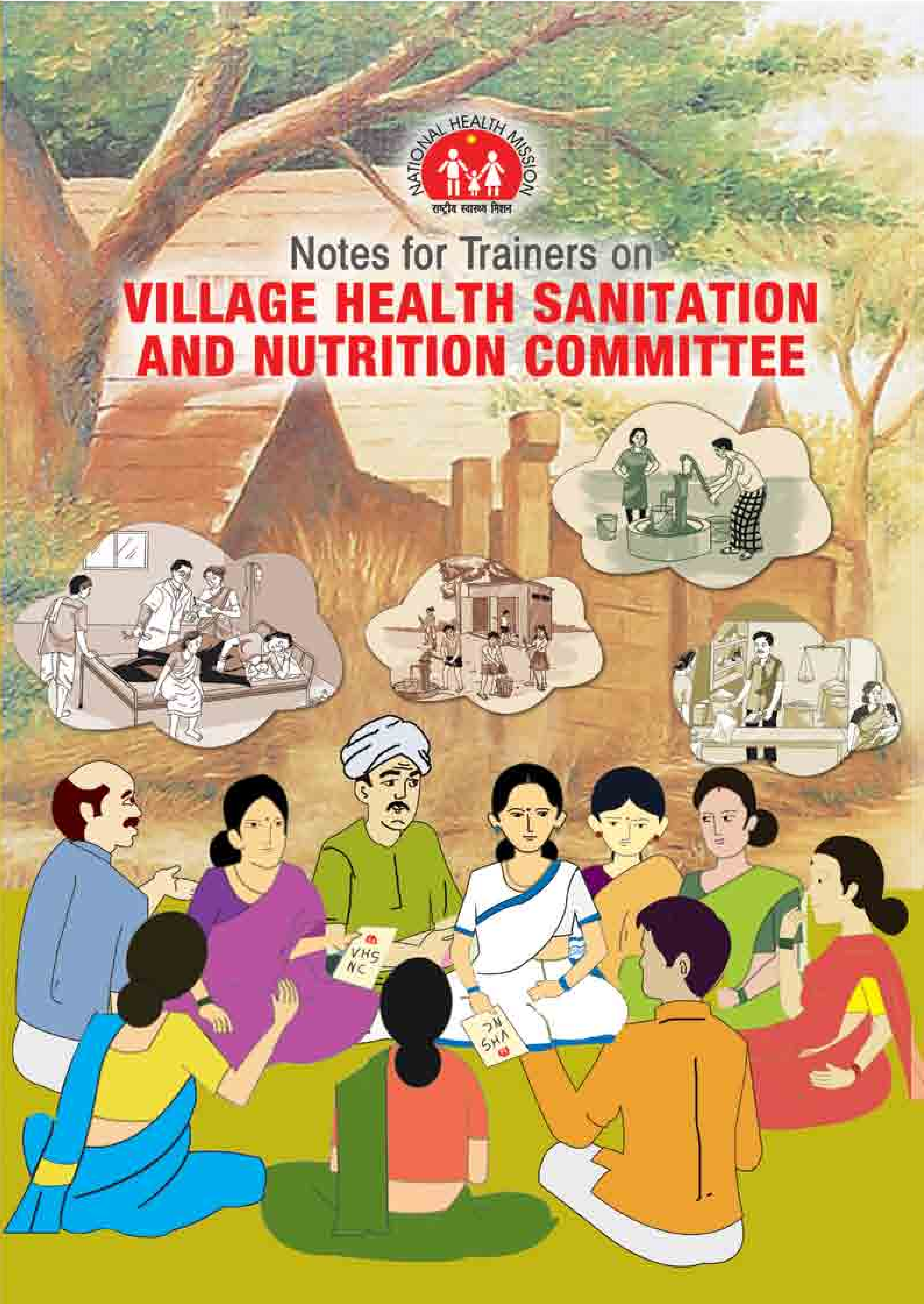
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
Notes for Trainers on
VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE
VHS NC
VHS NC

Notes for Trainers on

VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE

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TRAINING MANUAL ON TRAINING OF VHSNC MEMBERS

Notes for Trainers

The notes for trainers are intended for the use of state and district trainers involved in the training of members of the Village Health, Sanitation and Nutrition Committees (VHSNC).

The trainer notes are divided into six chapters and include facts and concepts that participants should become familiar with. In order to illustrate the concepts the chapters include several case studies which enable participants to apply the knowledge gained. At the end of each session a set of questions are included, which the participants should be encouraged to answer at the conclusion of the session.

The trainers will need to use a mix of participatory and didactic methods. For those sections that deal with facts and details about the VHSNC, the trainer should introduce the participants to the facts, and then ask them to read the section out aloud in turns. Before embarking on the training, trainers should become familiar with the contents of two accompanying booklets - the Handbook for members of the VHSNC and the section on VHSNC guidelines which are part of the Community Processes Guidelines. Details regarding training plan are given in the table below.

Training Plan

Sl. No.	Chapters to be Covered	Topics to be Covered	Days	Time
1	Chapter 1	‣ Community participation and need for VHSNCs ‣ Understanding Health ‣ The National Health Mission	Day 1	3 hours
2	Chapter 2	‣ Objectives of VHSNCs ‣ Formation of VHSNCs ‣ Composition of VHSNCs ‣ Responsibilities of key VHSNC members		3 hours
3	Chapters 3	Activities and Outcomes of VHSNC ‣ VHSNC Monthly Meetings ‣ Untied Fund and principles of utilization ‣ Management and Accounting of untied fund ‣ Maintaining Records	Day 2	3 hours
4	Chapter 4	‣ Monitoring and facilitating access to essential public services and correlating such access to health outcomes. ‣ Organizing local level community action for health promotion		3 hours
5	Chapter 5	‣ Facilitating Service Delivery in the village ‣ Village health planning	Day 3	4 hours
6	Chapter 6	‣ Annual Village Health Plan		2 hours

CHAPTER 01

COMMUNITY PARTICIPATION AND NEED FOR VHSNCs

Objectives of the Session

By the end of this session the VHSNC members will learn about:
- The importance of community participation
- The levels of community participation
- Objectives of National Health Mission (NHM) and the various institutions set up at different levels under NHM
- Health and its determinants

1.1 Community Participation

Method: Question- answers, matchstick game and explanation using case studies

Material: Board, marker pens and matchsticks

Duration: 45 minutes

- Activity: Matchstick Game: Invite one of the participants. Give him/her one matchstick and tell him/her to break it. It will break easily. Now tie a bundle of matchsticks together and tell the participant to break it. It will not break easily.
- Ask the participants what did they understand from this activity? You would get responses such as-"Our strength increases with collective efforts, collective action improves performance, working together helps in overcoming challenges better etc.
- Summarize the responses, link and use the key messages emerged to build an understanding of the concept of collective action and community participation.

Step 1: Ask the participants their perception about Community participation.

Step 2: List the answers on the board and proceed to-Ask the participants why is community participation in health important?

Step 3: Explain that Community participation in health is important because:

1. People know their health care needs and their involvement would prevent the mismatch between people's needs and services delivered, thus leading to increased utilization of health services.

2. Communities can play an important role in prevention of disease and take action on various social determinants of health.
3. People have both a right and a duty to be involved in the decisions that affect their lives. The experience of participation in one domain makes them more confident and empowers them to act on many other areas (such as health) that affect their lives.
4. Communities possess human, natural and financial resources that can be used to enhance the quality of health care and effectiveness of health care services.
5. Health is also one of the responsibilities of the Panchayats therefore there is need to enhance the involvement of community institutions like PRIs in health.

Step 4: Explain to the participants the levels of community participation through the following examples:

1. An ANM reports, "in my village all mother and children come for the VHND regularly. I have excellent community participation".

   This shows that the community is participating in benefits, as beneficiaries

2. A BMO reports, "we have good participation from the community in my block. We held five health camps and the community not only came for the camps, they also helped in putting up the stalls, and arranged for food and water".

   This shows that the community is participating in supporting programme activities for health.

3. In the VHSNC meeting, the members decided to make their village free of Malaria and TB. To achieve this they ensured- distribution and use of mosquito nets, insecticide spray to be done for every house and prompt referral for persons with cough or fever.

   This shows that the community is participating in implementing health programmes

4. In the Gram Sabha meeting of a village, the Anganwadi worker was asked to present the nutritional status of children in the village. After she had presented that only two children were malnourished, the villagers pointed out that as per the weights taken by the ASHA, nine children were malnourished and amongst them two were severely malnourished. The villagers also noted that out of the two Anganwadis in the village, one of them did not open regularly. Also, the VHND was not held in that Anganwadi, which was in a distant hamlet. Growth monitoring was not being done regularly in any of anganwadis as their weighing machines were not working. IFA tablets had not been supplied for children or adults in the last year to the ANM, AWW or ASHA. It was decided that the ward members will contact the Anganwadi and ANM supervisors about these issues and the Sarpanch will write to the Collector regarding lack of supply of IFA tablets.

   This shows that the community is participating in monitoring and evaluation of health programmes and taking action

   Amongst all the levels of participation, we find that in most cases, community participation is limited to participating in benefits and activities of the government.

1.2 Need for VHSNC

Step 5: Summarize the session by linking to the discussions above and explain that VHSNCs are one of the key interventions introduced by NRHM. They are an important mechanism for the community to participate at all levels, including implementing, monitoring and planning for health programmes.

1.3 Understanding Health and its Various Determinants

Objectives of the session

By the end of the session the VHSNC members will learn about:

- What constitutes good health and bad health
- The various determinant of health
- The principles enshrined in our health system

Method: Discussion using illustrative charts

- Display on a chart paper the illustration given in page 1 of the handbook that depicts a healthy family.
- Ask few participants to explain to the group why do they think the individuals in the family are healthy?
- Display on a chart paper the pictures from page 2 to 4 of the handbook. Using the illustrations try to get responses about the possible factors leading to ill health.
- Summarize the responses. Explain the concept of health and the difference between good and ill health as per the section below.
- Give questions for practice provided at the end of this section at page 8 to build further clarity.

