Indian Public Health Standard (IPHS) 
Guidelines for Sub-Centres 
Revised 2011
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message</td>
<td>v</td>
</tr>
<tr>
<td>Foreword</td>
<td>vi</td>
</tr>
<tr>
<td>Preface</td>
<td>vii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>viii</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Indian Public Health Standards for Sub-Centres</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Objectives of Indian Public Health Standards for Sub-Centre</td>
<td>3</td>
</tr>
<tr>
<td>Categorization of Sub-Centres</td>
<td>4</td>
</tr>
<tr>
<td>Services to be Provided in a Sub-Centre</td>
<td>6</td>
</tr>
<tr>
<td>Manpower</td>
<td>14</td>
</tr>
<tr>
<td>Physical Infrastructure</td>
<td>14</td>
</tr>
<tr>
<td>Furniture</td>
<td>16</td>
</tr>
<tr>
<td>Equipment</td>
<td>16</td>
</tr>
<tr>
<td>Drugs</td>
<td>16</td>
</tr>
<tr>
<td>Support Services</td>
<td>16</td>
</tr>
<tr>
<td>Waste Disposal</td>
<td>16</td>
</tr>
<tr>
<td>Record Maintenance and Reporting</td>
<td>17</td>
</tr>
<tr>
<td>Monitoring Mechanism: Monitoring may be made possible</td>
<td>17</td>
</tr>
<tr>
<td>Quality Assurance and Accountability</td>
<td>17</td>
</tr>
<tr>
<td>Annexures</td>
<td>19</td>
</tr>
<tr>
<td>Annexure 1: National Immunization Schedule for Infants, Children and</td>
<td>19</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td></td>
</tr>
<tr>
<td>Annexure 2: Job Functions of Health Worker Female/ANM, Health worker</td>
<td>21</td>
</tr>
<tr>
<td>male, AWW and ASHA</td>
<td></td>
</tr>
<tr>
<td>Annexure 3: Layout of Sub-Centre</td>
<td>34</td>
</tr>
</tbody>
</table>
Annexure 4: List of Furniture, Other Fittings and Sundry Articles ......................................................... 37
Annexure 5: Equipments and Consumables .......................................................................................... 38
Annexure 5A: Newborn Corner in Labour Room .................................................................................. 42
Annexure 6: Suggested List of Drugs .................................................................................................. 44
Annexure 7: Registers .......................................................................................................................... 46
Annexure 7A: IDSP Format .................................................................................................................. 47
Annexure 8: Checklist .......................................................................................................................... 49
Annexure 8A: A Simpler Checklist that can be Used by NGO/PRI/VHC/SHG ..................................... 51
Annexure 9: Proforma for Facility Survey of Sub-Centres on IPHS ................................................... 53
Annexure 10: Model Citizen’s Charter for Sub-Centres ..................................................................... 59
Annexure 11: List of Abbreviations .................................................................................................... 60

References ............................................................................................................................................ 62

List of Members of the Task Force Constituted for Revision of IPHS Documents ......................... 63
National Rural Health Mission (NRHM) is a genuine measure to strengthen the Rural Public Health System and has aroused many hopes and expectations. The Mission seeks to provide effective health care to the rural populace throughout the country, with special focus on States/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 developed and last released in January/February, 2007. These have since been used as the reference point for public health care infrastructure planning and upgradation in the States/UTs. IPHS are a set of standards envisaged to improve the quality of health care delivery in the country.

These IPHS documents have been revised keeping in view the changing protocols of the existing programmes and incorporating new needs, protocols and programmes, especially for providing due emphasis to the 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 Hospital at the District level. It is highly desirable that they should be fully functional and deliver quality care in a safe manner. I strongly believe that these IPHS guidelines will act as the main driver for continuous improvement in quality and serve as benchmarks for assessing the functional status of health facilities.

I call upon all States/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)
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 towards providing universal access to equitable, affordable and quality health care that is accountable and responsive to the people’s needs. In the implementation framework of NRHM, it is 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-Centres, PHCs, 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/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, so the need was felt to update the IPHS keeping in view the changing protocols of existing National Health Programmes, development of new programmes especially for non-communicable diseases and prevailing epidemiological situation in the country and different States/UTs of the country. The IPHS for Sub-Centres has been revised by constituting a task force comprising of various stakeholders under the chairmanship of Director General of Health Services. Subject experts, NGOs, State representatives, 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, equipments 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 three 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/UTs are expected to categorize the Sub-Centres and provide infrastructure according to the laid down guidelines in this document. This document will help the Centre, State Governments, and Panchayati Raj Institutions, to monitor effectively as to how many of the Sub-Centres are confirming to IPHS. In order to bring the Sub-Centres to IPHS level, additional funding that may be required will continue to be considered under NRHM.

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.

(K. Chandramouli)
Secretary (H&FW)
Ministry of Health & Family Welfare
Government of India

26th October 2010
New Delhi
The Sub-Centres are vital peripheral institutions for provision of primary health care to the people and play an important role in the implementation of various health & Family welfare programs at the grass-root level. One of the important components of National rural Health Mission (NRHM) is to strengthen the Sub-Centres to a level of Indian Public Health Standards (IPHS), which were first developed in early 2007. The aim of the IPHS is to provide services which are of optimum level and quality, fair and responsive to client’s needs, provided equitably and deliver improvement in the health and wellbeing of the population (Effective). In addition, services should be affordable (Economical) and should have inherent element of accountability.

A task force was constituted in early 2010 to review the existing IPHS, remove any mismatch between service and infrastructure provided if it is there, to incorporate new programmes and protocols in line with the changing requirements of the country and taking into consideration the minimum functional level needed for providing a set of assured services. The present revised document of IPHS for Sub-Centres has been prepared in consultations held over many months with task force members programme officers, Regional Directors, experts, health functionaries, Non-Governmental representatives, development partners, State/UT Government representatives etc. The contribution of all of them is well appreciated.

