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Mapping communitisation of health care system in Villages of Rajasthan and Uttarakhand; Exploring the role of Civil Society

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ABSTRACT

Health is one of the most important variable in the process of development and therefore is a matter of National and International concern. VHSNCs were conceptualized under NRHM as a responsible platform for village level health planning and monitoring, in which health workers, women, village members from vulnerable groups and minority communities can come together and plan for local issues of concern related to health, sanitation and nutrition. This research was intended to draw attention on the process of Communitisation for health as per the Human Rights Based Approach and assessing the functioning of the VHSNCs in terms of their strengths, weaknesses and challenges and threats faced in implementing this idea. The study was conducted in two states; Uttarakhand and Rajasthan. The study aimed at capturing the influence of state health policy and infrastructure and availability of facilitators like NGOs in amplifying the influence of VHSNCs. Using a qualitative research design, in-depth interviews and focus group discussions were conducted with VHSNC members, community members, NGO facilitators and health care providers to get a holistic perspective. The study revealed that, each village was unique in terms of socio - economic conditions, the issues of prime concern, community dynamics and availability of resources and any prior experience in community mobilsation around health issues. NGO intervention helped in smooth functioning of VHSNC. No synergy was observed between VHSNCs and health care service providers at primary level. However, ASHAs efforts were acknowledged at the community level. Being a new concept extensive training and constant guidance are pre requisites to improve their functioning. If committee members realize the potential of VHSNCs, gain clarity over its objectives and develop a sense of ownership towards committee, this multi – faceted body can bring desirable changes in the health scenario at the grassroots.

Key Words : Health, NGO, ASHAs, Minority communities, Civil society

INTRODUCTION

Health is not just limited to an individual; it is a state's concern. Providing health services and ensuring a healthy state is government's responsibility. There have been some improvements in health sector especially public health after independence. However, with constantly changing scenario, the demands of the health system are also going through a transition. India is undergoing change in

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demographic, environmental, social and economic level adding to the disease burden and growing demand for health care.

Overall health situation in the country has not been satisfied. Several factors contribute to this situation. An important one is that health is not considered as an issue of priority by the state. As per the economic survey 2015-16, the expenditure by government on health was 1.3% of the GDP, though it has increased over the years but still falls short to fulfill the existing gaps.

The role of government is crucial for addressing these challenges and achieving targets such as Health for All and Sustainable Development Goals (SDGs). The Ministry of Health and Family Welfare (MOHFW) plays a key role in guiding India's public health system. The improvement in the health of a population also depends on alteration in systems outside the formal health care system. It is indeed a challenge for the Indian government to reach out to its population in a systematic way especially those living in rural areas mainly due to structural and geographical constraints in improving their standard of living through opportunities for better livelihoods, health care, education and gender equity. The NHP 2013 revealed that in our country only 33 per cent of Government doctors were available in the rural areas where nearly 70 per cent of our population lives.

A much more recent concept formed on the lines of community participation is Communitisation. For the first time communitisation was introduced in Nagaland Communitisation of Public Institutions and Services Act, 2002. Communitisation has evolved out of a quest to improve public delivery systems. It refers to a unique partnership between government and the community; where in the best of both the systems come in partnership with each other and have defined roles. In this system, ownership of public resources and assets is handed over to the community. The community is granted powers to manage and maintain institutions and control service delivery with the aim of improving the delivery of public utility systems. On the other hand, state government performs the role of a supervisor. It is expected to monitor and assist the whole process.

Village Health Sanitation and Nutrition Committees (VHSNCs) envisaged under NRHM, now called National Health Mission (NHM), are based on the principle of communitisation. The committees are expected to take collective action on issues related to health and its social determinants at the village level and create a sense of demand towards quality health care among two thirds of the population devoid of it since many years.

Village Health Sanitation and Nutrition Committees (VHSNCs) :

One of the key elements of the National Rural Health Mission is the Village Health Sanitation and Nutrition Committee (VHSNC). VHSNC is aimed to support the process of decentralization at a local level under NRHM. VHSNCs are expected to provide a leadership platform for improving awareness and access of community for health services. The committee is also expected to support the Accredited Social Health Activist (ASHA), develop village health plans specific to the local needs, and serve as a mechanism to promote community action for health, in particular to social determinants of health. Alongside they are expected to monitor and facilitate access to essential public health services, organize health promotion activities, identify health problems and strategize plans to improve health condition, manage untied village health fund and maintain proper records.