Materials: Chart paper, display board and drawing pins

Duration: One hour

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.

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

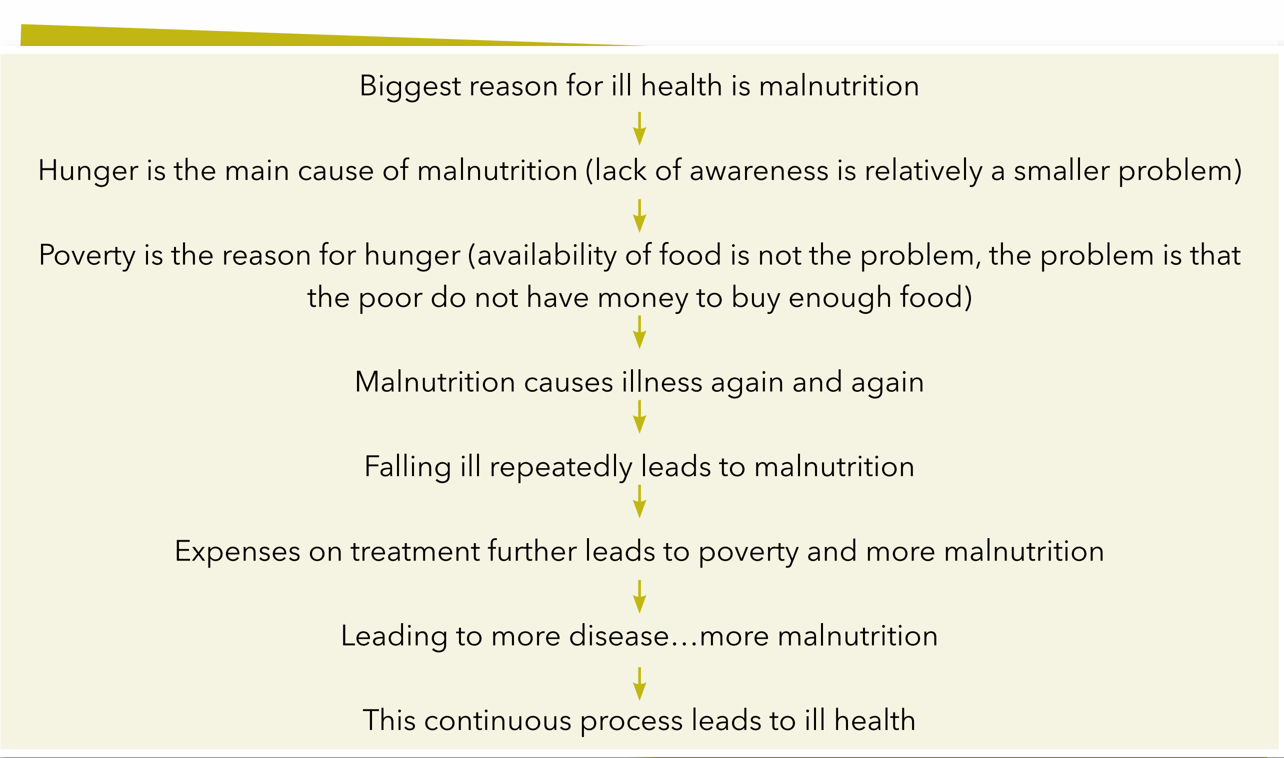
- Malnutrition
- Unsafe water and lack of sanitation
- Unhealthy living conditions
- Unhealthy habits-alcohol/drug abuse
- Hard labour and difficult work conditions
- Mental tension
- Patriarchy
- Lack of access to health services
- Lack of health education

Let us discuss these in more detail

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

Explain the link between malnutrition and ill health using the chart below:



2. Unsafe water and lack of sanitation

- 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

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 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

- 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:

- 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

- 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

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

- 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 Now Explain 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.

Questions for practice:

Q.1.Have you noticed any gaps in your area's sub- centre? List a few.

Q.2. Do the patients going to your area's PHC encounter any problems? What are the common problems encountered especially by the poorer patients?

Q.3.When do women wake up in the morning? What all do they do in a typical day till they sleep. How many hours of work does this add up to. How many hours of relaxation do they get? Repeat the same exercise for men and compare.

Q.4. Is health only related to illness? What is good health?

Q.5. How does malnutrition affect health of a person?

Q.6. How does patriarchy affect health of women?

Q.7. What do we mean by this statement- 'Health is our Right'?

1.4 The National Health Mission

Method: Participatory discussion using illustrative charts

- Ask the participants their perception of the National Rural Health Mission or National Health Mission.
- Based on the experiences shared and information given below explain the objectives of the National Rural Health Mission.
- Discuss key features of NHM and further elaborate on the objectives using the text given ahead.
- Display the pyramid on next page and explain the various institutions established under NHM for decentralized health planning.

Materials: Chart paper, display board and drawing pins

Duration: 30 minutes

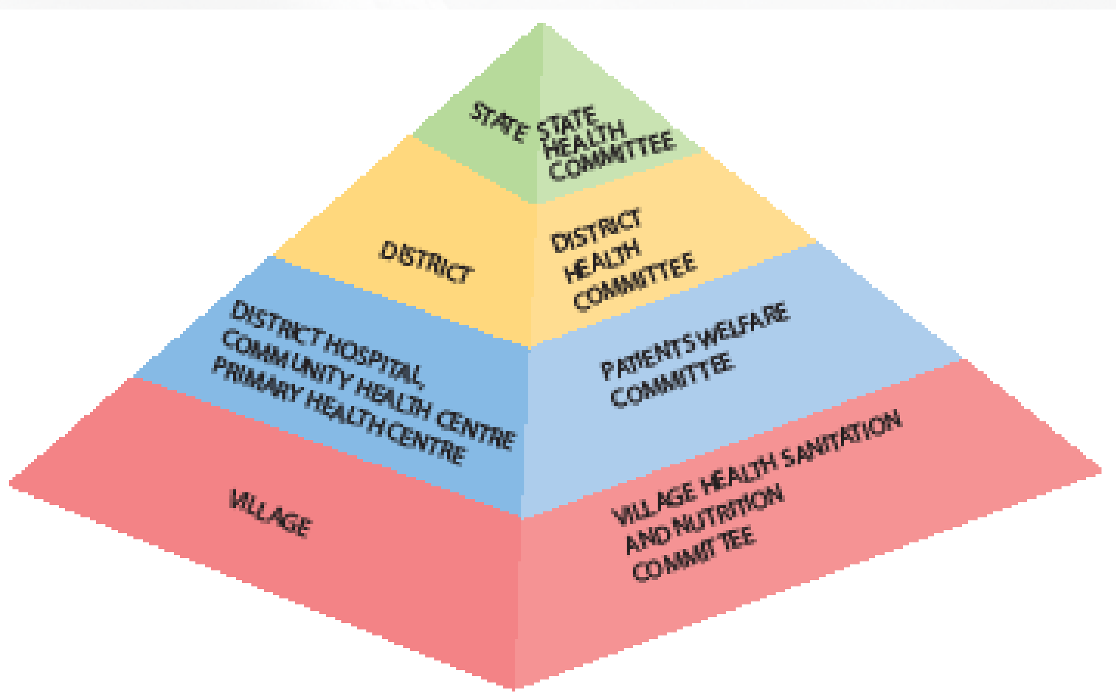
In 2005,the National Rural Health Mission was started in order to provide accessible, affordable and quality health care to people living in rural areas of our country. The Mission aimed to reduce maternal and child death and provide better access to health services especially to the vulnerable sections.In 2013, the NRHM was subsumed under the National Health Mission, which also addresses needs of people leaving in urban areas through the National Urban Health Mission.The National Health Mission aims to ensure universal access to health care through strengthening of health systems, institutions and capabilities.

Key features of National Health Mission are:

- Decentralized Health planning at the district, panchayat and village levels
- Setting up of public health standards for health facilities like Primary Health Centers, Community Health Centres etc.

- ASHA and community based monitoring
- Convergence between various departments like Rural development (RD), Health, Public Health Engineering Department (PHED), Women and Child Development (WCD) in order to improve access to public services
- Setting up of institutions at various levels.

The various institutions set up at different levels for decentralized health planning are as follows:



1.5 Public Health Facilities at Various Levels

Method:

- Ask the participants if they have visited sub centre, Primary Health Centre, Community Health Centre or District Hospital. Ask them to recall a little bit about the experience.
- Display the table given on next page.
- Explain the various services provided at each of the facilities and describe the link between various health facilities.

Materials: Chart paper, display board and drawing pins

Duration: 45 minutes

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

OBJECTIVES, FORMATION, COMPOSITION AND ROLES OF VHSNC MEMBERS

By the end of this sessions the VHSNC members will learn about:

- Objectives of VHSNCs
- Formation of VHSNCs
- Relationship of the VHSNC with panchayats
- Composition of VHSNCs
- Roles and responsibilities of VHSNC Members

2.1 Objectives of VHSNCs

Method:

- Ask participants about their understanding of the objectives of VHSNC.
- List the answers on the board. Display the case studies given below on a flp chart and explain using the case studies the objectives of the VHSNC.
- Use questions for practice given at the end of the session on page 14 to reinforce the concept.

Material: Board, marker pens and flipchart

Duration: 30 minutes

Some case studies highlighting various problems faced in villages:

- In Sitapur village, many children have diarrhoea at the same time. There is only one working handpump.
- In Korgaon VHND has not been held in the last four months as the ANM has been transferred to another area and no new ANM has been posted.
- In Siliyari the primary school opens only 2-3 days a week as the teacher does not come everyday. As a result, the children are also not getting their mid-day-meal daily.
- In Baigapara the Anganwadi has been closed for most of the month as the AWW, who is from another village, does not come daily.

