



Institute of Rural Research and Development®

**Report on Capacity-Building Needs:
Village Level Committee-cum-Village
Health and Sanitation Committee**

Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

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1. EXECUTIVE SUMMARY

This analysis of capacity-building needs of Village Level Health Committees (VLC) cum Village Health and Sanitation Committee (VHSC) is an attempt to explore the effectiveness of the VLC-cum-VHSC in influencing access and quality of health care delivery in 13 villages of District Mewat, State of Haryana, India. It investigates the level of awareness and knowledge of the existing VLC-cum-VHSC members pertaining to their roles and responsibilities, and also the functioning of VLC-cum-VHSC. Further, it explores the level of awareness of the members pertaining to Government schemes and health entitlements and the opinion of members towards some of the government programs. 89 members participated in this study, out of which 14 were male and 75 were female.

The findings of the study suggest that the effectiveness of the VLC-cum-VHSC in the villages is very limited. Most of the members are unaware of their roles and responsibilities and admit to having received no formal training, before being made members of the Committee. Some of them are not even aware of their membership of the Committees. The members do have information about government health care services, but the awareness is limited to only a few members and that too of a few services. The involvement of the members in the activities as stipulated in VLC-cum-VHSC guidelines is negligible, and even the monthly meetings are not organized on a regular basis. The members are not involved in budget tracking and many of them are not aware of the usage of annual funds granted to the Committee. Across villages, the level of knowledge and participation of the members varies. It has been observed that the literate members are usually better informed.

From the analysis, it is evident that there is need to build the capacities of the VLC-cum-VHSC members around their roles and responsibilities. The capacity-building program must aim to educate the members about the importance of VLC-cum-VHSC, the reason behind the formulation of VLC-cum-VHSC and its role in ensuring healthcare for all. The program must also ensure that the knowledge gained by the members gets translated into affirmative action by the members at the village level and the accountability of the Committee towards the community is established. The report also suggests that the program needs to be designed in a manner that accommodates the varied training needs of the members.

The focus areas for the training have been identified as: Constitution of VLC-cum-VHSC; Roles and responsibilities of the members; Information about Health entitlements, Government Health Schemes, Health services; Preparing a village health action plan; Budget Planning and Tracking; VLC-cum-VHSC – Community engagement; Promotion of women and child health; Involvement of VLC-cum-VHSC in planning, decision making, monitoring and evaluation; Regularity and Participation in VLC-cum-VHSC meetings; Linkage with District Administration;

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Participation of illiterate members in the affairs of the VLC-cum-VHSC; VLC-cum-VHSC as an effective health Committee at the Village level.

2. INTRODUCTION

The National Rural Health Mission (NRHM) set up by the Union cabinet in July, 2006 envisages the “Communitisation” of public health services enabling both, public health employees as well as local communities to develop a feeling of ownership in the Public Health Service Institution. The NRHM is mandated to enlarge the ownership and management of health services beyond public health functionaries and involve common people. According to NRHM guidelines the Communitisation of health services entails:

- People being made partners
- People having clearly defined rights
- People being given responsibility

To enable the realization of this vision at the grassroots, NRHM guidelines direct the District Health Administration to constitute Village Level Health Committees (VLC) cum Village Health and Sanitation Committee (VHSC) in villages under the Gram Sabha. Initially, VHSC was a separate body and was administered by District Health Department through District Hospital with Auxiliary Nurse Midwife (ANM) as its convener. The VLC was administered by Women and Child Department through ICDS with Anganwadi Worker (AWW) as its convener. As the roles and responsibilities of both the Committees were similar, the VHSCs were merged with the VLCs and were renamed as VLC-cum-VHSC.

The VLC-cum-VHSCs are now administered by Women and Child Department (ICDS) and funds are allotted by the State Health department. AWW is the convener of this Committee and Female Sarpanch or Panch is the Chairperson. The Committee is entrusted with the responsibility of enhancing people’s participation in improving health care services in the rural areas by increasing awareness about health and health entitlements with special focus on women and children. It is the key agency for developing a Village Health Plan & the entire planning of village Panchayat for NRHM. This Committee may identify area-specific unmet needs for reproductive health services and prepare need-based and demand driven socio demographic plans at the village level for providing responsive, people centered and integrated basic reproductive and child health care.

However, a universal healthcare system remains a distant dream, despite several efforts made by the Government to increase access to health care facilities in rural India. The health status of rural India, as represented by various statistics, is still a cause for grave concern. According to NFHS-III Survey (2005-06) in Rural Haryana, only 30 per cent of child deliveries had been conducted in health institutions, while the rest had been conducted by dais and untrained

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attendants, putting both mother and child at risk. Only 60.3 % of children in the age group of 12-23 months are fully immunized and 83.3 % of children in the age group of 6-35 months are anemic. It is believed that such indicators can be considerably improved if the community could access available Government health care facilities and schemes.

