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| DRAFT | **GUIDELINES FOR VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES (vhsnc)** |

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Acknowledgements

The Guidelines for the VHSNC are based on the experiences of states that have shown effective engagement with VHSNC such as Chhattisgarh, Orissa, Gujarat, Rajasthan and Kerala, from the work of the Advisory Group on Community Action on community monitoring pilots in several states. The guidelines were developed during a consultative workshop in January 2013. Inputs were also provided by members of the National ASHA Mentoring group and the members of the Advisory Group on Community Action.

## *I. Introduction:*

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One of the key elements of the National Rural Health Mission is the Village Health, Sanitation and Nutrition Committee (VHSNC). As the name suggests this committee is expected to take collective action on issues related to health and its social determinants at the village level. In the past few years VHSNCs have been set up at village level across states. The composition, capacity, activities and effectiveness of VHSNCs varies across the states, but comparing experiences and effectiveness across different contexts provides valuable learning. In this second phase of the NRHM, it is important to incorporate such learning to streamline the functioning of the VHNSC and support capacity building so that these institutions can emerge as vibrant village level organizations to improve the health status of their communities.

These guidelines are intended to assist states in supporting the constitution, capacity building and functioning of VHSNC so as to achieve positive outcomes. These new guidelines were developed in consultation with state programme officers and representatives of civil society and NGOs who have been working on building and guiding VHSNCs. States should utilize the guidelines to improve functioning of existing VHSNCs and build the confidence and ownership of the community particularly the marginalized over these institutions. The guidelines are flexible and can be adapted to state context.

1. *Objectives of the VHSNC*
2. To provide an institutional mechanism for the community to be informed of health programmes and government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.
3. To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
4. To provide an institutional mechanism for the community to voice health needs, experiences and issues with access to health services, such that the institutions of local government and public health service providers can take note and respond appropriately.
5. To empower panchayats with the understanding and mechanisms required for them to play their role in governance of health and other public services and to enable communities through their leadership to take collective action for the attainment of better health status in the village.
6. To provide support and facilitation to the community health workers – ASHA and other frontline health care providers who have to interface with the community and provide services.

*II. VHSNC and its relationship to Gram Panchayat*

The VHSNC is to be formed at the level of revenue village. The VHSNC will function under the ambit of the Panchayati Raj Institutions (PRI). The exact relationship between PRI and the VHSNC will be decided by the state. In states where the revenue villages are small and there are a number of VHSNCs within a Gram Panchayat, a coordination mechanism through either the Standing Committee on Health of the Gram Panchayat, or a Coordination Committee of the Gram Panchayat, that includes the chairpersons of the VHSNCs and members of the Standing Committee, would be desirable.

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

## *III. Composition of the Committee*

Village Health Sanitation and Nutrition Committee should have a minimum of 15 members. No upper limit is defined. A minimum critical size of the committee is essential for building effective processes of consultation and representation, but a very large committee can also impede smooth management and effective functioning. States have the flexibility to decide an optimum limit to the maximum number of members.

**Principles of composition of the VHSNC**

a) Elected members of the panchayat resident in the village should be enabled to lead

b) All those working for health or health related services should be able to participate

c) The voices of service users of health services- especially of mothers should find place

d) There should be representation from all community sub-groups, especially from poorer and more vulnerable sections . About 50% should be women members and SC/ST sections should be well represented.

e) All habitations/hamlets should have representation.

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

Based on these principles of composition, members of the committee will be drawn from the following categories:

1. Elected Gram Panchayat Members: Those resident in 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 organisations like Self Help Groups, Forest Management Committees, Youth Committees, etc. These members are also useful to ensure that every habitation and community is represented.
5. Pre-Existing Committees: If there are separate committees on School Education, Water and Sanitation or Nutrition, the first effort should be to integrate these committees with VHSNC. If that is not possible or till the time it has not been done, key functionaries of each of these bodies should be included as a member in the VHSNC and chairperson of the VHSNC should also become a member of these committees.
6. Service- Users: Pregnant women, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using the public services should also find place

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.