- A new alcohol shop has come up in Sumantpur village. Men from the village are now drinking more frequently. Men come there from surrounding villages and drink and create chaos on the road. This causes a lot of harassment for the women and girls of the village.
- Sariguda village saw four deaths due to malaria this year. Every year people get malaria and many have to be hospitalized.
- In Gari village under MNREGS, labourers have not been paid wages even three months after completing work.
- In Solapur, the dalit hamlet is 2 kms from the village. It does not have an angwanwadi and the ANM does not go here. The mothers and children find it difficult to come to the main village for VHND. As a result, many children are not immunized.
- In Rampur village, the ASHA's drug kit has not been refilled and there are no medicines left in the kit.
- In Kantipur, Take home ration has not been distributed in the anganwadi for the last 2 months.
- In Dimapur village, the ASHA had to intervene one night to stop a man from hitting his wife. Neighbours say that he beats her very often.
- In Kumarpur, for ANC, the ANM only distributes IFA and gives TT injection. She does not take the BP nor does she do an abdominal examination. The villagers are also not aware of the components of ANC.
- Taragaon is 25kms away from the main road with no regular transport facilities. During emergencies and deliveries, it is very difficult to get the patient to the hospital in time. As a result, the village has seen a number of neonatal deaths and a few maternal deaths in the last few years.

Tell the participants that in all these villages, the VHSNCs can play an important role in solving the specific problems. Therefore VHSNC is a forum through which:

1. The community can be informed of health programmes and government initiatives.
2. The community can participate in the planning and implementation of the programmes, and take collective action for the attainment of better health status in the village.
3. Convergent action on social determinants and all public services directly or indirectly related to health.
4. The community can voice health needs, experiences and issues with access to health services, for the institutions of local government and public health service providers to take note and respond appropriately.
5. Panchayats can be empowered with the understanding and mechanisms required for them to play their role in governance of health and other public services and provide leadership for collective action to improve health status.
6. Support and facilitation may be provided to the community health workers like ASHA and other frontline health care providers who have to interface with the community and provide services.

Questions for practice:

Q. 1.Identify at least 3 problems related to health in your village?

Q.2. Discuss how your VHSNC can resolve these cases. Who all need to be involved in this process?

Q. 3.Have you taken any action for health in your village? Give examples.

2.2 Formation

Method: Short lecture with discussion following the steps mentioned below.

Duration: 30 minutes

Step 1: Begin by discussing the level at which VHSNCs will be formed.

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).

Step 2: Explain the relationship of VHSNC with Gram panchayat.

The VHSNC will function under the ambit of the Panchayati Raj Institutions (PRI). It would be a sub-committee or a Standing committee of the Panchayat.

The VHSNC is headed by an elected woman ward Panch. Elected representatives of PRIs are its key members. Thus, it creates opportunities for involving the PRIs in planning and action around health.

The VHSNC can also contribute to the Gram Sabha by raising health related issues in the Gram Sabha meetings. This will also help the Gram Sabha to intervene in health related issues.

Step 3: Ask the participants as to what they understand by community led formation of VHSNC.

Step 4: Explain the process of formation of VHSNCs as given below by linking it to their responses.

- 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 later.
- 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.

Step 5: End the session by giving questions for practice given ahead.

Questions for practice:

Q. 1. Does your Panchayat have a Standing Committee on Health? Who are the members? What work does the Committee do?

Q.2. Have you ever discussed any health related issues in your Gram Sabha? Give examples.

2.3 Composition of the VHSNC

Method: Group discussion and short exercises for self-reflection on formation and composition of the committee.

- Begin the session by explaining the key principles governing the composition of VHSNC as given below and discuss the composition in detail.
- End the session with exercises and questions for practice given at page 18-19.

Duration: One hour fifteen minutes

Material: Handout table on formation of VHSNC given at page 18.

2.3 a Minimum number of members in a VHSNC

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

2.3 b Principles of composition of the VHSNC

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

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

There can be 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 .

2.3.c Who all should be included in VHSNC?

1. **Elected Gram Panchayat Members:** Those members who are residents of the village are to be preferred. 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 organizations 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 public services should also find place

2.3.d How should they be selected?

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

2.3.e Who can we call as special invitees?

Other than members a more general category of special invitees can be included. They are welcome to attend 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 have participated 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.

2.3.f Who will be the Chairperson ?

The Chairperson of the VHSNC will be 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.

2.3.g Who will be the Member-Secretary and Convenor?

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

2.3.h Why should ASHA become the Member-Secretary and Convenor of VHSNC?

This is 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.

2.3.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- since it would be time- consuming to change bank signatories- but that is a local decision.

ASHA Facilitator (or Block Mobiliser) 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 this meeting.

2.4 Joint Bank Account

Once the VHSNC has been formed, 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 with ASHA as per the above guidelines.

All withdrawals from VHSNC account must be done by a joint 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 withdrawal will only be done through a written approved proposal of the VHSNC with signatures of its members.The member secretary may be authorized expenditure of up to Rs 1000 for emergencies or undertaking any urgent activities.

2.4.a Why should VHSNC have two joint signatories?

Having two joint signatories reduces the possibility of any wrong doings. It is easy for a single person to indulge in corruption but having two people sign for withdrawal along with written approved proposal by the VHSNC members ensures that this does not happen. It also ensures more transparency.

Exercise 1:

- Divide the participants into four to five groups of their respective VHSNCs.
- Give to each group a handout containing the steps of formation of VHSNC, listed in the table given below.
- Revise the steps of formation of VHSNCs and tell the groups to tick the steps which have been completed in their village. This would enable the participants to see how far they have come in their village.

- Give five minutes to each group to discuss the steps of formation of VHSNC which were followed in their village. Ask one member of each group to talk about the process of formation of VHSNC in their village. Other participants are then asked which of the processes fall into the category of good practices and which did not.

Table on Formation of VHSNCs

Steps	Activity	Tick Yes/No
Step 1	Selection of Chairperson, and Convener and member secretary ASHA	
Step 2	ASHA, ASHA Facilitator, ANM, Chairperson with the help of Block Community Mobilizer undertake community mobilization.	
Step 3	ASHA, ASHA Facilitator, ANM and Chairperson through a consultative process with the community prepare a list of possible members of VHSNC, taking care to include leaders of SHGs, Anganwadi, Mother's Committee, Youth group, Water and Sanitation Committee, Forest Rights Committee and people form the marginalized sections, all hamlets etc.	
Step 4	Submit list of VHSNC members to Gram Sabha and ASHA Facilitator (or Block Mobilizer)	
Step 5	Resolution for formation of VHSNC passed by Gram Sabha	
Step 6	Bank account of VHSNC opened with Chairperson and Member-Secretary as joint signatories	

Questions for practice:

Q.1. Who all are members of your VHSNC. Please use the check list to see whether members cover all categories. Are there at least 50% women?

Category	Tick Yes/No
All Panchayat representatives	
All ASHA	
Anganwadi Workers	
ANM	
Teacher	
Handpump Mechanic	
MNREGA Rojgar sahayak	
Representatives of SHG	
Representatives of forest protection committee	
Representatives of youth club	
Women with young children	
Pregnant/lactating women	
Volunteer of Literary Campaign	
Motivator of Total sanitation Campaign	
Atleast 50% women	

Q.2. List the special invitees you have called to your VHSNC till date?

Q.3. Why is it important for the users of services to become members of the VHSNC?

Q. 4. Why is it important to have joint signatories instead of a single person?

Q. 5. Can the joint signatories take out money without approval of the other members of the VHSNC?

2.5 Responsibilities of key VHSNC Members

Objectives of the session

By the end of the session VHSNC members will learn about:

- The roles and responsibilities of various members

Method:

- Ask the participants what in their opinion will be the roles of key members of VHSNC.
- List the responses for each of the members on a board.
- Display the roles and responsibilities for each of the members on a chart paper as given below and summarize the session by linking it to their responses.
- Use Questions for practice given at page 21 to build clarity.

Material: Chart Paper, pens, drawing pins, display board.

Duration: 45 minutes

1. Chairperson of the Committee

The Chairperson will:

a. Be responsible for ensuring that meetings are held monthly.
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. Develop the annual or bi annual health plan for the village in consultation with the member secretary ASHA and other members and follows up on necessary action.
e. Ensure that the issues/plans emerging from village health monitoring and planning are reflected in the Gram Sabha and Gram Panchayat proceedings
f. 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 time frame 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.

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 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. Enable 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 and Nutrition as well as the Education, particularly in the context of the programmes like Mid-Day Meal, and most importantly 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 and challenges faced in implementing the respective programmes and will enable VHSNC to monitor and take action on social determinants of health. This allows VHSNC to ensure local level accountability in delivery of social sector programmes.

Questions for practice:

Q.1. What are the roles of the Anganwadi worker and ANM in the VHSNC?

Q. 2. What is the role of the ASHA as a Member Secretary in the VHSNC?

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.

All these activities will be covered in detail in this chapter.

3.1 VHSNC Monthly Meetings

Objectives of the session

By the end of the session the VHSNC members will learn about:

- Organizing meetings of VHSNC- importance of VHSNC meetings, regularity, venue, and person responsible for organizing meeting
- Structure of the meeting

Method:

- Ask the participants about the monthly meetings of their committee, where they are currently being held, which day they are held, how regular they are and what are the common issues discussed.
- Activity: Role play. Ask about eight to ten participants to volunteer. Enable them to choose the role of Member secretary, chairperson, ANM and Anganwadi worker etc. amongst themselves. Brief them about each of their roles, explain them the structure and process of VHSNC meetings as given ahead on page 23. Ask them to enact the situation of a monthly VHSNC meeting, while other participants are asked to observe carefully.
- At the end of the role play ask the other participants to share their observations. Write their responses on board. Based on the key messages emerged, end the session by using the details explained ahead in this section.

Duration: One hour

3.1.a Why is it important to hold Monthly VHSNC meetings?