The primary focus of Sub-Centre remains the RCH (Reproductive and Child Health) Services; however services in relation to important Non-communicable diseases have also been included. It has been decided not to promote all Sub-Centres for intra-natal facilities. The Sub-Centres which are well located with good infrastructure and catchment areas (Type C) will be promoted for providing delivery (intranatal) facilities. The Sub-Centres located in remote and inaccessible areas, which usually have poor infrastructure (Type A), the skilled birth attendance at the time of delivery will be ensured even at home. The other types of Sub-Centres (Type B) which do not have caseload of intranatal patients have been envisaged to provide all services related to non-communicable diseases and other new initiatives started by the Ministry of Health and Family Welfare. This type of categorization is expected to provide services as per need of population.

Setting standards is a dynamic process and this document is not an end in itself. Further revision of the standards will occur 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 state governments 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.

(Dr. R.K. Srivastava)
Director General of Health Services
Ministry of Health & Family Welfare
Government of India

26th October
2010 New Delhi
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) for Sub-Centres and Primary Health Centres. 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. K. Chandramouli, Secretary (H & FW) for the active encouragement received from him. I also gratefully acknowledge the initiative, inspiration and valuable guidance provided at every step by Dr. R.K. Srivastava, 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 thank Miss K. Sujatha Rao, Ex-Secretary (H&FW) for her valuable contribution and guidance in rationalizing the manpower requirements for Health Facilities, and also for her help in the finalization of this document. I would specially like to thank Dr. Shiv Lal, former Special DG and Advisor (Public Health), Dr. Ashok Kumar, CBHI Director, Dr. N.S. Dharm Shaktu, 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 and Dr. D.M. Thorat for their valuable contribution and guidance in formulating the IPHS for Sub-Centres.

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:

♦ Dr. Manohar Agnani, MD NRHM from State of MP Dr. Junaid Rehman from Kerala.
♦ Dr. Kamlesh Kumar Jain from Chhattisgarh.
♦ Dr. Y.K. Gupta, Dr. Kiran Malik, Dr. Avadesh Kumar, Dr. Naresh Kumar, Smt. Prabha Devi Panwar, ANM and Ms. Pushpa Devi, ANM from UP.
♦ Dr. P.N.S. Chauhan and Dr. Jayashree Chandra Joint Directors, Dr. S.A.S. Kazmi and Dr. L.B. Asthana Deputy
Directors, Dr. R.P. Maheshwari, Dr. (Mrs.) Pushpa Gupta, Div. Joint Director, Ujjain, Dr. Ramesh Makwana and Dr. (Mrs.) Bhusan Shrivastava from State of MP.

♦ Dr. R.S. Gupta, Dr. S.K. Gupta, Ms. Mamta Devi, ANM and Ms. Sangeeta Sharma, ANM from Rajasthan.
♦ Dr. Rajesh Bali from Haryana.
♦ NGO representatives Dr. P.K. Jain from RK Mission and Dr. Sunita Abraham from Christian Medical Association of India.

I express my sincere thanks to Dr. T.S. Siddhu, Medical Superintendent and other subject experts from Dr. RML Hospital, Dr. N.K. Mohanty, Medical Superintendent and other subject experts from Safdarjung Hospital and Architects of Central Design Bureau namely Sh. S. Majumdar, Dr. Chandrashekhar, Sh. Sridhar and Sh. M. Bajpai for providing inputs in respect of physical infrastructure and building norms.

I am also extremely grateful to Regional Directors of Health and Family Welfare, State Health Secretaries, State Mission directors and State Directors of Health Services for their feedback.

I shall be failing in my duty if I do not thank Dr. P.K. Prabhakar, Assistant Commissioner (ID), 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.

(Dr. Anil Kumar)
Member Secretary-Task force
CMO (NFSG)
Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India

26th October 2010
New Delhi
Indian Public Health Standards (IPHS) Guidelines for Sub-Centres

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 equipments, 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 3 categories (Types A, B and C) based upon population covered/catchment area, Geographical location and terrain, health seeking behavior, caseload, epidemiological situation, location of other facilities like PHC/CHC/FRU/Hospitals in the vicinity of Sub-Centre. Type A Sub-Centres are those that are located in a remote, difficult, hilly, desert or tribal area.
Such Sub-Centres in the country usually have poor infrastructure and are mostly located in small huts/makeshift arrangements. Here, Skilled Birth Attendance (SBA) trained ANMs would be conducting deliveries mostly at homes. Type B Sub-Centres are those where delivery facilities are available in near by health centres or where the case load for deliveries is poor; these will provide all other recommended services including services under Non-communicable disease programmes. Type C Sub-Centres are well located with good case load of deliveries; will be promoted as MCH Sub-Centres with provision of extra manpower, infrastructure, budget etc.

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 ANMs and one Male Health Worker at each type of the Sub-Centre, one Safai Karamachari at the Sub-Centre of Type B and C and one Staff Nurse at Type C Sub-Centres. The ANM to be posted at Type A Sub-Centres should mandatorily be SBA trained with a minimum of two and a half years of trainings including initial training in ANM School.

Facilities

The document includes a suggested layout indicating the space for the building and other infrastructure facilities for both Type B and Type C 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 and Sanitation 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 Standards. The monitoring process and quality assurance mechanism is also included.
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 145894 Sub-Centres functioning in the country as per Rural Health Statistics Bulletin, 2009.

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 strength of two ANMs and one Health Worker Male per Sub-Centre 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 depending upon Epidemiological Situation

In view of the current highly variable situation of Sub-Centres in different parts of the country and even within the same State, they have been categorized into 3 Types as A, B and C. Categorization has taken into consideration various factors namely population covered/catchment area, Geographical location and terrain, health seeking behavior, caseload, epidemiological situation, location of other facilities like PHC/CHC/FRU/Hospitals in the vicinity of the Sub-Centre. The details of the 3 types are as given under.

Type A

This may include Sub-Centres located in a remote, difficult, hilly, desert or tribal area. Such Sub-Centres in the country usually have poor infrastructure and are mostly located in small huts/makeshift arrangements. They may have no facility for conducting delivery at the Sub-Centre, but still the population of these areas is dependent on these Sub-Centres for providing delivery facility. The referral transport facility is likely to be poor. Here, ANMs would be conducting deliveries mostly at homes. Due to poor physical infrastructure and lack of space, providing labour room facilities and equipments at these Sub-Centres is not feasible.