All the selections are done by the community using these above categories and principles as guidelines. The ANM, AWW and ASHA along with the Panchayat leadership 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.

## 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.

## Member-Secretary and Convenor

The ASHA will be the Member-Secretary and Convenor of VHSNC. 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. The reasons for positioning ASHA as the convenor is based on state learnings that show VHSNCs tend to do much better where she is in the lead, because there is a more organised support mechanism and more sustained building of capacity of the VHSNC using her as the vehicle. She also has better community ownership and acceptance, given her role, the tasks she undertakes, and the fact that she has been involved in health related issues over the past few years. Finally the ASHA for successful achievement of her objectives especially as related to health promotion, prevention and community mobilisation requires an active VHSNC.

States that have appointed AWW as the member secretary should initiate the process of replacing them with ASHA or they can co-opt ASHA as the joint Member Secretary and Co-convener.

## *IV.* VHSNC Bank Account

Every VHSNC should have a bank account opened in the nearest bank, to which the untied fund of the VHSNC shall be credited. The district may recommend specific banks if additional services are promised, - but the VHSNC should have the final say. The Chairperson of the VHSNC and the Member Secretary should be the joint signatories of the VHSNC account. For those states which have nominated a functionary other than the ASHA (AWW or ANM), it is recommended that the ASHA be included as a third signatory. Wherever the ANM is one of the joint signatories of the account, she should be replaced with the member secretary of the VHSNC.

All withdrawals from VHSNC account must be done by a joint signature of both the signatories (if the account is operated by two signatories) are or by two of the three signatories (if the account is operated by three signatories).

## *V. Process of Formation and Renewal*

The formation of the VHSNC (for new VHSNCs or for replacing non functional VHSNCs) is a participatory process in which community mobilization to inform community about the composition and role of the committee is essential. The Gram Panchayat members, ASHA, ASHA facilitator (or Block Mobilizer) and ANMs will be responsible for selecting members through a consultative process with the community at village level. This list will be ratified with inclusion of further suggestions, at the next Gram Sabha meeting.

The VHSNC will be re-constituted after a new panchayat is elected. Thus the term of a committee shall be co-terminus with that of the Gram Panchayat where it is located. There should be no bar on reselecting those who have proved active and effective as VHSNC members, or dropping those who have not been active, provided the basic principles of the composition of VHSNCs are maintained. VHSNC can select new members to replace non active members or add a new member within the norms, by two thirds majority.

## *VI. Activities and Outcomes of the VHSNC*

The activities of the VHSNC are clustered into five broad categories.

1. **Monitoring and Facilitating Access to essential public services**- and correlating such access with health outcomes

There are many ways for a VHSNCs do this. One best practice is for every VHSNC to use a public services monitoring tool related to whether key services were available in the previous month. ( Annexure 1). For those services that were unavailable, the VHSNC maintains a Public Services Register in which members list the following:

a) Gap in service

b) Date of Meeting when the gap was noted;

c) Action to be taken and

d) Person(s) responsible for the action.

This is reviewed in the next meeting, and follow up conducted until the gap is resolved. This could take upto a few months or longer. This is a basic activity. From this activity other activities such as local corrective action, facilitation of service access, and seeking redressal can flow. In many states gaps are identified and acted upon even without the use of such a public service monitoring tool. But the use of such a tool enables a systematic and comprehensive approach. It is also easier to train members in the use of specific tool. Understanding how to make and use this register is one of the key elements of capacity building that is needed.

One important aspect to note is that other than health services the VHSNC also records access to related public services, including the access to work under MNREGA, rations from public distribution system, mid day meals, anganwadi services, safe drinking water, access to toilets, etc- making it the pre-eminent platform for local convergent action.