Regular meetings are a hallmark of functioning VHSNC. It is in the meeting that the VHSNC reviews situation, monitors, identifies a problem and plan for action on health and its various determinants.

The meeting also serves as an important platform for service providers to learn about the gaps from 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.

3.1.b How regularly should the VHSNC meet?

Meetings of VHSNC should be held at least once every month. It is better if there is a particular day or date 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.

3.1.c 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 to attend .

3.1.d Who should help in facilitating the meeting?

The ASHA and the ASHA facilitator should help to facilitate the meeting.

3.1.e 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.

3.1.f 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.

3.1.g The VHSNC meeting may be structured in the following manner

S.No.	Activity	Points to keep in mind
1.	There should be a rendition of motivational song at the start of the meeting	
2.	Sharing positive and successful stories	Please share stories of other VHSNCs that have been successful in bringing about some positive change
3	Review of last action plan	
4	Filling of Public Services register	
5	Filling of birth and death register	Discuss reasons for any diarrhoea, fever, TB, child or maternal deaths
6.	Formulating action plan	- The related proposal has to be written along with any applications to be forwarded - Copy to be kept with the ASHA Facilitator
7.	Providing information on campaign to be taken up next	These campaigns may be planned as per seasonal requirement. For example before malaria season, information on prevention and treatment of malaria can be given and action plan made for dealing with malaria in the season.
8.	Enumeration of expenses and record writing	Utilization certificate of every month to be handed over to ASHA Facilitator (or Block mobiliser)
9	Information about next meeting	Date, time and venue of next meeting to be fixed.

Note: Along with the meeting, the VHSNC members can visit the school, anganwadi, PHC etc.

Questions for practice:

Q.1. Does your VHSNC meet every month? Why is the monthly meeting of VHSNC important?
Q.2. How should the VHSNC meeting be structured?

3.2 Untied Fund and Principles of Utilization

Objectives of the session

By the end of this session the VHSNC members will learn about:

- What is the untied fund and why is it given
- What are the principles for utilization of untied fund

Method:

- Ask the participants whether they have some idea about the annual Untied Fund given to each VHSNC.
- Ask what in their opinion should the untied fund be used for? Explain the activities and principles of utilization by using the details given ahead.

- Discuss the three examples given at the end of Section 3.2 b. Ask them to identify the problematic in those examples and reinforce the principles of untied fund utilization.

Duration: 30 minutes

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

3.2.a Why is the untied fund given to the VHSNC?

The main purpose of the untied fund is not simply to spend it but 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.

Untied funds-

- Promote decentralization, i.e. allows the villagers to take decisions about spending on village health
- Create opportunities for the village community to gain capacity for collective decision making around health
- Provide support to the VHSNC in executing a plan. Any plan by the VHSNC includes activities for which funds are needed and for which no funds are required. Untied funds help to undertake those activities needing funds.
- 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.

3.2.b 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. Being an untied fund, it is to be utilized as per decision of the VHSNC. 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 exceptional cases such as that of a destitute women or very poor household, the untied grants could be used for health care needs of the poor household especially for enabling 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. 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.

Let us look at a few examples where, ignoring the principles of Untied fund, VHSNCs have been ordered to spend their money in a particular way,:

Example 1: In Ratanpur block, the BMO ordered all the VHSNCs to deposit Rs. 3000 per VHSNC for audit expenses.

Example 2: In one state, the State Malaria officer took out an order for all VHSNCs to pay the labour charges for DDT spraying in their villages.

Example 3: In another state, the letter transferring the untied fund to the VHSNC lists down the following eleven items for all the VHSNCs to mandatorily spend their funds on:

SN	Item/Activity
1.	BP Machine for the ANM
2.	ANC table
3.	Weighing machine Child
4.	Weighing machine Adult
5.	Wall writing on Yaws
6.	Wall writing on Polio
7.	Sari for ASHA
8.	Refreshments
9.	Four Plastic Chairs
10.	One table
11.	Stationery

3.2.c What is problematic in these examples?

The problematic thing in these examples is that through such orders, the UNTIED FUND is being made into a TIED FUND. This goes completely against the spirit of an Untied Fund.

Please remember: The untied fund, as the name suggests, does not and should not come with any guidelines for expenditure. This fund is given to the VHSNC to use, as they deem proper. Providing the untied fund is a significant step towards decentralized planning and execution of programmes. The VHSNC has a responsibility towards the community and Gram Sabha to utilise the fund with utmost transparency and accountability.

3.3 Managing the Untied Fund

Objective of the session:

In this session you will learn the management and accounting for the untied fund

Method:

- Ask the participants whether they have used untied funds of their VHSNC? What problems have they faced in managing and accounting these funds?
- Based on Section 3.3 (a and b) given ahead undertake a discussion on the management and accounting of the funds and link it to the problems shared by the participants.

Duration: 30 minutes

3.3.a Management of the Untied Village Fund

The management of funds is completely in the hands of the VHSNC. The decisions on utilization of untied funds will be related to the village planning exercises undertaken by 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 total up to Rs. 1000, for which details of activity and bills and vouchers should be submitted in the next VHSNC meeting and approval of the committee taken. This is important for emergency cases.

For example, in one village, a boy fell off the tree while playing in the evening. He was badly hurt and had to be taken to the hospital immediately. His parents had gone to another village to visit relatives and there was no one to take care of him. The ASHA had the emergency fund with her so she and the panch took the boy immediately to the hospital and took care of his expenses.

3.3.b Accounting for the Untied Village Fund

a. 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.

b. The annual Statement of Expenditure, prepared by VHSNC, will be forwarded by the Gram Panchayat to the appropriate block level functionaries of NRHM, with their comments.

c. 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.

d. 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.

Questions for practice:

Q.1. The Chairperson of a VHSNC told the members that money can be withdrawn only with the permission of the block medical officer. Is this correct or incorrect.why?

Q.2. In a VHSNC, the Chairperson and member secretary took out money without approval of the rest of the VHSNC members. What should be done in such a case? What is the correct process of withdrawing money?

Q.3. In one block, the BMO passed an order to all the VHSNCs to deposit Rs. 2000 per VHSNC with him to buy weighing machines. Was this a correct thing to do? Why not?

3.4 Maintaining Records

Method:

- Ask the participants to open Section 3.4 on page 19 of the Handbook for VHSNC members.
- Discuss each type of the records that are to be maintained by the VHSNC using the details given below.
- As a next step ask the participants to open annexures given at the end of the handbook and explain in detail the formats given in Annexure 1, 2, 3.
- Activity: Divide the participants in to five or more groups of their respective VHSNCs. To each group give exercise to fill Annexure 1, 2, 3.
- Ask one participant from each group to present, while other participants give suggestions.
- Give question for practice included at the end of this session to all participants.

Materials: Photocopies of Annexure 1, 2, 3.

Duration: One hour

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

a. 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.

b. 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).

c. Bank Pass Book

d. 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:

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

Questions for practice:

Q.1. Write resolutions for withdrawal of money and expenditure on the following items:

- Rs. 1000 given to an aged person for treatment of pneumonia
- Rs. 200 for wall writing
- Rs. 1500 for buying a weighing machine
- Rs. 25 to buy a register

CHAPTER 04

MONITORING

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

Objectives of the session

By the end of the session the VHSNC members will learn about:

- How to monitor village health
- What are the tools and methods to be used in monitoring
- What are the things to monitor and why
- Who is to monitor

Method

- Ask the participants to open Section 3.5 on page 19 of the Handbook for VHSNC members.
- Discuss the tools for monitoring: Village Health Register and Public Services Monitoring Tool. Start by explaining the importance and usefulness of using these tools by the VHSNC members.
- Ask the participants to open Annexure 4 at page 29 of the Handbook. Explain the format for village health register in detail.
- Ask the participants to open Annexure 5 at page 29 and 30 of the handbook. Link to Annexures and explain the services that need to be monitored and the mechanism of monitoring as per Section 4.2 and 4.3 on page 31 to 36 of the trainer notes.
- Use section 4.4 on page 36 of the trainer notes to discuss some other issues and problems that may emerge during VHSNC meetings.
- End the session by reinforcing the message to reach the marginalized communities by using section 4.5 given in page 37 of the trainer notes.

Duration: Two and half hours

As a first step VHSNC should assess the status of availability of key services in the village identify the problems and gaps and take action. Regular monitoring of village health and other related public services is an important task of the VHSNC.

4.1 How do we Monitor?

1. Maintain avillage health register (Annexure-4). This 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.

2. Use a Public Services monitoring Tool and register- This tool helps the VHSNC to ascertain 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 they fill Public Services Monitoring Register during the VHSNC meeting every month. (Annexure-5 and 5a)

   We have learnt in Chapter 1 that health includes both health services and all those aspects that determine health. Therefore we must remember that monitoring of health of the village does not only include health services like immunization and ANC and health related behaviours like use of mosquito nets, but also monitoring of the community's access to related public services and issues, like access to work under MNREGA, ration from public distribution system, mid-day meals, Anganwadi services, safe drinking water, access to toilets, child nutrition, safety of women, education etc. (You can modify the tool based on your local context and add any other issues that you find relevant to your area).

4.2 Some of the Services and Issues that Need to be Monitored by our VHSNC and why

4.2.a Child nutrition/Status of Anganwadi Centre

Why is it essential for our VHSNC to monitor nutrition of children in the village?

Malnutrition and ill health go hand in hand. A child who is malnourished keeps falling ill, making her more malnourished. We find in our villages that at-least one-third of children are malnourished and many are in the severe grade. Staying healthy is a basic right of children and that right must be protected. Unless malnutrition is correctly identified and recognized as a problem, it cannot be overcome.

How to identify and monitor malnutrition?