**Staff recommended**

One ANM *(Essential)*, Two ANMs: *(Desirable)*

One Health Worker (Male) *(Essential)*

**Guidelines**

♦ These Sub-Centres should provide RCH and outreach services on priority basis. In addition,

Sub-Centre with such unhygienic and inadequate Delivery Facilities pose a great risk to the mother and newborn.
they will also focus on prevalent diseases, tuberculosis, leprosy, nutrition, water and sanitation problems and Epidemics.

- ANMs of these Sub-Centres should mandatorily be Skilled Birth Attendance (SBA) trained with a minimum of two and a half years of trainings including initial training in ANM School.
- Extra payment should be made to Staff posted in these Sub-Centres.
- If there is shortage of Health worker males, he should be posted on priority in areas endemic for malaria/other vector borne diseases.
- Expected number of deliveries with a birth rate of 30 per month in 5000 population is 150 per year i.e., about 12 deliveries in a month.
- If the average number of deliveries conducted is **more than 10** deliveries per month, then an additional ANM should be posted to take care of the load.
- Budget provision should be made to employ helper for assistance at the time of delivery, if needed.
- ANM of this Sub-Centre may train community volunteer (helper) who may assist her during home deliveries.
- State Government should focus on such Sub-Centres for strengthening the infrastructure, as the population in these areas is solely dependent upon these Sub-Centres.

**Type B**

This would include following types of Sub-Centres:

i. Sub-Centres which may or may not have their own buildings/Labour room facilities but where at

*This Sub-centre in Assam, was having a poor delivery case load, may serve as Type B Sub-Centre.*
present occasional delivery may be taking place i.e., very low case load of deliveries.

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

iii. Sub-Centres in headquarter area.

iv. Sub-Centre located in area where good referral transport facilities are available.

Guidelines

These Sub-Centres may not be promoted for conducting deliveries at the facility and patients may be referred to nearby centers providing delivery facilities. However they will provide all other RCH services including mandatory registration of all pregnant women. In addition, they will provide all other recommended services including services under Non-communicable disease programmes. It is also to be ensured that the Staff of these Sub-Centres is provided training in all new programmes and refresher training is provided regularly.

Staff recommended

Two ANM (Essential)
One Health Worker (Male): (Essential)
One contractual Safai-worker (part-time)

Note: If there is shortage of Health worker males, then he should be posted on priority in areas endemic for malaria/other vector borne diseases.

Type C (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-Centres should be developed as a Delivery facility and should cater also to adjacent 2 to 3 Sub-Centre areas for delivery purpose. They will provide mainly RCH and outreach services. They will be expected to conduct more than 30 deliveries in a month. They should be provided with all labour room facilities and equipments, including Newborn care corner. ANMs of these Sub-Centres should be SBA trained.

Equipment, Drugs etc.

These centers may be provided extra equipments, drugs, supplies, materials and budget for smooth functioning.

Staff recommended

Two ANM (Essential)
One Health Worker (Male): (Essential)
One Staff Nurse (Essential)
One contractual full-time Safai-worker (Essential)

Services to be Provided in a Sub-Centre

Sub-Centres are expected to provide promotive, preventive and few curative primary health care services as given below:

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.

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

1. **Type A:** Shall provide mainly Reproductive and Child Health services through outreach activities and conducting domiciliary deliveries.

2. **Type B:** Shall provide all services as envisaged for the Sub-Centre except conducting delivery at the facility. In addition they should lay emphasis on Non-Communicable Diseases related services.
3. **Type C**: Shall act as Maternal and Child Health (MCH) centre with basic facilities for conducting deliveries and Newborn Care at the Sub-Centre.

The following is the consolidated list of services to be provided through three 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**

1. **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.
   
   - 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.
- Identification & basic management of STI/RTI.
- 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, if delivery facilities are available
- 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.
- In case of delivery at Type C Sub-Centre, minimum 24 hours of stay of 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 42\textsuperscript{nd} day for deliveries at home and Sub-Centre (both for mother & baby).
   - Ensure 3, 7 and 42\textsuperscript{nd} 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 28\textsuperscript{th} 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.

iv. 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 C)
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 LHV.s.).
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 diseases like malnutrition, infections, ARI, Diarrhea, Fever, Anemia etc. including IMNCI strategy.
- Name based tracking of all infants and children as per immunization programme.
- 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).

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

Desirable
- Staff of Sub-Centre may provide assistance to school health services for schools located in their area.

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.
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.

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 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.

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.
- Coordinate with ICDS programme for nutritional services including assessment, treatment, counseling, referral as per need for all cases of malnutrition in children less than 5 years identified by AWW.
- 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.

The services to be provided at VHND are listed below.
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 eg 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 and sanitation 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.

Desirable

- 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.
- Any 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 and sanitation committees, 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 and Sanitation Committee, PRI etc.

National Health Programmes

Communicable Disease Programme

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 C 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.
- 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.

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 all three types of Sub-Centres, however Type B Sub-Centres are expected to provide these services in a comprehensive manner

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.

**Referral transport** facility should be provided at all Type C Sub-Centres.

**Manpower**

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

<table>
<thead>
<tr>
<th>Type of Sub-Centre</th>
<th>Sub-Centre A</th>
<th>Sub-Centre B</th>
<th>Sub-Centre C (MCH Sub-Centre)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
<td><strong>Essential</strong></td>
<td><strong>Desirable</strong></td>
<td><strong>Essential</strong></td>
</tr>
<tr>
<td>ANM/Health Worker (Female)</td>
<td>1 (SBA trained)</td>
<td>+1</td>
<td>1 (Trained in Health Programmes)</td>
</tr>
<tr>
<td>Health Worker (Male)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Staff nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safai-worker*</td>
<td></td>
<td></td>
<td>1 (Part-time)</td>
</tr>
</tbody>
</table>

*On contractual basis (Safai-Karmachari may be provided from the untied fund provided under NRHM.).

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.

At least one ANM must stay at Sub-Centre headquarter village.

In villages above 5000 population, additional ANMs could be added on to the existing Sub-Centre at the ratio of at least one ANM for every additional 5000 population. Separate Sub-Centre would not be mandatory.

