Rapid Appraisal of Functioning of Village Health and Sanitation Committees (VHSCs) under NRHM in Orissa

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PREFACE

Despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in our country. The concerns shown by the organisations at the global level indicate that in view of the resurgence of various epidemics, both infectious and non-infectious, the situation can be handled only through a public health management approach. This urgency was realised and expressed in the Public Health Conference as the 'Calcutta Declaration', which called for creating appropriate structure for public health professionals and promoting reforms in public health education and training.

The National Institute of Health & Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and engaging in partnerships with public health institutions in the country to enhance their research capacity. As the nodal agency for imparting in-service training to health personnel and conducting research under the NRHM, the Institute is an ideal partner to bring the Department of Community Medicine in medical colleges, nursing colleges and other public health education and training institutions in the healthcare delivery system into the mainstream healthcare system, and also to provide a platform for building networks for capacity building in these institutions.

Currently, under the National Rural Health Mission many innovations have been introduced in the states to deliver healthcare services in an effective manner. State programme managers would wish to know how well these innovations are performing so that in case of gaps they could take corrective measures to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery system by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need was discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme relevant information at local and regional levels.

The Rapid Assessment of Health Interventions (RAHI), a collaborative effort with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of the 'Public Health Education and Research Consortium (PHERC)' of the National Institute of Health and Family Welfare to develop partnerships with different organisations working in the field of health and family welfare. The project objective is to accelerate programme implementation in the identified states by providing them with timely

and appropriate research inputs for addressing priority implementation problems. The specific objectives of this initiative are to develop a network of state/regional institutions for conducting health systems research and to provide technical support for steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of the RAHI Project, the UNFPA India Office supported 12 health system research projects. In this phase, five low-performing states, viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa, were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, 12 projects were finalised in a national workshop conducted at the NIHFW. The faculty of the NIHFW provided technical support for the finalisation of tools, training to investigators, planning and monitoring of data collection. A quality assurance mechanism was developed in consultation with the members of TAG and experts from the UNFPA. The progress of the projects was reviewed by the TAG from time to time. A draft report entitled **"A Rapid Appraisal of the Functioning of Village Health and Sanitation Committees (VHSCs) under NRHM in Orissa"** by the Kalinga Centre for Social Development (KCSD), Bhubaneswar, was finalised by the Institute in consultation with the UNFPA.

It is envisaged that the findings and recommendations of this study would trigger a series of follow-up measures by the programme managers concerned in the state. We also feel strongly about continued need for optimum engagement of available human resources in community medicine, paediatrics, obstetrics, and gynaecology departments of the medical colleges in such assessments. Such initiatives by the programme managers will end the current isolation of medical colleges and will be conducive for incorporating such public health interventions during undergraduate and post graduate training.

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We are also thankful to the officials of the Mission Directorate, NRHM Orissa, Chief District Medical Officers of the three districts and Block Medical Officers of the six Block PHCs/CHCs, District Panchayati Raj Officials and other functionaries for extending their support and co-operation during the study.

We extend our thanks to Dr. P. K. Mishra, Chairman of the Kalinga Centre for Social Development (KCSD), Bhubaneswar, for giving us all necessary support and Dr. Almas Ali, Distinguished Professor and Chief Advisor, KCSD, in conducting this study. Also, we express our gratitude to all our respondents in this research without whose cooperation and inputs the study would not have been completed.

The report attempts to provide insights into the operational aspects and the current capacity of the VHSCs in health planning and suggest feasible solutions for their effective functioning which policy- and decision-makers, civil society organisations and researchers can use to pursue their interest to bring about improvement in the management and implementation of the NRHM activities in the state.

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ABBREVIATIONS

ANM	:	Auxiliary nurse midwife
ASHA	:	Accredited social health activist
AWW	:	Anganwadi worker
BCC	:	Behaviour change communication
BEE	:	Block extension educator
BPO	:	Block programme officer
CBO	:	Community-based organisation
CDMO	:	Chief District Medical Officer
DHAP	:	District Health Action Plan
DPEO	:	District Panchayti Raj Officer
DPM	:	District Programme Manager
FGD	:	Focus Group Discussion
GPEO	:	Gram Panchayat Extension Officer
IDI	:	In-depth Interview
KCSD	:	Kalinga Centre for Social Development
KII	:	Key Informant Interview
KIIT	:	Kalinga Institute of Industrial Technology
Mo (Ic)	:	Medical Officer in-charge
NGOs	:	Non-government organisations
NIHFW	:	National Institute of Health & Family Welfare
NRHM	:	National Rural Health Mission
OBC	:	Other Backward Caste
PRI	:	Panchayati Raj Institution
RAHI	:	Rapid Appraisal of Health Interventions
RWSS	:	Rural Water Supply and Sanitation
SC	:	Scheduled Castes
SHG		Self-Help Group
ST	:	Scheduled Tribes
UNFPA	:	United Nations Population Fund
VHC	:	Village Health Committee
VHSC	:	Village Health and Sanitation Committee
VWSC	:	Village Water & Sanitation Committee

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EXECUTIVE SUMMARY

The National Rural Health Mission was launched in 2005 to provide accessible, affordable and quality healthcare services to the rural masses across the country. The National Institute of Health & Family Welfare (NIHFW), in collaboration with the UNFPA India Office, through a project named 'Rapid Appraisal of the Health Interventions (RAHI)' has carried out a rapid assessment of the various healthcare interventions under the mission. Twelve institutions from across the country have participated in the project. The rapid appraisals conducted under the RAHI project are in the five low-performing states, namely Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa and Uttar Pradesh, to critically look into the implementation process of the various schemes and innovations under the NRHM.

General Objective

To review the current status of formation, empowerment, functioning and capacity of VHSCs to address the healthcare need of the people in the context of the NRHM.

Methodology

The study was a non-experimental descriptive design, with both qualitative and quantitative techniques. The study area included six blocks, two in each in the districts of Ballenger, Kendrapada and Nabarangpur. The stakeholders in the study were the ASHAs, the AWWs, the ANMs, and members of PRIs and SHGs along with block and district-level officials. Record review, semi-structured interviews and key informant interviews and guidelines for conducting FGDs were used as tools for the study.

Salient Findings

- The awareness about VHSCs is highest among ANMs followed by ASHAs and CDMOs/MOs, PRI and SGH members, and the least was the panchayat officials among all stakeholders. With respect to involvement in the formation of the VHSCs it was highest among the ASHAs, ANMs and SHG members, followed by CDMO and PRI members. The panchayat officials were found to be not involved in the process.
- The knowledge about the objectives of the VHSC was highest among the ASHAs, ANMs, members of the SHGs, and the least among the members of the PRIs. Lack of

clear guidelines and instructions from state level has affected the VHSC formation process.