The VHSNCs are to be formed at the level of revenue village comprising a minimum of about 15 members including key stakeholders, Panchayat representative, frontline health workers, school teachers, community health volunteers, representative from Self Help Groups, Non-Government Organization etc. The chairperson of the committee should be preferably a woman elected member

of panchayat who is a resident of the village. ASHA is the Convener for the Committee. At least 50% members should be women. Each hamlet should be well represented. Every VHSNC should have a bank account jointly opened in the name of chairperson and ASHA (secretary), to which the un-tied fund of Rs. 10,000 shall be credited.

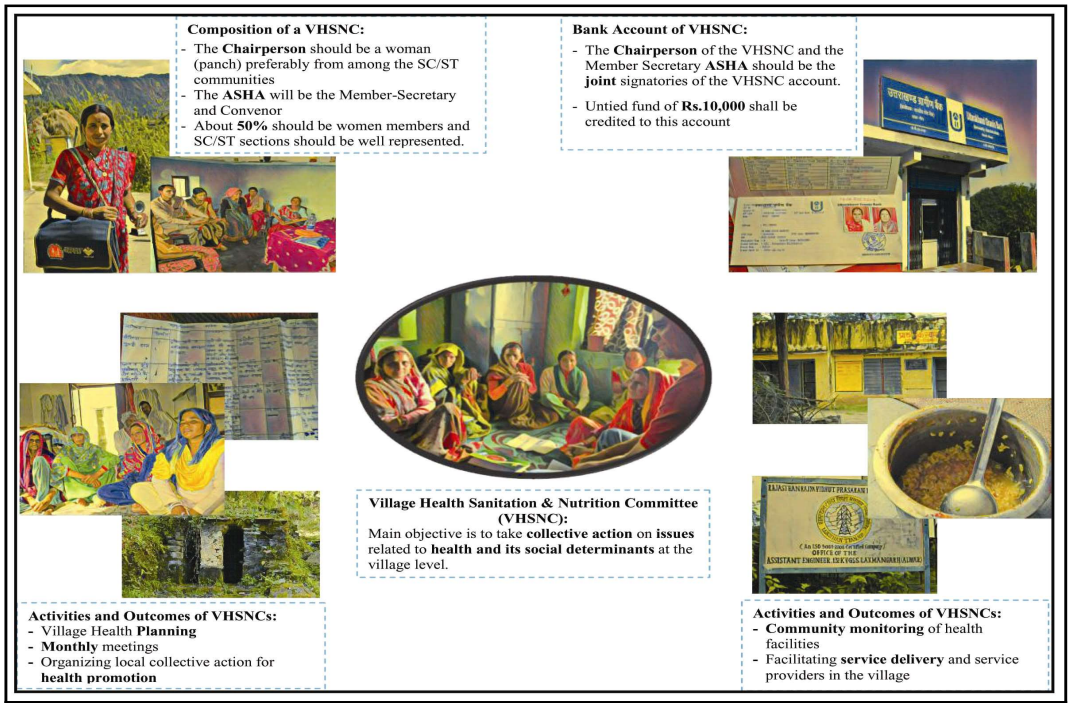

Fig. 1 : Overview of Village Health Sanitation and Nutrition Committees

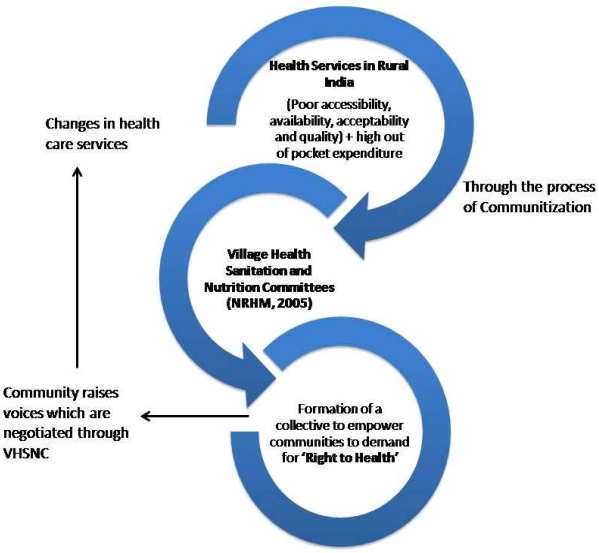

Fig. 2 : The concept of Village Health Sanitation and Nutrition Committees

Twelve years ago since the introduction of this concept of VHSNCs under NRHM, very few research studies have been carried out to understand their functioning. The factors that promote or deter the constitution and functions of VHSNC shave to be established in order to re – energize this concept with best practices. The researches so far have focused on studying knowledge level, utilization of funds, participation of members and capacity building by the govt. and identified NGOs. This study intends to focus beyond identifying knowledge gaps and mere existence of committees. It proposes to draw attention on the process of communitisation, empowerment of the committee members, factors that affected the functioning of VHSNCs, approaches used by a collective towards bringing desirable changes and bridging the gap between service providers and service utilizers and helping communities take ownership in health related matters.

General objective of the study was to examine the role and functioning of Village Health Sanitation and Nutrition Committees (VHSNCs) and their impact on seeking and provisioning of health care services. This paper focusses on the methods and processes employed by the VHSNCs to form, function and fulfill the set objectives under NRHM and understand the role of State and NGO as a facilitating agency in VHSNCs.

METHODOLOGY

Under NHM, revenue villages are entitled to form a VHSNCs which is one of the key elements of the programme. Uttarakhand and Rajasthan were selected. These two states have been selected considering the vast difference in their geographical localities and social determinants like gender differentials, socio – cultural practices, income and robustness of PRIs affecting the functioning of VHSNCs. Secondly, both the states have been listed as special focus state under NRHM out of a total of 18 states. These states either have weak public health indicators and/or weak health infrastructure.