3. RATIONALE FOR THE STUDY

Mewat is a District in the State of Haryana. This area lags behind the rest of Haryana on most development indicators. The total population of Mewat is about 10 lakh with average family size of 7.5. In Mewat there are 110 health sub-centers as against the requirement of 200 sub-centers, according to NRHM norms. A District Level Health Survey (DLHS-3) conducted by IIPS in 2007-08 for Mewat reveals that only 16.4% mothers got themselves registered in first trimester, only 15.3% had three ante-natal check-ups, 50.4% got at least one TT injection during pregnancy, only 13.9% were institutional deliveries, 7.8% children were breastfed within one hour of birth and the percentage of children (12-23 months) fully immunized was only 12.2%. The report further mentions that only 12.2 % of the population had access to toilet facilities and only about 32% had piped water facility, at their homes. This suggests that a large number of women and children are still out of the ambit of public health care services. There is a lack of basic hygiene and sanitation facilities and the available health care services are not availed by all.

IRRAD has been working in Mewat to promote health conscious rural communities and to improve utilization of available health care services. The objective is to promote safe deliveries, complete immunization, reduction in open defecation, reduction in incidence of diarrhea and improved referrals. Having worked closely with the community, it has been realized that to have a sustainable impact, to ensure participation of the community in the development process and to give voice to the needs, aspirations and rights of the community, there is a need to revive and strengthen community based Institutions. It is a belief that an institution comprised of members from the community would be more adept at addressing local issues and would also be instrumental in placing the responsibility of community welfare within the community itself. Hence the focus of IRRAD's rural health program has now shifted to working with the VLC-cum-VHSC.

To facilitate and empower the VLC-cum-VHSC to carry out their responsibilities in an effective manner, there is a need to build the capacity of Committee members, make them aware of their roles, responsibilities and about the health entitlements to further the cause of "Health for All". In order to design a detailed Capacity-Building program, it is imperative to assess the training needs of VLC-cum-VHSC members. Besides, helping to monitor the progress of the training and assessing the impact of the Training Program, the needs assessment will also help in creating an interest and a desire for participation among the participants.

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4. OBJECTIVE

- To assess the effectiveness of currently constituted VLC-cum-VHSCs.
- Based on an analysis of needs, design a curriculum to build capacity in areas which need to be strengthened, promoted or enhanced to ensure effective functioning of VLC-cum-VHSCs at the grassroots.

5. AREA OF STUDY

Institute of Rural Research and Development (IRRAD) has been working in some select villages of Mewat for the past 10 years. The villages have been selected based on their accessibility and potential for water harvesting-the flagship program of IRRAD. The organization pursues a holistic approach referred to as the Integrated Sustainable Village Development (ISVD), addressing the interrelated constraints, needs and opportunities of poor villages in a holistic manner. ISVD rests firmly on the belief that to be effective over the longer term, the women and village poor must be empowered to participate in advancing their own development. The four core centers at IRRAD which carry the vision forward include the Capacity Building Centre, the Natural Resource Management Center, the Rural Research Centre and the Policy, Governance and Advocacy Centre.

The present study was conducted with the VLC-cum-VHSC of 13 villages in four blocks (Taoru, Nagina, Nooh and Firozpur Zhirkha) of Mewat. IRRAD has been implementing its Health Program in these villages for more than 2 years. The names of the Villages are Goela, Dingerheri, Jaffarabad, Notki, Ghagas, Uletha, Karhera, Santhavari, Kotla, Agon, Pathkhori, Bhond and Raniyala.

6. METHODOLOGY

Primary data, both qualitative and quantitative, was collected from members of the VLC-cum-VHSC. The members were identified after procuring their names from the records of the ANM and AWW. Focus Group Discussions were held with the members of each VLC-cum-VHSC, following a Convenience Sampling approach wherein the members were invited to a common location in the village for discussions. Subsequently a structured questionnaire was administered to the members present during the FGDs to ascertain the members' level of awareness and participation in the Committee.