Where there is a PHC or a CHC located, then for the population falling within the immediate surrounding areas, the Sub-Centre staff would be located in the PHC or CHC itself. Thus every PHC or CHC would have Sub-Centre in its close vicinity, or co-located with it, in the same campus. Family level Data of the immediate surrounding areas would be collected and analysed as for that Sub-Centre.

**Note:** The staff of the Sub-Centre will have the support of ASHAs (Accredited Social Health Activists) wherever the ASHA scheme is implemented/similar functionaries at village level in other areas. ANM will hold weekly/fortnightly meeting with all the ASHAs working in her Sub-Centre area (approximately 5-7 ASHAs) and discuss the activities undertaken during the week/fortnight. She will guide them (ASHAs) in performance of their activities. ANM will inform ASHAs regarding date and time of the outreach sessions and will also guide them for mobilization of community. ANM will guide ASHAs in organizing the Village Health and Nutrition Days at Anganwadi Centres. She will take help of ASHA in updating eligible couple register of the village concerned. The job functions of ANM, Male Health worker, ASHA and AWW in the context of coordinated functions under NRHM 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 network (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.

- 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 C 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 four beds
  - One room for store
  - One room for clinic/office
  - One Toilet facility each in labour room and ward room (Essential) and also in waiting area (Desirable)

**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 2.7 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 C (MCH) Sub-Centres.

A typical layout plan for type B Sub-Centre with ANM residence having area of 85 square metres and type C 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)

- Quake 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, equipments etc. are as important as structural changes in the buildings.

- SC should not be located in low lying area to prevent flooding.

- Fire fighting equipments – 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/equipments 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 (for type A & C Sub-Centres), 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 C 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: ANMs of all types of Sub-Centres should be provided with facility of mobile phone. At Type C Sub-Centres, landline telephone facility should also 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. Transport facility for movement of the staff

Desirable

One moped for mobility support may be provided for all types of Sub-Centre. This should not be provided to any individual ANM/HWM. Fixed Transport allowance per month for the maintenance and POL of the mopeds for performing duties may be provided.

Waste Disposal

“Guidelines for Health Care Workers for Waste Management and Infection Control in Sub-Centres” are to be followed.
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 7.

Monitoring Mechanism:
Monitoring may be made possible

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 8.

Village Health and Sanitation Committee (constituted in each village under NRHM), will review the activities of the Sub-Centre. A simpler check-list that can be used by NGO/PRI/Village Health committee is given in Annexure 8A.

A detailed Facility Survey Format (Annexure 9) 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 10).
## NATIONAL IMMUNIZATION SCHEDULE FOR INFANTS, CHILDREN AND PREGNANT WOMEN

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>When to give</th>
<th>Dose</th>
<th>Route</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT-1</td>
<td>Early in pregnancy</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT-2</td>
<td>4 weeks after TT-1*</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT-Booster</td>
<td>If pregnancy occur within three years of last TT vaccinations*</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT-1</td>
<td>Early in pregnancy</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT-2</td>
<td>4 weeks after TT-1*</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT-Booster</td>
<td>If pregnancy occur within three years of last TT vaccinations*</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>For Infants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCG</td>
<td>At birth (for institutional deliveries) or along with DPT-1</td>
<td>0.1 ml</td>
<td>Intra-dermal</td>
<td>Left Upper Arm</td>
</tr>
<tr>
<td>Hepatitis B - 0</td>
<td>At birth for institutional delivery, preferably within 24 hrs of delivery</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Outer Mid-thigh (Antero-lateral side of mid thigh)</td>
</tr>
<tr>
<td>OPV - 0</td>
<td>At birth if delivery is in institution</td>
<td>2 drops</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>OPV 1, 2 &amp; 3</td>
<td>At 6 weeks, 10 weeks &amp; 14 weeks</td>
<td>2 drops</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>DPT 1, 2 &amp; 3</td>
<td>At 6 weeks, 10 weeks &amp; 14 weeks</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Outer Mid-thigh (Antero-lateral side of mid thigh)</td>
</tr>
<tr>
<td>Hepatitis B - 1, 2 &amp; 3</td>
<td>At 6 weeks, 10 weeks &amp; 14 weeks**</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Outer Mid-thigh (Antero-lateral side of mid thigh)</td>
</tr>
<tr>
<td>Measles</td>
<td>9-12 months</td>
<td>0.5 ml</td>
<td>Sub-cutaneous</td>
<td>Right upper Arm</td>
</tr>
<tr>
<td>Vitamin-A (1&lt;sup&gt;st&lt;/sup&gt; dose)</td>
<td>At 9 months with measles</td>
<td>1 ml (1 lakh IU)</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>For Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT booster</td>
<td>16-24 months</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Outer Mid-thigh (Antero-lateral side of mid thigh)</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; booster at 5 years age</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
<td></td>
</tr>
<tr>
<td>OPV Booster</td>
<td>16-24 months</td>
<td>2 drops</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>JE&lt;sup&gt;t&lt;/sup&gt;</td>
<td>16-24 months</td>
<td>0.5 ml</td>
<td>Sub-cutaneous</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>Vitamin A (2&lt;sup&gt;nd&lt;/sup&gt; to 9&lt;sup&gt;th&lt;/sup&gt; dose)</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; dose at 16 months with DPT/OPV booster. 3&lt;sup&gt;rd&lt;/sup&gt; to 9&lt;sup&gt;th&lt;/sup&gt; doses are given at an interval of 6 months interval till 5 years age</td>
<td>2 ml (2 lakh IU)</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>Vaccine</td>
<td>When to give</td>
<td>Dose</td>
<td>Route</td>
<td>Site</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>--------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>DT Booster</td>
<td>5 years</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
<tr>
<td>TT</td>
<td>10 years &amp; 16 years</td>
<td>0.5 ml</td>
<td>Intra-muscular</td>
<td>Upper Arm</td>
</tr>
</tbody>
</table>

* 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 (where ever implemented) and Measles before one year of age.

† JE in Select 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, HEALTH WORKER MALE, AWW AND ASHA IN THE CONTEXT OF COORDINATED FUNCTIONS UNDER NRHM

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 6 months 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 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\(^1\)

- 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 Cessation 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\(^2\).
- 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.

\(^1\) These are the desirable health activities that female health worker will assist the Male health worker.