Malnutrition means that a child weighs less in relation to her age. It is difficult to identify a malnourished child unless the weight is taken and compared against the standard weights for that age. Weights of children are supposed to be taken regularly in the Anganwadis. However, at times the weight are not taken in the Anganwadis either due to non-functioning scales, or capacity of

the worker. Even when weights are taken, many times the nutrition status of the children are not conveyed to their parents.

Therefore it is very important that the anganwadi of your village weighs children regularly. Once the weights are taken, the nutrition status should be conveyed to the parents and the VHSNC. The VHSNC, in the monthly meeting, should first discuss about the malnourished and severe malnourished children and make an action plan to help those families. All this has to be recorded in the public service monitoring register in the given format.

Preventing malnutrition through complementary feeding

As you are aware that children need to be exclusively breast fed in the first six months after birth. After six months, it is essential to give the child complementary feeding as at that time the child is growing and needs more food in addition to breast milk. If complementary feeding is not started at this time, even a healthy child may slip into malnutrition. It has been observed that many families are not aware of the importance of complementary feeding and as a result many children become malnourished after 6 months of age. In monitoring the number of children between six and nine months of age, who have not yet been started on complementary feeds, the VHSNC will help to spread awareness about this and also help prevent malnutrition amongst children in their village. You can find out more about malnutrition and strategies for preventing from your ASHA and AWW.

Monitoring the Anganwadi services

The anganwadi can play a major role in preventing malnutrition and also help to improve malnutrition. Therefore, it is important for the VHSNC to monitor the functioning of the anganwadi. The VHSNC has to see whether the services, especially supplementary nutrition have been provided regularly and what were the gaps in the previous months.

Monitoring food security

Poverty is one of the main causes of malnutrition. Therefore unless we address food security, our efforts to reduce malnutrition in our village may not be successful. Our VHSNC can help to monitor some of the significant food security programmes and see whether the entitlements are reaching the beneficiaries. Our VHSNC can ensure that no family or person in our village goes hungry.

What are some of the food security schemes that we can monitor?

Ration- The Public Distribution System(PDS) is an important scheme providing subsidized grain to the poor. The Supreme Court of India has ordered that 35kgs of rice should be given to each poor family. For many families, this is the mainstay of their survival. Many states have expanded this scheme for providing subsidized grain by adding more number of poor people and also by adding other items like dal and oil. Our VHSNC needs to monitor that our ration shop is providing all the items as per norms every month.

Pensions- There are people in our village who are very poor and who are not able to earn their livelihood either because of age, disability, lack of resources or circumstances. These most disadvantaged people are eligible to receive pensions. However, we find that many times the pension is late in reaching the beneficiary or is reduced due to corruption. The Supreme Court has ordered that pensions for a month should reach the beneficiary by the 7th of the next month. The VHSNC needs to monitor whether the pensions are being given on time. MNREGA- Mahatma Gandhi National Rural Employment Guarantee Act provides for a minimum of 100 days of work for everyone in the rural area. If implemented properly, this Act can have a very

significant impact on the livelihoods of the poor. The Act has the provision for paying of wages within 15 days of work. However, delayed wages are very common. This prevents the poorest households from seeking work under MNREGA. In order to ensure that the wages are given in time, the VHSNC needs to monitor it.

Indicators to be monitored for accessing Nutrition status in village are given below:

	Indicators	Jan	Feb	Mar
	Anganwadi Centres			
1	Did all Anganwadi centres 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 Anganwadi centre ?			
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 ?			
	Food Security			
10	Whether the ration shop provided all ration items during the last month ?			
11	Did the pensioners get pension in time ?			
12	Was the MNREGA payment made in time ?			

4.2.b Education

Improvements in education lead to better health outcomes. It is also the right for all girls and boys to have access to schools. In our villages we find that many children, especially girls, are forced to drop out due to various compulsions. We as a village need to ensure that the right to education of all children, whether girl or boy, are protected.

Regularity of teachers and of mid-day meal are two of the important aspects to monitor in a school. Mid-day-meal has an important contribution to make in ensuring nutrition, social equality and attendance of students.

Therefore VHSNC needs to monitor any drop outs, whether the menu for mid-day meal is being followed in the schools and teacher absenteeism.

The indicators to be monitored with regards to Education and Mid-day-meal are given below:

	Indicators	Jan	Feb	Mar
	Education			
13	Number of girls under the age group of 6-16 not attending the school ?			
14	Did all the schools teachers come to the schools regularly during the last month ?			
	Mid Day Meal			
15	Were pulse and vegetables served all days in cooked meal last week in all the schools (upto 8th) ?			

4.2.c Water and Sanitation

You all know how crucial clean drinking water is to a person's health. In most of our villages we can get clean drinking water from hand-pumps. However, we find that many of our hand pumps are non-functional. Also, we find that the water from the hand pumps does not have proper drainage and as a result collects around the hand pump and remains stagnant. This can lead to many waterborne diseases like diarrhea. Many villages have piped water and there too the VHSNC has to ensure that it is functional.

The government, through the Nirmal Gram Yojana, gives fund to BPL, ST, SC and IAY beneficiaries to construct toilets. The funds include Rs. 4600 in cash (Rs. 5100 in difficult and hilly areas), and Rs. 4500 as labour through MREGA. The beneficiary has to spend at least Rs. 900.

The VHSNC needs to monitor the status of clean drinking water, toilets and cleanliness in the village so that diseases like diarrhoea may be prevented.

The indicators to be monitored with regards to water and sanitation are given below:

	Indicators	Jan	Feb	Mar
	Water and Sanitation			
16	How many hand pumps are non-functional as on today?			
17	Number of hand pumps with stagnant water around -today			
18	Number of households not having access to functional toilets			
19	Number of households with household latrines constructed and used			

4.2.d Status of Women

As we have learnt in Chapter 1, the status of women affect their health greatly. Women can be healthy only if they are able to live their lives without violence and without harassment. However, we find that even in our villages, women are often subjected to violence and harassment. Our village cannot be called a healthy village if women and girls are continuing to face violence and harassment both at home and in the community. One of the forms of violence on women is early childhood marriages of girls. This makes them more likely to have an early pregnancy, putting them in danger to develop various complications and causes low birth weight babies, maternal and infant deaths.

Therefore every month our VHSNC needs to first identify if such cases of violence or harassment has occurred in the village and subsequently take action on it.

The indicator to be monitored with regards to status of women is given below:

	Indicators	Jan	Feb	Mar
	Status of women			
19	Number of cases of violence against women (including harassment of girls) during the last month?			
20	Number of cases of early childhood marriages reported			

4.2.e Health services, deliveries, and diseases

We finally come to the village health services and diseases that our VHSNC can monitor. This will help us to identify the gaps in these services and prioritise action in our village health plan.

Our VHSNC needs to monitor the following:

1. VHND- Village Health and Nutrition Day is the day of the month on which the ANM comes to the village for immunization. It takes place usually on the day the AWW provides take home rations. During the VHND, the ANM also conducts ANC for pregnant women and treats patients. It is an important day for providing healthcare services in the village.
2. Availability of drugs with the ASHAs- The ASHAs are provided with drugs essential for treatment of diseases at the village level. The state has to make provisions for regularly refilling the ASHA's drug kit.
3. Deliveries and referral transport- The VHSNC also needs to monitor the number of home deliveries in the village. It can also monitor the availability of referral transport. This will help the VHSNC to prioritise action for promoting institutional deliveries and providing referral transport.
4. Diseases- It is important for the VHSNC to know the number of fever and diarrhoea cases. This will help the VHSNC to understand the disease burden and plan for necessary action.
5. Use of mosquito nets- This is one of the health related behaviours that the VHSNC can monitor.

The indicators to be monitored with regards to health services and diseases are given below:

	Indicators	Jan	Feb	Mar
	Health Services			
21	Did the ANM come last month for the Immunization/VHND?			
22	Whether all children of all hamlets are being vaccinated in appropriate age?			
23	Whether the BP measurement of pregnant woman was done in the VHND?			
24	Did the ANM provide medicines to the patients free of cost ?			
25	Did all the ASHAs have more than 10 chloroquine tablets with them?			
26	Did all the ASHAs of the village had more than 10 Cotrimaxazole tablets with them?			
27	Whether the transportation facility was available to take the serious patients, delivery cases, sick newborn cases, etc to health facilities?			
28	Number of families not using mosquito net?			
29	Number of deliveries that took place in the home during the last month?			
30	Number of diarrhoea cases during the last month?			
31	Number of fever cases during the last month?			

4.3 Who among the VHSNC members should monitor?

In order to correctly gauge the status of the indicators, these aspects need to be monitored throughout the month. Therefore, for this, responsibilities for monitoring the various indicators have to be divided among the VHSNC members. The ASHA will be aware of the monthly status of quite a few of these indicators, especially the ones related to health services and diseases, like medicines available with ASHA, number of deliveries etc. For the other indicators, the other members should take responsibility.

Please note:

1. The responsibility has to be divided among the members so that the burden of responsibility does not fall on one person. The members may want to put all the responsibilities on the ASHA but this should be avoided. Taking responsibility would make all members participate equally and more actively and the help the VHSNC to function more democratically. With more people involved in monitoring, it will lead to the more credibility of the data.
2. A member responsible for providing a service should not be made to monitor that service. For example, the Anganwadi Worker should not be given the responsibility to monitor the AWC. Or a member of the SHG that is involved in providing Mid-day meal should not be given the responsibility of monitoring whether Mid-Day-Meal is being provided as per the guidelines.
3. It is better if the beneficiary of a particular service takes the responsibility to monitor that service. For example, members whose children go to the anganwadi can be given the responsibility of monitoring the anganwadi services. Similarly, members having school going children can monitor schools, pensioners take responsibility for monitoring pensions, a MNREGA worker for MNREGA wages and so on.

The complete format for the VHSNC Public Services Monitoring Tool is given in Annexure 5,based on which the Public Service Monitoring Register-Annexure 5a will be filled.

4.4 Experience Sharing by Members During VHSNC Meetings

In addition to the records and register, certain issues and problems may emerge during discussions in the VHSNC meetings. The VHSNC should discuss any such relevant issues and try to find a solution.