One further important dimension is for the VHSNC to clearly identify that if a service is not reaching 100% of beneficiaries, they need to assess which set of beneficiaries it reaches preferentially and who are actually excluded. Once this is identifed the corrective action provides for greater focus or different approaches to ensuring utilisation by this excluded group. In this way the VHSNC becomes one of the most important ways of addressing social determinants.

The ASHA’s role is not only of capacity building, she also acts as an agent of change. The ASHA uses the VHSNC to generate public awareness of health and other social sector programmes and convey that these are entitlements that everyone has a right to, thereby making special efforts to ensure that it reaches the marginalised.

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.

1. **Organising Local Collective Action for Health Promotion.**

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. We list some of the activities in which VHSNCs are involved:

1. Organising 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 mobilisation 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 sensitisation against poor environmental hygiene practices.

1. Organising teams for source reduction work- identify areas of mosquito larva breeding and taking appropriate anti-larval measures- i) pouring a 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 synergise efforts, need inputs from the health department.
2. **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 organisation of immunization sessions is 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.
2. VHSNCs need to allow outreach workers and community service providers to articulate their problems in these meetings. The meeting should identify who the ANM, Anganwadi worker, the school teacher and the ASHA are unable to reach and help these providers to reach these sections. In cases where providers are facing personal taunts or even harrasment, 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. Another major role that has emerged is that the committee can organise 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. 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. This is dealt with more fully in the next section.
7. **Village Health Planning**

Village health planning is understood differently across the districts. We give below some of the ways plans were made and used.

1. One method of making a village health plan is to identify the problems in access to public services and close the gaps. This type of planning enables understanding on why some pockets or habitations have lower access and can suggests actions to close the gaps. This is described in the section on “Monitoring and Facilitating access to essential public services”. The VHSNC must maintain a village register which records the following data to enable action:
   * 1. Total population of the village,
     2. Number of Households,
     3. Number of BPL families, with information on their religion, caste, language,
     4. Current beneficiary / target lists of services related to health, water and sanitation and nutrition to ensure access of all sections, particularly the marginalised groups.

Another means of taking action on information collected above is to assess gaps and organise local collective action to close these gaps. This plan is about what people can do by themselves.

A second mechanism to develop a village plan is to identify health care priorities and to take appropriate action at various levels:- health education action at the level of the family, collective action at the level of the community and asking for government action or services at the level of health systems. To do this requires higher capacity. However some villages have made an interesting start. Broadly we could divide this process into two-

* 1. Identifying health care priorities and
  2. Planning Action

*To understand health care priorities the VHSNC could :*

* + 1. Maintain a register where deaths over a period (quarterly) and their causes as perceived are recorded. 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, certainly deaths below the age of 40 should be discussed.
    2. Deaths are also indicative of disease loads. For every one maternal death, 30 women suffer from really troubling complications that could have been avoided. For every one malarial death, there are 50 to 100 persons who lost a week’s work and spent a huge sum of money due to malaria. So deaths even though tragic only represent a small part of the problem and conceal significant morbidity among the living.
    3. All VHSNCs must be encouraged to maintain this record of deaths and over time be able to identify report and be facilitated to conduct such verbal autopsies. In addition to this record of death, a discussion in the VHSNC may bring out other common problems that did not cause death but were causes of suffering and economic loss, and identify which of these were preventable.
    4. Records of disability that comes from a survey for disability.
    5. Focus Group Discussions can enable the identification of frequent causes of care seeking of outpatient clinic visits or hospitalisation. This also gives us a picture of disease loads. Based on this, the village could just list the ten most common causes of premature death, of hospitalisation and of going to a doctor and based on this, develop a plan.

*A plan could be developed around the following actions (suggested):*

1. 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.
2. Health education through inter-personal communication at the family level, supported by mass communication at community level. The content of this activity changes with the local health priority
3. Actions that can be undertaken at the community level with or without assistance of the community level care provider. eg organising health melas, screening camps, health education during village events or festivals, making the water sources safe for drinking, improving quality of mid day meal etc.
4. Actions that need to be undertaken at the health systems level- here the plan should enable informing the authorities especially at the block and the PHC levels - so that they could take appropriate action – preventive or curative.