- The results of the record review of VHSCs in Loisinga and Patnagarh blocks of Balangir district indicate that almost all committees (95%) were formed only about six months prior to the study. Majority of the members are found to be women (82%) and belong to the OBCs (69%), followed by SCs and STs (24%). The General Category members are the least at 6% in these committees.
- Orientation training has been done with CDMOs/MOs followed by the ASHAs, the ANMs, and DPOs/GPEOs. None of the PRIs and SHG members have received any training/orientation on the NRHM and the VHSC. Almost all among the ASHAs, the ANMs, PRI and SHG members are of the opinion that there is a need for detailed training on the VHSC, irrespective of the fact whether they have received training or not.
- Non-availability of information about the VHSC funds has arrested the functioning of the project. The average number of members participating in VHSCs meeting is decreasing and the lack of proper follow-up action on the planned activity due to the unavailability of funds is resulting in poor functionality of VHSCs. None of the VHSCs have received any funds.
- Lack of clarity about the VHCs at sub-centre level and VHSCs.
- With respect to skill-set available with the VHSCs to formulate the Village Health Plan (VHP) it has been observed that almost all CDMOs/MOs are aware of the VHP but none have received training on how to prepare a VHP and no guidelines have been given to them.
- Lack of institutional set-up at the village level to undertake village level planning and inter-sectoral coordination, convergence and involvement of the panchayats indicates that even if the community is given the ownership of the plans, it will be still a matter of concern.

Key Recommendations

- To take immediate steps to set up institutional mechanisms i.e. VHSC, and issue detailed consolidated instructions specifying membership of VHSCs, process of constitution, its integration with PRIs, funds flow mechanism, with clear roles and responsibilities of different office bearers. Support mechanisms at the district and block levels need to be established to ensure convergence, merger or re-designation of earlier health and allied committees at the village level.

- Financial information should be made available to each block, PHCs and below. If required, e-financial information systems can be established to ensure quick flow of information. Attempt has to be made to involve each concerned departments at all levels.

- Programme guidelines should be clearly explained to the implementers and other providers.

- Steps should be taken to avoid confusion relating to VHCs at sub -centre level and village healthcare and sanitation committee at the village level. The purpose of both the funds and function of both the committees are to be clearly explained to the providers as well as the beneficiaries. Efforts should be made to involve NGOs in facilitating formation process of VHSCs.

- IEC activities need to be intensified in the community particul arly on the provisions and entitlements under the NRHM. Social mobilisation around general health issues and health as a right of people need to take place for positioning of the ASHAs and VHSCs.

- Detailed training on VHSCs and their functioning should be imparted to the ASHAs, the AWWs and the ANMs so that they can approach the community with full knowledge and confidence. Further, the quality of the training is to be enhanced and refresher training on VHP and other functional aspects of VHSCs should be p rovided based on the need assessment.

CHAPTER 1

INTRODUCTION

The NRHM was launched on April 12, 2005 by the Government of India with an aim to provide effective healthcare to the rural populations throughout the country, but with a special focus on 18 states that have weak public health infrastructures. The NRHM emphasises on the community participation as one of the key approaches by which improvement in the healthcare system and health status of the people can be achieved and thereby ensure them universal access to equitable, affordable and quality healthcare that is accountable and responsive to their needs.

The mission seeks to empower local governments to plan, facilitate implementation, manage, control and be accountable for public health services at various levels. The idea is to realise that the decentralised planning, facilitation of implementation, oversight and monitoring through community involvement will likely to be more responsive to the healthcare needs of local communities and will be a step towards 'communitisation -- a hallmark of the NRHM.

To initiate the community-led action, the implementation framework of NRHM emphasises on committees at different levels. The Village Health & Sanitation Committee (VHSC) is a simple and effective management structure at the lowest level, comprising representatives from the village. Its key function is to prepare the village health plan, implement it and manage the fund which is earmarked as per the need of the community. This committee is a facilitating body for village level development programmes relating to health and sanitation and reflects the aspirations of the local community.

Operationalisation in the State

Orissa is one of the states where NRHM is currently operational since June 17, 2005. Following this, the state government has taken many initiatives to converge health and sanitation activities at village and subsequent levels, as early as January 2006.

Limited studies on operational aspects of VHSCs, their formation, functioning and inadequate feedback from community has necessitated the study on functioning of VHSCs in Orissa. The VHSCs are regarded as strategic institutions at village level, initiating community-led actions under NRHM and assumes importance from the view point of

community participation, decentralisation and integration of health to determinants of good health.

Rationale

Under the implementation NRHM framework the VHSCs will be constituted in over 6 lakh villages and be provided with untied funds by 2008 (100%). Out of which 30% VHSCs would be formed by 2007. The available reports do not give enough information and a clear depiction on the functional status of the VHSCs.

There is also a need to ascertain whether there is appropriate understanding among the members about their roles responsibilities and preparedness and capacities to prepare village health plan. Therefore, the present study was planned in Orissa with the following objectives:

General Objective

To review the current status of formation, empowerment, functioning and capacity of village health and sanitation committees to address the healthcare need of the people in the context of NRHM.

Specific Objectives

- To review the process of formation/composition of VHSCs and find out the deviations if any from the prescribed framework of guidelines
- To review the process of empowering VHSCs for the tasks expected -- assess the orientation/capacity building initiatives undertaken so far by the district or state health mission
- To assess the functioning of VHSCs i.e. frequencies of meeting, agenda and issues
- To review the process of funds flow to the VHSCs, and
- To assess the skill-set/resources available with the VHSCs to formulate village health plan and support required for this.

CHAPTER II

METHODOLOGY

Study Area: The study was carried out in three districts of Orissa -- Kendrapada, Mayurbhanj and Nabarangpur.

Study Design

Type of Study
Non-experimental descriptive design with a rapid appraisal method.

Type of Respondents
The ASHAs, the ANMs, members of PRIs and SHGs, Block MOs(I -c), CDMOs, GPEOs, and DPROs. Besides, the BEEs, executive engineers of RWSSs, DPMs and state programme manager of NRHM were also consulted during the study.

Sampling Design

Selection of district, blocks and villages
The study covered three (10%) of the 30 districts of the state selected purposively on the basis of low and better health indicators, Tribal concentration and non -Tribal areas. The districts covered belong to Tribal concentrated areas and one of them (Kendrapada) belongs to a non-Tribal area. In each district, two blocks were purposively selected for primary study where community-monitoring activity was started. A total of six blocks were covered under the study. The names of the districts and the blocks covered under the study are given below (Table-1).

Table 1: Districts and Blocks covered under the Study

District	Blocks
Balangir	Loisingha
	Patnagarh
Kendrapada	Derabisi
	Patamundai
Nawarangapur	Nabarangpur
	Tentulikhunti

From each selected blocks, 10 villages where the VHSCs have been formed were covered based on the availability. Selections of villages were done randomly.

Study Duration
October to December 2007.