Let us take an example to illustrate this: During a VHSNC meeting in Hasta village, the ASHA and other women expressed concern at the illegal cutting of trees in their village. People from outside the village had come and under the protection of the forest guard, were cutting trees like mahua, tendu and sal that are critical for the community's survival. The women were concerned that if all the trees were cut, it would affect their livelihood, nutrition and firewood source. The chairperson said that this was a big problem and other members agreed. It was planned that the ward panch, along with some of the members, will go to the sarpanch and tell her to intervene and stop the cutting of trees.

In another village, Sholapur, during the VHSNC meeting, a lady came crying to the meeting. She said that her husband had gone to another state for work along with other men. Most of the men had come back but the employer had kept back five of the men, including her husband, as bonded labour as they had to take loan for medical expenses from him. The employer was keeping them in very bad living conditions and was sending them to work in mines which were very unsafe. The

VHSNC members felt that they had to do something about this. Therefore they decided to meet the sarpanch regarding this issue and if necessary accompany him and the lady to complain to the District Collector.

4.5 Habitation Level Meetings by ASHA

One of the main roles of VHSNC is to help the weaker sections in the village. In order to do this, the VHSNC needs to first identify such people/families/habitations.

They are likely to be:

- a hamlet/habitation which is far from the main village due to which it is left out of immunization and ANC services
- a poor tribal family which is not able to provide treatment to their 3 year old child as they don't have money for medical expenses
- an elderly woman who lives alone and is not able to work and therefore stays hungry most of the days

Habitation level meetings organized by the ASHA can help in such identification. Through habitation level meetings the more disadvantaged groups will be active participants of village health planning. It will also help the VHSNC to set its agenda and prioritize and address the needs of the weaker sections. If the VHSNC is able to address issues and problems emerging out of the habitation level meetings, it will lead to better health outcomes for the marginalized and disadvantaged sections and reduce health inequity in the village.

4.6 Organizing Local Collective Action for Health Promotion

Method: Ask the participants about their perception of the local level community action. List the answers on the board and explain using the text given below.

Duration: 30 minutes

Health is a product of processes that take place at the level of the family and community. Much can be done at the community level for health promotion. Some activities in which VHSNCs can involve the communityfor health promotion are-

1. Organizing an event where volunteers gather and clean the village- especially decaying solid waste (a major breeding site for the kala-azar vector, the sand fly and for the common house-fly) and pools of stagnant water –where mosquitoes breed. The VHSNC could motivate voluntarism by mobilization and serve as an inspiring village organization, or they could pay local village youth for the task, or contract labour for this purpose. One advantage with the voluntary approach is that there is community sensitization against poor environmental hygiene practices.
2. Organizing teams for source reduction work- identify areas of mosquito larva breeding and taking appropriate anti-larval measures- 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. Insecticide spraying and introduction of larvivorous fish could also be done on the same day or soon after but such synergize efforts, need inputs from the health department.

CHAPTER 05

FACILITATING SERVICE DELIVERY

Method:

- Ask the participants to refer page 21 section 3.7 of the handbook.
- Ask few of them to take turns to read aloud the points mentioned in section 3.7. Discuss each of them in detail.
- Describe the format for death and birth register by asking the participants to refer to Annexure 6 and 7.
- Explain the importance of maintaining a death and birth register as per the section 5.1.a and 5.1 b given ahead.
- You should use the questions given on Page 40 of trainer notes to further build their understanding on importance of monitoring deaths in the village.

Duration: 45 minutes

5.1 Facilitating Service Delivery and Service Providers in the Village

The VHSNC serves as an important platform to facilitate access to services and services providers at the village.

1. Organization of the Village Health and Nutrition Day and support to the organization of immunization sessions is a key part of facilitating service access in the village. The VHND is both a platform for the community to access all the services provided by ANM and AWW at a site very near their homes, and the point for health education and counselling. 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. A detailed checklist to assess key services provided during VHND is given in Annexure 8.
2. VHSNCs need to allow outreach workers and community service providers to articulate their problems in these meetings. The meeting should identify whom 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.
3. Sometimes there are 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.

4. The meeting 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.
5. VHSNC can also support service delivery by organizing local tie-ups with vehicle owners to transport a patient to the hospital in time of need.
6. One specific type of service for VHSNCs to focus on is the registration of births and deaths. The focus should be that every newborn is registered, and a birth certificate issued by the appropriate authority 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.
7. 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 health and any outbreak should be immediately provided to the Sub centre ANM/ PHC Medical officer.

VHSNCs should maintain record of deaths and births in their village according to the formats mentioned in Annexure 6 and 7 respectively and is explained below-

5.1.a Maintaining a Death Register

All VHSNCs will maintain a register where deaths and their causes as perceived are recorded monthly. In addition to recording the deaths, you should also discuss the reasons for the deaths and how the deaths may have been prevented. The VHSNC should focus on cause of death and good quality reporting of such causes, as this can form the basis for village planning. All deaths should be followed by the issuance of a death certificate, including for stillbirths.

Why should we record the deaths in our village and their causes?

a. They tell us about the types of diseases and problems in our village

For example, If there is a maternal death in the village, it reflects that there can be another 30 women are suffering from really troubling complications that could have been avoided. If there is one malarial death, it shows that there are another 50 to 100 persons who have lost a week's work and spent a huge sum of money due to malaria.

b. They help us to assess the causes and remedies for the preventable causes of mortality in our village

For example, while discussing a maternal death that has occurred in the village, the members may have identified the following causes for death-1. Non-availability of transport facility for the woman to be taken to the hospital 2. Lack of financial resources with the family 3. Gaps in ANC resulting in non-identification of high-risk case. The VHSNC can now plan for addressing these gaps in order to prevent any maternal deaths in the future.

c. They point us to issues which require action at various levels and help us to identify and prioritize issues for collective planning in the VHSNC

For example, with regards to the above maternal death, the VHSNC can make an action plan to prevent maternal deaths in the village. Some of the action can be directly taken by the VHSNC

itself, like making arrangements for transport and financial support. For ensuring identification of high risk cases, the VHSNC can monitor the quality of ANC. It may also have to dialogue with the block or district health officials for more rigorous training and monitoring of ANMs on high risk cases by the health department.

Verbal autopsies: Where the death is of a pregnant woman (regardless of cause and the stage of pregnancy) or that of a child below one year this must be reported and followed up by an enquiry with family members. This sort of enquiry must be facilitated by a public health resource person such as a Medical Officer. The enquiry should discuss which of the deaths in the list was preventable and how it could have been averted. In fact every death below the age of 60 and certainly deaths below the age of 40 should be discussed.

5.1.b Maintaining a Birth Register

Along with deaths, registration of births is another activity of the VHSNC. The focus should be that every newborn is registered, and a birth certificate issued by the appropriate authority reaches the family within the given time standard.

Why should we record the births in our village?

The birth register records the name of mother, Sex of child, Date of Birth, Place of Birth and Birth Weight. It will help in monitoring institutional delivery and birth weight. It can also be potentially useful in improving home visits by ASHA for Home Based Newborn Care and for monitoring of neonatal deaths.

Questions for practice:

Q.1. a) Can you remember the deaths that happened in your village during the last two months? Record the information that you have in the death register format.

b) What does the above information on deaths tell you? What are the leading causes of deaths? Do you think they could have been prevented?

c) If you have to prevent such deaths in future, what steps need to be taken?

Q.2. Why should we monitor deaths in our village?

5.2 Community Monitoring of Healthcare Facilities

Method: Participatory discussion using the checklist given in Annexure 9 and elaborate by using the details given below.

Duration: 45 minutes

VHSNCs play a key role in community based monitoring under NRHM. In many districts VHSNCs have been oriented towards community monitoring of health care services in primary and secondary health care facilities in their area. Annexure 9 contains a checklist to assess quality of services at Public Health Facilities.

The monitoring activities discussed above are one of the components of community based monitoring. The other components are:

Filling scorecard for health facilities- The VHSNCs visit PHCs and dialogue with service users. This information is used to fill a scorecard with a number of parameters. These parameters relate to both the services available in the PHC/sub center and the quality of care.

Organizing Jan Samvads- VHSNCs of an area come together to organize Jan Sanwads which are forum for dialogue between the community and the authorities It also performs the task of grievance readressal. In the Jan Sanwad the PHCs which do well as per the scorecard are felicitated and those which are faring poorly in the scoring are singled out for appropriate action. Programmes such as Rashtriya Swasthya Bima Yojana and private sector partnerships are also monitored and their problems highlighted.

We will learn more about Community based monitoring under NRHM in a separate training.

Questions for practice:

Q.1. What are the various methods for monitoring health in our village?

Q.2. Why is it important for the members to share responsibilities for monitoring?

5.3 Village Health Planning

Objectives of the session

By the end of the module the VHSNC members will learn about:

- What is village health planning
- What are the steps of village health planning
- How to use the village health planning register

Method:

- Start the session by asking participants about their perception of village health plan.
- Elaborate the concept of village health plan by using the details included in this section and try to link to their responses.
- Explain each step given ahead to make the participants understand the process of village health planning. At this point also describe the use of public service monitoring tool and register in village health planning.
- Display on chart paper the possible levels of action and hold discussion as per section 5.3 c on Page 44 of the trainer notes.
- End the session with the case study given on page 45 of the trainer notes to build clarity on village health monitoring and planning.
- Use the examples in the end of section 5.3 at page 46 to make them understand how the public service monitoring register will need to be filled.
- Give Group Work- Divide the participants into four to five groups of respective VSHNCs. Give each group one or two problems to make village health plan. Tell the participant to document their plan in the format of Public Service Monitoring Register. Problems given under questions for practice at page 47 of trainer notes can be used for this purpose.

- Ask each group to present their work in five to seven minutes. Other participants can provide suggestions.
- End the session by summarizing the key steps of village health planning.