Such planning requires substantial degrees of knowledge as well as health systems capacity at the referral levels, with good linkages between the two. However caution is needed for this approach. Though such a village health plan is one of the possible activities of the VHSNC we should not over-project the possibilities of such planning- since the institutional capacity to support and respond to such plans is quite a major challenge. Most VHSNCs are better advised to start with the other activity groups first, and attempt this only if there is a good public health team which can support them.

1. **Community Monitoring of Health Care Facilities:**

In many districts VHSNCs have been oriented towards a community monitoring of health care services in primary and secondary health care facilities in their area.

VHSNCs visit PHCs or dialogue with service users- and use this information to fill a score card with a number of parameters. These parameters relate to both the services available in the PHC and the quality of care.

PHCs which do well should be felicitated- and those which are faring poorly in the scoring are singled out for appropriate action. The VHSNC could also offer to help, in cases where their assistance could make a difference.

The VHSNC also plays the role as a forum for grievance redressal on the community level issues related to health, sanitation and nutrition. It should dialogue with the service providers in case of any complaints regarding the services and also proactively monitor the access of services and schemes to the marginalised sections of the village and look into any malpractices. It must also communicate grievances not re-solved at the village level to the district grievance redressal committee, where this is appropriate.

As programmes such as Rashtriya Swasthya Bima Yojana and private sector partnerships increase it is important to monitor these schemes also and include these in the forum for grievances related to these.. Even where not accredited, the government has a role in regulation of the private sector to protect patient interests- and therefore complaints and problems faced in private sector services could also be taken up in the VHSNC.

Some VHSNCs have had a very positive outcome with organising Jan Samvads- which is a dialogue between the community and the authorities.

In most situations where VHSNCs have been effective in community monitoring of public health facilities, it has been actively facilitated by NGO support for the programme. The difference between this community monitoring and the earlier described facilitation of service providers is that community monitoring relates to health care services in public hospitals and private health care facilities outside the village.

The list discussed above is not exclusive, but represents the five most successful approaches to VHSNC functioning in the country. It would be useful for all states to compile best practices as related to the VHSNC into a source book for new ideas for VHSNCs to act upon.

## 6: Monthly Meetings

1. Meetings of VHSNC should be held at least once every month. It is suggested that there be one regular date- like the 5th of every month, or the first Saturday of every month- when the meeting is held to ensure that members can plan on ensuring attendance. A regular venue fixed at a convenient place preferably in a public facility like AWC, Panchayat Bhawan or School, which is easy to reach and accessible for all members also helps. Despite this the Member Secretary ASHA would in most circumstances need to remind the members of the meeting, and mobilise them to attend it.
2. A minutes register and a meeting attendance register would also facilitate proper functioning.
3. In a 15 member committee of well chosen active members, 7 persons represents a minimum quorum. But with large committees, whose composition is intended for social inclusion and mobilization, the meeting quorum could be even 33%.
4. The monthly meeting reviews work done, plans future activties and decides on how the untied funds are to be spent.

## 7: Management of Untied Village Health Fund

Every VHSNC is entitled to an annual untied grant of Rs.10,000 from the National Rural Health Mission (NRHM). The untied grant is a resource for community action at the local level. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures are key areas where these funds could be utilized. The fund shall only be used for community activities that involve benefit to more than one household. Exceptions to this are in case of a destitute women or very poor household, where the untied grants could be used for health care needs of the poor household especially for enabling access to care.

Decisions on expenditure should be taken in the VHSNC. 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. All payments from the untied grant must be done through the VHSNCs. VHSNC fund should preferably be not used for works or activities for which an allocation of funds is available through PRI or other departments.

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.

Every village is encouraged to contribute additional funds to the Village Health, Sanitation and Nutrition Committee.

