GUIDELINES FOR VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

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Introduction:

One of the key elements of the Community Processes component is the Village Health, Sanitation and Nutrition Committee. As the name suggests this committee is expected to take collective action on issues related to health and its social determinants. In the past few years since the National Rural Health mission was launched in 2005, VHSNCs have been set up in at village level across states. The constitution, capacity building and functioning of VHSNCs across the states is variable. In this phase of the NRHM, the endeavour is to streamline the functioning of the VHNSC and support capacity building so that they 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 of selected states in view of the experience gained over the past five years. States should utilize the guidelines to form new VHSNC or to streamline effective functioning of existing VHSNCs that currently do not enjoy the confidence and ownership of the community particularly the marginalized.

Objectives of the VHSNC component of NRHM:

1. To provide an institutional mechanisms for the community to be informed of health programmes and initiatives of the government and to participate in the planning and implementation of these programmes- leading to better outcomes of these health programmes.
2. To provide a platform for convergent action to ensure access to social determinants and all public services directly or indirectly related to health outcomes.
3. To provide an institutional mechanism for the community to voice their health needs and their experiences and issues with access to health services, such that the institutions of local government and the implementing public health service providers can take note of it and respond to it appropriately.
4. 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 under the leadership of panchayats to take such collective action as is required for the attainment of a higher health status in the village.

5. To provide support and facilitation to the community health workers- ASHAs- and to other frontline health care providers who have to interface with the community and provide services.

2. Constitution 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 relationships 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 to a gram panchayat, some coordination mechanism in the form of a standing committee of the gram panchayat made of the chairpersons of the VHSNCs would be desirable.

Where the population of revenue village is over 4000 the VHSNC can be at the level of ward (as in Kerala). All VHSNC falling in within the Gram Panchayat, are to be affiliated to the statutory Standing Committee on Health of the Gram Panchayat.

2: Membership

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 the very large size of the committee can also impede the effective functioning, because it may become difficult to manage. Therefore states have the flexibility to decide an optimum limit to the maximum number of members as per the state context.

Members will be drawn from the following categories:

1. All elected Gram Panchayat members of the village / or members of the traditional community local bodies such as –tribal councils (in areas where there are no elected gram panchayats). In case of large villages, the number of elected panchayat members in the VHSNC

should be limited to one third of the total number of VHSNC members, giving preference to elected women members.

2. Members of the permanent standing committees of the gram panchayat related to health, education, and social welfare
3. Members of standing committee on health of the block panchayat of the area
4. Members of Water and Sanitation Committee of the village
5. ASHA of the village, all ASHAs if more than one is present.
6. AWW, ANM, school teachers and other service providers
7. Volunteers / village level workers of other departments: Public Health and Engineering Department (PHED), ICDS, Education, Handpump Mechanic
8. Representatives of existing community based groups like Self Help Groups, Forest Management Committees, Youth Committees, etc
9. Beneficiaries – pregnant women, lactating mothers, mothers of under 5 children

Members of the Block and Zilla Panchayat of the corresponding area, ASHA Facilitator, and block community mobilizer should be invited as non-voting members.

Anganwadi worker, ASHA ANM and one teacher of the village school (if the village has school) must be included as members in all VHSNCs. Other members should be selected from among different categories of community groups and functionaries as listed above, as per the selection process based on consultations at the community level.

3: Chairperson

Chairperson of the VHSNC will be a woman elected member of the gram panchayat (panch). If there is no woman panch, then preference should be given to the SC/ST panch.

4: Member-Secretary and Convenor

ASHA will be the Member-Secretary and Convenor of VHSNC. If there are more than one ASHA in the VHSNC village, then one of them is to be selected by consensus as

Member-Secretary and convener for a period of one year and other ASHAs take this position on rotation basis through consensus.

5: **Joint Signatories of VHSNC account**

The joint signatories of the VHSNC account should be the Chairperson and the ASHA. For those states who have nominated a functionary other than the ASHA (AWW or ANM), it is suggested that the ASHA be included as a third signatory.