Duration: Three hours

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

In each monthly meeting, the status of action on previous month's plan is reviewed. A fresh action plan is prepared for 2-3 gaps/issues in each meeting. A plan, in order to get executed, might require funds or might not. For example ensuring immunization or monitoring of the Mid-day meal to ensure its implementation according to guidelines, or inclusion of eligible people for pensions do not need any extra funds. However, for activities that require funds, the VHSNC is provided with annually with an untied fund.

5.3.a Let us now look at the main steps involved in making a Village health plan

Step 1: First the VHSNC has to identify the gaps and problems with regards to status of health and related services in the village.

VHSNC members can do this with the help of:

Public Service Monitoring tool and register

The key items monitored by VHSNCs through this register include:

- Functioning of Anganwadi
- No. of malnourished children
- VHND and ANC services by ANM
- Institutional deliveries
- Use of Mosquito nets
- Availability of referral transport
- Availability of drugs with ASHA
- No. of Fever cases
- No. of Diarrhoea cases
- Functioning of Schools
- Functioning of PDS, MNREGS, MDM, Pensions etc.
- Cleanliness around hand-pumps
- Functioning of hand-pumps
- Violence against women

The VHSNC should record and discuss on all points mentioned above in the village health register. In addition the following should be used in the planning process:

1. Death registers through this the VHSNC would identify the preventable causes of death like diarrhoea, fever, TB, infant deaths and maternal deaths on which planning needs to be done.
2. Experiences of VHSNC members and discussions during VHSNC meetings: Experiences of VHSNC members will help to identify and prioritize issues for planning.
3. Habitation/village level meetings issues discussed in the habitation level meetings need to be highlighted by the ASHA or members of that habitation in order to understand the problems and gaps.

Step 2: Using these methods, the next step is to compare the various situations and identify the weakest habitations/sections

In identifying the problems using the above methods, the VHSNC needs to also discuss who are the people/habitations most affected by it. This will help to prioritize and focus the VHSNC's planning and resources on the people who need it the most.

Step 3: The reasons for the problem/weakness has to be then discussed.

The VHSNC has to identify the main cause(s) of the problem. You can do this by asking the families or persons most affected by the problem and related persons/service provider. Through this you will come to an understanding of the reasons of the problem. E.g. if a habitation has a large gap in immunization, the cause may be irregular VHND, distance, non-functioning Anganwadi, lack of information regarding dates of VHND or reluctance of families for immunization as it gives their children fever.

Please remember: No one purposely wants to remain ill or ridden with problems. Everyone wants to resolve their problems, but often circumstances make it difficult for people to come out of their situation. It is important that we don't start blaming people for their problems and instead identify the reasons and circumstances for the problems. It is only when we act together to change the circumstances that the problem will get resolved.

Let us understand through an example- In Tarigarh village the VHSNC identified one 3 year old child who was severely malnourished. She would frequently fall ill and was getting weaker day by day. Few of the members accused the family for not taking good care of their child. The ASHA and other members visited the family to understand the circumstances. They found that the family was very poor and both parents went for work daily to a nearby brick kiln. The child's 10 year old sister took care of her and her 5 year old brother. The family had taken the child to the CHC once when she fell very ill. The doctor told them that the child is weak and wrote medicines and expensive tonics. The family only had money to buy the medicines but not the tonics. The ASHA had visited their house earlier and had suggested that they take her to the NRC. However, the NRC was at the district hospital, far from the village and the mother couldn't go there on her own. Staying there for 15 days meant that they could not work for those days and they couldn't afford that. The child was getting extra take home rations from the AWC. However, the ration was saved for days when the parents were not able to go to work and then it was eaten by the whole family. After finding out these details, the members were able to understand the reasons for the situation. They listed them:

1. Abject poverty
2. Lack of adequate work and non-payment of minimum wages for the parents
3. Lack of childcare facilities for working parents
4. NRC difficult to reach without more support
5. Insensitivity of the doctor to the economic condition of the family

Step 4: Deciding the collective action needed by the village to get the gap addressed

Once the reasons for a problem are clear, the VHSNC can now make an action plan for addressing these issues. E.g. if a habitation has a gap in immunization due to irregular VHNDs, the VHSNC may decide to talk to the concerned ANM to resolve the issue. When the related service provider is present in the same meeting, it is often the case that the service provider commits to corrective action, and the issue gets resolved.

Step 5: Deciding the responsible persons to lead the collective action

The plan has to include names of VHSNC members who will take the responsibility for the action. This step is very important as if we do not pin down responsibilities, the tasks may not be done. It is also essential to see that the responsibility is divided equally among the members and one member does not have to bear all the responsibilities.

Step 6: Fixing the time frame for attempting the action

Along with fixing responsibilities, the other important step is fixing the time frame for the action. This helps the VHSNC to complete the tasks at hand in time and also to review whether the planned action has taken place.

Step 7: Reviewing the progress on items planned in previous/earlier meeting

In the subsequent meeting of the VHSNC, the progress made on the actions planned in the last few months is reviewed. You should applaud in case of an action with a successful outcome.

You will find that in some cases, the planned action is taken but the outcome is not successful. In such cases, further planning is done to decide on the next action required to solve the issue. There are situations when the action is not even attempted. In such cases, the steps of fixing responsibility and time-frame have to be reviewed/re-decided.

It is good to focus on the success rather than on failures, as it will help in keeping the morale of the group high.

5.3.b Using the Public Service Register

This register will help the VHSNC to plan and record this whole process of planning. This register will be filled during the meeting as discussions for the action plan take place. In the register the VHSNC will document the problem identified and the place, the possible causes as discussed in the meeting, the actions to be taken by the VHSNC, the person responsible for getting the tasks done and the timeline for it being completed. It also has a column for reviewing this plan the next month.

All the issues and problems discussed and planned for in a VHSNC will be filled in this register one after the other.

The Public Service Monitoring Register is given in annexure (5/5a)

5.3.c Levels of action

You will find that a plan usually needs to be developed around the following types of actions (suggested):

1. Actions that can be undertaken at the community level with or without assistance of the community level care provider. eg improving quality of mid day meal and anganwadi services, improving immunization and ANC, making the water sources safe for drinking etc.

2. Actions that people could take themselves at the family level. For example – many deaths due to heart disease or due to cancers relate to tobacco, betel chewing etc, and indicate that changes in life styles and behaviours and local health care practices practices are needed for prevention.
3. Health education through inter-personal communication at the family level, supported by mass communication at community level.
4. One important form of action is to inform the panchayats who would either appraise higher authorities of the gaps or organise local action with available funds. In this way – the capacity of the panchayats to govern the health care delivery and public services is improved upon.
5. Actions that need to be undertaken at the health systems level- here the plan should enable informing the authorities especially at the Block level

5.3.d Village Health Planning and the Gram Sabha

The Gram Sabha is an important forum for the VHSNC. VHSNC is accountable to the Gram Sabha and needs to present its accounts and activites to it. In addition to that, the VHSNC should involve the Gram Sabha in their action. The VHSNC members should regularly attend the Gram Sabha meetings and present the problems identified through village health planning. The Gram Sabha is mandated to act on these issues and can help to VHSNC to resolve some of the problems. This will also strengthen the gram sabha's capacity in intervening on health and nutrition issues.

Please remember: Let us again remember that village health planning is a continuous process. It may not be possible for the VHSNC to discuss all issues being monitored, in one meeting. The VHSNC in the monthly meeting will have to prioritise the issues as per the 'need of the hour' and the severity and criticality of the problem and planning on those issues.

This case study will help you to understand the process of village health monitoring and planning:

Case study- VHSNC improves the Aanganwadi centre

Village Sonpur is situated around 20 kms away from the Block headquarter. The village has a total population of 960 and the major caste group is Gond, Urao and Barga. The VHSNC (Village Health Sanitation and Nutrition Committee) meeting for the month of June was held on 29.06.2010. There were about 40 people present in the meeting including the Sarpanch, Panches, Anganwadi worker, Sahayika, ASHA, ASHA Facilitator and SHG members and villagers. The meeting was facilitated by the ASHA Facilitator.

During the discussion it was found that, the only Anganwadi centre of the village was closed for last two months and during this period THR (Take Home Ration) was not given to any beneficiary. Since the Anganwadi worker was present there, the Sarpanch asked her the reason of keeping the Anganwadi centre closed for two months and not distributing the THR during this period. As per the Anganwadi worker, she was on leave for 2 months, but she had asked the Sahayika to open Anganwadi centre in the meantime and provide related services in her absence. The Sahayika, disagreed with the Anganwadi worker. After a lot of argument, both of them agreed that they had been irresponsible and agreed to provide the THR for two months, to the beneficiaries immidately. It was also found that the Anganwadi worker was not taking the weights either of pregnant women or children. The ASHA explained to the members that it is only by taking weight that the nutritional grade could be identified and additional food and counseling could be given to the malnourished. She also told them that this is one of the main reasons for opening Anganwadi centers across the country. The Panchayat representatives and other Members were convinced and asked the

Anganwadi worker to weigh the pregnant women and children regularly and provide more quantity of THR to those who are malnourished. It was also decided that the AWW and the ASHA will visit the houses of malnourished children for nutritional counselling. One month was identified in which complete this.

As per the commitment, the Anganwadi worker distributed the THR of pending months to all the beneficiaries in two days. Afterwards, as directed by the VHSNC, both Anganwadi worker and Sahayika attended the VHSNC meeting monthly and in each meeting present an update on the services of Anganwadi centre and nutritional status of children.