Decisions taken on expenditure should be documented in the minutes. 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 last seven years experience with VHSNCs informs us that most often VHSNCs spend their funds on the following heads:

1. Village sanitation and cleanliness campaigns.
2. Source reduction- to reduce breeding of mosquitoes.
3. Conducting health melas or camps.
4. Improving facilities in anganwadi centers and sub-centers.
5. Incidental expenses ( tea, biscuits in monthly VHSNC meetings,)
6. Emergency transport for poor patients- where regular arrangements fail.
7. School health activities.
8. Incentives to ASHAs for some locally decided tasks- which are very specific to the particular village. .

Initially there was a problem due to lack of capacity and understanding at the village level, but this has changed considerably in most states and VHSNCs are now able to spend their money well. Further studies show that in many instances, delays in spending the money are largely due to delays in releasing funds, or different forms of trying to control or direct expenditure centrally- i.e. from the district or state level.

## 8. Accounting for the Untied Village Fund

* 1. VHSNC has to present an account of its activities and expenditures in the annual Gram Sabha, in which the plan and budget of the gram panchayat is discussed.
  2. 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.
  3. 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.
  4. At the state level disbursals done by the block or district NRHM will be treated as advances, and these advances will be treated as expenditures after the SOE for these advances has been received.
  5. District will conduct financial audit of VHSNC account on a test sample basis annually as a part of auditing district accounts.
  6. Utilisation Certificate (UC) should be based on the format given in Annexures.
  7. 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 present unspent funds are to be regarded as unsettled advances. District should top-up VHSNC funds on the unsettled advances.

## 9 : Records (Suggested formats are at Annexure)

1. Record of Meetings – with attendance signatures.
2. Record of approvals. given by members for expenditure/withdrawal
3. Bank Pass Book and Cash book
4. Village Health Services Monitoring Register
5. Birth Register
6. Death Register
7. Village Health Action Plans- document each years plan- or whenever made.

*VII. Responsibilities of key VHSNC members****:***

## Chairperson of the Committee

The Chairperson will-

1. Lead the monthly meetings of the committee and ensure smooth coordination amongst members for effective decision making. She/He is accountable for ensuring that meetings are held monthly.
2. Represent the VHSNC in the Standing Committee of the Panchayat on health and share details of work undertaken by VHSNC at the village level.
3. Develop the annual or the bi-annual work plan for the committee, in consultation with member secretary ASHA and other members and follows up on necessary actions.
4. Ensure that the village health plan prepared by the committee is reflected in the overall plan of the Gram Panchayat.
5. 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-

1. Fix the schedule and venue for monthly meetings of the committee and ensure that meetings are conducted regularly with participation of all members.
2. Draw attention of the committee on specific constraints and achievements related to health status of the village community and enable appropriate planning.
3. 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.
4. Maintain records on gaps identified in health or other related sectors, This includes identifying the cause of the gap, recording the decision on collective action as needed by the village to address the gap, and designating the persons responsible for leading the collective action, the specified timeframe to undertake the action, and recording follow up action.
5. 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.
6. Provide information on activity wise fund utilization to the committee every month and with bills and vouchers / documents on a quarterly basis. Also, 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 AWW: Is an important member of the VHSNC. She has a critical role in enabling VHSNC to take action on addressing malnutrition. She will do this through providing 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. She helps in mapping the marginalized households needing nutrition services and extends support in forming and implementing nutrition component of the village health plan. She is also 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. The VHSNC will ensure that the AWC provides hot cooked meals in accordance with norms.

4:ANM: She will provide information to VHSNC regarding available services, schemes, and services for maternity and child health. She will share details on marginalized groups or those unreached through health services and seek the support of the VHSNC to reach these populations. She will enable the committee prepare a village action plan to address this concern. The committee will hold the ANM accountable for smooth functioning of Sub-Centre and provision of quality services and regular conduct 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 on wider determinants of health such as drinking water, sanitation, female literacy, nutrition and women and child health. They will inform VHSNC on various developments and challenges faced in implementing the respective programmes and will enable VHSNC to take action on social determinants of health and contribute towards the synthesis of a comprehensive village health plan. This allows VHSNC to ensure local level accountability in delivery of social sector programmes.

