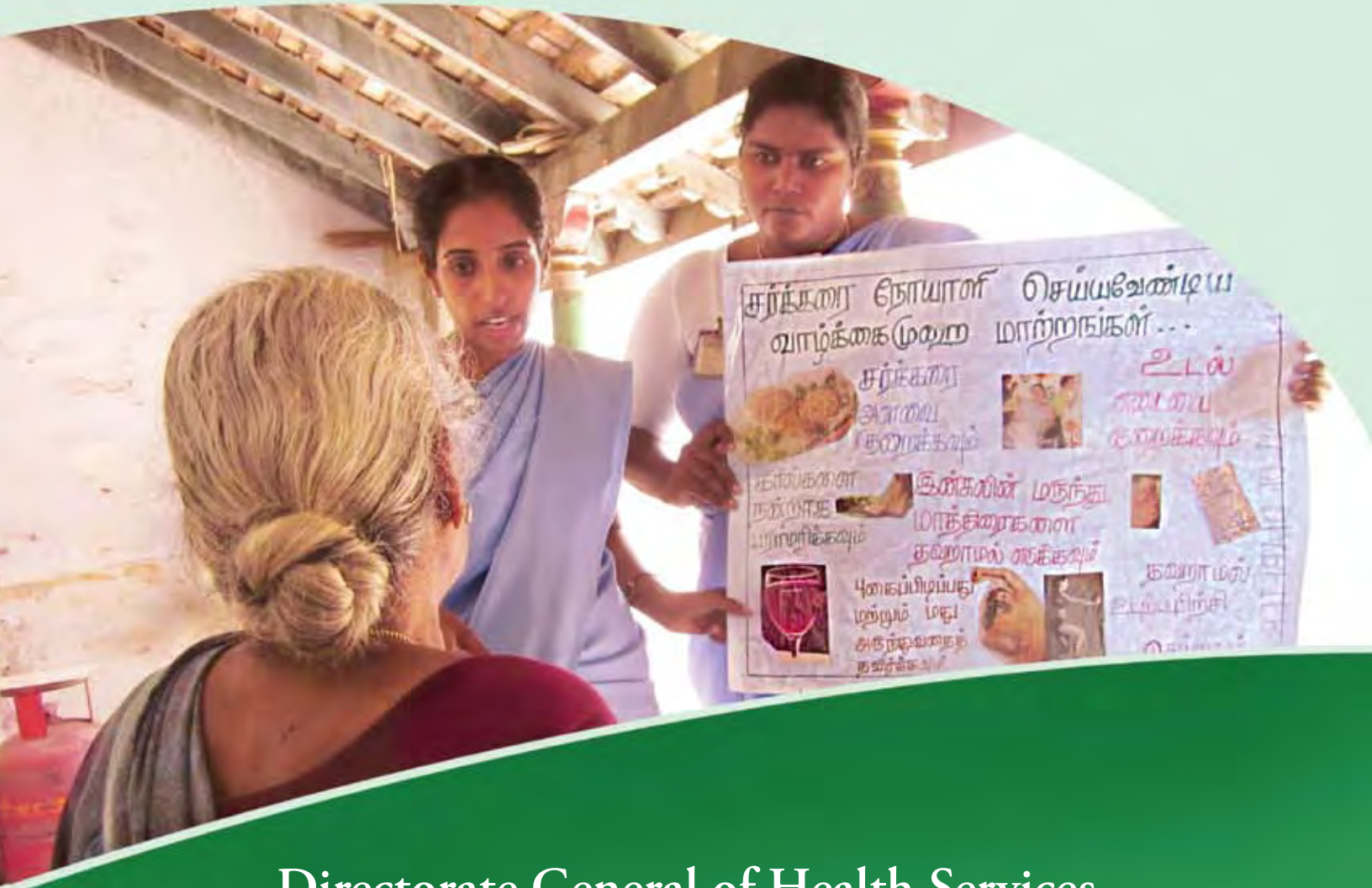
सत्यमेव जयते

Indian Public Health Standards (IPHS)
Guidelines for Sub-Centres
Revised 2012



Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India

Indian Public Health Standards (IPHS)
Guidelines for Sub-Centres

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CONTENTS

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

गुलाम नबी आज़ाद
GHULAM NABI AZAD

सत्यमेव जयते

स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार
निर्माण भवन, नई दिल्ली-110108
Minister of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi-110108

MESSAGE

National Rural Health Mission (NRHM) was launched to strengthen the Rural Public Health System and has since met many hopes and expectations. The Mission seeks to provide effective health care to the rural populace throughout the country with special focus on the States and Union Territories (UTs), which have weak public health indicators and/or weak infrastructure.

Towards this end, the Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals were published in January/February, 2007 and have been used as the reference point for public health care infrastructure planning and up-gradation in the States and UTs. IPHS are a set of uniform standards envisaged to improve the quality of health care delivery in the country.

The IPHS documents have been revised keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases. Flexibility is allowed to suit the diverse needs of the states and regions.

Our country has a large number of public health institutions in rural areas from Sub-centres at the most peripheral level to the district hospitals at the district level. It is highly desirable that they should be fully functional and deliver quality care. I strongly believe that these IPHS guidelines will act as the main driver for continuous improvement in quality and serve as the bench mark for assessing the functional status of health facilities.

I call upon all States and UTs to adopt these IPHS guidelines for strengthening the Public Health Care Institutions and put in their best efforts to achieve high quality of health care for our people across the country.

New Delhi

(Ghulam Nabi Azad)

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MINISTRY OF HEALTH & FAMILY WELFARE
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FOREWORD

The National Rural Health Mission (NRHM) launched by the Hon'ble Prime Minister of India on 12 April 2005, aims to restructure the delivery mechanism for health to providing universal access to equitable, affordable and quality health care responsive to the people's needs. The implementation framework of NRHM, envisaged that the public health institutions including Sub-centres would be upgraded from its present level to a level of a set of standards called "Indian Public Health Standards (IPHS)". IPHS for Sub-Centers (SCs), Primary Health Centers (PHCs), Community Health Centers (CHCs) and hospitals were developed and last released in January/February, 2007 and have since been used as the reference point for public health care infrastructure planning and up gradation in the States and Union Territories (UTs). Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Therefore the success of any nationwide program depends largely on the well functioning Sub-centres providing services of acceptable standards to the people.

As setting standards is a dynamic process, need was felt to update the IPHS keeping in view the changing protocols of existing National Health Programmes, introduction of new programmes especially for Non-Communicable Diseases and prevailing epidemiological situation in the country. The IPHS for Sub-centres has been revised by a task force comprising of various stakeholders under the Chairmanship of Director General of Health Services. Subject experts, NGOs, State representatives and health workers working in the health facilities have also been consulted at different stages of revision.

The newly revised IPHS for SC has considered the services, infrastructure, manpower, equipment and drugs in two categories of Essential (minimum assured services) and Desirable (the ideal level services which the states and UTs shall try to achieve). Sub-centres have been categorized into two categories depending upon the prevailing epidemiological situation and resources available in different parts of the country. This has been done to ensure optimal utilization of resources. States and UTs are expected to categorize the Sub-centres and provide infrastructure according to the laid down guidelines in this document.

I would like to acknowledge the efforts put by the Directorate General of Health Services in preparing the guidelines. It is hoped that this document will be useful to all the stakeholders. Comments and suggestions for further improvements are most welcome.

(P.K.Pradhan)

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सत्यमेव जयते

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PREFACE

The Sub-centres are vital peripheral institutions for providing primary health care to the people and play an important role in the implementation of various Health & Family Welfare programmes at the grass-root level. One of the important components of National Rural Health Mission (NRHM) is to strengthen the Sub-centres to the level of Indian Public Health Standards (IPHS), which were first prescribed in early 2007. The aim of the IPHS is to provide quality services which are of optimum level, fair and responsive to the client's needs, provided equitably and which deliver improvement in the health and wellbeing of the population (Effective). In addition, services should be affordable (Economical) and have inherent element of accountability.

A task force was constituted in early 2010 to review the existing IPHS, remove mismatch if any, between services and infrastructure provided, incorporate new programmes and protocols in line with the changing requirements of the country taking into consideration the minimum functional level needed for providing a set of assured services. The task of revision was completed as a result of consultations held over many months with task force members, programme officers, Regional Directors of Health and Family Welfare, experts, health functionaries, representatives of Non- Government organizations, development partners and State/Union Territory Government representatives after reaching a consensus. The contribution of all of them is well appreciated.

The primary focus of Sub-centre remains the Reproductive and Child Health (RCH) services. However, services in respect of important Non-Communicable Diseases have also been included. It has been envisaged not to promote all Sub-centres for intranatal facilities. The Sub-centres which are well located with good infrastructure, adequate catchment area and good caseload will be promoted for providing intranatal services at the Sub-centre in addition to all other recommended services. Such Sub -Centres will be categorized as Type B. The other type of Sub-centres (Type A) will provide all recommended services except the facilities for conducting delivery will not be available here. This type of categorization is expected to result in service provision as per the need of population.

Setting standards is a dynamic process and this document is not an end in itself. Further revision of the standards shall be undertaken as and when the Sub-centres will achieve a minimum functional grade. It is hoped that this document will be of immense help to the States/Union Territories and other stakeholders in bringing up Sub-centres to the level of Indian Public Health Standards, which will also help the country in achieving the National and Millennium Development Goals.

Jr nasad

(Dr. Jagdish Prasad)

ACKNOWLEDGEMENTS

The revision of the existing guidelines for Indian Public Health Standards (IPHS) for different levels of Health Facilities from Sub-Centre to District Hospitals was started with the formation of a Task Force under the Chairmanship of Director General of Health Services (DGHS). This revised document is a concerted effort made possible by the advice, assistance and cooperation of many individuals, Institutions, government and non-government organizations.

I gratefully acknowledge the valuable contribution of all the members of the Task Force constituted to revise Indian Public Health Standards (IPHS). The list of Task Force Members is given at the end of this document. I am thankful to them individually and collectively.

I am truly grateful to Mr. P.K. Pradhan, Secretary (H & FW) for the active encouragement received from him.

I also gratefully acknowledge the initiative, inspiration and valuable guidance provided by Dr. Jagdish Prasad, Director General of Health Services, Ministry of Health and Family Welfare, Government of India. He has also extensively reviewed the document while it was being developed.

I sincerely acknowledge the contribution of Dr. R.K Srivastava, Ex- DGHS and Chairman of Task Force constituted for revision of IPHS who has extensively reviewed the document at every step, while it was being developed.

I sincerely thank Miss K. Sujatha Rao, Ex-Secretary (H&FW) for her valuable contribution and guidance in rationalizing the manpower requirements for Health Facilities. I would specially like to thank Ms. Anuradha Gupta, Additional Secretary and Mission Director NRHM, Mr. Manoj Jhalani Joint Secretary (RCH), Mr. Amit Mohan Prasad, Joint Secretary (NRHM), Dr. R.S. Shukla Joint Secratary (PH), Dr. Shiv Lal, former Special DG and Advisor (Public Health), Dr. Ashok Kumar, DDG Dr. N.S. Dharm Shaktu, DDG, Dr. C.M. Agrawal DDG, Dr. P.L. Joshi former DDG, experts from NHSRC namely Dr. T. Sunderraman, Dr. J.N. Sahai, Dr. P. Padmanabhan, Dr. J.N. Srivastava, experts from NCDC Dr. R.L. Ichhpujani, Dr. A.C. Dhariwal, Dr. Shashi Khare, Dr. S.D. Khaparde, Dr. Sunil Gupta, Dr. R.S. Gupta, experts from NIHFW Prof. B. Deoki Nandan, Prof. K. Kalaivani, Prof. M. Bhattacharya, Prof. J.K. Dass, Dr. Vivekadish, programme officers from Ministry of Health Family welfare and Directorate General of Health Services especially Dr. Himanshu Bhushan, Dr. Manisha Malhotra, Dr. B. Kishore, Dr. Jagdish Kaur, Dr. D.M. Thorat and Dr. Sajjan Singh Yadav for their valuable contribution and guidance in formulating the IPHS documents.

I am grateful to the following State level administrators, health functionaries working in the health facilities and NGO representatives who shared their field experience and greatly contributed in the revision work; namely:

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Dr. R.S. Gupta, Dr. S.K. Gupta, Ms. Mamta Devi, ANM and Ms. Sangeeta Sharma, ANM from Government of Rajasthan.
Dr. Rajesh Bali from Government of Haryana.
NGO representatives: Dr. P.K. Jain from RK Mission and Dr. Sunita Abraham from Christian Medical Association of India.
Tmt. C. Chandra, Village Health Nurse, and Tmt. K. Geetha, Village Health Nurse from Government of Tamil Nadu.

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I shall be failing in my duty if I do not thank Dr. P.K. Prabhakar, Deputy Commissioner, Ministry of Health and Family Welfare for providing suggestions and support at every stage of revision of this document.

Last but not the least the assistance provided by my secretarial staff and the team at Macro Graphics Pvt. Ltd. is duly acknowledged.

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June 2012
New Delhi

EXECUTIVE SUMMARY

In the public sector, a Sub-Health Centre (Sub-centre) is the most peripheral and first point of contact between the primary health care system and the community. The Minimum Needs Program (MNP) was introduced in the country in the first year of the Fifth Five Year Plan (1974–78) with the objective to provide certain basic minimum needs and thereby improve the living standards of the people. In the field of rural health, the objective was to establish: one Sub-centre for a population 5000 people in the plains and for 3000 in tribal and hilly areas, one Primary Health Centre (PHC) for 30000 population in plains and 20000 population in tribal and hilly area, and one Community Health Centre (CHC/Rural Hospital) for a population of one lakh. However, as the population density in the country is not uniform, it shall also depend upon the case load of the facility and distance of the village/habitations which comprise the Sub-centre. A Sub-centre provides interface with the community at the grass-root level, providing all the primary health care services. As Sub-centres are the first contact point with the community, the success of any nation wide programme would depend largely on the well functioning Sub-centres providing services of acceptable standard to the people. The current level of functioning of the Sub-centres is much below the expectations.

In order to provide quality care in these Sub-centres, Indian Public Health Standards (IPHS) are being prescribed to provide basic primary health care services to the community and achieve and maintain an acceptable standard of quality of care. These standards would help monitor and improve functioning of the Sub-centre. Setting standards is a dynamic process. Currently the IPHS for Sub-centres has been prepared keeping in view the resources available with respect to functional requirement for Sub-centres with minimum standards, such as building, manpower, instruments and equipment, drugs and other facilities and desirable standards which represent the ideal situation. The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the community.

Service Delivery

- All "Minimum Assured Services" or **Essential** Services as envisaged in the Sub-centre should be available, which include preventive, promotive, few curative and referral services and all the national health programmes. The services which are indicated as **Desirable** are for the purpose that we should aspire to achieve for this level of facility.
- Keeping in view the current varied situation of Sub-centres in different parts of the country, Sub-centres have been categorized into 2 Types (Types A and B) taking into consideration various factors namely catchment area, health seeking behavior, case load, location of other facilities like PHC/CHC/FRU/Hospitals in the vicinity of the Sub-centre. Type A Sub Centre will provide all recommended services except that the facilities for conducting delivery will not be available here. If the requirement for delivery services goes up ,

the sub centre may be considered for upgradation to Type B. Type B Sub-centre, will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself. Although the main focus shall be to promote institutional deliveries, however, the facilities for attending to home deliveries shall remain available at both types of Sub-centres.

Minimum Requirement for Delivery of the Services

The following requirements are being projected based upon the expected number of beneficiaries for maternal and child health care, immunization, family planning and other services. This IPHS recommends two ANM (one essential & one desirable) and one Health Worker Male (essential) for Type A Sub-centre. For Type B Sub-centres, it is recommended to provide two ANMs (essential) and one Health Worker Male (essential). One Staff Nurse or ANM (if Staff Nurse not available) is to be provided for Type B Sub-centres (desirable), if number of deliveries at the Sub-centre is 20 or more in a month. Sanitation services should be provided through outsourcing on part time basis at Type A and full time basis at Type B.

Wherever two ANMs are provided, it shall be ensured that one of the ANMs is available at the Sub-centre and the Sub-centre remains open for providing OPD services on all working days. Only one of them may provide outreach services at a time.

The ANM posted at Type B Sub-centres should mandatorily be Skilled Birth Attendance (SBA) trained.

Facilities

The document includes a suggested layout indicating the space for the building and other infrastructure facilities for both Type A and Type B Sub-centres. A list of equipment, furniture and drugs needed for providing the assured services at the Sub-centres has been incorporated in the document. A Model Citizen's Charter for appropriate information to the beneficiaries, grievance redressal and constitution of Village Health Sanitation and Nutrition Committee for better management and improvement of Sub-centre services with involvement of Panchayati Raj Institutions (PRI) have also been made as a part of the Indian Public Health Standard. The monitoring process and quality assurance mechanism is also included.

INDIAN PUBLIC HEALTH STANDARDS FOR SUB-CENTRES

Introduction

In the public sector, a Health Sub-centre is the most peripheral and first point of contact between the primary health care system and the community. A Sub-centre provides interface with the community at the grass-root level, providing all the primary health care services. It is the lowest rung of a referral pyramid of health facilities consisting of the Sub-centres, Primary Health Centers, Community Health Centres, Sub-Divisional/Sub-District Hospitals and District Hospitals. The purpose of the Health Sub-centre is largely preventive and promotive, but it also provides a basic level of curative care.