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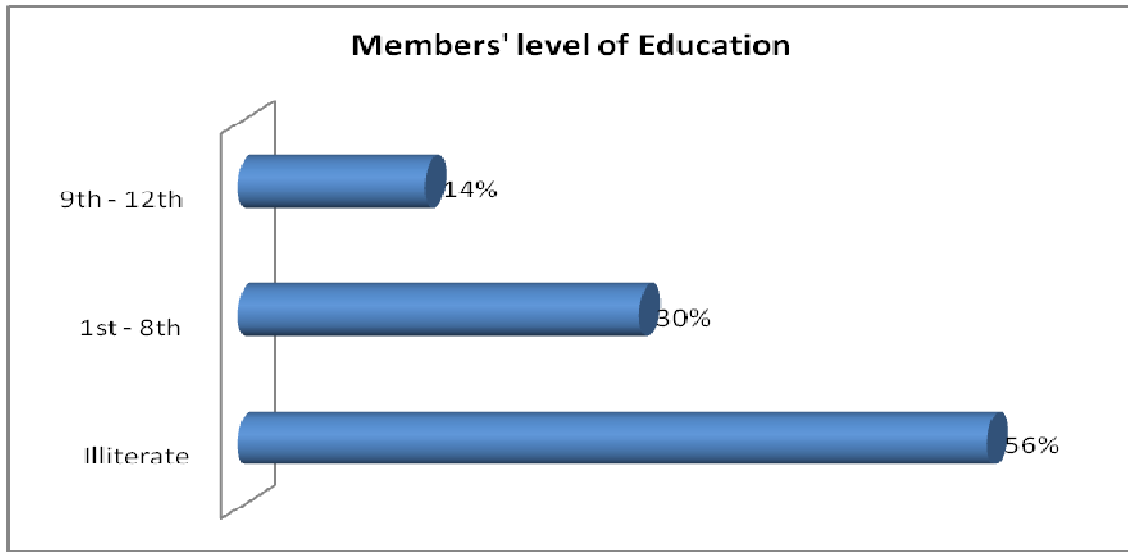
7. PROFILE OF RESPONDENTS

The following section reflects the profile of the VLC-cum-VHSC members. It is indicative of the composition of the members of the Committee. Furthermore, the analysis of the effectiveness of the VLC-cum-VHSC is related to this profile.

S. No.	Village	Male	Female	Total
1	Agon	0	8	8
2	Bhond	2	8	10
3	Dingerhedi	1	5	6
4	Ghaghas	2	3	5
5	Goela	0	7	7
6	Jaffarabad	0	6	6
7	Karhera	2	6	8
8	Kotla	1	8	9
9	Notki	1	7	8
10	Pathkhor	1	3	4
11	Raniyala	1	4	5
12	Santhavadi	2	4	6
13	Uletha	1	6	7
Total		14	75	89

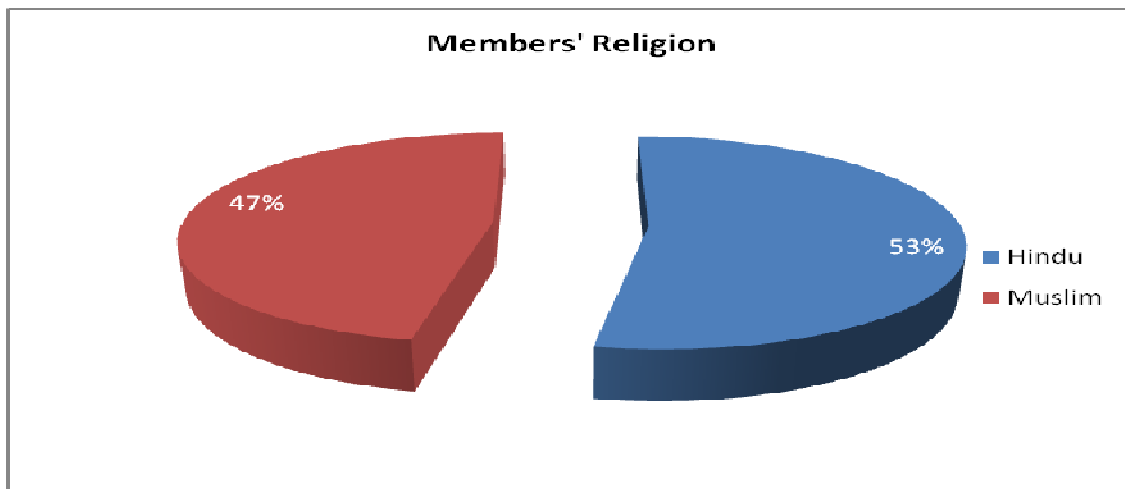
Table 1: Village wise detail of VLC-cum-VHSC Members participating in the Study

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Graph 1: Members level of Education

Level of education of the VLC-cum-VHSC members was looked into. More than half (56%) of the VLC-cum-VHSC members are uneducated as is represented in the graph above (Graph 1).