Table 1 : Comparative Analysis of Selective Health Indicators for the Two States under Study

Sr. No.	Indicator	India	Rajasthan	Uttarakhand
1.	Infant Mortality Rate	43	51	34
2.	Crude Birth Rate	22.9	26.7	18.9
3.	Neo natal mortality rate	30	37	25
4.	Under 5 mortality rate	51	58	36

Source: SRS Bulletin September, 2014

As one of the main objectives of the study was to understand the difference in functioning of VHSNCs with and without NGO intervention if any, districts were selected on the basis of existence of a NGO that had intervened in the area of VHSNCs. Two blocks from each of the two districts were selected, one with NGO intervention and other with no NGO intervention to maintain exclusivity. Three villages were purposely selected under each block. In total, 12 villages were selected.

To examine the methods and processes employed by the VHSNCs to form, function and fulfill their objectives, theme guide was developed to conduct focus group discussion with all committee members. Semi – structured interview schedules were developed for various stakeholders like committee members, health professionals and NGO functionaries. Along with these tools, checklist adapted from guidelines for community processes (NRHM, 2013) was included to assess the functioning of the committees. Records and documents maintained with VHSNCs were also seen.

To understand the role, functioning and participation of VHSNCs, interactions with all the

members of 12 selected committees were done. The interactions included meeting VHSNC members individually and in group and NGO facilitators. Non probability, purposive sampling technique was used for the purpose of selecting the VHSNC members for in depth interviews. In total 32 FGDs and 75 IDIs were conducted across two states. In Nainital district of Uttrakhand data was collected from Ramgarh block (with NGO intervention) and Bhetalghat block (without NGO intervention) and in Alwar district of Rajasthan from Lacchmagarh block (with NGO intervention) and Kathumar block (without NGO intervention). Atlas Ti was used to draw out themes across different stakeholders, and the emerging inductive themes were analyzed in detail.

RESULTS AND DISCUSSION

Composition and Functioning of VHSNCs :

It was observed that in six NGO intervened villages from both the states, the committees were broadly formed as per the guidelines issued in 2013 by the NRHM. All the committees comprised of 15 members on an average, with 50% of women members and other castes were also well represented. In all the six committees, the position of member - secretary and convener was occupied by ASHA in line with the guidelines. Other frontline workers like, Auxillary Nurse Midwife (ANM), Anganwadi worker (AWW) and Anganwadi helper (AWH) were a part of the committee. Community members were also found to be members in VHSNC in both the states.