As per population norms, there shall be one Sub-centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. As the population density in the country is not uniform, application of same norm all over the country is not advisable. The number of Sub-centres and number of ANMs shall also depend upon the case load of the facility and distance of the village/habitations which comprise the Sub-centres. There are 147069 Sub-centers functioning in the country as on March 2010 as per Rural Health Statistics Bulletin, 2010.

The Indian Public Health Standards (IPHS) for health Sub-centre lays down the package of services that the Sub-centre shall provide, the population norms for which it would be established, the human resource, infrastructure, equipment and supplies that would be needed to deliver these services with quality.

Setting standards is a dynamic process. These standards are being prescribed in the context of current health priorities and available resources. The Indian Public Health Standards (IPHS) are being prescribed to provide basic primary health care services to the community and achieve and maintain an acceptable standard of quality of care.

During the course of revision of current IPHS for Sub-centre, feedback through interactions with Health Worker Females/Auxillary Nurse and Mid-wife (ANMs) was taken regarding the wide spectrum of services that they are expected to provide, which revealed that most of the essential services enumerated are already being delivered by the Sub-centres staff. However, the outcomes of health indicators do not match with services that are said to be provided. Therefore it is desirable that manpower as envisaged under IPHS should be provided to ensure delivery of full range of services. Monitoring of services may be strengthened for better outcomes.

Objectives of the Indian Public Health Standards for Sub-Centre

a. To specify the minimum assured (essential) services that Sub-centre is expected to provide and the desirable services which the states/UTs should aspire to provide through this facility.
b. To maintain an acceptable quality of care for these services.

c. To facilitate monitoring and supervision of these facilities.

d. To make the services provided more accountable and responsive to people's needs.

Categorization of Sub-Centres

In view of the current highly variable situation of Sub-centres in different parts of the country and even with in the same State, they have been categorized into two types - Type A and Type B. Categorization has taken into consideration various factors namely catchment area, health seeking behavior, case load, location of other facilities like PHC/CHC/FRU/Hospitals in the vicinity of the Sub-centre. States shall be required to categorize their Sub-centres into two types as per the guidelines given below and provide services and infrastructure accordingly. This shall result in optimum use of available resources.

Type A

Type A Sub Centre will provide all recommended services except that the facilities for conducting delivery will not be available here. However, the ANMs have been trained in midwifery, they may conduct normal delivery in case of need. If the requirement for this goes up , the sub centre may be considered for up gradation to Type B. The Sub-centres in the following situations may be included in this category.

i. Sub-centres not having adequate space and physical infrastructure for conducting deliveries, due to which providing labour room facilities and equipment at these Sub-centres is not possible. However there may still be demand for delivery services from the community in these areas e,g, Sub-centres located in remote, difficult, hilly, desert or tribal area. In such areas, the transport facility is likely to be poor and the population is still dependent on these Sub-centres for availing delivery facilities. In such situations, ANMs would be required to conduct deliveries at homes and ANMs of these Sub-centres should mandatorily be Skilled Birth Attendance (SBA) trained. Such Sub-centres should be identified for infrastructure up gradation for conversion to Type B Sub-centres on priority.

HSC manalurpet - labour room - unhygienic condition corroded walls - floor not tiled - wooden delivery table

Sub-Centre with such unhygienic and inadequate Delivery Facilities pose a great risk to the mother and newborn.

ii. Sub-centres situated in the vicinity of other higher health facilities like PHC/CHC/ FRU/Hospital, where delivery facilities are available

iii. Sub-centres in headquarter area

iv. Sub-centres where at present no delivery or occasional delivery may be taking place i.e. very low case load of deliveries. If the case load increases, these Sub-centres should be considered for up gradation to Type B.

Staff recommended

One ANM **(Essential)**,

Two ANMs: **(Desirable** to split the population between them and one of them provides outreach services and the other is available at the Sub-centre)

One Health Worker (Male) **(Essential)**

Sanitation services should be provided through outsourcing on part time basis

Guidelines

- The facilities for conducting delivery will not be available at these sub-centres and patients may usually be referred to nearby centers providing delivery facilities. If the requirement for delivery services goes up , the sub centre may be considered for up gradation to Type B. These Sub-centres should provide all other recommended services and focus on outreach services, prevalent diseases, tuberculosis, leprosy, Non-communicable diseases, nutrition, water, sanitation and epidemics. It is also to be ensured that the Staff of these sub-centres is provided training in all new programmes on priority basis and refresher training is provided regularly.
- Extra payment should be provided to Staff posted in difficult areas.
- If there is shortage, Health Worker male should be posted on priority basis in areas endemic for vector borne diseases.

This Sub-centre in Assam, was having a poor delivery case load, may serve as Type A Sub-Centre.

Type B (MCH Sub-Centre)

This would include following types of Sub-centres:

i. Centrally or better located Sub-centres with good connectivity to catchment areas.
ii. They have good physical infrastructure preferably with own buildings, adequate space, residential accommodation and labour room facilities.
iii. They already have good case load of deliveries from the catchment areas.
iv. There are no nearby higher level delivery facilities.

Guidelines

Such Sub-centers should be developed as a delivery facility and should also cater to adjacent Type A sub-centres areas for delivery purpose. Type B Sub-centre, will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself. They will be expected to conduct around 20 deliveries in a month. They should be provided with all labour room facilities and equipment including Newborn care corner. ANMs of these Sub-centres should be SBA trained. These centers may be provided extra equipment, drugs, supplies, materials, 2 beds and budget for smooth functioning. If number of deliveries is 20 or more in a month, then additional 2 beds will be provided.

Staff recommended

Two ANM **(Essential)**
One Health Worker (Male): **(Essential)**
One Staff Nurse or ANM (if Staff Nurse not available) **(Desirable,** if number of deliveries at the Sub-centre is 20 or more in a month)
Sanitation services should be provided through outsourcing on full time basis

Services to be Provided in a Sub-Centre

Sub-centres are expected to provide promotive, preventive and few curative primary health care services. Keeping in view the changing epidemiological situation in the country, both types of Sub-centres should lay emphasis on Non-Communicable Diseases related services.

Given the understanding of the health Sub-centre as mainly providing outreach facilities, where most services are not delivered in the Sub-centre building itself, the site of service delivery may be at following places:

a. In the village: Village Health and Nutrition Day/ Immunization session.
b. During house visits.
c. During house to house surveys.
d. During meetings and events with the community.
e. At the facility premises. It is desirable, that the Sub-centre should provide minimum of six of hours of routine OPD services in a day for six days in a week. Wherever two ANMs are provided, it shall be ensured that one of the ANMs is available at the Sub-centre and the Sub-centre remains open for providing OPD services on all working days. Only one of them may provide outreach services at a time.

The main differences in services to be provided by the two types of Sub-centres are:

Type A: Shall provide all services as envisaged for the Sub-centre except the facilities for conducting delivery will not be available here.

Type B: They will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself. This Sub-centre will act as Maternal and Child Health (MCH) centre with basic facilities for conducting deliveries and Newborn Care at the Sub-centre.

Although the main focus shall be to promote institutional deliveries, however, the facilities for attending to home deliveries shall remain available at both types of Sub-centres. The following is the consolidated list of services to be provided through two types of Sub-centres. The services have been classified as **Essential (Minimum Assured Services) or Desirable (that all States/UTs should aspire to achieve).**

Maternal and Child Health

Maternal Health

i. Antenatal care:

Essential

- Early registration of all pregnancies, within first trimester (before 12th week of Pregnancy). However even if a woman comes late in her pregnancy for registration, she should be registered and care given to her according to gestational age.

Such a Sub-Centre having the case load may be developed as a MCH/type B Sub-Centre.

- Minimum 4 ANC including Registration Suggested schedule for antenatal visits:

  1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration, history and first antenatal check-up

  2nd visit: Between 14 and 26 weeks

  3rd visit: Between 28 and 34 weeks

  4th visit: Between 36 weeks and term

- Associated services like general examination such as height, weight, B.P., anaemia, abdominal examination, breast examination, Folic Acid Supplementation (in first trimester), Iron & Folic Acid Supplementation from 12 weeks, injection tetanus toxoid, treatment of anaemia etc., (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs).
- Recording tobacco use by all antenatal mothers.
- Minimum laboratory investigations like Urine Test for pregnancy confirmation, haemoglobin estimation, urine for albumin and sugar and linkages with PHC for other required tests.
- Name based tracking of all pregnant women for assured service delivery.
- Identification of high risk pregnancy cases.
- Identification and management of danger signs during pregnancy.
- Malaria prophylaxis in malaria endemic zones for pregnant women as per the guidelines of NVBDCP.
- Appropriate and Timely referral of such identified cases which are beyond her capacity of management.
- Counselling on diet, rest, tobacco cessation if the antenatal mother is a smoker or tobacco user, information about dangers of exposure to second hand smoke and minor problems

during pregnancy, advice on institutional deliveries, pre-birth preparedness and complication readiness, danger signs, clean and safe delivery at home if called for, postnatal care & hygiene, nutrition, care of newborn, registration of birth, initiation of breast feeding, exclusive breast feeding for 6 months, demand feeding, supplementary feeding (weaning and starting semi solid and solid food) from 6 months onwards, infant & young child feeding and contraception.

- Provide information about provisions under current schemes and programmes like Janani Suraksha Yojana.
- Identify suspected RTI/STI case, provide counseling, basic management and referral services.
- Counselling & referral for HIV/AIDS.
- Name based tracking of missed and left out ANC cases.

ii. Intra-natal care:

Essential

- Promotion of institutional deliveries
- Skilled attendance at home deliveries when called for
- Appropriate and Timely referral of high risk cases which are beyond her capacity of management.

Essential for Type B Sub-centre

- Managing labour using Partograph.
- Identification and management of danger signs during labor.
- Proficient in identification and basic fist aid treatment for PPH, Eclampsia, Sepsis and prompt referral of such cases as per'Antenatal Care and Skilled Birth Attendance at Birth'or SBA Guidelines.
- Minimum 24 hours of stay of mother and baby after delivery at Sub-centre. The environment at the Sub-centre should be clean and safe for both mother and baby.

iii. Postnatal care:

Essential

- Initiation of early breast-feeding within one hour of birth.
- Ensure post-natal home visits on 0,3,7 and 42nd day for deliveries at home and Sub-centre (both for mother & baby).
- Ensure 3, 7 and 42nd day visit for institutional delivery (both for mother & baby) cases.
- In case of Low Birth weight Baby (less than 2500 gm), additional visits are to be made on 14, 21 and 28th days.
- During post-natal visit, advice regarding care of the mother and care and feeding of the newborn and examination of the newborn for signs of sickness and congenital abnormalities as per IMNCI Guidelines and appropriate referral, if needed.
- Counselling on diet & rest, hygiene, contraception, essential newborn care, immunization, infant and young child feeding, STI/RTI and HIV/AIDS.
- Name based tracking of missed and left out PNC cases.

Child Health

Essential

- **Newborn Care Corner In The Labour Room to provide Essential Newborn Care (Annexure 5A): Essential If the Deliveries take Place at the Sub-centre (Type B)**

  Essential Newborn Care (maintain the body temperature and prevent hypothermia [provision of warmth/Kangaroo Mother Care (KMC)], maintain the airway and breathing, initiate breastfeeding within one hour, infection protection, cord care, and care of the eyes, as per the guidelines for Ante-Natal Care and Skilled Attendance at Birth by ANMs and LHVs.).

  Post natal visits as mentioned under 'Post natal Care'.
- Counselling on exclusive breast-feeding for 6 months and appropriate and adequate complementary feeding from 6 months of age while continuing breastfeeding. (As per National Guidelines on Infant and Young Child Feeding, 2006, by Ministry of WCD, Government of India).
- Assess the growth and development of the infants and under 5 children and make timely referral.
- **Immunization Services:** Full Immunization of all infants and children against vaccine

preventable diseases as per guidelines of Government of India (Current Immunization Schedule at **Annexure 1**).

- Vitamin A prophylaxis to the children as per National guidelines.
- Prevention and control of childhood

Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This scheme integrates cash assistance with delivery and post-delivery care.

While the scheme would create demand for institutional delivery, it would be necessary to have adequate number of 24X7 delivery services centre, doctors, mid-wives, drugs etc. at appropriate places. Mainly, this will entail

- Linking each habitation (village or a ward in an urban area) to a functional health centre- public or accredited private institution where 24X7 delivery service would be available,
- Associate an ASHA or a health link worker to each of these functional health centre.
- It should be ensured that ASHA keeps track of all expectant mothers and newborn. All expectant mother and newborn should avail ANC and immunization services, if not in health centres, atleast on the monthly health and nutrition day, to be organised in the Anganwadi or sub-centre.
- Each pregnant women is registered and a micro-birth plan is prepared.
- Each pregnant woman is tracked for ANC,
- For each of the expectant mother, a place of delivery is pre-determined at the time of registration and the expectant mother is informed,
- A referral centre is identified and expectant mother is informed,
- ASHA and ANM to ensure that adequate fund is available for disbursement to expectant mother,
- ASHA takes adequate steps to organize transport for taking the women to the pre-determined health institution for delivery.
- ASHA assures availability of cash for disbursement at the health centre and she escorts pregnant women to the pre-determined health centre.
- ASHA package in the form of cash assistance for referral transport, cash incentive and transactional cost to be provided as per guidelines.

Janani Shishu Suraksha Karyakram (JSSK)

JSSK launched on 1st of June of 2011 is an initiative to assure free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries and caesarian section operations and also treatment of sick newborn (up to 30 days after birth) in all Government health institutions across State/UT.

This initiative supplements the cash assistance given to pregnant women under the JSY and is aimed at mitigating the burden of out of pocket expenditure incurred by pregnant women and sick newborns,

Entitlements for Pregnant Women

1. Free and Zero expense delivery and Caesarian Section
2. Free Drugs and Consumables
3. Free Diagnostics (Blood, Urine tests and Ultrasonography etc. as required.)
4. Free diet during stay in the health institutions (up to 3 days fro normal deliveries and upto 7 days for caesarian deliveries)
5. Free provision of the Blood
6. Free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.
7. Exemption from all kinds of user charges

Entitlements for Sick newborn till 30 days after Birth

1. Free and zero expense treatment
2. Free Drugs and Consumables
3. Free Diagnostics
4. Free provision of the Blood
5. Free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.
6. Exemption from all kinds of user charges

diseases like malnutrition, infections, ARI, Diarrhea, Fever, Anemia etc. including IMNCI strategy.

- Name based tracking of all infants and children to ensure full immunization coverage.
- Identification and follow up, referral and reporting of Adverse Events Following Immunization (AEFI).

Family Planning and Contraception

Essential

- Education, Motivation and counselling to adopt appropriate Family planning methods.
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, Intra Uterine Contraceptive Devices (IUCD) insertions (wherever the ANM is trained in IUCD insertion).
- Follow up services to the eligible couples adopting any family planning methods (terminal/ spacing).

Safe Abortion Services (MTP)

Essential

- Counselling and appropriate referral for safe abortion services (MTP) for those in need.
- Follow up for any complication after abortion/ MTP and appropriate referral if needed.

Curative Services

Essential

- Provide treatment for minor ailments including fever, diarrhea, ARI, worm infestation and First Aid including first aid to animal bite cases (wound care, tourniquet (in snake bite) assessment and referral).
- Appropriate and prompt referral.

Desirable

- Provide treatment as per AYUSH as per the local need. ANMs and MPW (M) be trained in basic AYUSH drugs.
- Once a month clinic by the PHC medical officer. LHV, HWM and ANM should be available for providing assistance.

Adolescent Health Care

Desirable

- Education, counselling and referral.
- Prevention and treatment of Anemia.
- Counselling on harmful effects of tobacco and its cessation.

School Health Services

Essential

- Screening, treatment of minor ailments, immunization, de-worming, prevention and management of Vitamin A and nutritional deficiency anemia and referral services through fixed day visit of school by existing ANM/MPW
- Staff of Sub-centre shall provide assistance to school health services as a member of team

Control of Local Endemic Diseases

Essential

- Assisting in detection, Control and reporting of local endemic diseases such as malaria, Kala Azar, Japanese encephalitis, Filariasis, Dengue etc.
- Assistance in control of epidemic outbreaks as per programme guidelines.

Disease Surveillance, Integrated Disease Surveillance Project (IDSP)

Essential

- Surveillance about any abnormal increase in cases of diarrhea/dysentery, fever with rigors, fever with rash, fever with jaundice or fever with unconsciousness and early reporting to concerned PHC as per IDSP guidelines.
- Immediate reporting of any cluster/outbreak based on syndromic surveillance.
- High level of alertness for any unusual health event, reporting and appropriate action.
- Weekly submission of report to PHC in'S'Form as per IDSP guidelines.

Water and Sanitation

Desirable

- Disinfection of drinking water sources.
- Promotion of sanitation including use of toilets and appropriate garbage disposal.

Out reach/Field Services

Village Health and Nutrition Day (VHND)

VHND should be organised at least once in a month in each village with the help of Medical Officer, Health Assistant Female (LHV) of PHC, HWM, HWF, ASHA, AWW and their supervisory staff, PRI, Self Help Groups etc.

The number of VHNDs should be enough to reach every habitation/Anganwadi center at least once in a month. The ANM is accountable for these services, with the male worker also taking a due share of the work, and being in charge of logistics and organisation, especially vaccine logistics. Participation of Anganwadi workers, ASHAs and community volunteers would be essential for mobilization of beneficiaries and local organizational support.

Each Village Health and Nutrition Day should last for at least four hours of contact time between ANMs, AWWs, ASHAs and the beneficiaries.

The services to be provided at VHND are listed below.