Graph 2: Members Religion

Majority of the respondents, 53% belong to Hindu Religion while the rest 47 % belong to Muslim religion (Graph 2).

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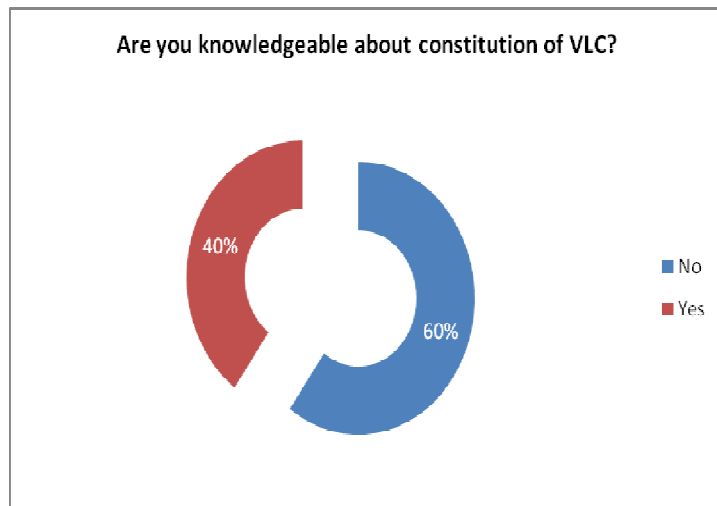
8. RESULTS AND DISCUSSIONS

Univariate and bivariate analysis of responses obtained has been undertaken. Furthermore, analysis has been sub divided into sections based on the issues that were explored during the interviews.

Member's level of knowledge about the constitution of VLC-cum-VHSC

For a Committee to function efficiently and effectively it is imperative for the members to be knowledgeable about its constitution, roles and responsibilities and activities.

As per a directive of the Haryana Government, a Village Level Committee (VLC) cum Village Level Health and Sanitation Committee (VHSC) is constituted to ensure greater participation and ownership of village communities leading to improvement in village health and service delivery. The Committee comprises of about 15 members with the Lady Sarpanch/Panch (nominated by the Panchayat) as its Chairperson and the Aanganwadi Worker (Selected by the Supervisor) as its Convener. The other members include one female School Teacher, Female Health Worker, Pradhan of Mahila Mandal, Pradhan of SMS, SHG Leader, ASHA, 3 educated adolescent girls of which at least one to be from schedule cast, Village



Chowkidar, Representative of NGO, a war widow(if any).

Graph 3: Knowledge about constitution of VLC-cum-VHSC

Members' level of knowledge about the constitution of VLC-cum-VHSC was explored. They were asked questions pertaining to the formation and membership of the VLC-cum-VHSC. The analysis reveals that a majority of the respondents (60%) are ignorant about the constitution of VLC-cum-VHSC (Graph 3). During the FGDs, some of the members mentioned that they had never been informed about the guidelines for the formation of the Committee. They did not know who could be members and the criteria for their selection. They were not aware of the objectives behind the constitution of this Committee. It was also observed that some of the members were not even aware of the existence of any such Committee in their village and came to know about their membership during the current study.

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Village	Members' knowledge about constitution of VLC	
	No	Yes
Agon	38%	63%
Bhond	60%	40%
Dingerheri	83%	17%
Ghaghas	80%	20%
Goela	43%	57%
Jaffarabad	50%	50%
Karhera	50%	50%
Kotla	78%	22%
Notki	63%	38%
Pathkhori	50%	50%
Raniyala	100%	0%
Santhavari	50%	50%
Uletha	43%	57%

Table 2: Village and Constitution of VLC-cum-VHSC

A comparative analysis reveals that in almost all the villages, a majority of the members are ignorant about the constitution of VLC-cum-VHSC. Only in village Agon and Uletha, more than 50% of the members are knowledgeable about the constitution (Table 2).

Highest Education	Knowledge about constitution of VLC cum VHSC	
	No	Yes
Illiterate	68%	32%
1st - 8th	52%	48%
9th - 12th	36%	64%

Table 3: Highest Education and Constitution of VLC-cum-VHSC

There seems to be a direct link between the level of education and the knowledge about the constitution of VLC-cum-VHSC. 68% of the uneducated members are ignorant about the constitution while 64% of the members having completed their elementary education were knowledgeable about the constitution of VLC-cum-VHSC (Table 3). This suggests that more efforts are required to increase the level of knowledge and awareness among uneducated members.