6: Process of Formation

The formation of the VHSNC (for new VHSNCs or for replacing non functional VHSNCs) will be undertaken as follows:

- Community mobilization should be done to inform community about memberships and role of committee
- The PRI, ASHA, ASHA facilitator (or Block Mobilizer) and ANMs will be responsible for selecting members through a consultative process with the community at village level
- Gram Sabha has to ratify the committee selection process and names of members selected
- Committee has to be re-constituted after a new panchayat is elected. 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. ASHA, AWW and ANM will remain as ex-officio members.
- VHSNC can select new members by two thirds majority to replace non active members or add a new member within the norms.

7: Roles of VHSNC

The key roles of the VHSNC relate to Promoting involvement of PRIs and local communities in health. This includes social mobilization, action on social determinants of health, planning and monitoring of community level health and related services. Every VHSNC is expected to meet on a monthly basis. States should designate a fixed day (e.g first Friday of every month), on which VHSNC meetings should be conducted across the state.

Key Activities:

- Generate public awareness of health and other social sector programmes and related entitlements
- Conduct a social and resource mapping to understand which communities have difficulty in accessing essential services, and undertake a needs assessment of the village health, sanitation and nutrition situation
- Prepare and execute village health plans to address local health gaps through collective action
- Monitor health and healthcare services at the village/community level being provided in terms of availability, quality, outreach, and their reach and access for marginalized sections. Regular support and monitoring of monthly Village Health and Nutrition day, Mid-Day Meal in school and cooked food, Take Home Ration and other services in AWC, are an essential part of this role of VHSNC.
- Appropriate use of Untied Village Health Fund and identification of resources available through other existing schemes and programmes. (like - Total Sanitation Campaign, MGNREGA, NRLM).
- Maintain a village register (Total population of the village, Number of Households, Number of families falling under BPL category, information on their religion, caste, language etc) and supervise the beneficiary / target lists of services related to health, water and sanitation and nutrition to ensure access of all sections, particularly the marginalised groups.
- Undertake the functions of birth and death registration, and maternal and infant death audits

(For an illustrative list of tasks related to the activities, please see Annexure 1)

8: Monthly Meetings

The monthly meetings of VHSNC should be done on fixed date at the Anganwadi centre wherever it exists. In villages where AWC is not present it should be done at a convenient place, which is easy to reach and accessible for all members .Member Secretary ASHA should inform the schedule and venue of the meeting in time to all members individually. Agenda items should be listed prior to the discussions and sufficient discussion is held on each item, ensuring that all members get opportunity

to understand and give opinion on the proposal being placed before the committee. For approving any proposal, signatures of all members should be taken during the meeting itself. An account of the previous month's activities, fund spent must be shared in every meeting. Bills, vouchers and other documents may be shared in every meeting and are otherwise mandated to be shared in quarterly meetings. Monthly meetings should also discuss how effectively different village level health and related services are reaching the marginalised sections.

Every monthly meeting should be attended by minimum 50% of the members to complete the quorum of the meeting. In case the quorum is not completed the decisions taken in the meeting should be ratified in the next meeting with the complete quorum.

9: Management of Untied Village Health Fund

Every VHSNC is entitled to an annual untied grant of Rs.10,000 from National Rural Health Mission (NRHM). The purpose of this untied grant is to enable community action and to ensure that Public Health activities at the village level receive priority attention. The fund can be used for any of the following activities: -

(i) As a revolving fund from which households can draw in times of need, to be returned in instalments thereafter. **Check.**

(ii) For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.

(iii) In case of a destitute women or very poor household, the untied grants could be used for health care need of the poor household.

(iv) The untied grant is a resource for community action at the local level and shall only be used for community activities that involve benefit of more than one household. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures shall be key areas where these funds could be utilized.

(v) Every village is free to contribute additional funds to the Village Health, Sanitation and Nutrition Committee. In villages where the community contributes financial resources to the VHSNC untied grant of Rs.10,000/-, additional incentive and financial assistance to the village could be explored.

States should not issue instructions or even suggestive guidelines on how the money is to be spent, since the funds are intended for local use based on local needs and cannot be determined at the state level. VHSNCs will not be directed to contract with

specific service providers for specific activities, regardless of the nature of the activity.

- All payments to be done by VHSNCs.
- Rates for work contract are to be fixed by the committee
- VHSNC fund should preferably be not used for works or activities for which an allocation of funds is available through PRI or other departments.
- Decision taken should be documented on a written resolution; with 50% of the total VHSNC members validating it.
- Departments and officials across all levels should not take decisions pertaining to untied fund utilization.
- Last seven years of experience have shown the following range of useful activities for VHSNC fund utilization – annexure no. ..