Data Collection Methods and Field Work

Sample Coverage
As per the design, a total of 60 review of records of the VHSCs, 18 FGDs, 18 IDIs, six key informant interviews (KIIs) were planned to be conducted during the study. However, only 25 reviews of records instead of 60 planned reviews could be conducted as t he VHSCs in four blocks of the six blocks were not available during the study period. Twenty four IDIs were conducted instead of 18 planned to maintain a uniformity of samples covered from ex - officio categories such as the ANMs and the ASHAs. The details o f interviews/reviews conducted during the study are shown in Table -2.

Table 2: Details of Interviews/Reviews Conducted under the Study

	Interviews/Reviews Conducted			
	Village	Block	District	Total
Review of VHSC records	25			25
Focus Group Discussions		18		18
ANMs		6		6
AWWs		6		6
SHG/PRI members		6		6
In-depth Interviews				24
ANMs/ASHAs	12			12
SHG/PRI members	12			12
Key Informant Interviews				12
CMOs/District Nodal Officers			3	3
District Panchayati Raj Officers			3	3
Block MOs-IC		3		3
Block Panchayati Raj Officers		3		3

Out of the six FGDs under SHG/PRI members' category, three FGDs were conducted with women SHG members and nine IDIs out of 12 members interviewed from SHG/PRI members were women.

Data Collection Methods

The primary data were collected through FGDs, IDIs and KIIs. The secondary data were collected through review of records. The data collection followed a step by step procedure. The KIIs were conducted at the district and block levels, the FGDs at block/CHC levels and IDIs and review of records at village level.

Guidelines for conducting FGDs, six semi-structured interviews schedules for IDIs and KIIS were used to collect information from different types of respondents. Besides, a check-list was used to review HSC records.

Quality Assurance

All the FGDs were recorded. Privacy and confidentiality were ensured during IDIs. To ensure the quality the principal investigator was present during all the FGDs out of which three FGDs were supervised by members of the Central Monitoring Team from NIHFW. Besides, the members of Central Monitoring Team were also present during four IDIs and two recorded reviews.

The information from the recorded interviews/FGDs was coded and transcribed with the help of field notes and further translated by the supervisors on the same day of the field study. The principal investigator supervised the data handling and data analysis.

Data Analysis Plan

Efforts were made to collect information from Village Water & Sanitation Committees (VWSCs), VHCs and VHSCs. Records of five VHCs and 20 VHSCs were reviewed in Nabarangpur and Kendrapada districts respectively. It was observed that the structure and composition of VHCs and VHSCs are different. Hence in the final analysis only information from record review of 20 VHSCs is included.

The final analysis was done step-by-step. Firstly, a stakeholder analysis was done to understand the consistencies/inconsistencies among the stakeholders and their geographical areas. Secondly, triangulation of data was done to summarise the data collected under the

study. For open-ended questions and a semi-quantification test of the responses were done using qualifiers.

Table 3: Qualifiers used in the Study for Qualitative Data

Proportion of Respondents	Adjectives used
<10 %	Very few
10-24 %	Some
25-49 %	Approximately half
50-74 %	Majority/Over half
75-89 %	Most
>90 %	Almost all

Ethical Clearance

The project structure was examined and cleared by the NIHFW's Ethical Committee Review Board for ethical considerations.

CHAPTER III

FINDINGS AND DISCUSSION

Process of Formation and Composition of VHSCs

To review the formation process of VHSCs, besides reviewing the records, an attempt was made to know the knowledge and awareness on VHSCs among the different stakeholders.

It has been observed that almost all of the ANMs, the CDMOs/MOs, most of the ASHAs and majority of SHG members know about the NRHM and VHSC, but only three out of the six PRI members and DPOs/GPEOs know about the NRHM. The knowledge about NRHM is highest among CDMOs/MOs and ANMs followed by the ASHAs. The awareness about NRHM is least among panchayat officials, PRI and SHG members. The awareness about VHSCs is highest among the ANMs, followed by the ASHAs and CDMOs/MOs, PRI and SHG members. The awareness about VHSCs is the least for the panchayat officials among all the stakeholders. With respect to involvement in VHSC formation it is highest among the ASHAs, the ANMs and SHG members followed by CDMOs and PRI members. The panchayat officials are found to be not involved in the process at all. The awareness about the objectives of the VHSCs is highest among the ASHAs, the ANMs, SHG members and the least among the PRI members. Only three ANMs and two CDMOs/MOs out of the six are aware of the off icebearers of VHSCs; the awareness about office bearers is meagre among the ASHAs, PRI and SHG members (Table-4).

Table 4: Knowledge and Awareness about VHSC among Different Stakeholders

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPEO (N = 6)	CDMO/MO (N = 6)
Know about NRHM	5	6	3	4	3	6
Know about VHSC	5	6	3	4	2	5
Belong to Village having a VHSC	3	2	2	3	Nil	Nil
Members of VHSC	3	2	2	3	Nil	Nil
Know about VHSC Objectives	3	3	1	3	Nil	Nil

Knows the office bearers of VHSC	1	3	1	1	Nil	2

It has been found that the awareness about the NRHM as well as of VHSCs is less among the community-based organisations and PRIs. Therefore, more IEC activities on information relating to various components of NRHM and VHSCs should be undertaken to create an enabling environment for the uptake of the VHSC activities at the community level.

"Ame mane nua kari nirbachit heichhu. panchayat re panchati kamiti vitare swasthya o parimal kamiti gota. athire pancha jana sadasys achhanti. sarpanch tara sabhapati o anya chari jana wardmember tara member. ame meeting kari swasthy scheme babadre janibaku anm o aww knu daki thilu. hele anm sethiku asunahanti. loka pratinidhi nku sampurna avoid kari sarakary karmachari mane chaluchanti. ame mane se babadare kichhi jan ninu. gaon starare gramy swasthy o parimal kamiti babadare kichhibi janinu".

["We are newly elected members to the Gram Panchayat. We know about the VHSCs are one of the statutory committees among five committees of the Gram Panchayat. The committee is consists of five members. The Sarpanch is the president of such committee with four ward members as members. To know about health programmes we have called the ANMs and the AWWs to the meeting. However, the ANMs are not coming to the meeting. The health department staff are totally avoiding us. Hence we didn't know anything about the village health and sanitation programmes." complain the PRI members in the Derabisi block of Kendrapada district.

In most of the places, no VHSCs have been formed. Even in plac es like Balangir where VHSCs have been formed the knowledge about the NRHM is very less among the community. There is an urgent need for more awareness building activities on NRHM as well as VHSCs in these areas.

"NRHM babadare sunichhun, hele bhal kari ni janbar. anm didi gaon thi meeting kari thile. se meeting thi gaon re swasthya o parimal kamitt gathan heba katha kahile."

["We have heard about NRHM and VHSCs from the ANMs. But we know very little about them. The ANM held a meeting in the village and told us about the formation and composition of VHSCs," say AWWs in the Patnagarh block of Balangir.