Let us now take up some more examples of village health planning and see how to record them in the Public Service Monitoring register:

Village- Motipur **Date of VHSNC Meeting- 3rd November 2013**

Gap in service	Name of the hamlet where the gap exist	Possible cause identified by VHSNC	Possible solution sought by VHSNC	Person responsible to get the work done	Date By which work will be done	Review (in next meeting)
Rita has been identified as severely malnourished	Kumharhamlet	Family too poor to go to NRC	VHSNC to fund the expenses Follow-up by AWW	Anganwadi worker	12th Nov	
Vegetables not being cooked daily in Primary school	Middle hamlet	SHGs in charge of MDM not aware of guidelines	SHG members need to be informed of the guidelines	Panchayat representative	20th Nov	
A TB patient about to default on DOTS	Kumharhamlet	The DOTS provider is the PHC Medical officer. The PHC is 10 kms from the village and the patient has to lose one day's wages each time he goes for DOTS.	ASHA of Kumhar hamlet to be made the DOTS provider for the patient	ANM	4th Nov	
Case of violence on woman	Main hamlet	The husband regularly beats his wife. They have two small children so she is scared even to tell people that he beats her.	To counsel her that she shouldn't be afraid and speak up against violence. To provide support to her in complaining to the panchayat or police	Woman Panch ASHA	10th Nov	

Questions for practice:

Q.1. Using the Village Health Register Format make plans for the following problems (This activity can be done by dividing the trainees into groups and giving each group 1-2 problems to solve):

- In Sitapur village, many children get diarrhoea at the same time.
- In Korgaon VHND has not been held in the last four months as the ANM has been transferred to another area and no new ANM has been posted.
- In Siliyari the primary school opens only 2-3 days a week as the teacher does not come everyday. As a result, the children are also not getting their mid-day-meal daily.
- In Baigapara the anganwadi has been closed for most of the month as the AWW, who is from another village, does not come daily.
- A new alcohol shop has come up in Sumantpur village. Men from the village are now drinking more frequently. Men come there from surrounding villages and drink and create chaos on the road. This causes a lot of harassment for the women and girls of the village.
- Sariguda village saw four deaths due to malaria this year. Every year people get malaria and many have to be hospitalized.
- In Gari village under MNREGS, labourers have not been paid wages even three months after completing work.
- In Rampur village, the ASHA's drug kit has not been refilled and there are no medicines left in the kit.
- In Kantipur, Take home ration has not been distributed in the anganwadi for the last 2 months.
- In Dimapur village, the ASHA had to intervene one night to stop a man from hitting his wife. Neighbours say that he beats her very often.
- In Kumarpur, for ANC, the ANM only distributes IFA and gives TT injection. She does not take the BP nor does she do an abdominal examination. The villagers are also not aware of the components of ANC.
- Taragaon is 25kms away from the main road with no regular transport facilities. During emergencies and deliveries, it is very difficult to get the patient to the hospital in time. As a result, the village has seen a number of neonatal deaths and a few maternal deaths in the last few years.

Q.2. What are the steps to be followed for village health planning?

Q.3. Identify three current health related problems in your village and plan for resolving them. How can the VHSNC prioritise issues?

CHAPTER 06

ANNUAL VILLAGE HEALTH PLAN

Objectives of the Session

By the end of the session the VHSNC members will learn about:

- The difference between the annual health plan and monthly village health planning.
- How to make an annual village health plan

Method: Short lecture and discussion using the details given below.

Duration: One hour

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.

6.1 How is the Annual Vvillage Health Plan Different from the Monthly Plan Discussed in the Earlier Chapter?

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	
April	Awareness campaign on diarrhoea
May	Monitoring Diarrhea
June	Awareness campaign on malaria
July	Monitoring malaria/school enrolment drive
August	
September	
October	
November	Newborn Health
December	

6.2. Let us now Learn how to make our VHSNC Annual Plan for Some of these Issues

6.2.a. Making an Annual Malaria Plan

To make an annual malaria plan all members divide themselves 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. They 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. Discussion on what corrective measures could be taken to reduce mosquitoes in that area is then undertaken.

After all the presentations, summarize and discuss how to make a village level malaria plan. Discuss the role of ASHA, VHSNCs, Panchayats, 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

6.2.b. 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 patientetc. 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.

Questions for practice:

Q.1. Make an annual health plan for diarrhea. Remember to include the following:

Steps to be taken to prevent diarrhea- availability of safe drinking water, health education
Steps to be taken to identify and treat diarrhea- Availability of medicines, awareness about diarrhea, household management of diarrhea, referral transport
Annual calendar

Q.2. Make an annual plan to ensure complete ANC for all pregnant women. Remember to include actions on:
Availability of complete ANC services
Awareness regarding ANC
Identification of high risk cases
Referral

Q. 3. Make an annual calendar of activities as per the prevalent health issues in your village.

ANNEXURE

Annexure 1: VHSNC Monthly Meeting Attendance Record

Village Health and Sanitation Committee, Village……...…………………,

GP.………………………...................……… Block.………….........……………………… Meeting Date:

……………………………...............................……….Meeting Time:…...……..

Meeting Chaired by.…………...…………

Serial 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 (PART2) of the cash book comprises expenditure.

PART 1- Income Details-(To be maintained on left side of the cash book)

S. 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	Source of donation/ income	Sign of Member Secretary

PART 2- Expenditure Details--(To be maintained on right side of the cash book)

S. No	Amount of Fund Spent by VHSNC	Details of Funds Spent by the VHSNC- (Voucher No. Bill No.)	Date of the expenditure	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-

- Total Population of the village
- Total Number of Households in the village
- Total Number of BPL Families; with details of their religion, caste and language
- Current beneficiaries/target lists for services related to health, water and sanitation, and nutrition to ensure access of all sections, particularly the marginalized groups.
- Details of Individuals with Disability

Annexure 5: Public Services Monitoring Tool

	Indicators	Jan.	Feb.	March
	Anganwadi Centre			
1	Did all Anganwadi centres 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 Anganwadi centre ?			
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?			

	Indicators	Jan.	Feb.	March
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?			
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

Serial 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: ______________________________

Serial 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: ______________________________

Serial No.	Name of Infant	Sex of Infant	Name of Mother and Father	Name of Hamlet	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		
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?		

Sl. No	Parameters	Assessment Yes/ No/ Partial/NA- Not applicable	Remarks
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 beneficiaries atleast 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	Anganwadi centre		
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 Offi cer 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)? ___________

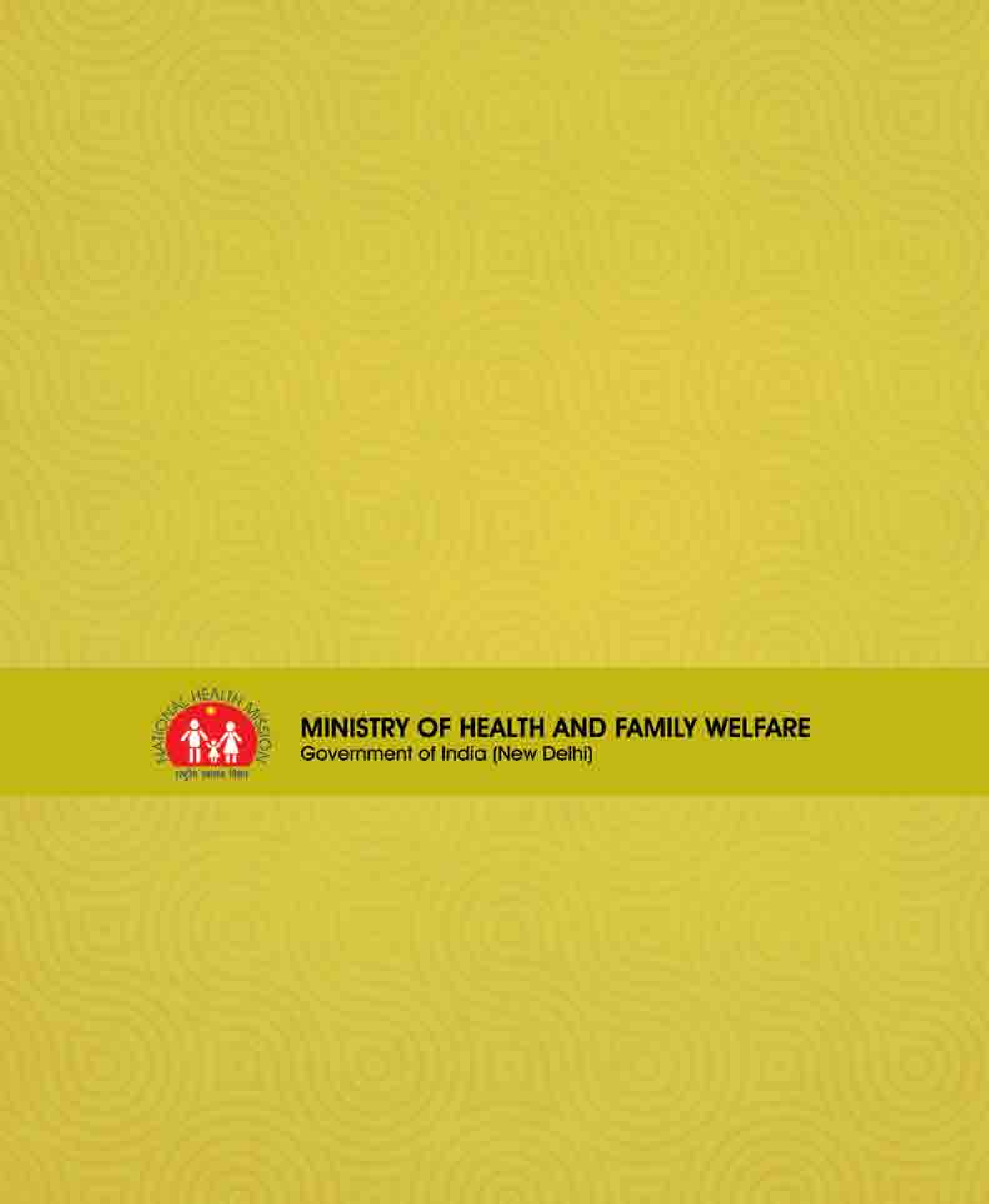
____

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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