10: Maintenance of Bank Account

The untied fund of the VHSNC shall be credited to a bank account, which will be operated with the joint signatures of ASHA along with the Chairperson of the Village Health & Sanitation and Nutrition Committee as per the norms notified by the state. All with-drawls 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).

11: Audit of the Untied Village Fund

a. 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 activities and expenditures will be shared with wider community and a social audit will be done.
b. The annual Statement of expenditure, prepared by VHSNC, will be approved by the Gram Panchayat based on the social audit thus conducted, which will then be submitted to the block level functionaries of NRHM.
c. All vouchers related to expenditures will be maintained by the VHSNC but will be shown to Gram Sabha during its annual presentation as a part of the social audit.
d. Expenditures will be shown as reported by VHSNC

e. Disbursals done by the block or district NRHM will be treated as advances.
f. State will conduct financial audit of VHSNC account on a 5% sample basis annually
g. Accounting should be based on the format in Annexure 2
h. In case of delayed fund receipts VHSNCs need to be given a six month period to expend funds beyond financial year end.

12: Records (Suggested formats are at Annexure)

1. Record of Meetings
2. Record of approvals given by members for expenditure/withdrawal
3. Bank Pass Book and Cash book
4. Village Health Plan
5. Village Health Monitoring Register
6. Birth Register
7. Death Register

13: Responsibilities of key VHSNC members:

(14) Chairperson of the Committee -
The Chairperson is the woman Ward Panch and will -

- Lead the monthly meetings of the committee and ensure smooth coordination amongst members for effective decision making.
- Represent the VHSNC in the Standing Committee of the Panchayat on health and share details of work undertaken by VHSNC at the village level.
- 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.
- Ensure that the village health plan prepared by the committee is reflected in the overall plan of the Gram Panchayat.

(15) Member Secretary and Convener of the meeting - ASHA acts as the member secretary and convener of the committee. She will -

- Fix the schedule and venue for monthly meetings of the committee and ensure that meetings are conducted regularly with participation of all members.

- Draw attention of the committee on specific constraints and achievements related to health status of the village community and enable appropriate planning.
- 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.
- Maintain records on gaps identified in health or other related sectors, Identifying the cause of the gap, decision on collective action needed by the village to address the gap, and responsible persons to lead the collective action, and the specified timeframe to undertake the action , and record follow up action.
- 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 and undertake regular update of the cashbook.
- 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 annual gram sabha, its social audit and getting the approval of the statement of expenditure (SOE) by the Gram Panchayat, and submission the SOE at the block level in time.

16: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. 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.

17: ANM: She will provide information to VHSNC regarding available services, schemes, and services for maternity and child health. She shares details on marginalized groups or those unreached through health services and seeks the support of the VHSNC ot reach these populations. She enables 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.

18: Role of representatives from other departments like Education, Water and Sanitation, and Department of Woman and Child Development

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.

19: Capacity Building and Training Strategy:

Capacity building of VHSNC members is a continuous process. Their knowledge base needs to be strengthened to attain 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.

20 Training Strategy

The training strategy involves-

1) **Training of ASHA Trainers, ASHA Facilitators and ASHAs**: This will enable states to develop a resource pool for training VHSNC members.
2) **Introductory Training-** This is two day induction training for **a**ll members of VHSNC, to orient them on key objectives, functions, roles and responsibilities of VHSNC.
3) **Intensive Training-** Five –Six core members of VHSNC will be selected by ASHAs and ASHA Facilitators for this intensive round of training. It will cover range of topics and build capacities for addressing the social determinants of health and acquire complex skills of village health planning and community based planning and monitoring. This training will be undertaken in nine days spread over a period of three months.
4) **Supplementary and Refresher Trainings-** Subsequently at least five days(**check**) of annual training should be planned in which existing skills could be reinforced or new skills specific to local needs can be introduced.

21: Supportive Supervision

A support structure at all levels of programme implementation (State, District, Block, Sub-Block level) is required for monitoring, mentoring and handholding of VHSNCs. The existing ASHA support structure should be used for undertaking all these functions related to VHSNCs. In areas where ASHA support structures do not exist they need to be constituted to meet the purpose.