VHSC Formation Process

Majority of CDMOs/MOs, ANMs, ASHAs knew about the formation process, while only one out of the six PRI members know about the proc ess of formation of VHSC and none of the panchayat officials had any knowledge about its formation. About 50% of the ASHAs, the ANMs and SHG members were involved in the formation. The involvement in the formation of VHSCs is highest among the ASHAs, the A NMs, SHG members (three out of six in each) followed by the CDMOs (two out of six) and PRI members (one out of six). The panchayat officials were not involved at all in the process. There are also no guidelines available with the other service providers ex cept CDMOs/MOs, majority of whom were given the guidelines. The ANMs and ASHAs were involved mostly on verbal instruction from their seniors. Three ANMs and ASHAs and two each CDMOs/MOs, SHG members informed that during formation the meeting was convened e ither by the AWWs or the ASHAs and ward member.

Table 5: Opinion of different stakeholders about formation process of VHSC

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPE O (N = 6)	CDMO/M O (N = 6)
Know about the formation process	4	4	1	3	Nil	4
Involved in formation	3	3	1	3	Nil	2
Received guidelines	Nil	Nil	Nil	Nil	Nil	5
Received verbal instruction from seniors	3	3	Nil	Nil	Nil	Nil
VHSC is registered	Nil	Nil	Nil	Nil	Nil	Nil
Presence of a bye-law	Nil	Nil	Nil	Nil	Nil	Nil
ASHA/AWW convened meeting	3	3	1	2	Nil	2
Ward member is within the committee	3	3	2	1	Nil	3

It has been observed that however the initial guideline are not adequate for making it operational, hence a new guideline on VHSC is expected to be in place shortly. Inadequate guidelines have virtually delayed the process of formation of VHSCs. The formation of VHSCs has been mainly facilitated by NGOs working in the area under community monitoring of the NRHM. The involvement of service providers are on the basis of verbal instructions from their seniors particularly for the ANMs and the ASHAs.

‘In the ASHA training itself the medican officer in -charge and BEE told us to form a committee in the village involving Sarpanch/ward member, the AWW, the ASHA, secretary/president of SHG, schoolteachers etc. However, no guideline was given to us,’ says an ASHA from Loisinga block of Balangir.

The inter-departmental convergence is an important area for initiating supportive action from all departments that influence outcomes of wider dete rminants of health. It is observed that the efforts to involve the panchyats have been quite delayed as the sensitisation for the District Panchayati Raj officials was held only in November 2007.

It is also gathered that VHSCs will be formed in each villa ge and PRI members should be actively involved in it. However, the detail on how to involve PRIs and the guidelines on it was not received by panchayat officials.

The sensitisation workshop on VHSCs was facilitated by district and block level NGOs and involved community monitoring process. The MOs, BEEs, BPOs, ANMs of these three blocks were also present during the workshop.

It is further gathered that only issue of guidelines or framework is not sufficient to ensure cooperation from the health personnel at the district and block levels.

The results of the record review of 20 villages of Loisinga and Patnagarh block of Balangir district indicates that almost all committees (95%) were formed within six months from the date of visit (Table-6).

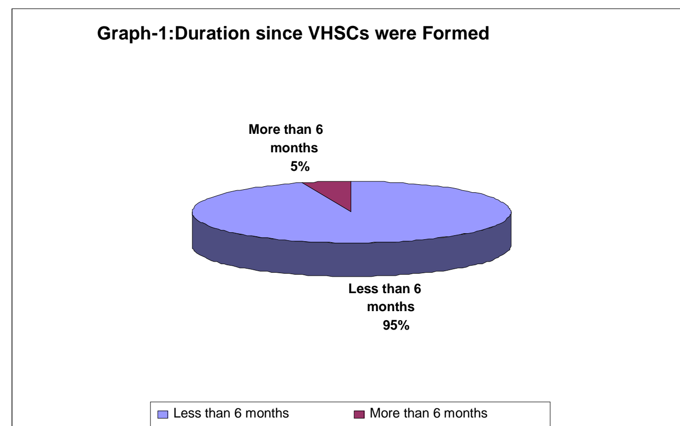


Table 6: Duration since VHSCs were formed

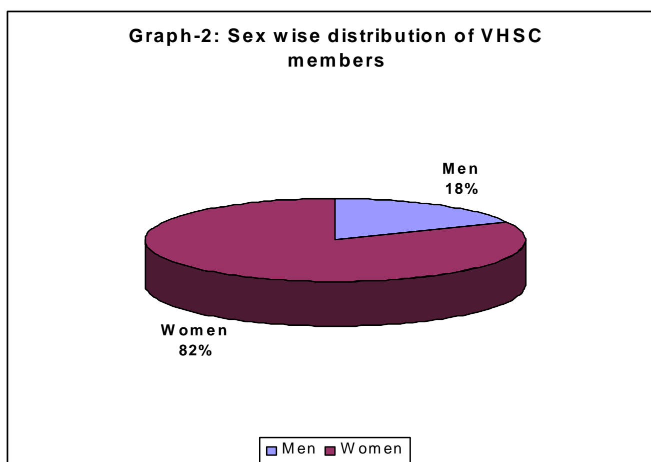
Months	Number	Percentage
Less than 6 months	19	95.0
More than 6 months	1	5.0
Total Villages	20	100.0

It has been observed that half of the VHSCs have 10 to 15 members (50%), while seven out of 20 VHSCs have members within the range of 16 to 20 (35%), the remaining three have over 20 members (15%) in the committees. It is observed that the range of membership among the committees varies from 10 to 31 (Table -7).

Table-7: Range of Committee Members in VHSCs (N = 20)

Range	Number	Percentage
10-15	10	50.0
16-20	7	35.0
20+	3	15.0
Total VHSCs	20	100.0

The record review also reveals that a total of 326 members participated in formation of VHSC activities in 20 VHSCs covered under the study. Out of which majo rity are found to be women (82%). Similar findings are also noted during the FGDs with the ANMs and ASHAs where almost all participants in from Balangir district are of opinion that the majority members in their committees are women (Table -8).