\(^2\) These are the desirable health activities that female health worker will assist the Male health worker.
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.
   * ANM should to be trained in AYUSH system for distribution of AYUSH medicine.

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 and Sanitation Committee (VHSC)
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 and sanitation committee members. 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.

Role of Anganwadi as a facilitator of ASHA:

Anganwadi Worker (AWW) will guide ASHA in performing following activities:

- Organizing health day once/twice a month. On health day, the women, adolescent girls and children from the village will be invited for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunization etc.
- IEC activity through display of posters, folk dance etc. on these days can be undertaken to sensitize the beneficiaries on health related issues including HIV/AIDS.
- Anganwadi worker will be depot holder for drug kits and will be issuing it to ASHA. The replacement of the consumed drugs can also be done through AWW.
- Participation in National Filaria Day.

Roles & Responsibilities of ASHA

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows:

- ASHA will take steps to create awareness and provide information to the community on determinants of health such a nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunization, care of the young children, contraception and prevention of common infections including Reproductive Tract infection/Sexually Transmitted Infection (RTI/STI) and HIV/AIDS.
- ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/Sub-Centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), Visit and treatment of sick newborn and children as per guidelines, family planning services, ICDS, sanitation and other services being provided by the Government.
- Tracking of all pregnancies by name for scheduled ANC/PNC services.
- She will work with local health committees of panchayats to develop a comprehensive village health plan.
- She will escort/accompany pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e., Primary Health Center/Community Health Center/First Referral Unit (PHC/CHC/FRU).
- Reporting of Maternal infant/child deaths.
- Depot holder for condoms, EC pills and Oral pills.
- ASHA will provide Primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment, Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORT), Iron Folic Acid Tablet and Syrups (IFA), Chloroquine, Disposable Delivery kits (DDK), Oral
Pills & Condoms, etc. A drug kit will be provided to each ASHA.

- Her role as a provider of direct services can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- Fulfillment of all these roles by ASHA is through continuous training and up-gradation of her skills.
- Her skills will improve gradually spread over two years’ or more.
- Participation in National Filaria Day.
- Identify the cases of skin patch with loss of sensation and bring them to the notice of Health worker male/females. Ensure that all the patients of Leprosy are taking regular treatment.

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 VHSC decisions.

E. Village Health & Sanitation Committee

1. MPW is expected to be a member of the Village Health and Sanitation 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. for community awareness and their involvement.

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 fluorosis.
  - 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 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 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 and sanitation 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 chulhas
- Coordination with Village Health and Sanitation 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.
Annexure 3

LAYOUT OF SUB-CENTRE

Layout of Type B 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 B Sub-centre
Standard design as/IPHS
Layout of Type C 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.

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 qrt. For 2 ANM & 1 staff nurse qrt. Incl. 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 C Sub-centre
Proposed addition on existing
Proto type Sub-centre as/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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Built up area</td>
<td>86 sq.m</td>
</tr>
<tr>
<td>Area under verandah</td>
<td>30 sq.m</td>
</tr>
<tr>
<td>Area under open stair</td>
<td>9 sq.m</td>
</tr>
<tr>
<td>Total area</td>
<td>125 sq.m</td>
</tr>
<tr>
<td></td>
<td>(1345 sq. ft)</td>
</tr>
</tbody>
</table>

Type C Sub-centre
Proposed addition on existing Proto type Sub-centre as/IPHS
Note for Annexure 4, 5 and 5A

In Type A Sub-Centre, due to poor Physical infrastructure and lack of space, it may not be feasible to provide most of the furniture and equipments listed below.

In Type B Sub-Centres, furniture and equipments required for Labour facilities need not be provided.

Type C Sub-Centres should be provided with all furniture and equipments 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.

<table>
<thead>
<tr>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination Table</td>
<td>1</td>
</tr>
<tr>
<td>Foot step</td>
<td>1</td>
</tr>
<tr>
<td>Table</td>
<td>1</td>
</tr>
<tr>
<td>Table for Immunization</td>
<td>1 (610 mm x 915 mm)</td>
</tr>
<tr>
<td>Chairs</td>
<td>3</td>
</tr>
<tr>
<td>Medicine Chest</td>
<td>1</td>
</tr>
<tr>
<td>Almirahs</td>
<td>1</td>
</tr>
<tr>
<td>Bench for waiting area</td>
<td>1</td>
</tr>
<tr>
<td>Stool</td>
<td>3</td>
</tr>
<tr>
<td>Labour table*</td>
<td>1</td>
</tr>
<tr>
<td>Beds with mattress*</td>
<td>4</td>
</tr>
<tr>
<td>Screen</td>
<td>1</td>
</tr>
<tr>
<td>Lamp</td>
<td>1</td>
</tr>
<tr>
<td>Clock</td>
<td>1</td>
</tr>
<tr>
<td>Fans</td>
<td>2</td>
</tr>
<tr>
<td>Tube light</td>
<td>3</td>
</tr>
<tr>
<td>Drum with tap for storing water</td>
<td>1</td>
</tr>
<tr>
<td>Waste disposal twin bucket for hypochlorite solution/bleach</td>
<td>As per need</td>
</tr>
<tr>
<td>Disposable Jars</td>
<td>-</td>
</tr>
<tr>
<td>Generator Facility*</td>
<td>1</td>
</tr>
<tr>
<td>Computer*</td>
<td>1</td>
</tr>
<tr>
<td>Refrigerator*</td>
<td>1</td>
</tr>
<tr>
<td>Room Heater/Cooler</td>
<td>as per requirement</td>
</tr>
</tbody>
</table>