Essential

- Early registration and Antenatal care for pregnant women – as per standard treatment protocol for the SBA.
- Immunization and Vitamin A administration to all under 5 children- as per immunization schedule.
- Coordination with ICDS programme for Supplementary nutritional services, health check up and referral services, health and nutrition education, immunization for children below 6 years, Pregnant & Lactating Mother and health and nutrition education for all women in the age group (15 to 45 years).
- Family planning counseling and distribution of contraceptives.
- Symptomatic care and management of persons with minor illness referred by ASHAs/AWWs or coming on their own accord.
- Health Communication to mothers, adolescents and other members of the community who attend the VHND session for whatever reason.
- Meet with ASHAs and provide training/support to them as needed.
- Registration of Births and Deaths.

Desirable

- Symptom based care and counselling with referral if needed for STI/RTI and for HIV/AIDS suspected cases.
- Disinfection of water sources and promotion of sanitation including use of toilets and appropriate garbage disposal.

Home Visits

Essential

- For skilled attendance at birth- where the woman has opted or had to go in for a home delivery.
- Post natal and newborn visits – as per protocol.
- To check out on disease incidences reported to Health Worker or she/he comes across during house visits especially where there it is a notifiable disease. Notify the M.O. PHC immediately about any abnormal increase in cases of diarrhoea/dysentery, fever with rigors, fever with rash, flaccid paralysis of acute onset in a child <15 years (AFP), Wheezing cough, Tetanus, fever with jaundice or fever with unconsciousness, minor and serious AEFIs which she comes across during her home visits and take the necessary measures to prevent their spread.

Desirable

- Visits to houses of eligible couples who need contraceptive services, but are not currently using them e.g. couples with children less than three years of age, where women are married and less than 19 years of age, where the family is complete etc.
- Follow up of cases who have undergone Sterilization and MTP, as per protocols especially those who can not come to the facility.
- Visits to community based DOTS providers, leprosy depot holders where this is needed.
- Visits to support ASHA where further counselling is needed to persuade a family to utilize required

health services e.g., immunization dropouts, antenatal care dropouts, TB defaulter etc.

- To take blood slides/do RDK test in cases with fever where malaria is suspected.

House-to-House Surveys

These surveys would be done once annually, preferably in April. Some of the diseases would require special surveys- but at all times not more than one survey per month would be expected. Surveys would be done with support and participation of ASHAs, Anganwadi Workers, community volunteers, panchayat members and Village Health Sanitation and Nutrition Committee members.

The Male Health worker would take the lead and be accountable for the organization of these surveys and the subsequent preparation of lists and referrals. The surveys would include.

Essential

- Age and sex of all family members.
- Assess and list eligible couples and their unmet needs for contraception.
- Identify persons with skin lesions or other symptoms suspicious of leprosy and refer: essential in high leprosy prevalence blocks.
- Identify persons with blindness, list and refer: Identify persons with hearing impairment/ deafness, list and refer.
- Annual mass drug administration in filaria endemic areas.

Desirable

- Identify persons with disabilities, list and refer and call for counselling where needed.
- Identify and list senior citizens who need special care and support.
- Identify persons with mental health problems and Epilepsy; list and refer.
- In high endemicity areas-survey for fever suspicious of kala- azar, for epidemic management of malaria, for detection of fluorosis affected cases etc.
- Ani other obvious disease/disorder; list and refer.

Community Level Interactions

Essential

- Focus group discussions for information gathering and health planning.
- Health Communication especially as related to National Health programmes through attending Village Health Sanitation and Nutrition Committee meetings, ASHA local review meetings and meetings with panchayat members/sarpanch, Self Help Groups, women's groups and other BCC activities.

Coordination and Monitoring

- Coordinated services with AWWs, ASHAs, Village Health Sanitation and Nutrition Committee PRI etc.

National Health Programmes

Communicable Disease Prgramme

a. National AIDS Control Programme (NACP):

Essential

- Condom promotion & distribution of condoms to the high risk groups.
- Help and guide patients with HIV/AIDS receiving ART with focus on adherence.
- IEC activities to enhance awareness and preventive measures about STIs and HIV/AIDS, PPTCT services and HIV-TB coordination.

Desirable

- Linkage with Microscopy Centre for HIV-TB coordination.
- HIV/STI Counseling, Screening and referral in Type B Sub-centres (Screening in Districts where the prevalence of HIV/AIDS is high).

b. National Vector Borne Disease Control Programme (NVBDCP):

Essential

- Collection of Blood slides of fever patients
- Rapid Diagnostic Tests (RDT) for diagnosis of Pf malaria in high Pf endemic areas.
- Appropriate anti-malarial treatment.
- Assistance for integrated vector control activities in relation to Malaria, Filaria, JE, Dengue, Kala-Azar etc. as prevalent in specific areas. Prevention of breeding places of vectors

through IEC and community mobilization. Where filaria is endemic, identification of cases of lymphoedema/elephantiasis and hydrocele and their referrals to PHC/CHC for appropriate management. The disease specific guidelines issued by NVBDCP are to be followed.

- Annual mass drug administration with single dose of Diethyl carbamazine (DEC) to all elligible population at risk of lymphatic filariasis.
- Promotion of use of insecticidal treated nets, wherever supplied.
- Record keeping and reporting as per programme guidelines.

c. National Leprosy Eradication Programme (NLEP):

Essential

- Health education to community regarding signs and symptoms of leprosy, its complications, curability and availability of free of cost treatment.
- Referral of suspected cases of leprosy (person with skin patch, nodule, thickened skin, impaired sensation in hands and feet with muscle weakness) and its complications to PHC.
- Provision of subsequent doses of MDT and follow up of persons under treatment for leprosy, maintain records and monitor for regularity and completion of treatment.

d. Revised National Tuberculosis Control Programme (RNTCP):

Essential

- Referral of suspected symptomatic cases to the PHC/Microscopy centre.
- Provision of DOTS at Sub-centre, proper documentation and follow-up.
- Care should be taken to ensure compliance and completion of treatment in all cases.
- Adequate drinking water should be ensured at Sub-centre for taking the drugs.

Desirable

- Sputum collection centers established in Sub-centre for collection and transport of sputum samples in rural, tribal, hilly & difficult areas of the country where Designated Microscopy Centres are not available as per the RNTCP guidelines.

Non-communicable Disease (NCD) Programmes

Note: These services are to be provided at both types of Sub-centres.

a. National Programme for Control of Blindness (NPCB):

Essential

- Detection of cases of impaired vision in house to house surveys and their appropriate referral. The cases with decreased vision will be noted in the blindness register.
- Spreading awareness regarding eye problems, early detection of decreased vision, available treatment and health care facilities for referral of such cases. IEC is the major activity to help identify cases of blindness and refer suspected cataract cases.

Desirable

- The cataract cases brought to the District Hospital by MPW/ANM/and ASHAS.
- Assisting for screening of school children for diminished vision and referral.

b. National Programme for Prevention and Control of Deafness (NPPCD):

Essential

- Detection of cases of hearing impairment and deafness during House to house survey and their appropriate referral.
- Awareness regarding ear problems, early detection of deafness, available treatment and health care facilities for referral of such cases.
- Education of community especially the parents of young children regarding importance of right feeding practices, early detection of deafness in young children, common ear problems and available treatment for hearing impairment/ deafness.

c. National Mental Health Programme:

Essential

- Identification and referral of common mental illnesses for treatment and follow them up in community.
- IEC activities for prevention and early detection of mental disorders and greater

participation/role of Community for primary prevention of mental disorders.

d. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke:

Essential

IEC Activities to promote healthy lifestyle sensitize the community about prevention of Cancers, Diabetes, CVD and Strokes, early detection through awareness regarding warning signs and appropriate and prompt referral of suspect cases.

e. National Iodine Deficiency Disorders Control Programme:

Essential

IEC Activities to promote consumption of iodized salt by the community. Testing of salt for presence of Iodine through Salt Testing Kits by ASHAs.

f. In Fluorosis affected (Endemic) Areas:

Essential

- Identify the persons at risk of Fluorosis, suffering from Fluorosis and those having deformities due to Fluorosis and referral.

Desirable

- Line listing of reconstructive surgery cases, rehabilitative intervention activities and referral services.
- Focused behaviour change communication activities to prevent Fluorosis.

g. National Tobacco Control Programme:

Essential

- Spread awareness and health education regarding ill effects of tobacco use especially in pregnant females and Non-Communicable diseases where tobacco is a risk factor e.g. Cardiovascular disease, Cancers, chronic lung diseases.
- Display of mandatory signage of "No Smoking" in the Sub-centre.

Desirable

- Counseling for quitting tobacco.
- Awareness to public that smoking is banned in public places and sale of tobacco products is banned to minors (less than 18 years) as well as within 100 yards of schools and educational institutions.
- Spread awareness regarding law on smoke free public places.

h. Oral Health:

Desirable

- Health education on oral health and hygiene especially to antenatal and lactating mothers, school and adolescent children.
- Providing first aid and referral services for cases with oral health problems.

i. Disability Prevention:

Desirable

- Health education on Prevention of Disability.
- Identification of Disabled persons during annual house to house survey and their appropriate referral.

j. National Programme for Health Care of Elderly:

Desirable

- Counseling of Elderly persons and their family members on healthy ageing.
- Referral of sick old persons to PHC.

Promotion of Medicinal Herbs

Desirable

Locally available medicinal herbs/plants should be grown around the Sub-centre as per the guidelines of Department of AYUSH.

Record of Vital Events

Essential

Recording and reporting of vital events including births and deaths, particularly of mothers and infants to the health authorities.

Manpower

In order to provide above mentioned services, different categories of Sub-centres should have the following personnel.

Type of subcentre	Sub-centre A		Sub-centre B (MCH Sub-centre)	
Staff	Essential	Desirable	Essential	Desirable
ANM/Health Worker (Female)	1	+1	2	
Health Worker (Male)	1		1	
Staff Nurse (or ANM, if Staff Nurse is not available)				1**
Safai-Karamchari*	1 (Part-time)		1 (Full-time)	

*To be outsourced.

** if number of deliveries at the Sub-centre is 20 or more in a month

The assured services of a Sub-centre would change considerably with the pattern of staff availability. Where there is only one ANM, Reproductive and Child Health services would have the first priority. Good logistics support is essential for maximizing the work output of the Sub-centre.

Note: The job functions of ANM, Health worker (Male) and Staff Nurse (if provided) are given at **Annexure 2**.

Physical Infrastructure

A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population. The States should also explore options of getting funds for space from other Health Programmes and other funding sources.

Location of the Centre

For all new upcoming Sub-centres, following may be ensured:

- Sub-centre to be located within the village for providing easy access to the people and safety of the ANM.
- As far as possible no person has to travel more than 3 km to reach the Sub-centre.
- The Sub-centre village has some communication net work (road communication/public transport/ post office/telephone).
- Sub-centre should be away from garbage collection, cattle shed, water logging area etc.
- While finalizing the location of the Sub-centre, the concerned Panchayat should also be consulted.

Building and Lay out

- **Boundary wall/fencing:** Boundary wall/fencing with Gate should be provided for safety and security.
- In the typical layout of the Sub-centre, the residential facility for ANM is included, however, it may happen that some of the existing Sub-centres may not have residential facilities for ANM. In that case, some house should be available on rent in the Sub-centre headquarter village for accommodating the ANM.
- Residential facility for Health Worker (Male), if need is felt, may be provided by expanding the Sub-centre building to the first floor. The entrance to the Sub-centre should be well lit and easy to locate. It should have provision for easy access for disabled and elderly. Provision of ramp with railing to be made for use of wheel chair/stretcher trolley, wherever feasible.
- The minimum covered area of a Sub-centre along with residential quarter for ANM will vary depending on land availability, type of Sub-centre and resources.
- Separate entrance for the Sub-centre and for the ANM quarter may be ensured.

- Type B Sub-centre should have, about 4 to 5 rooms with facilities of
  - Waiting Room
  - One Labour Room with one labour table and Newborn corner
  - One room with two to four beds (in case the no. of deliveries at the Sub-centre is 20 or more, four beds will be provided)
  - One room for store
  - One room for clinic/office
  - One Toilet facility each in labour room ward room and in waiting area (Essential)

    Residential Accommodation: This should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and Water Closet (WC). Residential facility for one ANM is as follows which is contiguous with the main Sub-centre area.
  - Room - 1 (3.3 m x 2.7 m)
  - Room - 2 (3.3 m x 2.7 m)
  - Kitchen - 1 (1.8 m x 2.5 m)
  - W.C (1.2 m x 9.0 m)
  - Bath Room (1.5 m x 1.2 m)

    Residential Facility for a minimum of 2 staff and desirably for 3 staff should be provided at Type B (MCH) Sub-centres.

    A typical layout plan for type A Sub-centre with ANM residence having area of 85 square metres and type B Sub-centre having an additional area of 65 square metres on ground floor and 125 square metres on first floor, with area/space specifications is given at **Annexure 3.**

Signage

- The building should have a prominent board displaying the name of the Centre in the local language at the gate and on the building.
- Prominent display boards in local language providing information regarding the services available and the timings of the Sub-centre should be displayed at a prominent place.
- Visit schedule of "ANMs" should be displayed.
- Suggestion/complaint box for the patients/ visitors and also information regarding the person responsible for redressal of complaints, be displayed.

Disaster Prevention Measures against Earthquake, flood and fire

(Desirable for all new upcoming facilities)

- Earthquake proof measures – Building structure and the internal structure of SC should be made disaster proof especially earthquake proof. Structural and non-structural elements should be built in to withstand quake as per geographical/ state govt. guidelines. Non-structural features like fastening the shelves, equipment etc. are as important as structural changes in the buildings.
- SC should not be located in low lying area to prevent flooding.
- Fire fighting equipment – fire extinguishers, sand buckets, etc. should be available and maintained to be readily available when there is a problem.
- The health staff should be trained and well conversant with disaster prevention and management aspects.

Environment Friendly Features

The SC should be, as far as possible, environment friendly and energy efficient. Rain-Water harvesting, solar energy use and use of energy-efficient bulbs/ equipment should be encouraged.

Furniture

Adequate furniture that is sturdy and easy to maintain should be provided to the Sub-centre. The list of furniture has been annexed. (**Annexure 4)**

Equipment

The equipment provided to the Sub-centres should be adequate to provide all the assured services in the Sub-centres. This will include all the equipment necessary for conducting safe deliveries at Sub-centre (for type B Sub-centres), home deliveries (for both Type A and Type B), immunization, contraceptive services like IUD insertion, etc. In addition, equipment for first aid and emergency care, water quality testing, blood smear collection should also be available. Maintenance of the equipment should be ensured either through

preventive maintenance/prompt repair of non-functional equipment so as to ensure uninterrupted delivery of services. A standard mechanism should be in place for the same. The list of equipment has been annexed (**Annexure 5).** Proper sterilization of all equipment and compliance of all Universal precautions are to be ensured.

Drugs

The list of drugs that should be available as per the guidelines in given at **Annexure 6**. Accurate records of stock should be maintained.

Support Services

a. **Laboratory:** Minimum facilities of Urine Pregnancy Testing, estimation of haemoglobin by using a approved **Haemoglobin Colour Scale** (only approved test strips should be used), urine test for the presence of protein and sugar by using **Dipsticks** should be available. (Instructions should be followed from the leaflet provided by the manufacturer)

b. **Electricity:** Wherever facility exists, uninterrupted power supply has to be ensured for which inverter facility/solar power facility is to be provided. Generator facility is made available at Type B Sub-centres.

c. **Water:** Potable water for patients and staff and water for other use should be in adequate quantity. Towards this end, adequate water supply and water storage facility (over head tank) with pipe water should be made available especially where labour room is attached. Safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the centre. Water source for Sub-centre be provided by the Panchayat and where there is need a tube well with fitted water pump be provided. For continuous water supply, States may explore the option of rain water harvesting, solar energy for running the pumps etc.

d. **Telephone:** At Type B Sub-centres, landline telephone facility should be provided.

e. **Assured Referral linkages:** Either through Govt/ PPP model for timely and assured referral to functional PHCs/FRUs in case of complications during pregnancy and child birth.

f. **Toilet:** Toilet facility for use of patients/attendants and Sub-centre Staff must be provided in all Sub-centres. In case of Type B Sub-centre, additional one Toilet facility each in labour room and ward room are also to be provided. Regular cleaning of Toilets should be ensured.

Waste Disposal

Infection Management and Environment Plan "Guidelines for Health Care Workers for Waste Management and Infection Control in Sub Centres" of Ministry of Health and Family Welfare, Government of India are to be followed. Standards for Deep Burial Pit as per Bio-Medical Waste (Management and Handling) Rules, 1998 are given at Annexure 7

Record Maintenance and Reporting

Proper maintenance of records of services provided at the Sub-centres and the morbidity/mortality data is necessary for assessing the health situation in the Sub-centre area. In addition, all births and deaths under the jurisdiction of sub- centre should be documented and sex ratio at birth should be monitored and reported. A list of minimum number of registers to be maintained at Sub-centre is given in **Annexure 8**.

Monitoring Mechanism

Internal mechanisms: Supportive supervision and Record checking at periodic intervals by the Male and Female Health supervisors from PHC (at least once a week) and by MO of the PHC (at least once in a month) etc. A check list for Sub-centres is given at **Annexure 9**.

External mechanisms: Sub-centres will be under the oversight of Gram Panchayats. A simpler check-

list that can be used by PRI/NGO/SHG is given in **Annexure 9A**.

A detailed Facility Survey Format **(Annexure 10)** is also given to monitor periodically whether the Sub-centre is up-to the level of Indian Public Health Standards (IPHS).