Graph-2: Sex wise distribution of VHSC members

Table 8: Sex wise distribution of VHSC members

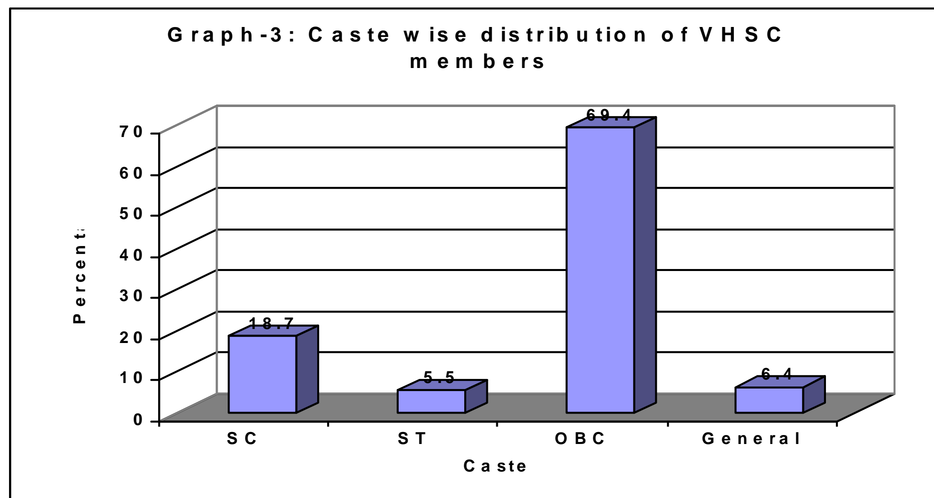
Sex	Number	Percentage

Men	58	17.8
Women	268	82.2
Total number of committee members	326	100.0

With respect to caste/tribe wise distribution of VHSC members, out of 326 members, majority are OBCs (69%), followed by SCs & STs at 24%. The General Category members are found to be least at 6% (Table-9).

Table 9: Caste-wise Distribution of VHSC members

Caste/Tribe	Number	Percentage
SCs	61	18.7
STs	18	5.5
OBCs	226	69.4
General	21	6.4
Total number of committee members	326	100.0



It has been observed that out of 20 VHSCs, all committees are represented by the ASHAs and SHG member (100%) of the village. The AWW is a member in 19 VHSCs (95%). Eighteen VHSCs are found to have ward members (90%) in their committees. Most of the committees have adolescent girls (70%). Twelve committees have the ANMs (60%) as members. Half of the committees (50%) have teachers as members. Nearly one-third of the

committees (30%) have members from village youth clubs. Four VHSCs have Sarpanch in their committee (20%). Samiti members and Naib sarpanchs are also members in one VHSC (5% each). There are also representatives from PTA (15%) and local NGOs (5%) in the committee (Table-10).

Table 10: Type of VHSC Committee Members as per the Records (N = 20)

Committee Members	Number of Villages	Percentage
SHGs	20	100.0
ASHAs	20	100.0
AWWs	19	95.0
Ward members	18	90.0
Adolescent girls	14	70.0
ANMs	12	60.0
Teachers	10	50.0
Youth Club members	6	30.0
Sarpanchs	4	20.0
PTA Secretaries	3	15.0
Samiti members	1	5.0
Naib Sarpanchs	1	5.0
NGO representatives	1	5.0
Total Villages	20	100.0

With respect to the composition of VHSCs by different membership category, it has been observed that in all committees at least two ex-officio members are present. In all committees either the SHG president or the secretary is a member. The PRIs (ward members/sarpanchs) are also found in almost all committees (95%). Other community members such as teachers, adolescent girls are also present in half of the VHSCs (70%) under the study. Almost half of the committees (45%) also have representatives from youth clubs, NGOs, PTA. (Table-11).

Table 11: Composition of VHSC by Membership Category

Category of members	Number Villages	Percentage
Ex-officio Members (ASHAs/AWWs/ANMs)	20	100.0
SHG presidents/secretaries	20	100.0

PRI Members	19	95.0
Other community members such as teachers, adolescent girls	14	70.0
Representatives from community based organizations/User-groups	9	45.0
Total Villages	20	100.0

Most of the VHSCs do not have conveners (60%). In the remaining 40% of the VHSCs either AWWs (25%) or ASHAs (15%) are designated as the convener of the committee (Table-12).

Table-12: Convener of VHSCs

Convener	Number	Percentage
No Convener	12	60.0
AWWs	5	25.0
ASHAs	3	15.0
Total Villages	20	100.0

Majority VHSCs do not have a chairperson (65%). In remaining 35%, ward member/Sarpanch is designated as the chairperson. The findings of FGDs reveal that ANMs also highlight in most of the committees in Patnagarh and almost half in Loisinga block do not have office-bearers. Similarly, according to the FGDs of the ANMs, it has been revealed that almost all VHSCs in Patnagarh and some of them in Loisinga block of Balangir do not have office-bearers (Table-13).

Table 13: Chairperson of VHSCs

Chairperson	Number	Percentage
No Chairperson	13	65.0
Ward members/Sarpanchs	7	35.0
Total Villages	20	100.0

As per the NRHM implementation framework, the VHSC chairperson would be a panchayat member and the convener would be an ASHA or in the absence of the ASHA it would be an AWW. However over 60% of VHSCs in Balangir districts do not have office -bearers as they are told that a guideline would be received from the state with the details of the office-bearers. Present committees will designate the office -bearers amongst their members as per the requirements of state guidelines.

Capacity-Building and Empowerment of VHSC Members

All the ASHAs and ANMs received training on NRHM b ut only four ASHAs and three ANMs out of six received specific orientation on VHSCs. It has been observed that the training received on NRHM is the highest among the ANMs, the ASHAs, followed by CDMOs/MOs and DPOs/GPEOs. The stakeholders who received orien tation on VHSC are the highest among CDMOs/MOs, followed by the ASHAs, the ANMs and DPOs/GPEOs. None of the PRIs and SHG members got training on NRHM and VHSC.

Regarding usefulness of the training there is a wide variation in the perception among different stakeholders. Almost all the ASHAs, the ANMs, PRI and SHG members are of opinion that there is a need for detailed training on the VHSCs irrespective of the fact whether they have received training or not. However, approximately half of the DPEOs/GPEOs are of the view that they need detailed training on NRHM and VHSC (Table-14).

Table 14: Perception of Capacity -Building on VHSC among Different Stakeholders

	ASHAs (N = 6)	ANMs (N = 6)	PRIs (N = 6)	SHGs (N = 6)	DPOs/ GPEOs (N = 6)	CDMOs /MOs (N = 6)
Received any training or orientation on NRHM	6	6	Nil	Nil	2	4
Received specific training or orientation on VHSC	4	3	Nil	Nil	2	5
Remembers training/orientation contents on VHSC	4	3	Nil	Nil	2	5
Perception about the usefulness of training	3	2	Nil	Nil	1	5
Think that detail training is needed	6	6	6	6	2	Nil

"There was a special orientation session for 2 hours on September 2007 at Loisinga CHC. They were told about the VHSC during this orientation session where BEE, MO (Ic), PHC doctor, and the ANM, we re present along with the representatives from the NGOs," informs an ASHA form Balangir district.

However, there is considerable confusion among the health staff, particularly the ANMs, on how to distinguish the committee at sub -centre level and village level with the same name

(Village Health Committee) which is going to be designated as Village Health Sanitation Committee. Therefore it is gathered that there is a need for clarity on committee at village level and sub-centre level and linkages between these two committees.

"Amara confusion rahuchhi jadi gaonre village health committee heba tahale sub-centre re kahinki kamiti ku village health kamiti kuhajauchhi"
["We have a confusion that if there will be village health committees in every village, why are we naming the committee at the sub-centre as Village Health Committee," point out the ANMs from Tentulikhunti block.]