It was noticed that in villages with no NGO intervention, the committees were not formed in accordance with the revised guidelines (NRHM, 2013). Many norms related to composition of the committee like SC/ST women chairperson, ensuring a minimum of 15 members, etc. were not met by all the committees.

Presence of ASHA was the only common factor in composition of VHSNCs across 12 villages. According to the guidelines, chairperson of a VHSNC should be a woman elected member of the Village Council (Gram Panchayat) from Schedule Caste/ Schedule Tribe (SC/ST) community (preferably) and in case of no woman candidate, preference should be given to any Panch from SC/ST. In six non-NGO intervened villages, chairperson of the committees was not a member of village council.

Bank Account and Untied Funds :

According to the guidelines (NRHM, 2013), every VHSNC should have a bank account opened in the nearest bank, to which the untied fund of the VHSNC shall be credited. It should be jointly maintained by the Chairperson of the VHSNC and the member secretary *i.e.* ASHA. All withdrawals from VHSNC account must be done by a joint signature of both the signatories. Ramgarh block (Nainital, Uttarakhand) was found to be the only block in which all the three VHSNCs had opened a new account on the basis of revised guidelines. Exactly opposite was the situation in Kathumar block (Alwar, Rajasthan) where accounts were in the name of ASHA and chairperson, however chairperson was not selected as per the revised guidelines. Apart from opening new bank account nothing else was in accordance to the revised guidelines.

Untied funds gave flexibility to VHSNCs to spend on areas, as thought to be essential by them, for the development of the village in the areas related to health, sanitation and nutrition. The idea behind the concept of untied funds was to empower the committee and instill a sense of independence to take substantial steps with the consensus of all the members. Some broad guidelines were mentioned in NRHM, though researcher observed that there was fear among committee

members to spend untied funds. They feared the subsequent audits as they had never received any training or guidelines to spend the funds. It was observed that committee members were not able to utilize the provision of flexibility resourcefully.

VHSNCs from Ramgarh and Betalghat blocks (Nainital, Uttarakhand) had not received untied funds since 2012 – 2013. In Lacchmangarh (Alwar, Rajasthan), before intervention of NGO, VHSNCs had never received untied fund. For the first time in 2016, that to only Rs. 5000 was credited in the account as untied funds. As the amount was credited few months before data collection, none of the villages had utilized the credited amount in any activity. In Kathumar block (Alwar, Rajasthan), VHSNCs had received Rs.3000 for the first time in May – June' 2016; they had not spent the money even after three - four months, when researcher collected the data in October 2016.

Participation of Members :

ASHA, most participative member :

ASHA, was considered to be the most active member in VHSNCs. She was Member Secretary and Convener of VHSNC as per the guidelines. ASHA, single handedly, was expected to convene VHSNC meetings, mobilise community members for committee activities, maintain records, disseminate relevant information related to VHSNC and was accountable for any VHSNC activity. According to the committee members, ASHA was regarded as the face of VHSNC. She was given maximum amount of responsibility, was considered to be the authentic source of information (health and related issues) and was most accessible health care worker. It was noticed that management of VHSNCs was considered ASHA's work and responsibility. Apart from 5 - 6 core members who volunteered for various activities of VHSNC, no one considered it a part of their duty. Lack of orientation of all the members led to a feeling of non- connectedness with the committee and as a result it was seen as other's task, such as of ASHA's.

Chairperson, least participative member :

The Chairperson of VHSNCs is supposed to lead the monthly meetings of the committee, ensure smooth coordination amongst members for effective decision-making, represents the VHSNC in the Standing Committee of the Panchayat on issues related to health and share details of work undertaken by VHSNC at the village level. It was observed that chairperson did not take any responsibility in accordance to the position occupied. The chairpersons themselves admitted that they were least participative in any activity or decisions led by the committee.

