



***VHSNC***

# Objectives

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- ▶ An ***institutional mechanism*** to inform the community of health programmes and government initiatives and ensure their participation in the planning and implementation of these programmes
- ▶ A platform for **convergent action** on social determinants and public services directly or indirectly related to health.
- ▶ An avenue **for the community to voice health needs, experiences and issues with access to health services**, to enable local government and public health service providers to respond appropriately.
- ▶ Empower **panchayats to play their role in governance of health** and other public services and to enable communities to take collective action for attainment of a higher health status in the village.
- ▶ **Support and facilitate the work of ASHA**, and other frontline health care providers.



# ***Constitution of VHSNC and its relationship to Gram Panchayat***

- ▶ VHSNC to be formed at the level of revenue village - for every 1000 to 1500 population – and function under the ambit of the Panchayati Raj Institutions
- ▶ In states with several revenue villages and thus a number of VHSNCs within a Gram Panchayat, create a coordination mechanism through either the Standing Committee on Health or a Coordination Committee of GP, that includes the chairpersons of VHSNCs and members of Standing Committee.
- ▶ VHSNCs may preferably act as a sub- Committee or a Standing Committee of the Gram Panchayat and function under the latter's oversight



## ***Composition of VHSNC- Principles***

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- a) Size: approx, 15: no upper limit
- b) Elected resident member of the panchayat,
- c) all those working for health or health related services should participate
- d) Service users of health services- especially of mothers
- e) Representation from community sub-groups, all habitations and hamlets

***About 50% should be women members; SC/ST sections should be well represented.***

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# *Members*

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- ▶ Elected Gram Panchayat members
- ▶ ASHA of the village, (or all ASHAs of village)
- ▶ Front line staff of government health related services - AWW, ANM and school teachers if resident of village. Volunteers / village level workers of other departments: Public Health and Engineering Department (PHED), ICDS, Education, Handpump Mechanic (if resident of village)
- ▶ Community Based Organizations - Representatives of other existing CBOs / committees (SHGs, Forest Management Committees, Youth Committees/ VWSC / DWCD committee)
- ▶ Pre existing Committees – If any, committees on school education, Watsan – first effort to integrate with VHSNC, if not possible then include members as VHSNC members
- ▶ Service Users: Pregnant women, mothers & patients with chronic diseases



# *Invitees*

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- ▶ Other functionaries who provide the services to the village but are not resident can be involved as invited members.
- ▶ Medical Officer of PHC, Facilitator of the ASHA Programme, Block Development Officer and Panchayat Secretary to attend the VHSNC meeting once or twice in year.
- ▶ ASHA Facilitators who are also facilitators for other community processes including VHSNC should attend the VHSNC meetings more regularly.



# ***Chairperson and Member Secretary***

## **CHAIRPERSON**

### **- Elected Representative**

**A woman elected member of the Gram Panchayat (Panch) preferably from among the SC/ST/marginalised communities.**

**- If there is no woman Panch, then preference should be given to any Panch from the SC/ST.**

**- Gram Panchayat should take a decision with the ANM & ASHA playing a facilitating role.**

## **MEMBER SECRETARY**

**ASHA - Member-Secretary and Convenor of VHSNC.**

**If there is more than one ASHA, then one ASHA has to be selected by consensus as Member Secretary**

***Could also be by rotation after a two or three year period as it would be time- consuming to change bank signatories- but that is a local decision.***



# ***Process of Formation***

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- ▶ Community awareness / mobilization on role, membership and composition
- ▶ Community level consultative process to select members facilitated by PRI, ASHA, ASHA facilitator / or Block Mobilizer
- ▶ Gram Sabha to ratify the committee selection process and names of members selected
- ▶ Committee to be re-constituted after a new Panchayat is elected, term of committee can be co terminus with that of Gram Panchayat.
- ▶ VHSNC can select new members by *two thirds majority* to replace non active ones or add a new member within norms.