It is observed during the IDIs with PRI members that out of six none of them have received training/orientation either on NRHM or VHSC. All of them are of the opinion that they need detailed training on these activities.

"Loka pratinidhi mananku swasthy babadare training dia jau. semanannkar dayitwa babadare bujha jau."
["People's representatives should be trained about health programmes, including VHSCs. They need to be told about their roles and responsibilities," say PRI members of the Derabisi block in Kendrapada district.

Four CDMOs/MOs out of the six interviewed got training on the NRHM, but those in Balangir and Nabarangpur did not receive training. Five CDMOs/MOs got orientation training on VHSCs during the training programmes and other meetings and all of them remember the content and find the orientation and training useful. However they are of the opinion that a clear guideline from the authority on this is needed.

The CDMOs and MOs were sensitised on the formation of VHSCs on different occasions by the community monitoring process being facilitated by NGOs in the district, which was helpful in understanding the importance of having functional VHSCs at village level.

Functioning of VHSCs

It has been found that knowledge about the role of VHSCs is the highest among the CDMOs/MOs (4 out of 6), the ASHAs (4 out of six), followed by the ANMs (3), SHG members (3) and PRI members (1). About 50% of the ASHAs, the ANMs, the CDMOs/MOs and SHG members are able to recall the frequency of the meetings held where the proceedings were recorded. The PRI members' involvement seems to be less as only one out of six knew about the role of a VHSC, its frequency of meeting but the DPOs/GPEOs are quite unaware about the role of VHSCs and frequency of meeting etc.

According to most of the ANMs, VHSCs meetings are held regularly. Similarly, when it comes to the monitoring of the VHSC activities, according to most of CDMOs/MOs (4) it is done by seniors, while only half of the ANMs (3) and ASHAs (2) say so. Only one each CDMO/MO, the ANM and the ASHA said the health action plan was prepared with the help of committee members (Table -15).

Table-15: Perception on Functioning of VHSC among Different Stakeholders

	ASHAs (N = 6)	ANMs (N = 6)	PRIs (N = 6)	SHGs (N = 6)	DPOs/ GPEOs (N = 6)	CDMOs /MOs (N = 6)
Know about the role of VHSC	4	3	1	3	Nil	4
Able to tell about the Frequency of meeting	3	3	1	3	Nil	3
Opine meeting held regularly	2	3	1	2	Nil	2
Opine proceedings are recorded	3	3	1	Nil	Nil	3
Monitoring system is in place	3	3	Nil	Nil	Nil	6
Activities monitored by seniors	2	3	Nil	Nil	Nil	4
Confirms initiatives taken by the VHSC	1	2	Nil	Nil	Nil	2
Village health plan prepared	1	1	Nil	Nil	Nil	1

"We have the meeting at AWW Centre on the second Tuesday of every month, where the Sarpanch, AWW, ASHA, ward member, SHG president and secretary, school teacher are present. The proceedings of the meeting are recorded by the ASHA herself," says an ASHA at the Loisinga block of Balangir district.

"Members are not attending the meeting with interest. They need a lot of persuasion and are not interested in VHSC activities unless they get some incentives, poi nts out an ANM from Patnagarh block of Balangir district.

“VHSC meeting prati masa dwitiya mangal bara dina gaon re heuchi. Sub -centre level re prati masa third mangal bara re meeting heuchi. Se meeting ku ANM jauchanti. Meeting re gaon ra lokamananku swasthya babadare sachetan kara jauchi. Gaon ra paribesh sapha sutara kariba pain katha heuchi”.

‘The VHSC meeting is held on the second Tuesday of every month at the village level and on the third Tuesday at the sub-centre level. The ANMs are attending these meetings. These meetings discus how to make the villagers aware of health and the need for maintaining cleanliness in the village environment,” Report the ANMs at Loisinga block FGD.

Since there is no fund available at the village level for VHSC activities, the organisers face lot of difficulties by incurring meeting expenses. Hence the members generally loose interest in participating after one or two meetings.

“Meeting heuchhi. hele log kahuchhan meeting daki kari amku cha fa bi nain debar au kichi kam bi ni habar. Ame ni asun. Panchayat ke meeting pain gale 45 tanka dauchan. Ame kahin lagi e meeting ku asmu?”

[“Meeting is held regularly, but the members complain us that we are not giving tea and snacks at the meeting. Besides, no concrete activities are being discussed at these meetings. We get Rs. 45 when go to the panchayat. Why should we go for this meeting?”] ANMs of Patnagarh block revealed in the FGD.

“Why should we go to the meeting; what is the benefit of going there?” asked PRI members of Nawarangpur at the FGD.

The number of meetings held since it formation varies from one to five among the VHSCs. The percentage of VHSCs having two meeting is 75% and the number of VHSCs having more than three meetings is only 5%. The average number of participants decreases steadily from the first meeting (16.3) to the fifth meeting (14.6) (Table -16).

Table 16: Frequency of Meetings Held by VHSCs (N = 20)

Number of Meetings Held by VHSCs	Number of VHSCs	Percentage of VHSCs	Total Number of Participants	Average Number of Participants
Only one meeting	20	100	326	16.3
Two meetings	15	75	222	15.6
Three meeting	7	35	74	14.8

Four meeting	1	5	11	14.7
Five meetings	1	5	11	14.6

In majority of VHSCs, the meetings are held regularly (60%). In 25% committees, no second meetings are held. In 15% VHSCs the meetings are held irregularly. During FGDs most of the AWWs, ANMs and SHG members inform that the meetings are held regularly (Table - 17).

Table 17: Regularity of Meeting Held by VHSCs (N = 20)

Number of Meetings Held by VHSCs	Number	Percentage
Regular meeting	12	60
No second meeting was held	5	25
Meeting held Irregularly	3	15
Total VHSCs	20	100.0

The records of the various decisions taken by VHSCs in different meetings, reveal that in all committees the members discussed about the formation of VHSCs and the objectives. In the subsequent meetings issues relating to cleanness and sanitation (50%), awareness about health programmes (30%), village survey (25%), immunization (10%), change of convener from ASHA to AWW (10%) use of sub-centre untied fund (5%) and undertaking IEC/wall painting (5%) are discussed.

Table 18: Decisions Taken in VHSC Meetings

Decision Taken	Number	Percentage
Formation of VHSC	20	100.0
Cleanness & Sanitation	10	50.0
Awareness about health programmes	6	30.0
Village Survey	5	25.0
Immunization	2	10.0
Change of Convenor from ASHA to AWW	2	10.0
Use of Sub-Centre Untied fund	1	5.0
IEC Activity/Wall painting	1	5.0
Total Villages	20	100.0

It has been observed that even if the meeting is taking place in some of the villages having VHSCs, the average number of participants is decreasing and there is no proper follow-up on the planned activity because of lack of funds resulting in poor functioning of VHSCs.