Religion	Knowledge about constitution of VLC cum VHSC	
	No	Yes
Hindu	55%	45%
Muslim	64%	36%

Table 4: Religion and Constitution of VLC-cum-VHSC

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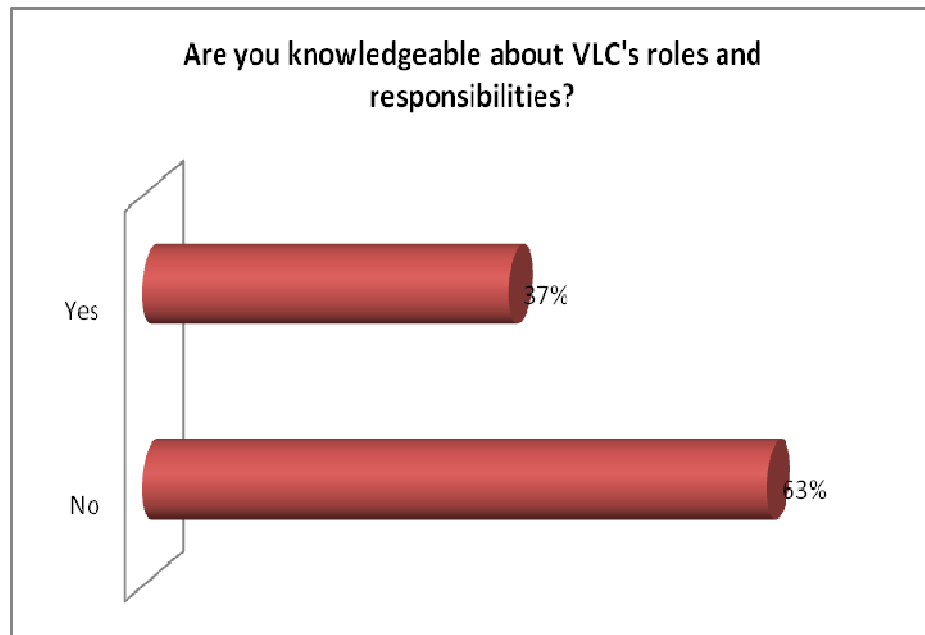
It has also been observed that the religion of the members has no significant impact on their level of knowledge. More than 50% members in both the religious groups are ignorant about the constitution of the Committee (Table 4).

Members' level of knowledge about the roles and responsibilities of VLC-cum-VHSC

The chief functions of VLC-cum-VHSC include:

- Ensure 100% registration of all births and deaths.
- Make a Village Health Plan in accordance with the health priorities of the village.
- Maintain accounts and timely submission of Utilization Certificates and the Statement of Expenditure for funds received and expended.
- Oversee village-level implementation of all programmes relating to the health of women and children, and receive feedback from the beneficiaries under various programmes.
- Maintain "Child Tracking" record in every village in the Anganwadi Centers in order to monitor every child's birth, survival, nutrition, health, education and protection etc.
- Deal with social issues pertaining to women such as domestic violence, dowry, female foeticide, early marriage etc.
- Meet once a month and maintain records of the proceedings.
- Take forward new initiatives such as supply of food items to Anganwadi Centers through Self Help Groups, mobilization of mothers to keep watch over quality of food and other services etc.

In the light of above mentioned functions, members' level of knowledge about VLC-cum-VHSC's roles and responsibilities was investigated. 63% of the members report to having received



Graph 4: Knowledge about roles & responsibilities of VLC-cum-VHSC

no knowledge about the roles and responsibilities of the Committee as well as their obligations as Committee members (Graph 4).

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In the FGDs most of the members mentioned that they did not have any knowledge pertaining to the activities of the VLC-cum-VHSC and were not aware of activities carried out in the past by the Committee. The members further mentioned that they were not even aware that as Committee members, they were accountable to the community for performance of certain activities.

Religion	Knowledge about VLC cum VHSC's roles and responsibilities		
	No	Yes	Can't Say
Hindu	57%	43%	0%
Muslim	69%	29%	2%

Table 5: Religion and Roles and responsibilities of VLC-cum-VHSC

A religion wise comparison reveals that a higher percentage of members (69%) belonging to the Muslim religion are unaware of the roles and responsibilities as compared to members belonging to Hindu religion, as has been observed earlier as well (Table 5). This again confirms the importance of the need to focus on Muslim members during capacity-building.

Highest Education	Knowledge about VLC cum VHSC's roles and responsibilities		
	No	Yes	Can't Say
Illiterate	72%	28%	0%
1st - 8th	59%	37%	4%
9th- 12th	27%	73%	0%

Table 6: Education and Roles and responsibilities of VLC-cum-VHSC

As in the case of knowledge about constitution, a similar correlation is observed in members' level of education and their level of knowledge about the roles and responsibilities of the VLC-cum-VHSC. 73% of the members with elementary education are aware of their roles and responsibilities, while 72% of the illiterate members are ignorant about it (Table 6). This again emphasizes the finding that uneducated members would require greater attention during the capacity-building trainings.

