/No
- Is there a part-time attendant (female) available? Yes/No

Availability of Infrastructure at the Sub-centre

- Is there a designated government building available for the sub-centre? Yes/No
- Is the building in working condition? Yes/No
- Is there a regular water supply at this sub-centre? Yes/No
- Is there regular electricity supply at this sub-centre? Yes/No
- Is the blood pressure apparatus in working condition in this sub-centre? Yes/No
- Is the examination table in working condition in this sub-centre? Yes/No
- Is the steriliser instrument in working condition in this sub-centre? Yes/No
- Is the weighing machine in working condition in this sub-centre? Yes/No
- Are there disposable delivery kits available in this sub-centre? Yes/No

Availability of Services at the Sub-centre

- Does the doctor visit the sub-centre at least once a month? Yes/No
- Is the day and time of this visit fixed? Yes/No
- Is facility for delivery available in this sub-centre during a full 24-hour period? Yes/No
- Is treatment of diarrhoea and dehydration offered by the sub-centre? Yes/No
- Is treatment for minor illness like fever, cough, cold, etc. available in this sub- centre? Yes/No
- Is facility for taking a blood slide in the case of fever for detection of malaria available in this sub-centre? Yes/No
- Are contraceptive services available at this sub-centre? Yes/No
- Are oral contraceptive pills distributed through this sub-centre? Yes/No
- Are condoms distributed through the sub-centre? Yes/No

b. Observation Checklist for PHC Centre

General Information

Name of the PHC village: _____

Total population covered by the PHC:_____

Availability of Infrastructure

- Is there a designated government building available for the PHC? Yes/No
- Is the building in working condition? Yes/No
- Is water supply readily available in this PHC? Yes/No
- Is electricity supply readily available in this PHC? Yes/No
- Is there a telephone line available and in working condition?

Availability of Staff in the PHC

- Is a Medical Officer available/appointed at the centre? Yes/No
- Is a Staff Nurse available at the PHC? Yes/No
- Is a health educator available at the PHC? Yes/No
- Is a health worker-male(MPW) available/appointed? Yes/No
- Is a part time attendant (female) available? Yes/No

General Services

Availability of Medicines in the PHC

- Is the anti-snake venom readily available in the PHC? Yes/No
- Is the anti-rabies vaccine readily available in the PHC? Yes/No
- Are drugs for malaria readily available in the PHC? Yes/No
- Are drugs for tuberculosis readily available in the PHC? Yes/No

Availability of Curative Services

- Is cataract surgery done in this PHC? Yes/No
- Is primary management of wounds done at this PHC? (stitches, dressing etc. Yes/No
- Is primary management of fracture done at this PHC? Yes/No
- Are minor surgeries done at this PHC? Yes/No
- Is primary management of cases of poisoning done at the PHC? Yes/No
- Is primary management of burns done at the PHC? Yes/No

Reproductive and Maternal Care and Abortion Services

Availability of Reproductive and Maternal Health Services

- Are ante-natal clinics regularly organised by this PHC? Yes/No
- Is facility for normal delivery available in the PHC 24 hours a day? Yes/No
- Are facilities for tubectomy and vasectomy available at the PHC? Yes/No
- Are internal examination and treatment for gynaecological conditions and
- Disorders like leucorrhoea and menstrual disturbance available at the PHC? Yes/No
- Is facility for abortion- Medical Termination of Pregnancy (MTP) available at this PHC? Yes/No
- Is treatment for anaemia given to both pregnant as well as non- pregnant women? Yes/No
- How many deliveries have been conducted in the last quarter (three months)? _____

_____

Child Care and Immunisation Services

- Are low birth-weight babies treated at this PHC? Yes/No
- Are there fixed immunisation days? Yes/No/No information
- Are BCG and measles vaccine given at this PHC? Yes/No
- Is treatment for children with pneumonia available at this PHC? Yes/No
- Is treatment of children suffering from diarrhoea with severe dehydration done at this PHC? Yes/No

Laboratory and Epidemic Management Services

- Is laboratory service available at the PHC? Is blood examination for anaemia done at this PHC? Yes/No
- Is detection of malaria parasite by blood smear examination done at this PHC? Yes/No
- Is sputum examination to diagnose tuberculosis conducted at this PHC? Yes/No
- Is urine examination of pregnant women done at this PHC? Yes/No

MINISTRY OF HEALTH AND FAMILY WELFARE
Government of India (New Delhi)