PRI should also be involved in the monitoring. The following may be monitored:

- Access to service (equity). Location of Sub-centres - ensuring it to be safe to female staff and centrally located, well in side the inhabited area of the village.
- Registration and referral procedures; promptness in attending to clients; transportation of emergency maternity cases etc.
- Management of untied fund for the improvement of services of the Sub- centre
- Staff behaviour
- Other facilities: waiting space, toilets, drinking water in the Sub-centre building.

Quality Assurance and Accountability

This can be ensured through regular skill development training/Continuing Medical Education (CME) of health workers (at least one such training in a year), as per guidelines of NRHM.

In order to ensure quality of services and patient satisfaction, it is essential to encourage community participation. To ensure accountability, the **Citizens' Charter** should be available in all Sub-centres (**Annexure 11).**

Annexure 1

NATIONAL IMMUNIZATION SCHEDULE FOR INFANTS, CHILDREN AND PREGNANT WOMEN

Immunization programme provides vaccination against seven vaccine preventable diseases

Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1 & 2	Early in pregnancy and 4 weeks after TT-1* [one dose (booster)* if previously vaccinated within last 3 years]	0.5 ml	Intra-muscular	Upper Arm
TT-Booster	If pregnancy occur within three years of last TT vaccinations*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth (for institutional deliveries) or along with DPT-1 (upto one year if not given earlier)	0.1 ml (0.05 ml for infant up to 1 month)	Intra-dermal	Left Upper Arm
Hepatitis B - 0	At birth for institutional delivery, preferably within 24 hrs of delivery	0.5 ml	Intra-muscular	Outer Mid-thigh (Antero-lateral side of mid thigh)
OPV - 0	At birth for institutional deliveries within 15 days	2 drops	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Outer Mid-thigh (Antero-lateral side of mid thigh)
Hepatitis B - 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks**	0.5 ml	Intra-muscular	Outer Mid-thigh (Antero-lateral side of mid- thigh)
Measles 1 & 2	At 9-12 months and 16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
Vitamin-A (1^{st} dose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For Children				
DPT booster	16-24 months	0.5 ml	Intra-muscular	Outer Mid-thigh (Antero-lateral side of mid- thigh)
	2^{nd} booster at 5 years of age	0.5 ml	Intra-muscular	Upper Arm
OPV Booster	16-24 months	2 drops	Oral	Oral
JE†	16-24 months	0.5 ml	Sub-cutaneous	Upper Arm

Vaccine	When to give	Dose	Route	Site
Vitamin A (2^{nd} to 9^{th} dose)	2^{nd} dose at 16 months with DPT/OPV booster. 3^{rd} to 9^{th} doses are given at an interval of 6 months interval till 5 years age	2 ml (2 lakh IU)	Oral	Oral
DT Booster	5 years	0.5 ml	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

* TT-2 or Booster dose to be given before 36 weeks of pregnancy.

** A fully immunized infant is one who has received BCG, three doses of DPT, three doses of OPV, three doses of Hepatitis B and Measles before one year of age.

† JE in Selected Districts with high JE disease burden (currently 112 districts)

Note: The Universal Immunization Programme is Dynamic and hence the immunization schedule needs to be updated from time to time.

Annexure 2

JOB FUNCTIONS OF HEALTH WORKER FEMALE/ANM, STAFF NURSE, HEALTH WORKER MALE

Job Functions of Health Worker Female (ANM)

She will carry out the following functions:

She will carry out all the activities related to various programs in a integrated manner when visiting the village/households

Maternal and Child Health

1. Register and provide care to pregnant women throughout the period of pregnancy. Ensure that every pregnant woman makes at least 4 (Four) visits for Ante Natal Check-up including Registration.

   Suggested schedule for antenatal visits

   1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up However, even if a woman comes late in her pregnancy for registration, she should be registered, and care given to her according to gestational age.

   2nd visit: Between 14 and 26 weeks

   3rd visit: Between 28 and 34 weeks

   4th visit: Between 36 weeks and term

   Provide ante natal check ups and associated services such as IFA tablets, TT immunization etc.

2. Test urine of pregnant women for albumin and sugar. Estimate haemoglobin level.
3. Refer all pregnant women to PHC/CHC for RPR test for syphilis and Blood grouping.
4. Refer cases of abnormal pregnancy and cases with medical and gynaecological problems to Health Assistant Female (LHV) or the Primary Health Centre.
5. Conduct deliveries in Sub-centre, if facilities of a Labour room are available and in her area when called for.
6. Supervise deliveries conducted by Dais and assist them whenever called for.
7. Refer cases of difficult labour and newborns with abnormalities, help them to get institutional care and provide follow up to the patients referred to or discharged from hospital.
8. ANM will identify the ultimate beneficiaries, complete necessary formalities and obtain necessary approvals of the competent authority before disbursement to the beneficiaries under Janani Suraksha Yojana **(JSY)** and by 7th of each month will submit accounts of the previous month in the prescribed format to be designed by the State. ANM will prepare a monthly work schedule in the meeting of all accredited workers to be held on every 3rd Friday of every month, which is mandatory. The guideline under JSY is to be followed. In addition ANM will take weekly/fortnightly meetings with all ASHAs of her area to guide and monitor them.

9. Tracking of all pregnancies by name for scheduled ANC/PNC services.
10. Make post- natal home visits on 0, 3, 7 and 42nd day for deliveries at home and Sub-centre and on 3, 7, and 42nd day for institutional delivery. Post-natal visits are to be made for each delivery happened in her area and she should render advice regarding care of the mother and care and feeding of the newborn.
11. In case of Low Birth weight Baby, a total of six post natal visits are to be made on 0, 3, 7, 14, 21 and 28th day to screen for congenital abnormalities, assess the neonate for danger signs of sickness etc. as per IMNCI guidelines and appropriate referral.
12. Initiation of early breast-feeding within one hour of birth, exclusive breastfeeding for 6 months and timely weaning at 6months as per Infant and Young Child Feeding Guidelines.
13. Assess the growth and development of the infants and under 5 children and make timely referral.
14. Provide treatment for all cases of Diarrhoea, acute respiratory infections (pneumonia) and other minor ailments and refer cases of severe dehydration, respiratory distress, infections, severe acute malnutrition and other serious conditions as per IMNCI guidelines/National Guidelines.
15. Educate mothers individually and in groups in better family health including maternal and child health, family planning, nutrition, immunization, control of communicable diseases, personal and environmental hygiene.
16. Assist Medical Officer and Health Assistant (Female) in conducting antenatal and postnatal clinics at the Sub-centre.

Family Planning

1. Utilize the information from the eligible couple and child register for the family Planning programme. She will be squarely responsible for maintaining eligible couple registers and updating at all times.
2. Spread the message of family planning to the couples and motivate them for family planning individually and in groups.
3. Distribute conventional contraceptives and oral contraceptives to the couples, provide facilities and to help prospective acceptors in getting family planning services, if necessary, by accompanying them or arranging for the Dai/ASHA to accompany them to hospital.
4. Provide follow-up services to female family planning acceptors, identify side effects, give treatment on the spot for side effects and minor complaints and refer those cases that need attention by the physician to the PHC/ Hospital.
5. IUCD insertion can be done by a trained ANM.
6. Establish female depot holders, help the Health Assistant (Female) in training them, and provide a continuous supply of conventional contraceptives to the depot holders.
7. Build rapport with acceptors, village leaders, ASHA, Dais and others and utilize them for promoting Family Welfare Programme.
8. Identify women leaders and train them with help of the Health Assistant (Female).
9. Participate in Mahila Mandal meetings and utilize such gatherings for educating women in Family Welfare Programme.

Medical Termination of Pregnancy

1. Identify the women requiring help for medical termination of pregnancy and refer them to nearest approved institution.
2. Educate the community of the consequences of unsafe abortion methods and septic abortion; inform them about the availability of services for medical termination of pregnancy.

Nutrition

1. Identify cases of Low Birth weight, malnutrition among infants and young children (zero to five years), give the necessary treatment and advice and refer serious cases to the Primary Health Centre.

2. Distribute Iron and Folic Acid tablets as prescribed to pregnant women, nursing mothers, **adolescent girls** and syrups to young children (up to five years), as per the national guidelines.
3. Administer Vitamin A solution to children as per the guidelines.
4. Educate the community about nutritious diet for mothers and children.
5. Coordinate with Anganwadi Workers.

Universal Programme on Immunization (UIP)

1. Immunize pregnant women with tetanus toxoid.
2. Administer DPT vaccine, oral poliomyelitis vaccine, measles vaccine and BCG vaccine to all infants and children, (Hepatitis B in pilot areas) as per immunization schedule.
3. Ensure injection safety, safe disposal and record, report and manage minor & serious Adverse Event Following Immunization (AEFI). Submit monthly UIP reports, weekly surveillance reports (AFP, Measles under IDSP). Serious AEFI and outbreak should be reported immediately.
4. ANM is responsible for cold chain maintenance for vaccines during fixed and outreach sessions.
5. Manage waste generated during immunization as per GOI/CPCB guidelines.
6. Preparing work plan, estimating beneficiaries and logistics, preparing due list of expected beneficiaries in coordination with Anganwadi worker and ASHA/mobilizer on the session day and ensure their vaccination through adequate mobilization.
7. Maintain Tracking Bag/Tickler box at each Sub-centre, file updated counterfoils and utilize them for follow up.
8. Tracking of dropouts and left outs, records/ reports (including MCH register and immunization card counterfoils), surveillance/reporting Vaccine Associated Paralytic Poliomyelitis (VAPP) and AEFI incidents in catchment area.
9. Indent order of vaccines and logistics should be weekly based on the due beneficiary list. HW/Alternate Vaccinator should receive the required quantity of vaccine and logistics on the day of Immunization and supply to the session site.
10. Work plan indicating village, place, date & time of organizing proposed session, including the names of ASHA and AWW must be displayed at each Sub-centre.
11. Posters/Paintings on key messages, Immunization schedule, Positioning during vaccine administration, Safe Injection Practices, VVM, AEFI awareness, use of Hub cutters.
12. Village-wise dropout list for display at Sub-centre
13. Norm for due beneficiaries: 3 per session.

Communicable Diseases

1. Notify the MO, PHC immediately about any abnormal increase in cases of diarrhoea/ dysentery, fever with rigors, fever with rash, flaccid paralysis of acute onset in a child <15 years (AFP), , Tetanus, fever with jaundice or fever with unconsciousness, minor and serious AEFIs which she comes across during her home visits, take the necessary measures to prevent their spread, and inform the Health Assistant (Male)/LHV to enable him/her to take further action.
2. HIV/STI Counseling, HIV/STI screening after receiving training.
3. Leprosy
    - Impart Health Education on Leprosy and its treatment to the community.
    - Refer suspected new cases of leprosy and those with complications to PHC.
    - Provide subsequent doses of MDT to patients Ensure regularity and completion of treatment and assist health supervisor in retrieval of absentee/defaulter.
    - Update the case cards at Sub-centres & treatment register at sector PHC.
    - Assist leprosy disabled people in self care practices, monitor them and refer them to PHC when ever required.

4. Assist the Health Worker (Male) in maintaining a record of cases in her area, who are under treatment for malaria, tuberculosis and leprosy, and check whether they are taking regular treatment, motivate defaulters to take regular treatment and bring these cases to the notice of the Health Worker (Male) or Health Assistant (Male).
5. Give Oral Rehydration solution to all cases of diarrhea/dysentery/vomiting. Identify and refer all cases of blindness including suspected cases of cataract to M O, PHC.
6. Education, Counselling, referral, follow-up of cases of STI/RTI, HIV/AIDS.
7. Malaria
    - She will identify suspected malaria fever cases during ANC or Immunisation Clinic and home visits, and will make blood smears or use RDT for diagnosis of Pf malaria.
    - To advise seriously ill cases to visit PHC for immediate treatment. All the fever cases with altered sensorium must be referred to PHC/District Hospital. The cases will be referred after collection of blood smear and performing RDT. To arrange transportation for such patients from home to the PHC/District Hospital.
    - To contact all ASHAs/FTDs of the area during visit to the village and collect blood smears for transportation to laboratory. To cross verify their records by visiting patients diagnosed positive between the previous and current visit.
    - To provide treatment to positive cases as per the drug policy.
    - To replenish the stock of micro slides, RDKs and/or drugs to ASHAs/FTDs wherever necessary.
    - To keep the records of blood smears collected and patients given anti-malarial treatment.
    - To ensure early diagnosis & radical treatment of the diagnosed positive cases (PV & PF) compliance of Radical Treatment (PF – 45 mg …. & PV – 15 mg) for 15 day.
    - To take all precautions to use properly sterilized needles and clean slides while collecting blood smears.
    - She will ensure that all pregnant women are provided insecticidal treated nets in high malaria endemic areas.
8. Where Filaria is endemic:
    - Identification of cases of lymphoedema/ elephantiasis and hydrocele and their referrals to PHC/CHC for appropriate management.
    - Training of patients with lymphoedema/ elephantiasis about care of feet and home based management remedies.
    - Identification and training of drug distributors including ASHAs and Community Health Guides for mass drug distribution of DEC + Albendazole on National Filaria Day.
9. Where Kala-Azar is endemic:
    - From each family
        a. She shall enquire about the presence of any fever cases having a history of prolong fever more than 15 days duration in a village during her visit.
        b. She will refer such cases to the nearest PHC for clinical examination by the Medical Officer and confirmation by RDK.
        c. She shall take the migratory status of the family/guest during last three months.
    - She will also follow up and persuade the patients to ensure complete treatment.
    - She will keep a record of all such cases and shall verify from PHC about their diagnosis during the monthly meeting or through health supervisor during her visit.
    - She will carry a list of all Kala-azar cases in her area for follow up and will ensure, administration of complete treatment at PHC.

- She will assist the male health worker in supervision of the spray activities.
- She will conduct all health education activities particularly through inter-personal communication by carrying proper charts etc. for community awareness and their involvement.

10. Where Dengue/Chikungunya is endemic
    a. From each family
        - She shall enquire about the presence of any fever case having rash and joint pain a village during her visit.
        - She will refer such cases to the nearest PHC for clinical examination by the Med Officer and for laboratory confirmation by sending blood sample to the nearest Sentinel Surveillance hospital.
    b. She will supervise the source reduction activities in her area including at the time of observance of anti-Dengue month
    c. She will coordinate the activities carried out by Village Health Sanitation and Nutrition Committee.
    d. She will conduct health education activities particularly through inter-personal communication by carrying proper charts etc. for social mobilization and community awareness to eliminate source of Aedes breeding and also guide the community for proper water storage practices.
11. Where JE is endemic:
    a. From each family
        - She shall enquire about the presence of any fever case having encephalitis presentation.
        - She will refer such cases to the nearest PHC for early diagnosis and management of such cases.
    b. She will conduct health education activities particularly through inter-personal communication by carrying proper charts etc. for social mobilization and community awareness for early referral of cases.

Non-Communicable Diseases

- IEC Activities for prevention and early detection of hearing impairment/deafness in health facility, community and schools, harmful effects of Tobacco, mental illnesses, Iodine Deficiency Disorders (IDD), Diabetes, CVD and Strokes.
- House to House surveys to detect list & refer cases of hearing & visual impairment and (along with annual survey register/enumeration survey. Minimum is annual survey, desirable to be done twice yearly subject to availability of second ANM).
- Sensitization of ASHA/AWW/PRI about prevention and treatment of deafness.
- Mobilizing community members for screening camps and assisting in conduction of screening camps to identify hearing or visual impairment cases if needed.
- Motivation for quitting and referrals to Tobacco Cassation Centre at District Hospital.
- Sensitization of ASHA/AWW/PRI about the Non-communicable diseases.
- Identification and referral of carer of common mental illnesses and Epilepsy for treatment and follow them up in community.
- Greater participation/role of Community for primary prevention of NCD and promotion of healthy lifestyle.
- Ensuring regular Testing of salt at household level for presence of Iodine through Salt Testing Kits by ASHAs.
- In Fluorosis affected districts
    - IEC to prevent Fluorosis.
    - Identify the persons at risk of Fluorosis, suffering from Fluorosis and those having deformities due to Fluorosis.
    - Line listing, source reduction activities, reconstructive surgery cases, rehabilitative intervention activities, focused local action and referral of what is not possible locally.
- Promoting formation and registration of Self Health Care Group of Elderly Persons'.

- Oral Health education especially to antenatal and lactating mothers, school and adolescent children, first aid and referral for cases of oral problems.
- Health communications on Disability, Identification of Disabled persons and their appropriate referral.

Vital Events

Record and report to the health authorities the vital events including births and deaths, particularly of mothers and infants in her area.

Record Keeping

1. Maintenance of all the relevant records concerning mothers, children and eligible couples in her area.
2. Register (a) pregnant women at earliest contact (b) infants zero to one year of age (c) women aged 15-44 years (d) Under and above five children (e) Adolescents.
3. Maintain the pre-natal and maternity records and child care records.
4. Prepare the eligible couple and child register and maintaining it up-to-date.
5. Maintain the records as regards contraceptive distribution, IUD insertion. Couples sterilized, clinics held at the Sub-centre and supplies received and issued.
6. Prepare and submit the prescribed weekly/ monthly reports in time to the Health Assistant (Female).
7. While maintaining passive surveillance register for malaria cases, she will record:
   - No. of fever cases
   - No. of blood slides prepared
   - No. of malaria positive cases reported
   - No. of cases given radical treatment

Treatment of Minor Ailments

1. Provide treatment for minor ailments, first-aid for accidents and emergencies and refer cases beyond her competence to the Primary Health Centre/Community Health Centre or nearest hospital.
2. Provide treatment as per AYUSH* as needed at the local level.