Across villages, except for Agon, Pathkhori and Goela, a majority of members in other villages are not aware of the roles and responsibilities of VLC-cum-VHSC (Table 7). It has been observed that the level of knowledge varies from village to village and hence the capacity-building program must be designed to address these varied needs.

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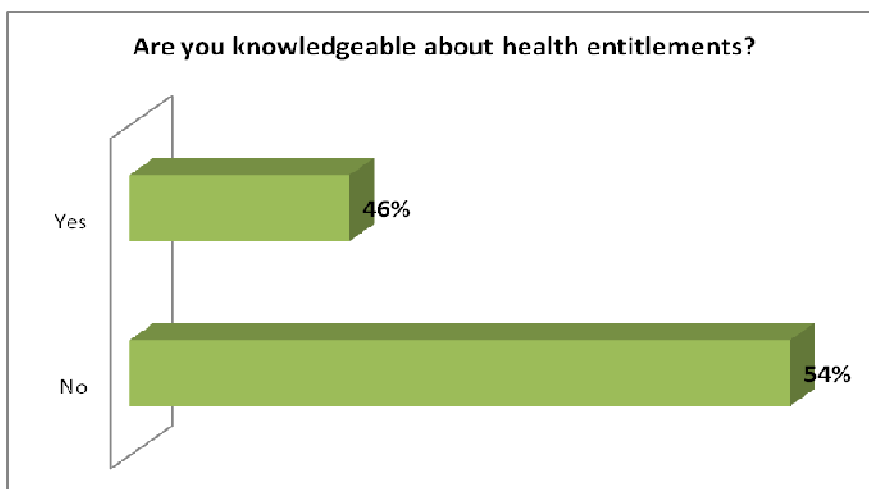
Village	Knowledge about VLC cum VHSC's roles and responsibilities		
	No	Yes	Can't say
Agon	38%	63%	0%
Bhond	60%	40%	0%
Dingerheri	67%	33%	0%
Ghaghas	100%	0%	0%
Goela	14%	86%	0%
Jaffarabad	67%	33%	0%
Karhera	75%	25%	0%
Kotla	78%	22%	0%
Notki	63%	25%	13%
Pathkhor	50%	50%	0%
Raniyala	100%	0%	0%
Santhavari	67%	33%	0%
Uletha	57%	43%	0%

Table 7: Village and Roles and responsibilities of VLC-cum-VHSC

Members' level of knowledge about Health Entitlements

As mentioned above, one of the responsibilities of the VLC-cum-VHSC is to oversee village level implementation of all programs relating to development of women and children and receive feedback from beneficiaries under various programs. For the VLC-cum-VHSC to be able to carry out this responsibility, it is imperative that its members are knowledgeable about various Government schemes and policies. This section assesses the level of knowledge of VLC-cum-VHSC members about various Government schemes for women and child development.

Members were asked if they were aware of schemes like “Janani Suraksha Yojna”, “ICDS”, “free ANC”, “free delivery van”, “Kishori Shakti Yojna”, or “Laadli Yojna”. Majority (54%) of the members are unaware of these schemes (Graph 5).



Graph 5: Knowledge about Health Entitlements

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During the FGDs, members expressed that being illiterates they generally did not come to know about these schemes. In case they knew about any schemes, they seldom availed benefits owing to the lack of information about the procedures associated with these schemes. This suggests that there is a need to provide detailed information on entitlements and schemes to the members to enable them to use information for the benefit of the beneficiaries.

Village	Knowledge about health entitlements and Govt. Schemes		
	No	Yes	Can't Say
Agon	38%	63%	0%
Bhond	60%	40%	0%
Dingerheri	50%	50%	0%
Ghaghas	40%	60%	0%
Goela	43%	57%	0%
Jaffarabad	67%	33%	0%
karhera	50%	50%	0%
kotla	78%	22%	0%
Notki	63%	38%	0%
Pathkhori	25%	75%	0%
Raniyala	60%	20%	20%
Santhavari	50%	50%	0%
Uletha	57%	43%	0%

Table 8: Village and Health Entitlements

During the village wise analysis, it is observed that in most of villages, more than 50% of the members are uninformed about any Government scheme (Table 8). However, the level of knowledge of members varies from village to village and hence the capacity-building program needs to be designed in a manner that would accommodate the varied needs of the members.