## *VIII. Capacity Building and Training Strategy*

Capacity building of VHSNC is a continuous process. The knowledge base of members needs to be strengthened for a clear understanding of the objectives, functioning and roles of VHSNC. The training curriculum should aim to build their capacities for addressing the social determinants of health and finally enable them acquire complex skills of village health planning and community based planning and monitoring.

The ASHA Training structure as it exists should provide training to VHSNC members. NGOs can be used to provide additional capacities for the training process.

Though the ideal process would be a two to five day training camp for all members resource constraints and capacity for such training is limited. The focus in most programmes therefore has been on training ASHAs very well so that they could provide leadership, if possible training two or three more members in two or three one day sessions in moderate size groups at the sector level and most importantly, supportive supervision with facilitators attending VHSNC meetings and providing guidance and thereby building capacity in the course of the meeting.

The training strategy for VHSNC members involves-

1. **Training of ASHA Trainers, ASHA Facilitators and ASHAs**:

This will enable states to develop a resource pool for training VHSNC members. It is also understood that it is through them that most VHSNCs would receive supportive supervision and knowledge inputs. A three day training is adequate to start with but would require to be repeated every six months at least.

1. **Training a core team-** This is two day training of five members of each VHSNC for a two day period – if residential or three days if non-residential. The front line workers of government departments are not part of this five. In this training, a hand book would be introduced and they would be trained in the use of the handbook. Such trainings may need to be conducted at the sub-block level. This would orient them on key objectives, functions, roles and responsibilities of VHSNC. Subsequently they should receive a one day review cum training session every quarter – or at least once every six months.
2. **Orientation Sessions for front line workers:** ANMs, AWWs, and other front line workers who are members of VHSNCs would receive a two day non residential orientation session on VHSNCs- and what is expected of them. This could be conducted at the block level.

## *IX. Supportive Supervision*

This is key to effective functioning of the VHSNC. A significant part of the capacity building process will take place as part of supportive supervision.

Supportive supervision in this context will mean a designated and well trained person attending the VHSNC meeting and ensuring that members understand and have the skills and support to carry out all their functions. The existing ASHA support structure is best used for undertaking this. They have the orientation and have the skills for community interaction- and most important it is more cost effective. . In areas where ASHA support structures do not exist they need to be constituted to meet the supervision needs of both programmes. A support structure is required at all levels of programme management (State, District and Block,) for monitoring, mentoring and handholding of VHSNCs- and again savings are maximal if we overlap this with the ASHA support structure. This support structure is outlined in the accompanying table 1.