According to the records of VHSCs, the committees have undertaken awareness activity on health programmes, village survey, participated in cleaning of drainages and tube-well surroundings, helped in immunization of children, overseen usage of sub-centre fund and IEC/wall painting activities at villages (Table-19).

Table-19: Activities Undertaken by VHSCs

Activities Undertaken	Number	Percentage
Created awareness about health programmes	6	30.0
Undertaken village survey	5	25.0
Participated in cleaning of drain and tube-well surrounding	4	20.0
Helped during immunization	2	10.0
Use of sub-centre untied fund	1	5.0
Oversee the IEC activity/wall painting	1	5.0
Total Villages	20	100.0

Funds flow to VHSCs

About half of CDMOs/MOs and ANMs (3) know that there is a provision of funds for VHSCs. Only some of the ASHAs (one out of 6) and PRI members (1) know about provision of funds for VHSC. All ASHA, ANM and CDMO/MOs were of opinion that no funds were received for VHSC activity by them (Table -20).

Table 20: Opinion on Fund Flow to VHSC among Different Stakeholders

	ASHAs (N = 6)	ANMs (N = 6)	PRIs (N = 6)	SHGs (N = 6)	DPOs/ GPEOs (N = 6)	CDMOs /MOs (N = 6)
Know about provision of funds for VHSC	1	3	1	Nil	Nil	3
No fund received by VHSC	6	6	Nil	Nil	Nil	6

However during IDIs, one ANM from Tentulikhunti block of Nabarangpur opined that the village health committee at sub-centre level got the untied fund, which was being spent mostly on five broad heads--cleanliness, sanitation, sub-centre contingencies, health awareness activities, health promotional activities, and emergency fund for referral during delivery.

"Monthly meeting re bee agyan kahithile amar sub-centre untied fund ru prati gaon re sapha saphi kariba pain kichhi kichhi paisa kharcha heba pare kamiti pai pa isa asile kharcha heba". ["In the monthly meeting, BEE asked us to spend some money from untied fund for village cleaning and sanitation activities. The expenditure on other activities of VHSC in each village would be met once they received money," inform ANMs of the Loisinga block of Balangir district at the FGD.

"SHG maa mane sapha saphi kari thile. kamiti ke paisa nain asi. Semane paisa nai nei," inform AWWs of the Patnagarh block of Balangir district at their FGD.

The SHG members took up cleaning activity in the village. No money came to the committee. Hence they did not receive any money for their work.

During record review it has also been noticed that none of the VHSCs in Balangir have received funds (Table-21).

Table 21: Fund Flow to VHSCs as per Record Review

Funds Received	Number	Percentage
Yes	Nil	0.0
No	20	100.0
Total Villages	20	100.0

Available skill-set/resources with the VHSCs to Formulate Village Health Plan

With regard to the opinion of different stakeholders on the skill -set available with VHSCs to formulate the VHP, it has been observed that almost all CDMOs/MOs are aware about the VHP. Only some ASHA (1) and ANM (1) are of the opinion VHP has been made in their locality. However, almost all stakeholders excepting ASHAs and ANMs are of opinion that VHP has not been made in their area (Table -22).

Table 22: Opinion on skill-set/resources available with VHSCs to Formulate Village Health Plan among different Stakeholders

	ASHAs (N = 6)	ANMs (N = 6)	PRIs (N = 6)	SHGs (N = 6)	DPOs/GPEOs (N = 6)	CDMOs/MOs (N = 6)
Aware about Village Health Plan	1	2	Nil	Nil	Nil	6
VHP made in their locality/area of operation	1	1	Nil	Nil	Nil	Nil
No training on VHP has been organised	6	6	6	6	6	6
No guideline on VHP	6	6	6	6	6	6
No VHSC is formed	3	3	3	3	6	3
No idea whether to take up VHP in the current year	6	6	6	6	6	2

Two out of the six ANMs and only one ASHA are aware of the VHP. Almost all stakeholders are of opinion that even if the VHP are formed involving the VHSC members none have received training on how to prepare a VHP and no guidelines have been received by them. Majority of CDMs/MOs, ANMs, ASHAs, PRI members, ASHAs are of the

opinion that no VHPs have been formed in their area. Almost all ASHAs, ANMs, PRIs, SHGs, DPOs/GPEOs inform that they do not have any ideas whether that VHP in their area will be taken up by VHSC in the current year or not. However, most of the CDMOs/MOs report that in the current year they have a plan to take up preparation of VHP through VHSCs.

"Gaon starare village health plan kebe hei nahin sethi AWW plan kariba. asha ta kamabi kariparuni. se kan health plan kariba. ASHA just kama kariba start karichhi. ASHA to adhika ASHA kariba katha nuhen. Nmaku AWWku sahajya karibaku padiba (health plan kariba pain). AWW kahaku involve kariba se select kariba".
["The VHP has never been done at our village level. The AWW can do this. The ASHA is not being able to perform her duties properly. We should not expect more from the ASHA. We have to help the AWW to prepare the health plan. The AWW has to identify who to involve in the preparation of health plan and find out the capacity gaps," complains the ANM of the Sanmosinga block of Nabarangpur district at the FGD.

The whole process has to be facilitated by NGOs having experience in community mobilisation, micro-planning and capacity-building. It has been revealed that the facilitation is affected by the perception of some of the community members that whenever the ANM or AWW calls a meeting, it is for a government programme and they expect some short-term incentives benefit from the meeting. Hence the meeting needs to be organised by the community members themselves. A clear plan to follow up with the panchayat and villages is necessary to ensure that VHSCs implement the plan, which again need to be facilitated by some community-based organisations or NGOs, at least in the initial periods.

CHAPTER IV

RECOMMENDATIONS

Areas of Concern	Actions Recommended
Policy issues	
Lack of institutional set-up at the village level to undertake village-level planning	➢ Since the district health plan has to be prepared by 2009, steps should be taken to set up institutional mechanisms such as village health and sanitation committees at the villages ➢ Support mechanisms at the district and block level are to be established to ensure the convergence, merger or re-designation of earlier health and allied committees at the village level
Lack of clear guidelines and instructions from the state has affected the VHSC formation process	➢ As NRHM guidelines envisage formation of VHSCs in every village in association with the panchayats. But the exact guidelines are not specified in view of wide variations between the states. The states should issue detailed and consolidated instructions specifying membership of VHSCs, process of constitution, their integration with PRIs, funds flow mechanism with clear roles and responsibilities of different office bearers.
Non-availability of information about the VHSC funds and its availability	➢ The financial information should be made available to each block, PHCs and below. If required e-financial information systems can be established to ensure quick flow of information. ➢ The average number of members participating in VHSCs meeting is decreasing and lack of proper follow-up on the planned activity due to unavailability of funds resulting in poor functionality of VHSCs. Steps should be taken to immediate release of funds to the villages where the VHSC has been formed.
Inter-sectoral co-ordination, convergence and involvement of Panchayati Raj institutions	➢ The efforts by the Rural Development and Health and Family Welfare Departments are not adequate. Also, the step to sensitise the District Panchayatiraj Departments has been initiated much latter. Attempt