Highest Education	Knowledge about health entitlements and Govt. Schemes		
	No	Yes	Can't Say
Illiterate	68%	32%	0%
1st - 8th	44%	52%	4%
9th - 12th	18%	82%	0%

Table 9: Education and Health Entitlements

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As mentioned earlier, the level of education has a significant impact on the level of knowledge of the VLC-cum-VHSC members. Table 9 above, depicts the same regarding knowledge about health entitlements and government schemes. A majority (68%) of the members, unaware of the health entitlements and schemes, are illiterate. As the level of literacy increases, the level of knowledge also increases.

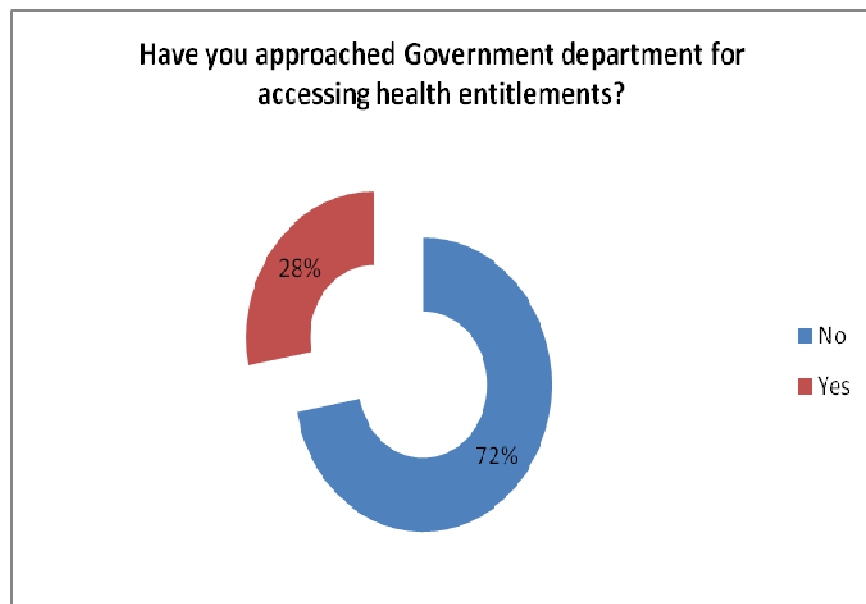
Religion	Knowledge about health entitlements and Govt. Schemes		
	No	Yes	Can't Say
Hindu	45%	53%	2%
Muslim	64%	36%	0%

Table 10: Religion and Health Entitlements

A religion-wise analysis reveals that a larger number of Muslim members (64%) do not have knowledge about the health entitlements and schemes as compared to Hindu members (45%) (Table 10). A similar trend has been observed earlier as well. This further stresses that Muslim members need more exposure and training to increase their level of awareness.

Members were further asked if they had availed any health entitlement that they were aware of, from the Administration.

More than two third of the members, stated that they had never approached any department or official for accessing any health entitlement, neither for themselves nor



Graph 6: Do the members access health entitlements?

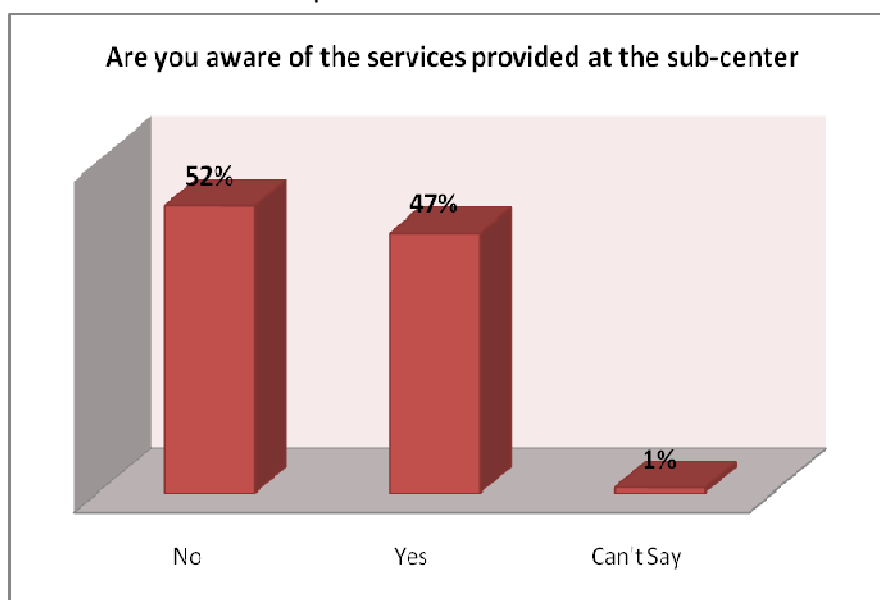
for the community (Graph 6). In the FGD, the members had mentioned that either they were not aware of the entitlements or they were hesitant to approach the Government officials. This suggests that there is a need to encourage VLC-cum-VHSC members to be more communicative with Government Officials and to shed their perceived fear.