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

* For Type C Sub-Centres only.
Annexure 5

EQUIPMENTS AND CONSUMABLES

List of Equipments

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

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Item Description</th>
<th>Quantity/Kit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Essential</td>
</tr>
<tr>
<td>1</td>
<td>Basin 825 ml. ss (Stainless Steel) Ref. IS 3992</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Basin deep (capacity 6 litre) ss Ref: IS: 5764 with Stand</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Tray instrument/Dressing with cover 310 x 195x63mm SS, Ref IS: 3993</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Flashlight/Torch Box-type pre-focused (4 cell)</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Torch (ordinary)</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Dressing Drum with cover 0.945 liters stainless steel</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Hemoglobinometer – set Sahli type complete</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Weighing Scale, Adult 125 kg/280 lb</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Weighing Scale, Infant (10 Kg)</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Weighing Scale, (baby) hanging type, 5 kg</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Sterilizer</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Surgical Scissors straight 140 mm, ss</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Sphygmomanometer Aneroid 300 mm with cuff IS: 7652</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Kelly’s hemostat Forceps straight 140 mm ss</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>Vulsellum Uterine Forceps curved 25.5 cm</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>Cusco’s/Graves Speculum vaginal bi-valve medium</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>Sims retractor/depressor</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>Sims Speculum vaginal double ended ISS Medium</td>
<td>1</td>
</tr>
<tr>
<td>Sl. No.</td>
<td>Item Description</td>
<td>Quantity/Kit</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Essential</td>
</tr>
<tr>
<td>19</td>
<td>Uterine Sound Graduated</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>Cheatle’s Forcep</td>
<td>1</td>
</tr>
<tr>
<td>21</td>
<td>Vaccine Carrier</td>
<td>2</td>
</tr>
<tr>
<td>22</td>
<td>Ice pack box</td>
<td>8</td>
</tr>
<tr>
<td>23</td>
<td>Sponge holder</td>
<td>2</td>
</tr>
<tr>
<td>24</td>
<td>Plain Forceps</td>
<td>5</td>
</tr>
<tr>
<td>25</td>
<td>Tooth Forceps</td>
<td>2</td>
</tr>
<tr>
<td>26</td>
<td>Needle Holder</td>
<td>2</td>
</tr>
<tr>
<td>27</td>
<td>Suture needle straight</td>
<td>10</td>
</tr>
<tr>
<td>28</td>
<td>Suture needle curved</td>
<td>10</td>
</tr>
<tr>
<td>29</td>
<td>Kidney tray</td>
<td>4(big) &amp; 4 (small)</td>
</tr>
<tr>
<td>30</td>
<td>Artery Forceps, straight, 160mm Stainless steel</td>
<td>5</td>
</tr>
<tr>
<td>31</td>
<td>Dressing Forceps (spring type), 160mm, stainless steel</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
<td>Cord cutting Scissors, Blunt, curved on flat, 160 mm ss</td>
<td>1</td>
</tr>
<tr>
<td>33</td>
<td>Clinical Thermometer oral &amp; rectal</td>
<td>1 each</td>
</tr>
<tr>
<td>34</td>
<td>Talquist Hb scale</td>
<td>1</td>
</tr>
<tr>
<td>35</td>
<td>Stethoscope</td>
<td>1</td>
</tr>
<tr>
<td>36</td>
<td>Foetoscope</td>
<td>1</td>
</tr>
<tr>
<td>37</td>
<td>Hub Cutter and Needle Destroyer</td>
<td>1</td>
</tr>
<tr>
<td>38</td>
<td>Ambu Bag(Paediatric size) with Baby mask</td>
<td>1</td>
</tr>
<tr>
<td>39</td>
<td>Suction Machine</td>
<td>1</td>
</tr>
<tr>
<td>40</td>
<td>Oxygen Administration Equipment</td>
<td>1</td>
</tr>
<tr>
<td>41</td>
<td>Tracking Bag and Tickler Box (Immunization)</td>
<td>1</td>
</tr>
<tr>
<td>42</td>
<td>Measuring Tape</td>
<td>1</td>
</tr>
<tr>
<td>43</td>
<td>I/V Stand</td>
<td>1</td>
</tr>
</tbody>
</table>

**Note:** Number of equipments 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 C 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
Specimen 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 C 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 Amoxicillin, Tablet Metronidazole, Tablet Misoprostol, Tablet Paracetamol, ORS.

**Pocket 3: Supplies**


**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
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

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item Description</th>
<th>Essential</th>
<th>Desirable</th>
<th>Quantity</th>
<th>Installation</th>
<th>Training</th>
<th>Civil</th>
<th>Mechanical</th>
<th>Electrical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Open care system: radiant warmer, fixed height, with trolley, drawers, O₂-bottles</td>
<td>E</td>
<td></td>
<td>1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Resuscitator (silicone resuscitation bag and mask with reservoir) hand-operated, neonate, 500 ml</td>
<td>E</td>
<td></td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Weighing Scale, spring</td>
<td>E</td>
<td></td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Pump suction, foot operated</td>
<td>E</td>
<td></td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Thermometer, clinical, digital, 32-34 °C</td>
<td>E</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Light examination, mobile, 220-12 V</td>
<td>D</td>
<td></td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>Hub Cutter, syringe</td>
<td>E</td>
<td></td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Consumables

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item Description</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Intra Venous Cannula 24 G, 26 G</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Extractor, mucus, 20 ml, ster, disp Dee Lee</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Tube, feeding, CH07, L40cm, ster, disp</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Oxygen catheter 8 F, Oxygen Cylinder</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Sterile Gloves</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>
## Annexure 6

### SUGGESTED LIST OF DRUGS

**Note:** Drug Requirements would be same for all three Types of Sub-Centre except the drugs to manage Deliveries may not be required for Type B Sub-Centres.

#### KIT- A for Sub-Centres

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

#### KIT- B for Sub-Centres

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Name of the Drug/Form</th>
<th>Dosage</th>
<th>Quantity/Kit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Methylergometrine Tablets IP</td>
<td>Methylergometrine maleate IP 0.125 mg</td>
<td>240 tablets</td>
</tr>
<tr>
<td>2</td>
<td>Paracetamol Tablets IP</td>
<td>Paracetamol IP 500 mg</td>
<td>1000 tablets</td>
</tr>
<tr>
<td>3</td>
<td>Methylergometrine Injection IP</td>
<td>Methylergometrine maleate 0.2 mg/ml; 1 ml in each ampoule</td>
<td>10 ampoules</td>
</tr>
</tbody>
</table>
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. Ampicillin
- 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:
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

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 7A

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............................