Work done by VHSNCs with NGO Intervention :

Pertaining to specific problems faced by an individual village, work done by VHSNCs differed. Major work done by VHSNCs block wise where untied funds were spent is as follows:

– In NGO intervened blocks such as Ramgarh (Nainital, Uttarakhand) and Lacchmangarh (Alwar, Rajasthan), meetings were conducted monthly on a regular basis. A date was fixed in case of change of meeting venue, the members were informed on prior basis. Mostly meetings took place at ASHA's house / Panchayat Ghar / community temple / AWC or any other central point. Minutes of meetings were mostly taken by ASHA or NGO representative. On an average, 10 - 12 members attended the meetings.

– In Ramgarh (Nainital, Uttarakhand), VHSNCs made annual health plan and carried out activities to address various issues based on it. To maintain the community and instill in their people

the importance of cleanliness, VHSNC members organized rallies with school children, involved community women for cleaning of spring water body (*Naula),* built permanent cemented dustbins (*Kudhadaan Peeth*) at common community spots like school, temple, main road, village council office (*Panchayat Bhawan*), etc. Almost all houses had a temporary dustbin (*Kuccha Kudhadaan Peeth*).

Health care mobile van *(Sachal Ki Gaadi*) was a state initiative, where in a van equipped with a doctor, ultrasound facility and other basic facilities used to visit the village. VHSNC members of Simayal village wrote a letter to CHC (Ramgarh) showing concern of van's irregularity. Action was taken and regularity of van was improved in response. Once a month, Village Health and Nutrition Day (*Poshan Divas*) was celebrated and Hemoglobin camps were organized. Village VHSNC bought a Palanquin (*Doli)* to carry an ill person or delivery cases from their respective houses to the main road; all these activities were carried out to improve the health seeking behaviour of the community members, especially women. Ramgarh block received untied funds on time initially; hence they could plan and spend money accordingly. Also support and guidance by NGO at every step gave them confidence to take decisions. It was because of NGO's training and presence of NGO functionary in each meeting that made a difference in VHSNC's outlook.

– In Lacchmangarh (Alwar, Rajasthan), VHSNCs had taken initiatives to bridge the gap between service providers and service users in the area of health. Before active functioning of VHSNC, PHC in Sorai village was not functional. There was no ANM and AWC did not function as per the guidelines. After VHSNC's intervention, PHC was opening on a regular basis and a doctor was deputed. ANM was transferred from the village and another ANM came regularly for vaccination and follow up. Problem of water was one of the main issues faced by people in Lacchmangarh. Women in Moliya village got together with the help of VHSNC and worked towards solving the issue of water and electricity. Also, committee efforts resulted in grant of scholarship to school girls in Moliya village.

Work done by VHSNCs without NGO Intervention :

In villages where the NGO intervention was missing, there was dearth of information among the members. There was no uniformity in selection of members, composition of VHSNCs, and close to nil performance. Members were not serious as far as VHSNCs were concerned.

No records related to VHSNCs like minutes of the meetings, expenditure of untied funds, etc. were shown to the researcher in both the blocks, except for Seem village in Betalghat block (Nainital, Uttarakhand). As observed, ASHA or Pradhan did not maintain any records or copy of records. Interviews with other members revealed that no exercise of maintaining records was carried out. It reflected the fact that VHSNCs were not taken seriously in those villages. Non-functioning of VHSNCs led to manipulations such as writing minutes without conducting meetings, taking signatures of members who did not attend meetings, up keeping of records of expenditures, etc.

Role of NGOs in functioning of VHSNCs :

The support extended by Central Himalayan Rural Action Group (Chirag) in Ramgarh block (Nainital, Uttarakahnd) and Doosra Dashak in Lacchmangarh block (Alwar, Rajasthan) was of utmost importance, as considered by the committee members. They gave full credit to the NGOs for generating awareness, formation and smooth functioning of the committee along with much needed motivation and guidance. They helped them in disseminating information in their community, guided committees to conduct meetings and to fulfill official formalities and in organizing activities.

NGOs role was of paramount significance when it came to functioning of VHSNCs. It was not only that VHSNC's benefitted but even NGO functionaries got a chance to grow. As pointed out by NGO functionaries, they learnt the ways to motivate people and sustain a team by facilitating committees, apart from working on health and sanitation issues that increased their technical knowledge.