Team Activities

1. Attend and participate in staff meetings at Primary Health Centre/Community Development Block or both.
2. Coordinate her activities with the Health Worker (Male) and other health workers including the Health volunteers/ASHA and Dais.
3. Coordinate with PRI and Village Health Sanitation and Nutrition Committee.
4. Draft annual **Village Health Plan** with the help of Health Worker (Male), PRI and VHSC for submitting the same to block.
5. Meet the Health Assistant (Female) each week and seek her advice and guidance whenever necessary.
6. Maintain the cleanliness of the Sub-centre.
7. Dispose medical waste as per the IMEP guidelines, of GOI.
8. Organize, participate and guide in organizing the VHN Days at Anganwadi Centers.
9. Participate as a member of the team in camps and campaigns.

House-to House Surveys

These surveys would be done once in April annually. Some of the diseases would require special surveys- but at all times not more than one survey per month would be expected. Surveys would be done with support and participation of HW (male), ASHAs, Anganwadi Workers, community volunteers, panchayat members and Village Health Sanitation and Nutrition Committee. Other details are given on page no. 11.

Role of ANM as a Facilitator of ASHA

Auxiliary Nurse Midwife (ANM) will guide ASHA in performing the following activities:

- She will hold weekly/fortnightly meeting with ASHA and discuss the activities undertaken during

the week/fortnight. She will guide her in case ASHA had encountered any problem during the performance of her activities.

- ANM will act as a resource person for the training of ASHA.
- ANM will inform ASHA regarding date and time of the outreach session and will also guide her for bringing the beneficiary to the outreach session
- ANM will participate and guide in organizing the Health Days at Anganwadi Centres.
- She will take help of ASHA in updating eligible couple register of the village concerned.
- She will utilize ASHA in motivating the pregnant women for coming to sub- centre for initial checkups. ASHA will also help ANMs in bringing married couples to Sub-centres for adopting family planning methods.
- ANM will guide ASHA in motivating pregnant women for taking full course of IFA Tablets and TT injections etc.
- ANMs will orient ASHA on the dose schedule and side affects of oral pills.
- ANMs will educate ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- ANMs will inform ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.
- Train in Salt Testing using salt Testing Kits.

The second ANM will follow similar job responsibilities as the above. It is to be ensured that one ANM out of the two is available at the Sub-centre. Other ANM will perform the field duties. The time schedule for their turn visits be prepared with the approval of the Panchayats involved.

Job Functions of Health Worker Male

Note: The Health worker Male will make a visit to each family once a fortnight. He will record his visit on the main entrance to the house according to the Instructions of the State/UT.

His duties pertaining to different National Health Programme are:

He will carry out all the activities related to various programmes in a integrated manner when visiting the village/households

National Vector Borne Disease Control Programme (NVBDCP)

Malaria

A. **Early Diagnosis & Complete Treatment**

1. To conduct fortnightly domiciliary house-to-house visit, in areas where FTDs/ASHAs have not been deployed, as per schedule developed by Medical Officer in-charge of PHC in consultation with the District Malaria Officer.
2. To collect blood smears (thick and thin) or perform RDT from suspected malaria cases during domiciliary visits to households and keep the records in M-1, to transport slide collected along with M1 to Lab for examination. To provide treatment to positive cases as per the drug policy.
3. To advise seriously ill cases to visit PHC for immediate treatment. All the fever cases with altered sensorium must be referred to PHC/ District Hospital by him. The cases will be referred after collection of blood smear and performing RDT. To arrange transportation for such patients from home to the PHC/District Hospital.
4. To contact all ASHAs/FTDs of the area during visit to the village and collect blood smears and M2 for transmission to laboratory. To cross verify their records by visiting patients

diagnosed positive between the previous and current visit.

5. To replenish the stock of microslides, RDKs and/or drugs to ASHAs/FTDs wherever necessary.
6. To keep the records of blood smears collected and patients given anti-malarials in M1.
7. To ensure early diagnosis & radical treatment of the diagnosed positive cases (PV & PF) compliance of RT (PF – 45 mg …. & PV – 15 mg for 15 day.
8. To take all precautions to use properly sterilized needles and clean slides while collecting blood smears.

B. Integrated Vector Control Programme

1. To decide dumping sites for insecticides.
2. MPW should know the malaria-metric indices of his villages & should have micro action plan of his Sub-centre area.
3. To supervise the work of spray squads.
4. To deploy the squads (two pumps) in such a way that each squad works in a house at a time and all the squads under his supervision work in adjacent houses for convenience of supervision.
5. To make an abstract of spray output showing insecticide consumed, squads utilized, human dwellings sprayed, missed, locked, refused and rooms sprayed/rooms missed in the proforma prescribed.
6. MPW (Male) will ensure the quality of spray in the human dwellings.
   - The spray should be uniform.
   - The deposit should be in small discrete droplets and not splashes.
   - All sprayable surfaces like walls, ceilings etc. should be covered.
   - If the ceiling is thatched, it should be sprayed so as to cover both sides of rafters/bamboos, if necessary the ceiling should have two coats each starting from opposite direction.
   - All false ceilings and attics should be sprayed.
   - If houses are built on stilts/platforms, the under surface of platform should also be covered.
7. To put a stencil on the wall of the house indicating spray status of the human dwelling (All rooms and verandahs are counted).
8. To ensure that spray men use protective clothing and wash the spray equipment daily. The washing of the equipment, etc. should not pollute local drinking water source or water used for cattle. The spray men should wash the exposed surface of their body with soap and water.
9. To ensure that all precautions are taken by spray men to avoid contamination of food material or cooked food or drinking water in the house. These can be protected by covering with a plastic sheet. Similarly, fodder for animals should be protected.
10. To ensure the community owned bed-nets are timely treated with insecticide before transmission season of malaria.

C. IEC/BCC

1. To educate the community about signs & symptoms of malaria, its treatment, prevention and vector control.
2. Advance spray information to community/ villages.
3. To participate in the activities of anti-malaria month.
4. Sensitize the community for sleeping under Long Lasting Insecticidal Net (LLIN) in the high endemic areas.

D. Recording & Reporting

1. To maintain record of fever cases diagnosed by blood slides/RDTs in M1 and prepare a Sub-centre report (M4) for all cases in the

area, including those of ASHAs and FTDs and submit it to PHC.

2. To keep a record of supervisory visits in Tour diary and submit to MO-PHC during monthly meetings for verification.
3. To keep records & reports as per guidelines of NVBDCP.
4. Minutes of VHSNC decisions.

E. Village Health Sanitation & Nutrition Committee

1. MPW is expected to be a member of Village Health Sanitation and Nutrition Committee. He must take part in the meetings actively and lead the discussions. He must convey the importance of source reduction activities.

Where Filaria is Endemic

1. Identification of cases of lymphoedema/ elephantiasis and hydrocele and their referrals to PHC/CHC for appropriate management.
2. Training of patients with lymphoedema/ elephantiasis about care of feet and with home based management remedies.
3. Identification and training of drug distributors including ASHAs and Community Health Guides for mass drug administration of DEC+ Albendazole on National Filaria Day.

Where Kala-Azar is Endemic

1. From each family
   a. He shall enquire about the presence of any fever cases having a history of prolong fever more than 15 days duration in a village during his visit.
   b. He will refer such cases to the nearest PHC for clinical examination by the Medical Officer and confirmation by RDK.
   c. He shall take the migratory status of the family/guest during last three months.
2. He will also follow up and persuade the patients to ensure complete treatment.
3. He will keep a record of all such cases and shall verify from PHC about their diagnosis during the monthly meeting or through health supervisor during his visit.
4. He will carry a list of all Kala-azar cases in his area for follow up and will ensure administration of complete treatment.
5. He will supervise the spray activities in his area.
6. He will conduct all health education activities particularly through inter-personal communication by carrying proper charts etc. for community awareness and their involvement.

Where Acute Encephalitis Syndrome/Japanese Encephalitis is Endemic

1. From each family he shall enquire about presence of any fever cases with encephalitic presentation.
2. He will guide the suspected cases to the nearest diagnostic and treatment centre (Primary Health Care Centre or Community Health Centre) for diagnosis and treatment by the medical officer.
3. He will keep a record of all such cases and shall verify from PHC about their diagnosis during the monthly meeting or through health supervisor during his visit.
4. He will carry a list of all JE cases in his area for follow up.
5. He will assist during the spray activities in his area.
6. He will conduct all health education activities particularly through inter-personal communication by carrying proper charts etc. and also assist health supervisors and other functionaries in their education activities.

Where Dengue/Chikungunya is Endemic

1. He will guide the suspected cases of Dengue/ Chikungunya to the nearest PHC/CHC and treatment centre for clinical diagnosis and treatment by the medical officer..
2. He will keep a list of all Dengue/Chikungunya cases for follow up and also helping referral of the cases.
3. He will supervise the source reduction activities in his area and also assist the vector control activities.

4. He will coordinate the activities carried out by Village Health Sanitation & Nutrition Committee.
5. He will ensure source reduction activities during observance of anti Dengue month during July.
6. He will conduct health education activities particularly through inter-personal communication by carrying proper charts etc. for social mobilization and community awareness to eliminate source of Aedes breeding and also guide the community for proper water storage practices.

National Leprosy Eradication Programme (NLEP)

- Impart Health Education on Leprosy and its treatment to the community.
- Refer suspected new cases of leprosy and those with complications to PHC.
- Provide subsequent doses of MDT to patients ensure regularity and completion of treatment and assist health supervisor in retrieval of absentee/ defaulter.
- Update the case cards at Sub-centres & treatment register at sector PHC.
- Assist leprosy disabled people in self care practices, monitor them and refer them to PHC when ever required.

National Blindness Control Programme (NBCP)

- Identify and refer all cases of blindness including suspected cases of cataract to Medical Officer, PHC.

Revised National Tuberculosis Control Programme (RNTCP)

- Identify persons especially with fever for 15 days and above with prolonged cough or spitting blood and take sputum smears from these individuals. Refer these cases to the M.O. PHC for further investigations.
- Check whether all cases under treatment for Tuberculosis are taking regular treatment, motivate defaulters to take regular treatment and bring them to the notice of the medical officer PHC.
- Educate the community on various health education aspects of tuberculosis programme.
- Assist the ASHA/similar village health volunteer to motivate the TB patients in taking regular treatment.

Universal Immunization Programme

- Assistance to HW for administering all UIP vaccines like OPV, BCG, DPT, TT, Measles, Hepatitis B, JE etc. to all the beneficiaries including pregnant women and provision of Vitamin A prophylaxis as per immunization schedule.
- Assistance to HW(F) for conducting VHN Day in coordination with other partners
- Assist the Health Assistant (male)/Health Assistant (female)/LHV in the school health programme
- Educate the people in the community about the importance of immunization against the various communicable diseases.

Reproductive and Child Health Programme (RCH)

- Utilize the information from the eligible couple and child register for the family planning Programme.
- Spread the message of family planning to the couples and motivate them for family planning individually and in groups.
- Distribute conventional contraceptives and oral contraceptives to the couples.
- Help prospective acceptors of sterilization in obtaining the services, if necessary by accompanying them or arranging for the ASHA/ Dai to accompany them to the PHC/Hospital.
- Provide follow up services to male family Planning acceptors, and refer those cases that need attention by the physician to PHC/Hospital.

- Build rapport with satisfied acceptors, village leaders, ASHA, Dais and others and utilize them for promoting Family Welfare Programme.
- Identify the male community leaders in each village of his area.
- Assist the Health Assistant male in training the leaders in the community and in educating and involving the community in family welfare Programme.
- Identify the women requiring help for medical termination of pregnancy, refer them to the nearest approved institution and inform the Health Worker (female).
- Educate the community on the availability of service for Medical Termination of Pregnancy.
- Educate mother/family/community on home management of diarrhea and ORS, personal hygiene especially hand washing before feeding the child.
- Provide care and treatment for Diarrhoea, ARI and other common newborn and childhood illnesses.
- Report any outbreak of diarrhoea disease.
- Measures such as chlorination of drinking water to be carried out.
- Proper sanitation to be maintained.
- Encourage use of latrines.
- Identify and refer cases of genital sore or urethral discharge or non-itchy rash over the body to medical officer.

Communicable Diseases

- HIV/STI Counseling, HIV/STI screening after receiving training.
- Identify cases of diarrhoea/dysentery, fever with rash, jaundice encephalitis, diphtheria, whooping cough and tetanus, Poliomyelitis, neo-natal tetanus, acute eye infections and notify the Health Assistant male and M.O. PHC immediately about these cases.
- Carry out control measures until the arrival of the Health Assistant (Male) and assist him in carrying out these measures.
- Educate the community about the importance of control and preventive measures against communicable disease and about the importance of taking regular and complete treatment.

Non-Communicable Diseases

- IEC Activities for prevention and early detection of hearing impairment/deafness in health facility, community and schools, harmful effects of Tobacco, mental illnesses, IDD, Diabetes, CVD and Strokes.
- House to House surveys to detect list & refer cases of hearing and visual impairment and maintain records.
- Early detection of hearing impairment and cases of deafness and level appropriate referrals.
- Sensitization of ASHA/AWW/PRI about prevention and treatment of deafness.
- Mobilizing community members for screening camps and assisting in conduction of screening camps if needed.
- Motivation for quitting and referrals to Tobacco Cassation Centre at District Hospital.
- Sensitization of ASHA/AWW/PRI about the Non-communicable diseases.
- Identification and referral of common mental illnesses and Epilepsy cases for treatment and follow them up in community.
- Greater participation/role of Community for primary prevention of NCD and promotion of healthy lifestyle.
- Ensuring regular Testing of salt at household level for presence of Iodine through Salt Testing Kits by ASHAs.
- In Fluorosis affected districts
  - IEC to prevent flourosis.
  - Identify the persons at risk of Fluorosis, suffering from Fluorosis and those persons having deformities due to Fluorosis.
  - Line listing source reduction activities, reconstructive surgery cases, rehabilitative intervention activities, focused local action and referral of what is not possible locally.
- Promoting formation and registeration of **'Self Health Care Group of Elderly Persons'**.

- Oral Health education especially to antenatal and lactating mothers, school and adolescent children, first aid and referral of cases with oral problems.
- Health messages on Disability, Identification of Disabled persons and their appropriate referral.

House- to House Surveys

These surveys would be conducted once annually in April. Some of the diseases would require special surveys- but at all times not more than one survey per month would be expected.

Surveys would be done with support and participation of ASHAs, Anganwadi Workers, community volunteers, panchayat members and Village Health Sanitation and Nutrition Committee members.

The Male Health Worker would take the lead and be accountable for the organization of these surveys and the subsequent preparation of lists and referrals.

Environment Sanitation

- Chlorinate the public water sources including wells at regular intervals.
- Educate the community on
  a. The method of disposal of liquid wastes
  b. The method of disposal of solid waste
  c. Home sanitation
  d. Advantage and use of sanitary type of latrines
  e. Construction and use of smokeless c hulhas
- Coordination with Village Health Sanitation and Nutrition Committee.

Primary Medical Care

- Provide treatment for minor ailments, first aid for accidents and emergencies and refer cases beyond his competence to the nearest hospital or PHC/CHC.

Health Education

- Educate the community and family planning about the availability of maternal and child healths services and encourage them to utilize the facilities.

Nutrition

- Identify cases of Low Birth Weight and malnutrition among infants and young children (0-5 years) in his area, give the necessary treatment and advice or refer them to the anganwadi for supplementary feeding and refer serious cases to the PHC.
- Educate the community about the nutritious diet for mothers and children utilizing locally available food.

Vital Events

- Enquire about births and deaths occurring in his area, record them in the births and deaths register, sharing the information with ANM and report them to the Health Assistant (Male)/Health Assistant (Female).
- Educate the community on the importance of registration of births and deaths.

Record Keeping and other Miscellaneous functions

- Survey all the facilities in his area and prepare/ maintain maps and charts for the village.
- Prepare, maintain and utilize family and village records.
- Assist the ANM to prepare and maintain the eligible couple as well as maternal & child health register.
- Maintain a record of cases in his area, who are under treatment for tuberculosis and leprosy.
- Prepare and submit the prescribed monthly reports in time to the Health Assistant (Male).
- While maintaining passive surveillance register for malaria cases, he will record:
  - No. of fever cases
  - No. of blood slides prepared
  - No. of malaria positive cases reported
  - No. of cases given radical treatment
- Prepare an annual Village Health Plan in association with ANM, PRI and VHSC members and submit the same to block.