<table>
<thead>
<tr>
<th>Name of the health worker/Volunteer/Practitioner</th>
<th>Name of the Supervisor</th>
<th>Name of the Reporting Unit</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>&lt;5yr</td>
<td>≥5yr</td>
</tr>
</tbody>
</table>

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 8

CHECKLIST

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

<table>
<thead>
<tr>
<th>Services</th>
<th>Existing</th>
<th>Expected</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternal Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC registration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC registered in 1\textsuperscript{st} trimester</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC provided at least 4 antenatal checkups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC whose BP has been monitored</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of ANC whose Hb has been monitored</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC whose Urine has been examined for sugar and protein</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC diagnosed as high risk pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of ANC given 100 IFA tablets during pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of women given booster/2 doses of TT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of pregnancy cases with danger sign and symptoms referred to higher institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of deliveries occurred in institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Post natal cases visited with Minimum 3 PNC Visits within 1\textsuperscript{st} week of delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.e. on 0, 3, 7\textsuperscript{th} day.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of missed – out cases of ANC/PNC tracked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of deliveries conducted at the Sub-Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are deliveries being monitored through Partograph?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are MCH Card being given to the beneficiaries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of pregnancies detected by utilizing Pregnancy Test Kits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child health:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of fully immunised infants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of children who received measles vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- less than 1year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- more than 1 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of newborns whose birth weight has been taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of newborns whose birth weight has been less than 2500 gms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of under five children with Grade I Malnutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of under five children with grade II malnutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of under five children with Grade III Malnutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Existing</td>
<td>Expected</td>
<td>Remarks</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of eligible couples registered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of protected couples with any FP method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of couples who have adopted permanent method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tubectomy and Type:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minilap Sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interval Sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Post partum Sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laparoscopic Sterilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vasectomy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of Eligible Couples using spacing methods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IUCD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nirodh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Counseling services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infrastructure Available</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of own/rented Sub-Centre building</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking water facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste disposal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence for Health Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANM, HW(Male)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equipment Availability In working condition As per list</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drugs Availability As per list</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transport facility for the staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring Mechanism:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Supervisory visits by</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Supervisor(Male)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MO I/C of PHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) By Village Health Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Citizens’Charter</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record Keeping and Reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births &amp; Deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other registers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reports sent to PHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of Fever cases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of Blood slides prepared</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of Malaria positive cases reported</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of cases given radical treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of cases of minor illnesses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- treated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- referred</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annexure 8A

A SIMPLER CHECKLIST THAT CAN BE USED BY NON-GOVERNMENTAL ORGANIZATION/PANCHYATI RAJ INSTITUTIONS/VILLAGE HEALTH COMMITTEE/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
Health Worker-Male (MPW) – 1
Staff Nurse (for Type C Sub-Centre only)
Contractual Safai-Worker – 1

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 9

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 and Sanitation 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

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Personnel</th>
<th>Existing</th>
<th>Recommended</th>
<th>Current Availability at Sub-Centre (Indicate Numbers)</th>
<th>Remarks/Suggestions/Identified Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Health Worker (Female)</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Health Worker (Male)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Contractual <em>Safai Karmachari</em> to keep the Sub-Centre clean and assisting ANM.</td>
<td>-</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Physical Infrastructure (As per specifications)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Particulars</th>
<th>Current Availability at Sub-Centre</th>
<th>If available, area in Sq. mts.)</th>
<th>Remarks/Suggestions/Identified Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Location</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Where is this Sub-Centre located?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Within Village Locality Far from village locality If far from locality specify in km</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Whether located at an easily accessible area? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. The distance (in Kms.) of Sub-Centre from the remotest place in the coverage area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Travel time to reach the Sub-Centre from the remotest place in the coverage area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. The distance (in Kms.) of Sub-Centre from the PHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. The distance (in Kms.) of Sub-Centre from the CHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Building</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Is a designated government building available for the Sub-Centre? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. If there is no designated government building, then where does the Sub-Centre located</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Rented premises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Other government building</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Any other specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Area of the building (Total area in Sq. mts.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. What is the present condition of the existing building</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. What is the present stage of construction of the building</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Construction complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Construction incomplete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Compound Wall/Fencing (1-All around; 2-Partial; 3- None)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. Ramp for use of trolley/wheel chair users (present/not present)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>h. Condition of plaster on walls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Well plastered with plaster intact every where;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Plaster coming off in some places;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Plaster coming off in many places or no plaster)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sl. No.</td>
<td>Particulars</td>
<td>Current Availability at Sub-Centre</td>
<td>If available, area in Sq. mts.</td>
<td>Remarks/Suggestions/Identified Gaps</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td>Condition of floor:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Floor in good condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Floor coming off in some places</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Floor coming off in many Places or no proper flooring)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Whether the cleanliness is Good/Fair/Poor? (Observe)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Are any of the following close to the Sub-Centre? (Observe) (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Garbage dump</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Cattle shed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Stagnant pool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Pollution from industry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Is boundary wall with gate existing? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Prominent display boards in local language (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Separate public utilities for males and females (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Suggestion/complaint box (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Labour room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Labour room available? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>If labour room is present, number of deliveries carried out?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>If labour room is present, but deliveries not being conducted there, then what are the reasons for the same?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Staff not staying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Poor condition of the labour room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>No power supply in the labour room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Any other specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Clinic Room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Examination room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td><strong>Water supply</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify))</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>a. Whether overhead tank and pump exist (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>b. If overhead tank exist, whether its capacity sufficient? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>c. If pump exist, whether it is in working condition? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sl. No.</td>
<td>Particulars</td>
<td>Current Availability at Sub-Centre</td>
<td>Remarks/Suggestions/Identified Gaps</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Waste disposal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. How the medical waste disposed off (please specify)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Electricity/Communication/Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Regular electric supply available? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Backup generator/Inverter available (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Communication facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Transport facility for movement of staff (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Residential facility for the staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current Availability at Sub Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Health Worker (Female)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Whether Health Worker (Male) available in the Sub-Centre?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Is he staying at Sub-Centre Head Quarter village? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Staff Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equipment (As per list)

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Available</th>
<th>Functional</th>
<th>Remarks/Suggestions/Identified Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Drugs (As per essential drug list)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Available</th>
<th>Quantity</th>
<th>Remarks/Suggestions/Identified Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Furniture

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

## Quality Control

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Particular</th>
<th>Whether functional/available as per norms</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Citizen’s charter in local language (Yes/No)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>External monitoring: Village Health and Sanitation Committee, evaluation by independent external agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Availability of various guidelines issued by GOI or State Govt. (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annexure 10