Conclusion :

The study clearly revealed that the composition, functioning and dynamics of each VHSNC differed and varied from each other. However, there were some gaps which were common and served as obstacles in letting VHSNCs reach their full potential.

Communitisation, as a process rests on foundation stones of ownership and participation. However in reality, it was found to be missing for VHSNCs. Only few members took responsibility and in some villages even that was missing as committees were only established on papers.

Committee members lacked enthusiasm; this factor was guided by lack of orientation and training given to VHSNCs. The study reveals better performance of VHSNCs that received training vis-à-vis the untrained ones. Absence of support system, lack of monitoring and low motivation did not let VHSNCs to sprout to the fullest.

According to the study, VHSNCs are connected to three components, which affect their existence and can deeply impact their functioning, if explored further, at the grassroots level. Social Determinants, Local Governance and Existing Health Systems are three crucial dimensions to VHSNCs. Health committees have a lot of potential which at present goes unrecognized; it is believed if local government, primary level health systems and community members join hands and work together in VHSNCs, there will be no limits in the process of development.

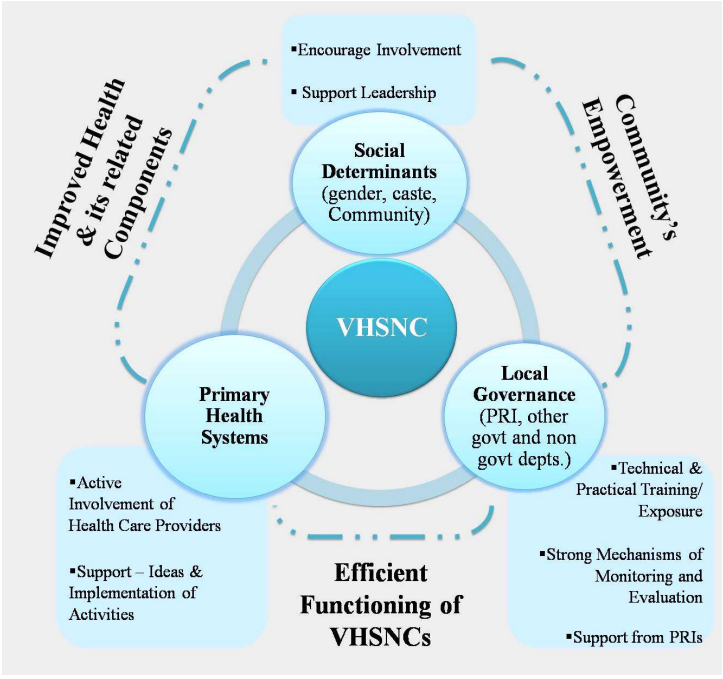

Fig. 3 : How VHSNCs can be an instrument of Communitisation of health and achieve desired outcomes

Social determinants as a variable have many sub sections ranging from micro to macro level. As per VHSNC design, if committee involves people from all the sections of the society, from all the castes, give women and men equal right to voice their opinions, support and encourage the chairperson (SC – ward member), it will lead to a sense of ownership among the community at large. Community members will feel connected. VHSNCs can become a platform where people will feel free to demand their rights and act as a collective, leading to community empowerment.

Secondly, support from local government bodies like PRIs and other government / non government departments (forest, education, water, youth, SHG etc.) can have an impact on functioning of VHSNCs.

Irrespective of government efforts to reach the last mile over the years to ensure quality of health to all; there are lacunae in the existing public health system. On the other hand, presence of ASHA, regular round of immunization, and medical assistance in CHC and district hospital made were some of the positive and only options available to people.

VHSNCs, as a body, have a lot of scope to improve basic conditions of the community. With right kind of training and support (financial and technical), they can transmute the village in their capacity. They serve multiple roles; as a bridge that connects general public to government, as a monitoring agency to improve public service, as a community integrated body to improve living conditions. This multi – faceted body was designed to bring desirable changes in the community. Twelve years down the line, the VHSNCs are still figuring out their role and identifying their capacities. Being a new concept, extensive training and constant guidance is of prime importance looking at the present situation. It is important that members realize the potential, gain clarity over VHSNCs objectives and identify means to achieve them and develop a sense of ownership towards such committee.

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