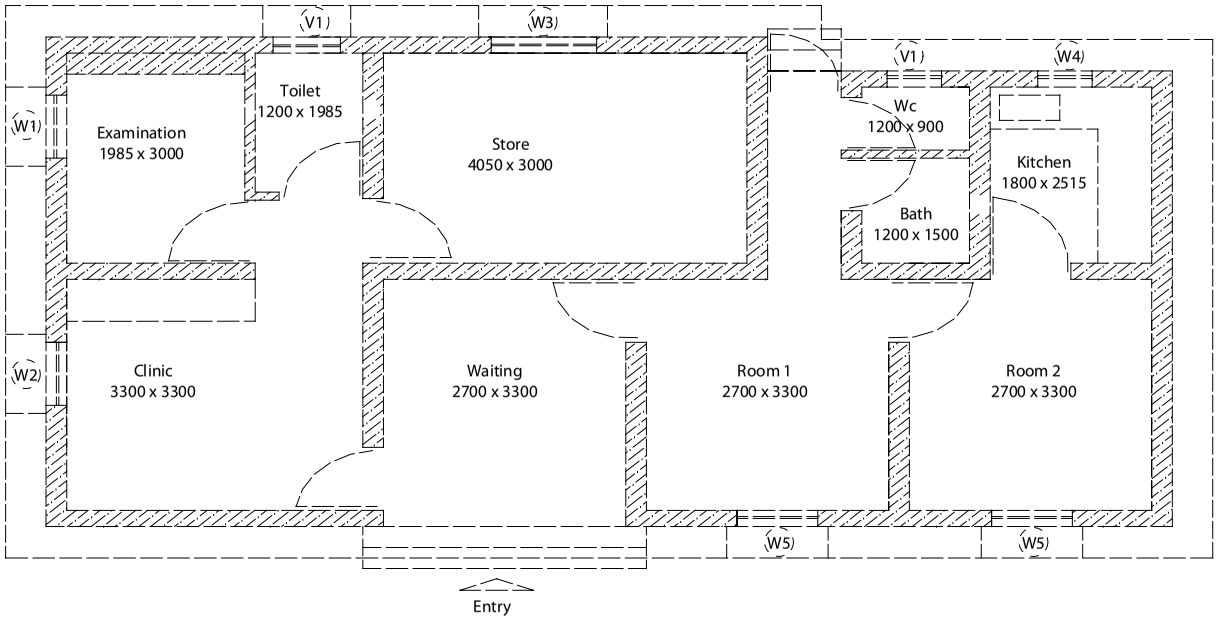
Job Responsibilities of Staff Nurse (wherever to be provided)

1. All RCH related activities including conducting deliveries, episiotomy etc. as envisaged for a Type B Sub-centre
2. Supervision and facilitation of Immunization work
3. Supportive Supervision and facilitation of all the work to be done by Health worker (female and male)
4. Training of subordinate staff
5. Running the Sub-centre OPD
6. Ensuring quality in delivery of all services

Annexure 3

LAYOUT OF SUB-CENTRE

Layout of Type A Sub-Centre



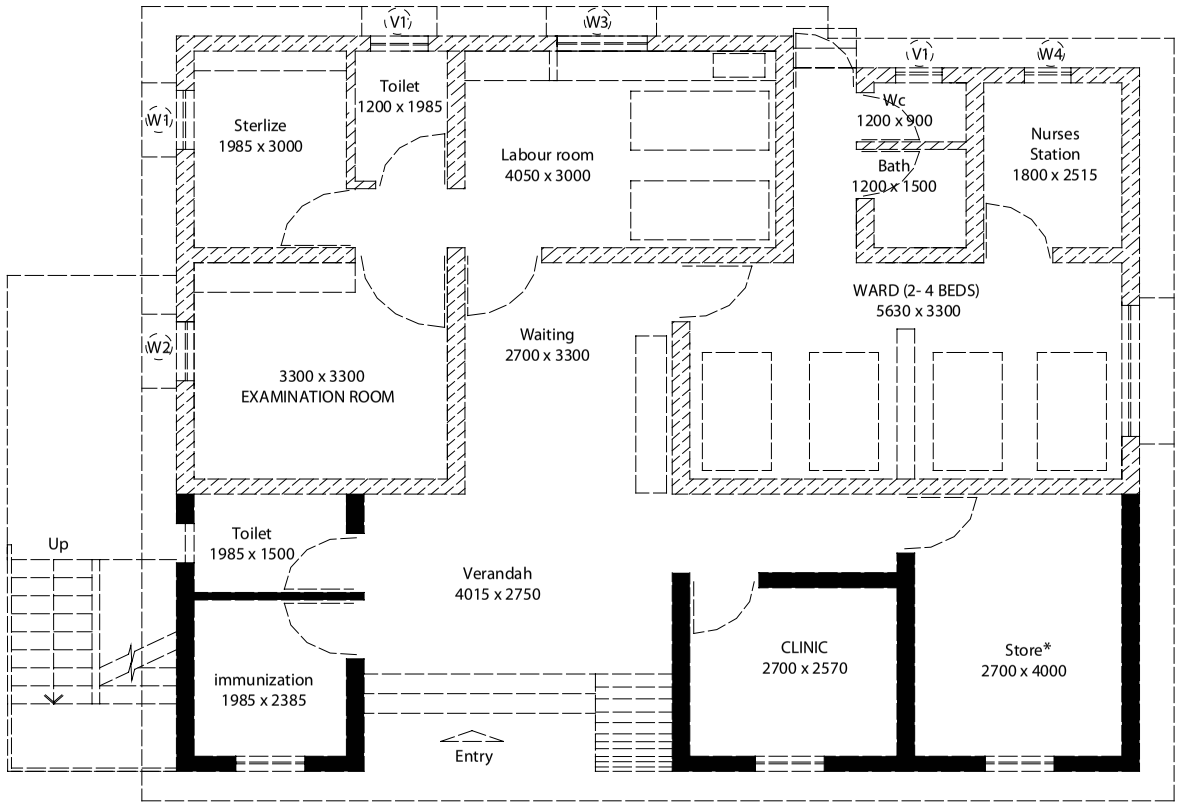
Ground floor plan

Notes:
Efforts should be made to retain the door positions as shown in the drawing. Window positions may be changed according to site specific requirements for adequate ventilation.

Total covd. Area = 85 sq. m
= 915 sq. ft

Type A Sub-centre
Standard design as per IPHS

Layout of Type B Sub-Centre



Stair f. Flr.
Res. For staff nurse & ANM

Ground floor plan

Notes:
Efforts should be made to retain the door positions as shown in the drawing. Window positions may be changed according to site specific requirements for adequate ventilation.

On ground floor

Existing area	= 85 sq. m. (915 sq. ft)
Proposed addition	= 65 sq. m. (700 sq. ft)
Total	= 150 sq. m. (1615 sq. ft)

On first floor

Res qtr. For 2 ANM & 1 staff nurse qrt.
Incld stair = 125 sq. m = 1345 sq. ft.

Proposed existing shown thus
Proposed addition shown thus

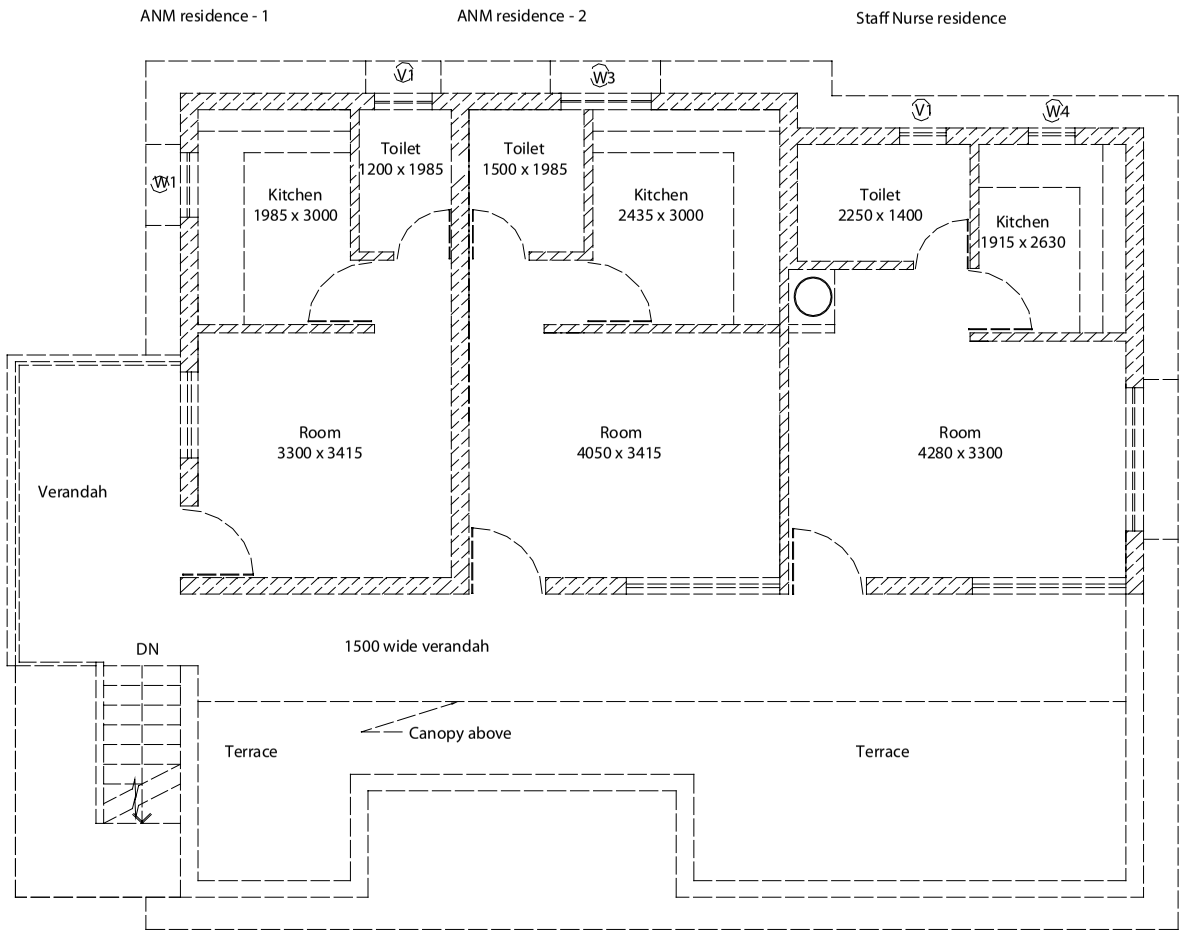
* This room may be used for doctor's chamber, whenever rural doctor is provided

Area statement

Existing area	= 85 sq. m. (915 sq. ft)
Addition on G.F.	= 65 sq. m. (700 sq. ft)
Addition on F.F.	= 125 sq. m. (1345 sq. ft)
Total addition	= 190 sq. m. (2045 sq. ft)

Type B Sub-centre

Proposed addition on existing
Proto type Sub-centre as per IPHS



First floor plan

Notes:
Efforts should be made to retain the door positions as shown in the drawing. Window positions may be changed according to site specific requirements for adequate ventilation.

Built up area	= 86 sq, m
Area under verandah	= 30 sq. m
Area under open stair	= 9 sq. m
Total area	= 125 sq. m (1345 sq. ft)

Type B Sub-centre

Proposed addition on existing Proto type Sub-centre as/IPHS

Note for Annexure 4, 5 and 5A

In **Type A** Sub-centres, furniture and equipment required for delivery facilities at the Sub-centre, will not be provided.
Type B Sub-centres should be provided with all furniture and equipment including those required for Labour Room and Newborn care.

Annexure 4

LIST OF FURNITURE, OTHER FITTINGS AND SUNDRY ARTICLES

Following list is suggestive and not exhaustive; quantity may vary as per requirement, usage and availability of space and Type of Sub-Centre.

	Essential	Desirable
Examination Table	1	
Foot step		1
Table	1	
Table for Immunization		1 (610 mm x 915 mm)
Chairs	3	5
Medicine Chest	1	
Almirahs		1
Bench for waiting area	1	2
Stool	3	5
Labour table*	1	
Beds with mattress*	4	
Screen	1	
Lamp	1	3
Clock	1	
Fans	2	3
Tube light	3	
Sundry Articles		
Buckets	1	2
Mugs	1	2
Kerosene stove	1	
Sauce pan with lid	1	
Water Jug	1	1
Dust Bin with lid	1	
Rubber/plastic sheet	As per need	
Drum with tap for storing water	1	
Waste disposal twin bucket for hypochlorite solution/bleach	As per need	
Disposable Jars	-	as per requirement
Generator Facility*	1	
Computer*	1	
Refrigerator*	1	
Room Heater/Cooler	as per requirement	

The above list may be modified based on the local requirements and available space in the building.

* For Type B Sub-centres only.

Annexure 5

EQUIPMENT AND CONSUMABLES

List of Equipment

Following list is suggestive and not exhaustive; quantity may vary as per requirement and usage.

Sl. No.	Item Description	Quantity/Kit	
		Essential	Desirable
1	Basin 825 ml. ss (Stainless Steel) Ref. IS 3992	**1**	**+1**
2	Basin deep (capacity 6 litre) ss Ref: IS: 5764 with Stand	**1**	
3	Tray instrument/Dressing with cover 310 x 195x63mm SS, Ref IS: 3993	**1**	
4	Flashlight/Torch Box-type pre-focused (4 cell)	**1**	
5	Torch (ordinary)	**2**	
6	Dressing Drum with cover 0.945 liters stainless steel	**1**	
7	Hemoglobinometer – set Sahli type complete	**1**	
8	Weighing Scale, Adult 125 kg/280 lb	**1**	
9	Weighing Scale, Infant (10 Kg)	**1**	
10	Weighing Scale, (baby) hanging type, 5 kg	**1**	
11	Sterilizer	**1**	
12	Surgical Scissors straight 140 mm, ss	**1**	
13	Sphygmomanometer Aneroid 300 mm with cuff IS: 7652	**1**	**2**
14	Kelly's hemostat Forceps straight 140 mm ss	**1**	
15	Vulsellum Uterine Forceps curved 25.5 cm	**1**	
16	Cusco's/Graves Speculum vaginal bi-valve medium	**1**	
17	Sims retractor/depressor	**1**	
18	Sims Speculum vaginal double ended ISS Medium	**1**	

Sl. No.	Item Description	Quantity/Kit	
		Essential	Desirable
19	Uterine Sound Graduated	**1**	
20	Cheatle's Forcep	**1**	
21	Vaccine Carrier	**2**	
22	Ice pack box	**8**	
23	Sponge holder	**2**	**+2**
24	Plain Forceps	**5**	
25	Tooth Forceps	**2**	
26	Needle Holder	**2**	
27	Suture needle straight	**10**	
28	Suture needle curved	**10**	
29	Kidney tray	**4(big) & 4 (small)**	
30	Artery Forceps, straight, 160mm Stainless steel	**5**	**+5**
31	Dressing Forceps (spring type), 160mm, stainless steel	**1**	
32	Cord cutting Scissors, Blunt, curved on flat, 160 mm ss	**1**	**+1**
33	Clinical Thermometer oral & rectal	**1 each**	
34	Talquist Hb scale	**1**	
35	Stethoscope	**1**	
36	Foetoscope	**1**	
37	Hub Cutter and Needle Destroyer	**1**	
38	Ambu Bag(Paediatric size) with Baby mask	**1**	
39	Suction Machine		**1**
40	Oxygen Administration Equipment	**1**	
41	Tracking Bag and Tickler Box (Immunization)		**1**
42	Measuring Tape	**1**	
43	I/V Stand	**1**	

Note: Number of equipment required may vary according to case load and usage.

List of Consumables

Syringe (10 cc, 5 cc, 2 cc) and AD Syringes (0.5 ml and 0.1 ml) for immunization	As per requirement
Disposable gloves	As per requirement
Mucus extractor	As per requirement
Disposable Cord clamp	As per requirement
Disposable Sterile Urethral Catheter (rubber plain 12 fr)	As per requirement
Foley's catheter (Adult)	As per requirement
Dry cell/Battery	As per requirement
Dipsticks for urine test for protein and sugar	1 container of 25 strips

Urine Pregnancy test Kits	As per requirement
Disposable lancet (Pricking needles)	As per requirement
Disposable Sterile Swabs	As per requirement
Glass Slide box of 25 slides	As per requirement
Routine Immunization Monitoring Chart	As per requirement
Blank Immunization Cards/Joint MCH Card (one per pregnant mother) and Tally Sheets (one per immunization session)	As per requirement
Whole Blood Finger Prick HIV Rapid Test and STI Screening Test each (In Type B Sub-centres in high prevalence districts to be provided by NACO)	300 (Desirable)
Reagents such as Hydrochloric acid, acetic acid, Benedict's solution, Bleaching powder, Hypochlorite solution, Methylated spirit etc.	As per requirement
Partgraph charts	As per requirement
Cleaning material, detergent	As per requirement
Speciman collection Bottles	As per requirement
IV canula and Intravenous set	As per requirement
200 watt Bulb	2
Black Disposal bags	As per requirement
Red Disposal Bags	As per requirement
Salt - Iodine test kit	As per requirement

Requirements for a fully Equipped and Operational Labour Room

(Essential if delivery is conducted at the Sub-Centre i.e. Type B Sub-Centre)

Privacy of a woman in labour should be ensured (a quality assurance issue).

A fully equipped and operational labour room must have the following:

1. A labour table with Mattress, pillow and Kelly's pad
2. McIntosh Sheet
3. Suction machine
4. Facility for Oxygen administration
5. Sterilization equipment
6. 24-hour running water
7. Electricity supply with back-up facility (generator with POL)
8. Attached toilet facilities
9. **Newborn Corner: Annexure 5A**
10. Emergency drug tray: This must have the following drugs for emergency obstetric management before referral
    * Inj. Oxytocin
    * Inj Magnesium sulphate
    * Inj. Methyl ergometrine maleate
11. Delivery kits, including those for normal delivery and assisted deliveries.

Requirements for Home Delivery by Skilled Birth Attendant

A. Home Delivery Kit

The delivery kit should contain disposable items, as well as supplies and essential drugs required for conducting a home delivery.

Pocket 1: Disposable Delivery Kit

Soap, new blade, clean thread, clean sheet, gloves, plastic apron, gauze piece.

Pocket 2: Drugs

Injection Gentamicin, Injection Magnesium sulphate 50%, Injection Oxytocin, Capsules Ampicillin, Tablet Metronidazole, Tablet Misoprostol, Tablet Paracetamol, ORS.