<table>
<tr><th>Sl. No.</th><th>Level</th><th>Name of the Structure</th><th>Composition</th></tr>
<tr><td rowspan="3">I</td><td rowspan="3">State</td><td>State Mentoring Group for ASHA and Community Processes</td><td>Experts and practitioners in the field of Community Health representing NGOs, training and research institutions, academia and medical colleges</td></tr>
<tr><td>State Management Team (housed within SPMU)</td><td>Nodal Officer – ASHA programme / Community Processes or
One ASHA Programme Manager
will head this small team of consultants</td></tr>
<tr><td>State ASHA / Community Processes Resource Centre. (Outsourced or placed in SHSRC)</td><td>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.</td></tr>
</table>

			States with less than 20,000 ASHAs do not need Documentation & Communication Officer and Regional Coordinators
		State Training Team[1]	State Trainers- Synonymous with State Training Sites described in Draft-ASHA Guidelines 2013[2]
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]	District/ASHA Trainers synonymous with the district training sites
III	**Block**	Block ASHA/ Community Processes	Block Medical Officer/ Nodal Officer Block Community Mobilizer All ASHA Facilitators

[1]A team of state trainers trained and accredited at national training sites.

[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.

[3]A team of ASHA trainers for each district drawn from the sub district level, trained and accredited at the state level training sites.

		Team	*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.*

22: Monitoring

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

- No. of revenue villages in the district
- No of VHSNCs formed
- Constitution of the committee
- Monthly meetings held
- No. of VHSNCs with Joint Account opened
- Dates of release of the un-tied fund
- Total Fund spent

Section below describes the Monitoring process at various levels-

Sub block level- ASHA Facilitators should attend at least six meetings of VHSNC in a year and also assess their overall functioning through reviews with individual ASHAs during the monthly cluster meetings. She should gather information on- regularity of monthly meetings, judicious utilization of un-tied funds, community involvement in making village health plan and check status of record maintenance.

Block Level-Block Community Mobilizer should review functioning of VHSNCs through

1. Supportive supervision visits by participating in at least two VHSNC meetings every month, and assessing action taken by them on the set of activities mentioned below:
    - 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 Diarrhea cases
    - Functioning of Schools
    - Functioning of PDS, MNREGS, MDM, Pensions etc.
    - Cleanliness around hand-pumps
    - Functioning of hand-pumps
2. Monthly meetings with ASHA Facilitators to gather information on functioning of VHSNC on- a) Regular monthly meetings

b) Amount of funds utilized

c) VHNDs held and

d) No. of VHSNCs who participated in Jan Samwad

3. Facilitating a progress review of functioning of VHSNCs by Health related Standing Committee of the Block Panchyat.

District Level-The District Community Mobilizer should visit a sample of randomly selected 30 VHSNCs and check from the list of activities (as detailed above) as to how many VHSNCs have taken action on these of activities.

District and State level Performance monitoring of VHSNCs should be based on few key indicators-

a)	% of VHSNCs having regular monthly meeting
b)	% of VHSNCs with fund utilization of over 50% ?
c)	% of VHNDs held over planned
d)	% of VHSNCs which participated in Jansamwad[4]

23: Grievance Redressal

The VHSNC has to also play 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 should also dialogue with the community and individual households in case of any difficulties being faced by service providers in mobilising them to access services. As a community level committee which works under the mandate of PRIs it can give instructions to village level service providers in case of problems in the reach and quality of the services.

VHSNC is also mandated to take up the health and related issues of its village at the block level in case of any complaints and disputes regarding the providers and the provision of services in its village or on any issue regarding access of the village community to the health facilities. VHSNC will take up the issues and complaints to the block panchayat's standing committee on health, who should take up the issue and complaint with the concerned Block Medical Office or any other official as required.

[4] One Gram Sabha meeting exclusively should be held once every year to review the progress of VHSNCs. The states should designate one specific day of the year for this purpose, such as October 2nd of every year, which is

Annexures

1. **Illustrative list of activities which can be undertaken by VHSNC**
2. **Format of Village Health Plan (from Orissa guidelines)**
3. **Format for record of proceedings**
4. **Database format**
5. **Illustration of Lot Quality Survey Assurance technique**
6. **VHND Guideline with details of VHND activities**

   Commitment