# VHSNC account

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- Every VHSNC is entitled to Rs. 10,000
- Joint Signatories : Chairperson and Member Secretary
- States which have nominated a functionary other than the ASHA as member secretary (AWW or ANM)- should be replaced with ASHA.
- All withdrawals from VHSNC account must be done by a joint signature of both the signatories.
- The Member Secretary may be authorized expenditure of up to Rs 1000 for emergencies



# ***VHSNC Activities***

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- Monitoring and Facilitating Access to Public Services and Correlating with Health Outcomes
- Organizing collective Action at local level for Health Promotion
- Facilitating service delivery at the village level
- Village Health Planning
- Community Monitoring of Health Facilities
- Monthly Meetings
- Management and accounting of untied village health fund
- Maintaining records



# *Monitoring and Facilitating Access to Public Services and co-relating with Health Outcomes*

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- ▶ Use a public services monitoring tool related to whether key services were available in the previous month
  - ▶ For those services that were unavailable, the VHSNC maintains a Public Services Register with the following:
    - ▶ Gap in service
    - ▶ Date of Meeting when the gap was noted;
    - ▶ Action to be taken and
    - ▶ Person (s) responsible for the action.
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# PUBLIC SERVICES MONITORED BY VHSNC



Health Services



MNREGA



Rations from Public distribution system



Mid Day Meals



AWC Services



Access to Clean Toilet



Safe Drinking Water

	<b>Indicators</b>	<b>Month</b>
	<b>Anganwadi Centre</b>	
<b>1</b>	Did all Anganwadi centres open regularly during the month ?	
<b>2</b>	Number of children aged 3 - 6 years?	
<b>3</b>	Number of children aged 3 - 6 years who came regularly to Anganwadi centre ?	
<b>4</b>	No. of 0-3 year children in village	
<b>5</b>	No. of 0-3 year children who are in malnourished or severe malnourished grade	
<b>6</b>	Was the weight measurement of children done in all centres last month?	
<b>7</b>	Were pulse and vegetables served all days in cooked meal last week in all the centres?	
<b>8</b>	Was Ready to Eat food distributed in all centres on each Tuesday during the last month?	
	<b>Complementary Feeding</b>	
<b>9</b>	Number of children aged 6-9 months whose complementary feeding has not started yet	
	<b>Health Services</b>	
<b>10</b>	Did the ANM come last month for the Immunization/ VHND ?	
<b>11</b>	Whether all children of all hamlets are being vaccinated in appropriate age ?	
<b>12</b>	Whether the BP measurement of pregnant woman was done in the VHND ?	
<b>13</b>	Did the ANM provide medicines to the patients free of cost ?	
<b>14</b>	Did all the ASHAs have more than 10 chloroquine tablets with them ?	
<b>15</b>	Did all the ASHAs of the village had more than 10 Cotrimaxazole tablets with them ?	
<b>16</b>	Whether the transportation facility was available to take the serious patients, delivery cases, sick newborn cases, etc to health facilities ?	
<b>17</b>	Number of families not using mosquito net ?	
<b>18</b>	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 ?	
<b>Food Security</b>		
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 ?	
<b>Education</b>		
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 ?	
<b>Mid- Day Meal</b>		
26	Were pulse and vegetables served all days in cooked meal last week in all the schools (upto 8th) ?	
<b>Handpump</b>		
27	How many hand pumps are non-functional as on today?	
28	Number of hand pumps with stagnant water around -today?	
<b>Individual Household Latrines</b>		
29	Number of households with individual household latrines constructed and used?	
<b>Others</b>		
30	Number of cases of violence against women during the last month ?	
31	Number of cases of early childhood marriages reported?	

# ***Organizing Local Collective Action at local level for Health Promotion***

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- Organising volunteers to clean the village: especially decaying solid waste and pools of stagnant water
- Building teams for source reduction for prevention of vector borne diseases



# *Facilitating Service Delivery at the village level*

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- Support to Village Health and Nutrition Day for delivery of immunization and ANC/PNC, and other services
  - Enable outreach workers and community service providers to articulate their problems in these meetings. (Identify the unreached and support providers in reaching these sections).
  - Provide amenities at AWC, Sub center, - to help users and provider
  - Serves as an important platform for feedback from service providers **and** community on key gaps and the likely solutions. (e.g.: organise local tie-ups with vehicle owners for emergency transport)
  - Registration of births and deaths
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# *Village Health Planning*

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1. Identify the problems in access to public services and close the gaps by monitoring and facilitating access to public services
  2. Identifying issues and developing a medium to long term plan:
    - Identifying health care priorities
    - : Maintain a register where deaths over a period (quarterly) and their causes (as perceived) and are recorded.
    - : Deaths are also indicative of disease loads. VHSNCs must be encouraged to maintain record of deaths : facilitated to conduct verbal autopsies
    - : Records of disability from a survey for disability.
    - : Focus Group Discussions can enable the identification of frequent causes of care seeking of outpatient clinic visits or hospitalisation
    - : Identifying left out households/marginalized
- B. *A plan for action:*
- Health education through inter-personal communication at the family level, and at community level.
  - Actions at the family level
  - Actions at the community level with or without assistance of the community level care provider
  - Actions that need to be undertaken at the health systems level
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# ***Community Monitoring of Health Facilities***