Pocket 3: Supplies

Syringes with needle (2ml, 5ml, 10ml) Needles 22G, Intravenous set, Ringer lactate solution 500 ml, Adhesive tape, Blood pressure apparatus with stethoscope, Measuring tape, Partographs, Dipsticks for testing sugar and proteins in urine, Puncture –proof box, Thermometer, Spirit, cotton and gauze, Torch, Plain Rubber catheter and Foley's catheter, Mucus sucker, Ambu bag and mask, Mouth gag, Trash bag.

B. Home Birth Checklist

1. Clean home
2. Clean surfaces in room where woman will give birth
3. Light for birth attendant (flashlight)
4. Clean gowns for mother
5. Sanitary napkins
6. Bath towels
7. Clean sheets
8. Plastic sheeting to protect mattress (to be placed under sheets during delivery- can cut up large plastic bags if necessary)
9. Disinfectant soap
10. Cord clamp/Thread which can be boiled.
11. Disposable sterile new blade (to cut the cord)
12. Disposable single-use gloves
13. One trash can (preferable lined with plastic bags) for trash and/or waste products
14. Clean cotton blankets to receive newborn Diapers
15. Clean clothes for newborn
16. If it is cold, a source of heat should be provided so that the newborn is not born into a cold environment. A 200 watt bulb is appropriate. A traditional heating option, which generates minimal smoke, in case there is no electricity, may be used.

Annexure 5A: NEWBORN CORNER IN LABOUR ROOM

Delivery rooms in Labour rooms are required to have separate resuscitation space and outlets for newborns. Some term infants and most preterm infants are at greater thermal risk and often require additional personnel (Human Resource), equipment and time to optimize resuscitation. An appropriate resuscitation/ stabilization environment should be provided as provision of appropriate temperature for delivery room and resuscitation of high-risk preterm infants is vital to their stabilization.

Services at the Corner

This space provides an acceptable environment for most uncomplicated term infants, but may not support the optimal management of newborns who may require referral to Special Newborn Care Unit (SNCU). Services provided in the Newborn Care Corner are;

- Care at birth
- Resuscitation
- Provision of warmth
- Early initiation of breastfeeding
- Weighing the neonate

Configuration of the Corner

- Clear floor area shall be provided for in the room for newborn corner. It is a space within the labour room, 20-30 sq. ft. in size, where a radiant warmer will be kept.
- Oxygen, suction machine and simultaneously-accessible electrical outlets shall be provided for the newborn infant in addition to the facilities required for the mother.
- **Clinical procedures:** administration of oxygen, airway suctioning would be put in place.
- Resuscitation kit should be placed in the radiant warmer.
- Provision of hand washing and containment of infection control if it is not a part of the delivery room.
- The area should be away from draught of air, and should have power connection for plugging in the radiant warmer.

Equipment and Consumables Required for the Corner

Item No.	Item Description	Essential	Desirable	Quantity	Installation	Training	Civil	Mechanical	Electrical
1	Open care system: radiant warmer, fixed height, with trolley, drawers, O^2-bottles	E		1	X	X	X	X	X
2	Resuscitator (silicone resuscitation bag and mask with reservoir) hand-operated, neonate, 500 ml	E		1		X			
3	Weighing Scale, spring	E		1		X			
4	Pump suction, foot operated	E		1		X			
5	Thermometer, clinical, digital, 32-34 ^{0}C	E		2					
6	Light examination, mobile, 220-12 V		D	1	X				X
7	Hub Cutter, syringe	E		1		X			
Consumables									
8	Intra Venous Cannula 24 G, 26 G	E							
9	Extractor, mucus, 20 ml, ster, disp Dee Lee	E							
10	Tube, feeding, CH07, L40cm,ster,disp	E							
11	Oxygen catheter 8 F, Oxygen Cylinder		D						
12	Sterile Gloves	E							

Annexure 6

SUGGESTED LIST OF DRUGS

Note: Drug Requirements would be same for both types of Sub-Centre except the drugs to manage Deliveries may not be required for type A Sub-centres.

KIT- A for Sub-Centres

Sl. No	Name of the Drug/Form	Dosage	Quantity/Kit
1	Oral Rehydration Salts IP	Reduced osmolarity ORS as per WHO-Sachet of 21.8 gm	300 packets
2	Iron & Folic Acid Tablets (IFA) – large (as per the standards provided)	Dried Ferrous Sulphate IP eq. to Ferrous Iron 100 mg & Folic Acid IP 0.5 mg	15000 tablets
3	Folic Acid Tablets IP	Folic Acid IP 5 mg	1500 tablets
4	Iron & Folic Acid Tablets (IFA) – small (as per the standards provided)	Dried Ferrous Sulphate IP eq. to Ferrous Iron 20 mg & Folic Acid IP 0.1 mg	13000 tablets
5	Trimethoprim & Sulphamethoxazole Tablets IP (Pediatric)	Trimethoprim IP 20mg/Sulphamethoxazole IP 100 mg	1000 tablets
6	GV Crystals (Methylrosanilinium Chloride BP)		250 gm
7	Zinc Sulphate Dispersible Tablets USP	Zinc Sulphate USP eq. to Elemental Zinc 20 mg	1050 tablets
8	Iron & Folic Acid Syrup (as per standards provided)	Ferrous iron (derived from Ferrous Sulphate, Ferrous Fumarate, Ferrous Gluconate or Ferrous Ascorbate) 100 mg and Folic Acid IP 0.5 mg per 5ml; 100 ml in each bottle	400 bottles
9	Water – Miscible Vitamin Concentrate IP (Vitamin A Syrup)	Each ml contains: Vitamin A, 100 000 IU ; 100 ml in each bottle	12 bottles

KIT- B for Sub-Centres

Sl. No	Name of the Drug/Form	Dosage	Quantity/Kit
1	Methylergometrine Tablets IP	Methylergometrine maleate IP 0.125 mg	240 tablets
2	Paracetamol Tablets IP	Paracetamol IP 500 mg	1000 tablets
3	Methylergometrine Injection IP	Methyergometrine maleate 0.2 mg/ml; 1 ml in each ampoule	10 ampoules

Sl. No	Name of the Drug/Form	Dosage	Quantity/Kit
4	Albendazole Tablets IP	Albendazole IP400 mg	200 tablets
5	Dicyclomine Tablets IP	Dicyclomine hydrochloride IP10 mg	180 tablets
6	Chloramphenicol Eye Ointment IP	1 % w/w Chloramphenicol in applicaps; 250 mg in each applicap	500 applicaps
7	Povidone Iodine Ointment USP	Povidone Iodine USP 5% w/w; 15g in each tube	10 tubes
8	Cotton Bandage (As per Schedule F II)	Each bandage of 7.6 cm X 1 metre	120 Rolls
9	Absorbent Cotton IP	Each roll of 100 gm	10 Rolls

Kit A and B are being supplied at present biannually. Contents of the kits may be revised from time to time. As and when revised, same is to be followed

Desirable

Additional Drugs required for Emergency obstetric Situations to be provided by SBA trained ANMs

Inj. Gentamycin
Inj. Magnesium Sulphate
Inj. Oxytocin
Cap. Ampicillim
Tab. Metronidazole
Tab. Misoprostol 200 mg

Other Drugs and vaccines:

1. BCG, DPT, OPV, Measles, TT, Hepatitis B, JE and any other vaccines as per Immunization Schedule and campaign vaccines (if any).
2. Syrup Cotrimoxazole
3. Tab. Cotrimoxazole 80+400 mg (for adults)
4. Syrup Paracetamol
5. Tab. Albendazole 400 mg
6. Adhesive tape (leucoplast & Micropore)
7. Savlon solution (Anti-septic Solution)
8. Betadine solution (Povidone Iodine solution 5%)
9. Clove oil
10. Gum paints

Medicines and other consumables required for responsibilities regarding different National Disease Control Programmes:

1. Tab. and syrup Chloroquine for treatment of P. vivax and A.C.T Blister pack for treatment of P.F. cases.
2. Tab. Primaquine (2.5 mg and 7.5 mg).
3. Tab. DEC (Di Ethyle Carbamazine – only in filaria endemic areas)
4. Anti leprosy drugs (MDT Blister Packs) for patients under treatment.
5. Rapid Diagnostic Kits for Malaria under National Vector Borne Disease Control Programme.
6. Anti-tuberculosis drugs as supplied under RNTCP (only in DOT centres).

Contraceptive supplies required for Family Planning:

1. Condoms (Nirodh)
2. Oral pills
3. Copper – T (380-A)
4. Emergency contraceptive pills

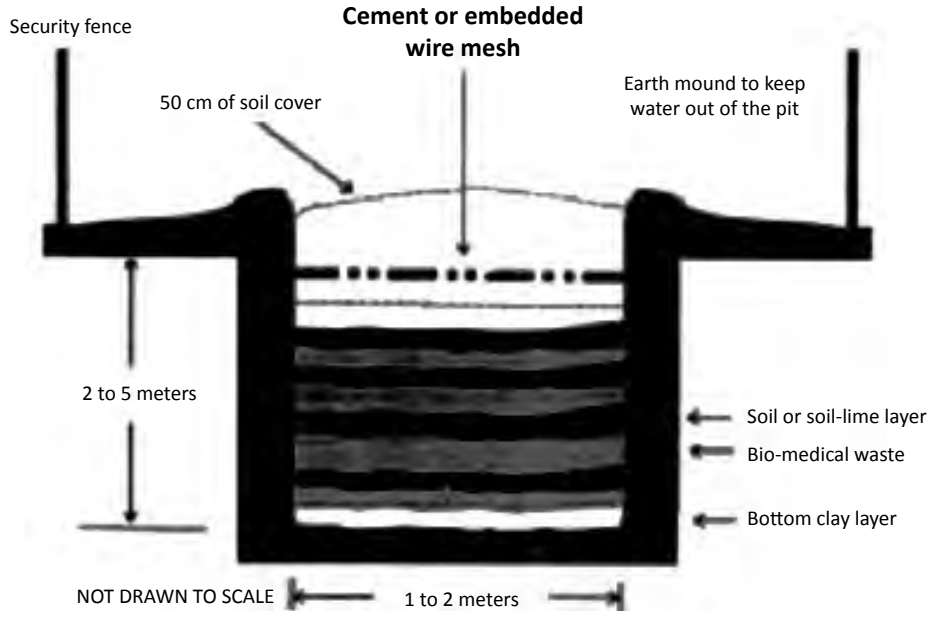
List of Drugs being provided in ASHA Drug Kit

1. Disposable Delivery Kit for Clean deliveries at Home
2. Tab. Iron
3. Tab. Folic Acid
4. Tab Punarvadu Mandur (ISM Preparation of Iron)
5. Syrup Iron
6. ORS Packets
7. Tab. Paracetamol
8. Tab. Dicyclomine
9. Povidone Iodine Ointment 5% tube
10. GV Paint
11. Cotton Absorbent roll of 500 gms
12. Bandages, 4cmx4meters
13. Tab. Chloroquine
14. Condoms
15. Oral Contraceptive Pills (in cycles)
16. Emergency Contraceptive Pills
17. Thermometers

Annexure 7

STANDARDS FOR DEEP BURIAL PIT; BIO-MEDICAL WASTE (MANAGEMENT AND HANDLING) RULES, 1998

1. A pit or trench should he dug about 2 meters deep. It should be half filled with waste, then covered with lime within 50 cm of the surface, before filling the rest of the pit with soil.
2. It must be ensured that animals do not have any access to burial sites. Covers of galvanised iron/ wire meshes may be used.
3. On each occasion, when wastes are added to the pit, a layer of 10 cm of soil shall be added to cover the wastes.
4. Burial must be performed under close and dedicated supervision.
5. The deep burial site should be relatively impermeable and no shallow well should be close to the site.
6. The pits should be distant from habitation, and sited so as to ensure that no contamination occurs of any surface water or ground water. The area should not be prone to flooding or erosion.
7. The location of the deep burial site will be authorised by the prescribed authority.
8. The institution shall maintain a record of all pits for deep burial.



Annexure 8

RECORDS AND REPORTS

Annexure 8A: Registers

1. Eligible Couple Register including Contraception
2. Maternal and Child Health Register:
   a. Antenatal, intra-natal, postnatal
   b. Under-five register:
      i. Immunization
      ii. Growth monitoring
   c. Above Five Child immunization
   d. Number of HIV/STI screening and referral
3. Births and Deaths Register
4. Drug Register
5. Equipment Furniture and other accessories Register
6. Communicable diseases/Epidemic Register/ Register for Syndromic Surveillance
7. Passive surveillance register for malaria cases.
8. Register for records pertaining to Janani Suraksha Yojana.
9. Register for maintenance of accounts including untied funds.
10. Register for water quality and sanitation
11. Minor ailments Register
12. Records/registers as per various National Health Programme guidelines (NLEP, RNTCP, NVBDCP, etc.)

Note:

1. As many registers as possible should be integrated.
2. Health Management Information System (HMIS) Reporting Format for Sub-Centre may be strictly followed for collection, recording and reporting of Data.

Annexure 8B: IDSP FORMAT

Reporting Format for Syndromic Surveillance (Form S) under Integrated Disease Surveillance Project

The Health Worker is required to transfer the information from the 'Register for Syndromic Surveillance' to Form S (Reporting Format for Syndromic Surveillance). The information in the registers of the AWW, village volunteers and non-formal providers will also be transferred to the Form S, at the Sub-Centre. Each reporting unit will be assigned a Unique Identifier or ID No. which will be filled in by the District Surveillance Unit and the Health Worker should leave this space blank. The Health Worker will fill the information on reporting week (copy the information from the 'Register for Syndromic Surveillance').

Form S will be provided in triplicate (three copies). The first and second pages of Form S (colors Yellow and Green respectively), will be separated from the third page (color – Blue). The third page (Blue color page) will be retained by the Health Worker and the first and second pages (Yellow and Green) will be given/sent to the Medical Officer of the supervising PHC on the Monday, following the end of a particular reporting week.

Form S
Reporting Format for Syndromic Surveillance

(To be filled by Health Worker, Village Volunteer, Non-formal Practitioners)

State..... District..... Block..... Year.....

Name of the health worker/Volunteer/Practitioner	Name of the Surpervisor	Name of the Reporting Unit

ID No./Unique idenlifier (To be filled by DSU_)	Reporting week	From dd mm yy
		To dd mm yy

	a	b	c	d	e	f	g	h	i	j	k	l	m	n
	Cases						Total	Deaths						Total
	Male			Female				Male			Female			
	<5yr	≥5yr	Total	<5yr	≥5yr	Total		<5yr	≥5yr	Total	<5yr	≥5yr	Total	
1. Fever														
Fever <7 days														
1. Only Fever														
2. With Rash														
3. With Bleeding														
4. With Daze/Semiconsciousness/ unconsciousness														
Fever > 7 days														
2. Cough with or without fever														
<3 weeks														
>3 weeks														
3. Loose Watery Stools of Less Than 2 Weeks Duration														
With some/Much Dehydration														
With no Dehydration														
With Blood in Stool														
4. Jaundice cases of Less Than 4 Weeks Duration														
Cases of acute Jaundice														
5. Acute Flaccid Paralysis Cases in Less Than 15 Years of Age														
Cases of Acute Flaccid Paralysis														
6. Unusual Symptoms Leading to Death or Hospitalization that do not fit into the above.														

Date: signature

Annexure 9

CHECKLIST

Checklist for Internal Monitoring of Sub-Centres: quarterly/half yearly/annually

Services	Existing	Expected	Remarks
Population covered			
Maternal Health			
No. of ANC registration			
No. of ANC registered in 1st trimester			
No. of ANC provided at least 4 antenatal checkups			
No. of ANC whose BP has been monitored			
No of ANC whose Hb has been monitored			
No. of ANC whose Urine has been examined for sugar and protein			
No. of ANC diagnosed as high risk pregnancy			
No. of ANC given 100 IFA tablets during pregnancy			
No. of women given booster/2 doses of TT			
No. of pregnancy cases with danger sign and symptoms referred to higher institutions			
No. of deliveries occurred in institutions			
No. of Post natal cases visited with Minimum 3 PNC Visits within 1st week of delivery i.e. on 0, 3, 7th day.			
No. of missed – out cases of ANC/PNC tracked			
No. of deliveries conducted at the Sub-Centre			
Are deliveries being monitored through Partograph?			
Are MCH Card being given to the beneficiaries?			
No. of pregnancies detected by utilizing Pregnancy Test Kits.			
Child health:			
No. of fully immunised infants			
No. of children who received measles vaccine - less than 1year - more than 1 year			
No. of newborns whose birth weight has been taken			
No. of newborns whose birth weight has been less than 2500 gms			
No. of under five children with Grade I Malnutrition			
No. of under five children with grade II malnutrition			
No. of under five children with Grade III Malnutrition			

Services	Existing	Expected	Remarks
Family Planning No. of eligible couples registered No. of protected couples with any FP method No. of couples who have adopted permanent method **Tubectomy and Type:** • Minilap Sterilization • Interval Sterilization • Post partum Sterilization • Laparoscopic Sterilization			
Vasectomy **No. of Eligible Couples using spacing methods** • IUCD • Oral pills • Nirodh • Emergency contraception • Counseling services **Infrastructure Available** Availability of own/rented Sub-Centre building Examination room Labour room Drinking water facility Toilets Electricity Waste disposal Residence for Health Workers ANM, HW(Male) **Equipment Availability In working condition As per list** **Drugs Availability As per list** **Transport facility for the staff** **Monitoring Mechanism:** a) Supervisory visits by LHV Health Supervisor(Male) MO I/C of PHC b) By Village Health Sanitation and Nutrition Committee **Citizens'Charter** Record Keeping and Reporting Births & Deaths Other registers Reports sent to PHC No. of Fever cases No. of Blood slides prepared No. of Malaria positive cases reported No. of cases given radical treatment No. of cases of minor illnesses - treated - referred			

Annexure 9A : A SIMPLER CHECKLIST THAT CAN BE USED BY NON-GOVERNMENTAL ORGANIZATION/PANCHAYATI RAJ INSTITUTIONS/ SELF HELP GROUPS

General Information

Name of the village

Name of the District

Total population covered by the Sub-Centre:

Distance from the PHC

Availability of the Staff in the Sub-Centre

Following staff appointed in the Sub-Centre?