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 11

LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEFI</td>
<td>Adverse Effects Following Immunization</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AIIMS</td>
<td>All India Institute of Medical Sciences</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Check-up</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infections</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AYUSH</td>
<td>Ayurveda, Yoga &amp; Naturopathy, Unani, Siddha and Homeopathy</td>
</tr>
<tr>
<td>AWWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guérin Vaccine</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>DDK</td>
<td>Disposable Delivery Kit</td>
</tr>
<tr>
<td>DEC</td>
<td>Diethyl Carbamazine</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short Course</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, Pertussis and Tetanus Vaccine</td>
</tr>
<tr>
<td>DT</td>
<td>Diphtheria and Tetanus Vaccine</td>
</tr>
<tr>
<td>EAG</td>
<td>Empowered Action Group</td>
</tr>
<tr>
<td>FRU</td>
<td>First Referral Unit</td>
</tr>
<tr>
<td>FTD</td>
<td>Fever Treatment Depot</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSCC</td>
<td>Hospital services Consultancy Corporation</td>
</tr>
<tr>
<td>IDSP</td>
<td>Integrated Disease Surveillance Programme</td>
</tr>
<tr>
<td>ID/AP</td>
<td>Infrastructure Division/Area Projects</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron and Folic Acid</td>
</tr>
<tr>
<td>IMEP</td>
<td>Infection Management and Environment Plan</td>
</tr>
<tr>
<td>IPHS</td>
<td>Indian Public Health Standard</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intra Uterine Contraceptive Device</td>
</tr>
<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana (JSY)</td>
</tr>
<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
</tr>
<tr>
<td>LLIN</td>
<td>Long Lasting Insecticidal Net</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi Drug Treatment in Leprosy</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles Mumps Rubella Vaccine</td>
</tr>
<tr>
<td>MNP</td>
<td>Minimum Needs Programme</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancies</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-communicable Disease</td>
</tr>
<tr>
<td>NICD</td>
<td>National Institute of Communicable Diseases</td>
</tr>
<tr>
<td>NIHFW</td>
<td>National Institute of Health &amp; Family Welfare</td>
</tr>
<tr>
<td>NLEP</td>
<td>National Leprosy Eradication Programme</td>
</tr>
<tr>
<td>NMMP</td>
<td>National Malaria Eradication Programme</td>
</tr>
<tr>
<td>NPCB</td>
<td>National Programme for Control of Blindness</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>NVBDCP</td>
<td>National Vector Borne Disease Control Programme</td>
</tr>
<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Re-hydration Solution</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Check-up</td>
</tr>
<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
</tr>
<tr>
<td>RBC</td>
<td>Red Blood Corpuscle</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RDK</td>
<td>Rapid Diagnostic kits 9 e.g., malaria, typhoid etc.)</td>
</tr>
<tr>
<td>RHS</td>
<td>Rural Health Services</td>
</tr>
<tr>
<td>RKS</td>
<td>Rogi kalyan Samiti</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infections</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled Birth Attendance</td>
</tr>
<tr>
<td>SC</td>
<td>Sub-Centre</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>VAPP</td>
<td>Vaccine Associated Paralytic Poliomyelitis</td>
</tr>
<tr>
<td>VHND</td>
<td>Village Health and Nutrition Day</td>
</tr>
<tr>
<td>VHSC</td>
<td>Village Health &amp; Sanitation Committee</td>
</tr>
<tr>
<td>VVM</td>
<td>Vaccine Vial Monitor</td>
</tr>
<tr>
<td>WBC</td>
<td>White Blood Corpuscle</td>
</tr>
<tr>
<td>WC</td>
<td>Water Closet</td>
</tr>
</tbody>
</table>
REFERENCES

2. Bulletin on Rural Health Statistics in India (2009), Infrastructure Division, Department of Family Welfare; Ministry of Health & Family Welfare, Government of India.
LIST OF MEMBERS OF THE TASK FORCE CONSTITUTED FOR REVISION OF IPHS DOCUMENTS

1. Dr. R.K. Srivastava, DGHS - Chairman
2. Dr. Shiv Lal, Former Special DG and Advisor (PH)- Co-Chairman.
3. Dr. B. Deoki Nandan, Director NIHFW
4. Sh. Amarjit Sinha, Ex-Joint Secretary, NRHM, Ministry of Health & F.W., Nirman Bhawan, New Delhi.
5. Dr. Amarjit Singh, Executive Director, Jansankhya Sthirata Kosh, 283, August Kranti Bhawan, 1st Floor, Annie Besant Gate, Bhikaji Cama Place, New Delhi - 110066.
6. Dr. T. Sunderraman, Executive Director, NHSRC, NIHFW Campus, Baba Gang Nath Marg, Munirka, New Delhi - 110067.
7. Dr. N.S. Dharmshaktu, DDG (NSD), Dte. G.H.S., Nirman Bhawan, New Delhi.
8. Dr. C.S. Pandav, Prof. and Head, Community Medicine, AIIMS, New Delhi.
9. Dr. Bir Singh, Vice-President, IAPSM.
11. Dr. S.K. Satpathy, Public Health Foundation of India, Aadi School Building, Ground Floor, 2 Balbir Saxena Marg, New Delhi - 110016.
12. Dr. S.D. Khaparde, DC (ID), Ministry of Health & F.W., Nirman Bhawan, New Delhi.
14. Dr. J.N. Sahay, Advisor on Quality improvement, NHSRC, NIHFW Campus, Baba Gang Nath Marg, Munirka, New Delhi - 110067.
15. Dr. Jugal Kishore, Professor of Community Medicine, Maulana Azad Medical College, Bahadur Shah Zafar Marg, New Delhi 110002.
16. Dr. A.C. Dhariwal, Director NVBDCP, 22, Sham Nath Marg, New Delhi - 110054.
17. Dr. S. Kulshreshtha, ADG, Dte. GHS., Nirman Bhawan, New Delhi.
18. Dr. Anil Kumar, CMO (NFSG), Dte. G.H.S.- Member Secretary
19. One District CMO level officer from State of Tamil Nadu
20. One District CMO level officer from State of Bihar.