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 1** | | | |
|  | **Level** | **Name of the Structure** | **Composition** |
| **I** | **State** | State Mentoring Group for ASHA and Community Processes | Experts and practitioners in the field of Community Health representing NGOs, training and research institutions, academia and medical colleges |
| State Management Team (housed within SPMU) | Nodal Officer – ASHA programme / Community Processes or  One ASHA Programme Manager  will head this small team of consultants |
| State ASHA / Community Processes Resource Centre.  ( Outsourced or placed in SHSRC) | A dedicated resource Centre for States with more than 20.000 ASHAs. Consists of   * + - Team Leader     - Programme Manager - ASHA     - Programme Manager - Village Health Sanitation and Nutrition Committee and other community processes     - Consultant - Documentation & Communication     - Regional Training and Supportive Supervision Coordinators\*     - Data Assistant     - Accounts assistant     - One office attendant.   \*Large states would benefit by engaging a Regional Training and Supportive Supervision Coordinator responsible for minimum six districts to supervise and support the recurrent and periodic trainings related to ASHA and other community processes. |
| * States with less than 20,000 ASHAs do not need Documentation & Communication Officer and Regional Coordinators |
|  |  | State Training Team[[1]](#footnote-2) | * State Trainers- Synonymous with State Training Sites described in Draft-ASHA Guidelines 2013[[2]](#footnote-3) |
| **II** | **District** | District Coordination Committee for ASHA/ Community Processes | * Committee functions under the strategic guidance and leadership of District Health Society. * It is convened by District Nodal Officer/CMHO and functions through a full time District Community Mobilizer. * It includes, at least five to eleven members, such as members from ASHA mentoring group, programme officers and representatives from district training sites, and also one or two representative from District Planning and Monitoring Committee formed under NRHM. |
|  |  | District ASHA/ Community Processes Team | District Community Mobilizer  District Data Assistant  All Block Community Mobilizers  *One district level mobilizer should extend support to maximum ten blocks. In case districts have more than ten blocks a second district mobilizer should be selected.* |
|  |  | District Training Team[[3]](#footnote-4) | District/ASHA Trainers synonymous with the district training sites |
| **III** | **Block** | Block ASHA/ Community Processes Team | Block Medical Officer/ Nodal Officer  Block Community Mobilizer  All ASHA Facilitators  *Three personnel at block level are needed for VHSNC support. One would be BCM and the remaining two should be drawn from the pool of ASHA Trainers.* |
| **IV** | **Sub Block** |  | One ASHA Facilitator 20 ASHAs( 10 in special situations )  The Non-High Focus states and Union Territories may assign the role of ASHA Facilitators to the additional/ second ANM at the Sub-Centres.  States having less than 20,000 ASHAs could utilise existing support mechanisms at PHC level to support ASHAs. But dedicated ASHA Facilitators must be recruited in areas of geographic dispersion and those with marginalised and vulnerable populations.  *ASHA Facilitators should attend at least six meetings of VHSNC in a year.* |

## 

## *X. Monitoring*

The District Community Mobilizer would assist DPMU in maintaining a detailed data base on VHSNCs. The data base should have information on-

1. No. of revenue villages in the district
2. No of VHSNCs formed
3. Composition of the committees
4. Monthly meetings held
5. No. of VHSNCs with Joint Accounts opened
6. Dates of release of the un-tied fund to each
7. Total Fund spent by each VHSNC – as per UCs received.

Other than this, the district community mobilisers reviews once a month, if possible twice a month meeting of the block coordinators who similarly conduct once a month meeting of facilitators. In these meetings, the information regarding functionality is received and the facilitators are trained through assistance in solving the problems they face. All supervisory staff must make a sample visit to VHSNC meetings and facilitators must try and attend almost all VHSNC meetings, at least once in two months.

|  |
| --- |
| 1. % of VHSNCs having regular monthly meeting 2. % of VHSNCs who have submitted UCs 3. % of VHSNCs who have submitted UCs with over 90% of their funds spent. 4. % of VHNDs held as compared to VHNDs planned |

**Annexures**

* 1. Illustrative list of activities which can be undertaken by VHSNC
  2. VHND Guidelines.

**Annexure 1 - Illustrative list of activities and areas which are supported and monitored by VHSNC**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **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 ? |  |  |  |
| **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 ? |  |  |  |
|  | **Others** |  |  |  |
| **29** | Number of cases of violence against women during the last month ? |  |  |  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Gap Identified in table above | Date on which identified | Action to be taken | Person responsible | What happenned next. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. A team of state trainers trained and accredited at national training sites. [↑](#footnote-ref-2)
2. The state shall designate one state level training center for every six districts which will have a faculty of at least four to six state trainers. The state will also designate five or more sub district training sites at which ASHAs will be trained. [↑](#footnote-ref-3)
3. A team of ASHA trainers for each district drawn from the sub district level, trained and accredited at the state level training sites. [↑](#footnote-ref-4)