Health Worker-Female (ANM) – 2	Yes	No
Health Worker-Male (MPW) – 1	Yes	No
Staff Nurse (or additional ANM if Staff Nurse not available for Type B Sub-Centre only)	Yes	No
Contractual Safai-Worker – 1	Yes	No

Availability of Infrastructure at Sub-Centre

♦ Designated government building available for the Sub-Centre?	Yes	No	
♦ Water regularly available in the Sub-Centre?	Yes	No	
♦ Whether regular electricity supply to the Sub-Centre?	Yes	No	
♦ Examination table in working condition in the Sub-Centre?	Yes	No	No Information
♦ Is the sterilizer instrument in working condition in the Sub-Centre?	Yes	No	No Information
♦ Is the weighing machine in working condition in the Sub-Centre?	Yes	No	No Information
♦ Are the disposable delivery kits available in the Sub-Centre?	Yes	No	No Information

Availability of Services at the Sub-Centre

♦ Does the doctor visit the Sub-Centre at least once in a month?	Yes	No

- Is the day and time of this visit fixed? Yes No
- Are the residents of the village aware of the timings of the doctor's visit? Yes No
- Is the Antenatal care (Inj. T.T. IFA tablets, weight and BP checkup) provided in the Sub-Centre? Yes No
- Is the facility for referral of complicated cases of pregnancy/delivery available at Sub-Centre for 24 hours? Yes No
- Does the ANM/ASHA any trained personnel accompany the woman in labour to the referred care facility at the time of referral? Yes No
- Are the immunization services as per government schedule provided by the Sub-Centre? Yes No
- Is the treatment of diarrhea and dehydration available in the Sub-Centre? Yes No
- Is the treatment of minor illness like fever, cough, cold etc. available in the Sub-Centre? Yes No
- Is the facility for taking Peripheral blood smear in case of fever for detection available in the Sub-Centre? Yes No
- Are the contraceptive services like insertion of Copper – T, distributing Oral contraceptive pills or condoms provided by the Sub-Centre? Yes No

Are the Services of the Sub-Centres being Utilized by SC, ST or other Backward Classes

Total number of beneficiaries of all the services provided by the Sub-centres in the last quarter:

Out of these how many beneficiaries belong to SC?

Out of these how many beneficiaries belong to ST?

Out of these how many beneficiaries belong to other backward classes?

Annexure 10

PROFORMA FOR FACILITY SURVEY OF SUB-CENTRES ON IPHS

Identification

Name of the State: _____

District:_____

Tehsil/Taluk/Block _____

Name of the Village _____

Location Name of Sub-Centre: _____

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

Services

Population Covered (in numbers)

MCH Care Including Family Planning

Service Availability (Yes/No)

a. Ante-natal care
b. Intranatal care
c. Post-natal care
d. Newborn Care
e. Child care including immunization
f. Family Planning and contraception
g. Adolescent health care
h. Assistance to school health services
i. Facilities under Janani Suraksha Yojana
j. Treatment of minor ailments
k. First Aid (specify)

Availability of Specific Services (Yes/No)

a. Does the doctor visit the Sub-centre at least once in a month?
b. Is the day and time of this visit fixed?
c. Are the residents of the village aware of the timings of the doctor's visit?

d. Does the Health Assistant (male) or LHV visit the Sub-centre at least once a week?
e. Is the Antenatal care (Inj. T.T, IFA tablets, weight and BP check up) provided by those in the Sub-centre?
f. Are the facilities of Haemoglobin testing, Urine Testing for protein and sugar and Urine Test for pregnancy available?
g. Is the facility for referral of complicated cases of pregnancy/delivery available at Sub-centre for 24 hours?
h. Does the ANM/ASHA/any trained personnel accompany the woman in labour to the referred care facility at the time of referral?
i. Are the Immunization services as per Government schedule provided by the Sub-centre
j. Is the ORS for prevention of diarrhea and dehydration available in the Sub-centre?
k. Is the treatment of minor illness like fever, cough, cold, worm dis-infestation etc. available in the Sub-centre
l. Is the facility for taking Peripheral blood smear in case of fever for detection available in the Sub-centre?
m. Are the contraceptive services like insertion of Copper-T, distributing Oral contraceptive pills or condoms provided by the Sub-centre?
n. Is it a DOTS centre?

Other Functions and Services Performed (Yes/No)

a. Disease including VAPP and AEFI Surveillance
b. Control of local endemic diseases
c. Promotion of sanitation
d. Field visits and home care
e. National Health Programmes including HIV/AIDS control programme

Monitoring and Supervision Activities (Yes/No)

a. Training of traditional birth attendants and ASHA
b. Monitoring of Water quality in the village
c. Watch over unusual health events
d. Coordinated services with AWWs, ASHA, Village Health Sanitation and Nutrition Committee, PRIs
e. Coordination and supervision of activities of ASHA
f. Proper maintenance of records and registers
g. Tracking of drop out and left out cases of immunisation
h. Is there a Village Health Plan/Sub-centre Plan?
i. Is the scheme of ASHA implemented in Sub-centre?

Manpower

Sl. No.	Personnel	Existing	Recommended	Current Availability at Sub-centre (Indicate Numbers)	Remarks/ Suggestions/ Identified Gaps
1.	Health Worker (Female)				
2.	Health Worker (Male)				
3.	Staff Nurse				
4.	Contractual *Safai Karmachari* to keep the Sub-centre clean and assisting ANM.				

Physical Infrastructure (As per Specifications)

Sl. No.	Particulars	Current Availability at Sub-Centre	If available, area in Sq. mts.)	Remarks/Suggestions/ Identified Gaps
1.	**Location** a. Where is this Sub-Centre located? b. Within Village Locality Far from village locality If far from locality specify in km c. Whether located at an easily accessible area? (Yes/No) d. The distance (in Kms.) of Sub-Centre from the remotest place in the coverage area e. Travel time to reach the Sub-Centre from the remotest place in the coverage area f. The distance (in Kms.) of Sub-Centre from the PHC g. The distance (in Kms.) of Sub-Centre from the CHC			
2.	**Building** a. Is a designated government building available for the Sub-Centre? (Yes/No) b. If there is no designated government building, then where does the Sub-Centre located ▪ Rented premises ▪ Other government building ▪ Any other specify c. Area of the building (Total area in Sq. mts.) d. What is the present condition of the existing building e. What is the present stage of construction of the building ▪ Construction complete ▪ Construction incomplete f. Compound Wall/Fencing (1-All around; 2-Partial; 3- None) g. Ramp for use of trolley/wheel chair users (present/not present) h. Condition of plaster on walls ▪ Well plastered with plaster intact every where; ▪ Plaster coming off in some places; ▪ Plaster coming off in many places or no plaster)			

Sl. No.	Particulars	Current Availability at Sub-Centre	If available, area in Sq. mts.)	Remarks/Suggestions/ Identified Gaps
	i. Condition of floor: ■ Floor in good condition ■ Floor coming off in some places ■ Floor coming off in many Places or no proper flooring) j. Whether the cleanliness is Good/Fair/Poor? (Observe) k. Are any of the following close to the Sub-Centre? (Observe) (Yes/No) ■ Garbage dump ■ Cattle shed ■ Stagnant pool ■ Pollution from industry			
3.	Is boundary wall with gate existing? (Yes/No)			
4.	Prominent display boards in local language (Yes/No)			
5.	Separate public utilities for males and females (Yes/No)			
6.	Suggestion/complaint box (Yes/No)			
7.	Labour room a. Labour room available? (Yes/No) b. If labour room is present, number of deliveries carried out? c. If labour room is present, but deliveries not being conducted there, then what are the reasons for the same? ■ Staff not staying ■ Poor condition of the labour room ■ No power supply in the labour room ■ Any other specify			
8.	Clinic Room			
9.	Examination room			
10.	**Water supply** Source of water (1- Piped; 2-Bore well/hand pump/tube well; 3-Well; 4- Other (specify))			
11.	a. Whether overhead tank and pump exist (Yes/No) b. If overhead tank exist, whether its capacity sufficient? (Yes/No) c. If pump exist, whether it is in working condition? (Yes/No)			

Sl. No.	Particulars	Current Availability at Sub-Centre	If available, area in Sq. mts.)	Remarks/Suggestions/ Identified Gaps
12.	**Waste disposal** a. How the medical waste disposed off (please specify)?			
13.	**Electricity/Communication/ Transport** a. Regular electric supply available? (Yes/No) b. Backup generator/Inverter available (Yes/No) c. Communication facilities Telephone (Yes/No) d. Transport facility for movement of staff (Yes/No)			
14.	**Residential facility for the staff**	**Current Availability at Sub Centre**	**If available, area in Sq. mts.)**	**If available whether staff staying or not?**
	a. Health Worker (Female) b. Whether Health Worker (Male) available in the Sub-Centre? c. Is he staying at Sub-Centre Head Quarter village? (Yes/No) d. Staff Nurse			
15.	**Toilet facilities**			

Equipment (As per List)

Equipment	Available	Functional	Remarks/Suggestions/ Identified Gaps

Drugs (As per essential Drug List)

Drug	Available	Quantity	Remarks/Suggestions/ Identified Gaps

Furniture

Sl. No.	Item	Current Availability at Sub-centre	If available, numbers	Remarks/Suggestions/ Identified Gaps
1.	Examination Table			
2.	Writing Table			
3.	Chairs			
4.	Medicine chest			
5.	Labour table			
6.	Wooden screen			
7.	Foot step			
8.	Coat rack			
9.	Bed side table			
10.	Stool			
11.	Almirahs			
12.	Lamp			
13	Fans			
14.	Tube lights			
15.	Basin stand			
16.	Buckets			
17.	Mugs			
18	Kerosene stove			
19.	Sauce pan with lid			
20.	Water receptacle			
21.	Rubber/plastic shutting			
22.	Talquist Hb scale			
23.	Drum with tap for storing water			
24.	Others (specify)			

Quality Control

Sl. No.	Particular	Whether functional/ available as per norms	Remarks
1.	Citizen's charter in local language (Yes/No)		
2.	Internal monitoring: supportive supervision and record checking at periodic intervals by the male and female Health Assistants from PHC (at least once a week) and by MO (at least once in a month)		
3.	External monitoring: Village Health Sanitation and Nutrition Committee, evaluation by independent external agency		
4.	Availability of various guidelines issued by GOI or State Govt. (Specify)		

Annexure 11

MODEL CITIZEN'S CHARTER FOR SUB-CENTRES

Preamble

Sub-centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework, which enables citizens to know.

- What services are available?
- The quality of services they are entitled to.
- The means through which complaints regarding denial or poor qualities of services will be addressed.

Objectives

- To make available quality health care services and the related facilities for citizens.
- To provide appropriate advice, treatment, referral and support that would help to cure the ailment to the extent medically possible.
- To redress any grievances in this regard.

Commitments of the Charter

- To provide access to available facilities without discrimination.
- To provide emergency care, if needed on reaching the Sub-centre (SC).
- To provide adequate number of notice boards detailing the location of all the facilities and the schedule of field visits.
- To provide written information on diagnosis and treatment being administered.
- To record complaints and respond at an appointed time.

Grievance Redressal

- Grievances that citizens have will be recorded
- Aggrieved user after his/her complaint recorded would be allowed to seek a second opinion at PHC.

Responsibilities of the Users

- Users of SC would attempt to understand the commitments made in the charter.
- User would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- Instruction of the SC personnel would be followed sincerely, and
- In case of grievances, the redressal mechanism machinery would be addressed by users without delay.

Performance Audit and Review of the Charter

- Performance audit may be conducted through a peer review every two to three years after covering the areas where the standards have been specified.

Annexure 12

LIST OF ABBREVIATIONS

AEFI	:	Adverse Effects Following Immunization
AIDS	:	Acquired Immune Deficiency Syndrome
AIIMS	:	All India Institute of Medical Sciences
ANC	:	Ante Natal Check-up
ANM	:	Auxiliary Nurse Midwife
ARI	:	Acute Respiratory Infections
ASHA	:	Accredited Social Health Activist
AYUSH	:	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
AWW	:	Anganwadi Worker
BCG	:	Bacillus Calmette-Guérin Vaccine
CHC	:	Community Health Centre
CME	:	Continuing Medical Education
CMO	:	Chief Medical Officer
DDK	:	Disposable Delivery Kit
DEC	:	Diethyl Carbamazine
DOTS	:	Directly Observed Treatment Short Course
DPT	:	Diphtheria, Pertussis and Tetanus Vaccine
DT	:	Diphtheria and Tetanus Vaccine
EAG	:	Empowered Action Group
FRU	:	First Referral Unit
FTD	:	Fever Treatment Depot
HIV	:	Human Immunodeficiency Virus
HSCC	:	Hospital services Consultancy Corporation
IDSP	:	Integrated Disease Surveillance Programme
ID/AP	:	Infrastructure Division/Area Projects
IEC	:	Information, Education and Communication
IFA	:	Iron and Folic Acid
IMEP	:	Infection Management and Environment Plan
IPHS	:	Indian Public Health Standard
IUD	:	Intra Uterine Device

IUCD	:	Intra Uterine Contraceptive Device
JSY	:	Janani Suraksha Yojana (JSY)
LHV	:	Lady Health Visitor
LLIN	:	Long Lasting Insecticidal Net
MCH	:	Maternal and Child Health
MDT	:	Multi Drug Treatment in Leprosy
MMR	:	Measles Mumps Rubella Vaccine
MNP	:	Minimum Needs Programme
MO	:	Medical Officer
MTP	:	Medical Termination of Pregnancies
NCD	:	Non- communicable Disease
NICD	:	National Institute of Communicable Diseases
NIHFW	:	National Institute of Health & Family Welfare
NLEP	:	National Leprosy Eradication Programme
NMEP	:	National Malaria Eradication Programme
NPCB	:	National Programme for Control of Blindness
NRHM	:	National Rural Health Mission
NVBDCP	:	National Vector Borne Disease Control Programme
OPV	:	Oral Polio Vaccine
ORS	:	Oral Re-hydration Solution
PHC	:	Primary Health Centre
PHN	:	Public Health Nurse
PNC	:	Post Natal Check-up
PRI	:	Panchayati Raj Institution
RBC	:	Red Blood Corpuscle
RCH	:	Reproductive and Child Health
RDK	:	Rapid Diagnostic kits (e.g., malaria, typhoid etc.)
RHS	:	Rural Health Statistics
RKS	:	Rogi kalyan Samiti
RNTCP	:	Revised National Tuberculosis Control Programme
RTI	:	Reproductive Tract Infections
SBA	:	Skilled Birth Attendance
SC	:	Sub-centre
STI	:	Sexually Transmitted Infections
TOR	:	Terms of Reference
TT	:	Tetanus Toxoid
VAPP	:	Vaccine Associated Paralytic Poliomyelitis
VHND	:	Village Health and Nutrition Day
VHSC	:	Village Health & Sanitation Committee
VHSNC	:	Village Health Sanitation & Nutrition Committee
VVM	:	Vaccine Vial Monitor
WBC	:	White Blood Corpuscle
WC	:	Water Closet

REFERENCES

1. **National Rural Health Mission 2005-2012 – Reference Material (2005)**, Ministry of Health & Family Welfare, Government of India.
2. **Bulletin on Rural Health Statistics in India (2009), Infrastructure Division**, Department of Family Welfare; Ministry of Health & Family Welfare, Government of India.
3. **Guidelines for Operationalising 24x7 PHC**, Maternal Health Division, Department of Family Welfare, Ministry of Health & Family Welfare, Government of India.
4. **Guidelines for Ante-Natal Care and Skilled Attendance at Birth by ANMs and LHVs (2005)**, Maternal Health Division, Department of Family Welfare, Ministry of Health & Family Welfare, Government of India.
5. **RCH Phase II, National Program Implementation Plan (PIP) (2005)**, Ministry of Health & Family Welfare, Government of India.
6. **Guidelines for Setting up of Rogi Kalyan Samiti/ Hospital Management Committee**, Ministry of Health & Family Welfare, Government of India.
7. **Indian Standard: Basic Requirements for Hospital Planning**, *Part-1 up to 30 Bedded Hospital, IS: 12433 (Part 1)-1988*, Bureau of Indian Standards, New Delhi.
8. **Indian Public Health Standards (IPHS) for Community Health Centre (2007)**, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India.
9. **Operational Guidelines on Maternal and Newborn Health (April 2010), Ministry of Health & Family Welfare, Government of India.**

LIST OF MEMBERS OF THE TASK FORCE CONSTITUTED FOR REVISION OF IPHS DOCUMENTS

(As per order No. T 21015/55/09 – NCD, Dte.GHS, dated 29-1-2010 and minutes of meeting of Task Force held on 12-2-2010)

1. Dr. R.K. Srivastava, Director General of Health Services – Chairman
2. Dr. Shiv Lal, Special DG (PH), Dte.GHS, Nirman Bhawan, New Delhi – Co-Chairman.
3. Sh. Amarjit Sinha, Joint Secretary, NRHM, Ministry of Health & F.W., Nirman Bhawan, New Delhi.
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