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- ▶ PHC visits and dialogue with service users-: use this information to fill a score card
- ▶ PHCs which do well should be felicitated; those faring poorly in the scoring singled out for appropriate action.
- ▶ Serve as the forum for grievance redressal on community level issues related to health, sanitation and nutrition. It
- ▶ Dialogue with the service providers in case of any complaints
- ▶ Proactively monitor the access of services and schemes to the marginalised sections.
- ▶ Communicate grievances not resolved at the village level to the district grievance redressal committee,



# *Monthly Meetings*

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- ▶ Monthly meetings of VHSNC to be held on a fixed date / day
- ▶ Venue: Public facility like AWC, Panchayat Bhawan or School.
- ▶ In a 15 member committee minimum quorum will be 50% but in large committees the quorum could be 33%.
- ▶ Objective of monthly meeting : Work done, plan future activities, and decide on use of untied funds.
- ▶ Records: Meeting minutes (with attendance signatures), record of financial approvals, cash book, public service monitoring register, Birth register, Death register

# *Management of Untied Fund*

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- ▶ Funds can be used on Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures
- ▶ The fund shall only be used for community activities that involve benefit of more than one household.
- ▶ In case of a destitute women or very poor household the untied funds grants can be used for health care need of the household especially for enabling access to care.
- ▶ Decision on what to spend on, should be taken at the local level, a direction or suggestion from above can be given only in exceptional cases and 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.
- ▶ 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.
- ▶ VHSNC fund should preferably be not used for works or activities for which an allocation of funds is available through PRI or other departments



# *Accounting of the Untied Fund*

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- ▶ 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.
  - ▶ 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.
  - ▶ All vouchers related to expenditures will be maintained by the VHSNC and should be made available to Gram Sabha, or audit or inspection team appointed by district authorities for up to 3 years. After that the Statement of Expenditure (SOE) should be maintained for 10 years.
  - ▶ At the state, level disbursements 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.
  - ▶ District will conduct financial audit of VHSNC accounts on a test sample basis annually as a part of auditing of district accounts.
  - ▶ In case of delayed fund receipts VHSNCs need to be given a six month period to spend funds beyond financial year end.
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# ***VHSNC training***

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- ▶ Capacity building is a continuous process
- ▶ Training curriculum to build capacities for addressing the social determinants of health and village health planning and community based planning and monitoring.
- ▶ Ideal process - 2-5 day training camp for all members but not feasible due to resource constraints
- ▶ Alternate - training ASHA facilitators and ASHAs to train upto 5 members in 2-3 day sessions in moderate size groups at the sector level and building capacity over time during the course of the meetings.



# ***VHSNC training***

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- ▶ Training of ASHA Trainers, ASHA Facilitators and ASHAs: - to develop a resource pool for training VHSNC members. A 3 day training to be repeated every six months
- ▶ Training a core team: training of five members of each VHSNC for a two or three days period. (Two days if residential or three days if non-residential). Front line workers of government departments are not part of this five.
- ▶ To be conducted at the sub-block level.. Subsequently a one day review cum training session every quarter – or at least once every six months.
- ▶ Two day Orientation Sessions for front line workers



# *Support and Monitoring*

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- ▶ Existing ASHA support structure ----- have the orientation and skills for community interaction- and also it is cost effective.
  - ▶ District Nodal Officers assist DPMU in maintaining a detailed data base on VHSNCs
  - ▶ District Nodal Officers review once or twice a month meeting of the block nodal officers who similarly conduct once a month meeting of facilitators
  - ▶ All supervisory staff must make a sample visit to VHSNC meetings and facilitators must attend almost all VHSNC meetings, at least once in two months.
  - ▶ Awards for best performing VHSNC
  - ▶ ***Indicators of functionality -***
    - a. % of VHSNCs having regular monthly meeting
    - b. % of VHSNCs who have submitted UCs
    - c. % of VHSNCs who have submitted UCs with over 90% of their funds spent
    - d. % of VHNDs held as compared to VHNDs planned
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**THANK YOU**

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