	has to be made to involve each departments concerned at all levels.
Programme-Level Issues	
Programme managers 'knowledge on implementation guidelines, composition of VHSCs are incomplete which affect the uniformity in the structure, composition of committees already formed VHSCs	➢ Due to incomplete knowledge of VHSCs the formation and facilitation activities have not been taken seriously by the programme managers ➢ Programme guidelines should be clearly explained to the implementers and other providers
Confusion among the health staff regarding the village health committees at sub-centre level and VHSCs	➢ Steps should be taken to avoid confusion relating to VHCs at sub-centre level and VHSCs at the village level. ➢ The purpose of both the funds and function of both the committees are yet to be clearly explained to providers as well as the people
The process of formation and functioning of VHSCs needs facilitation by the community based organisation/ NGOs	➢ Since VHSCs involve synergetic action of various representatives of community-level institutions it requires a well planed, continuous process of social mobilisation and environment building for which facilitation by CBOs/NGOs having good rapport with different stakeholders. Efforts should also be made to involve NGOs in facilitating the formation process of VHSCs.
IEC/BCC	
Lack of adequate knowledge on NRHM and VHSCs among different stakeholders	➢ IEC activities need to be intensified in the community particularly on the provisions and entitlements under NRHM. ➢ The health committees already formed and going to be formed in the near future require enabling environment. Besides, social mobilisation activities around general health issues and health as a right of the people need to take place for positioning of ASHAs and VHSCs.
Infusing confidence in ASHAs to handle VHSC activities and convene their meeting, instead of AWWs	➢ The state guideline suggests AWWs to be the convenors of VHSCs unlike national level guidelines. On the other hand, health staff at the ground level feel the AWWs are appropriate persons to handle the

Issues	Recommendations
	accounts and also convene the meeting the for various reasons.
	➢ It is necessary to undertake behaviour change and communication (BCC) activities at different levels which will help the ASHAs emerge in a leadership role within the community
Training/Capacity Building	
No specific training on VHSC to the ASHAs, and other potential committee members	➢ Detailed training on VHSC and its functioning should be imparted to the ASHAs, the AWWs and the ANMs so that they can approach the community with full knowledge and confidence
Retraining/re-fresher training sessions relating to VHP is yet to be undertaken	➢ The quality of the training needs to be enhanced and refresher training on VHP and other functional aspects of VHSCs should be provided based on the need assessment
	➢ Regular interactive sessions with the seniors to solve the field level problems based on the two way system of communication and supportive supervision and monitoring
Capacity-building plan for VHSC members is not clear	➢ Attempt should be made to prepare a clear programme of capacity building supplemented with handholding support by facilitators and good reference and reading materials to be used by the committees at the time of need besides the conducting training programmes
PRI/ Community-level Issues	
PRI members aren't sensitised on their roles and responsibilities in NRHM related activities	➢ Since panchayat elections in March 2008, many members are newly-elected. So, there is a need for undertaking sensitisation programme and advocacy workshops at district and below.
	➢ Linkages between the standing sub-committees of the panchayats and VHSCs is necessary

Limitation of the Study

- Since the VHSCs are not in place in the other districts except for a few places in three blocks of Balangir district, the study could not review the records of VHSCs.

- The involvement of district programme mangers (DPMs), block extension educators (BEEs), block programme officers (BPOs) are also critical, therefore further studies need to incorporate them as respondents.

Future Direction of Research

With the increasing number of PRI and SHG members expressing their interest to be involved in the healthcare activities and to take up ownership of these programmes, a study to access the preparedness of managing the healthcare services at different level is needed. Other areas of the research could be public private partnership (PPP) under NRHM and its impact, functioning of Rogi Kalyan Samitis (RKS), District Health Planning, ground level synergies and actions for decentralised planning to have an overall view of NRHM implementation in Orissa.

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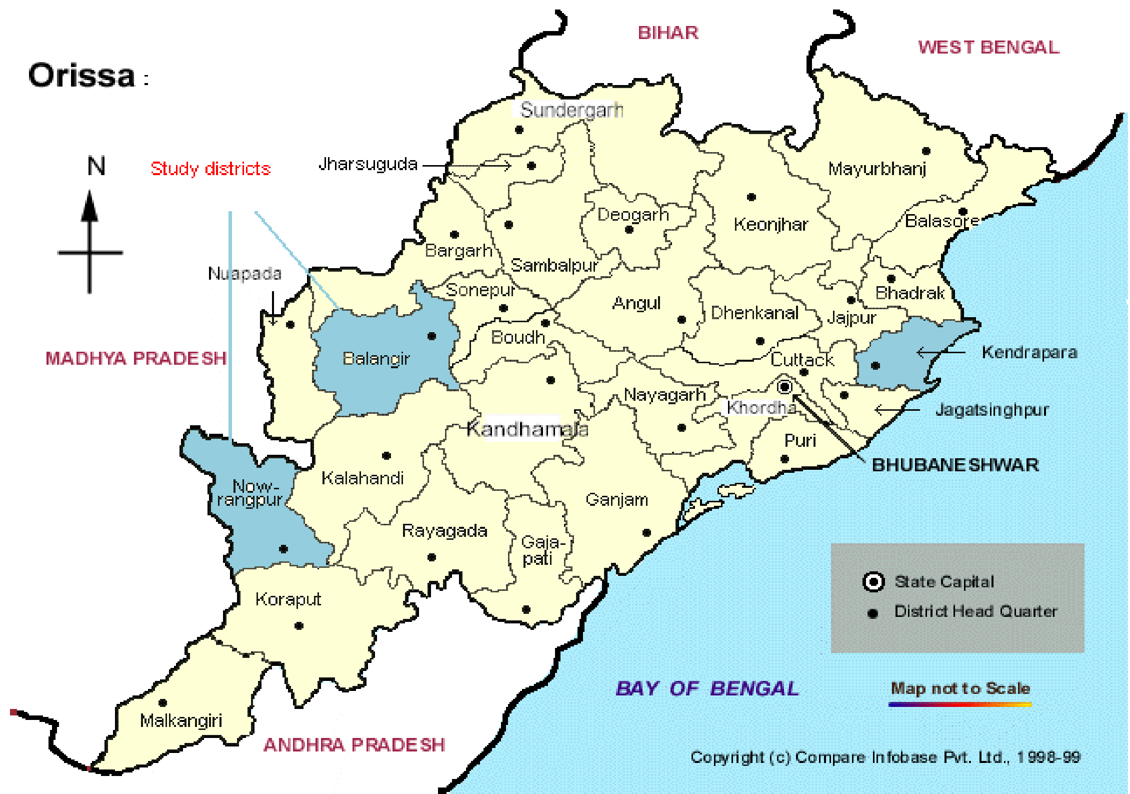
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