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Members' level of knowledge about Government Health Care System

A health Sub-Centre is the first contact point between the community and the health care delivery system. A Sub-Center caters to a population of 3000 (tribal/hilly areas) to 5000 (plain areas) people. Hence, a Sub-Center can have more than one village under its jurisdiction, depending upon the population of the villages. A Sub-Center is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker (MPW). Every Sub-Center is entitled to an annual untied grant of Rs. 10,000 /-. This grant is provided by the **State Department of Health and Family Welfare** and is kept in a joint account, which is operated by the ANM and the local Village Sarpanch. The primary tasks of the ANM are to:

- Ensure the registration of all pregnancies and a minimum of 4 antenatal checkups, along with 100 IFA tablets and two T.T. injections to pregnant women.
- Appropriately and promptly refer cases of high-risk pregnancies. Provide skilled attendance at home deliveries, post partum care and contraceptive advice.
- Ensure full immunization and Vitamin A doses to children, prevention and control of childhood diseases like malnutrition, infections etc.
- Provide curative services for treatment of minor ailments.
- Maintain relevant records concerning mothers, children and eligible couples in the area. Provide information on different family planning and contraception methods and contraceptives.
- Provide counseling and correct information on safe abortion services.
- Coordinate services with AWWs, ASHA, VLC-cum-VHSC and PRI for observance of Health Day, Nutrition Day at AWW center at least once a month.
- Coordinate and supervise the activities of ASHA workers.



Whether or not the members were aware of the services provided by the Sub-Center was investigated. Only 50% of the members stated that they were aware of the services provided at the Sub Center by the ANM (Graph 7).

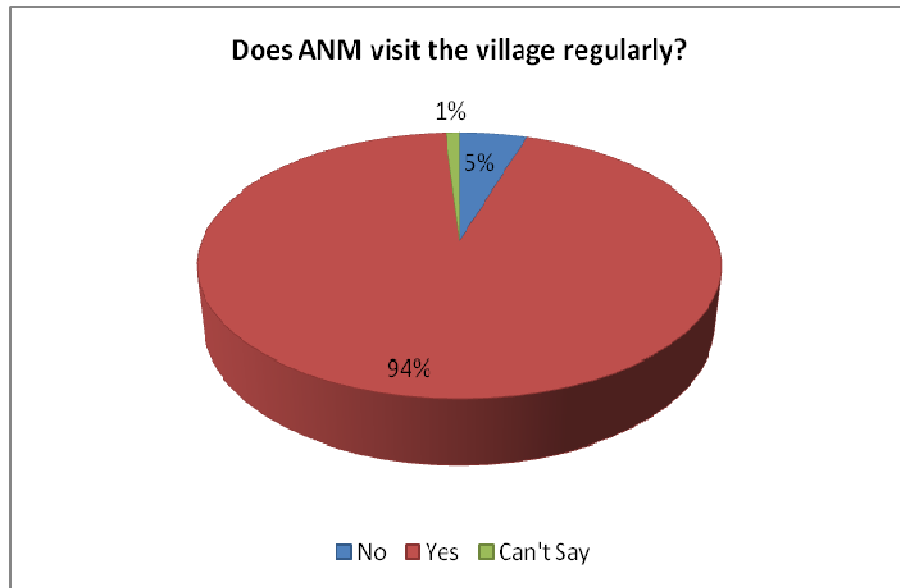
Graph 7: Knowledge about services provided by the Sub Center/ANM

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During the FGDs, members expressed that they were not aware of the OPD timings at Sub Centers and the services provided there by the ANM. They further stated that the villagers prefer to go to private clinics for treatment as they did not get proper attention and treatment at Government facilities. This suggests a need to create awareness among members, and subsequently the villagers, about their health rights and the responsibility of Government health functionaries towards the villagers.

When enquired about the ANM visits in the village, 94% of the members stated that ANM visits to the village were regular for immunization, pulse polio, ANC & distribution of general medicines (Graph 8).

However, during the FGDs, it was observed that the members were not aware of the role of ANM in VLC-cum-VHSC. Even some of the ANMs lacked clarity about their roles and responsibilities in



Graph 8: Does ANM visit the village regularly

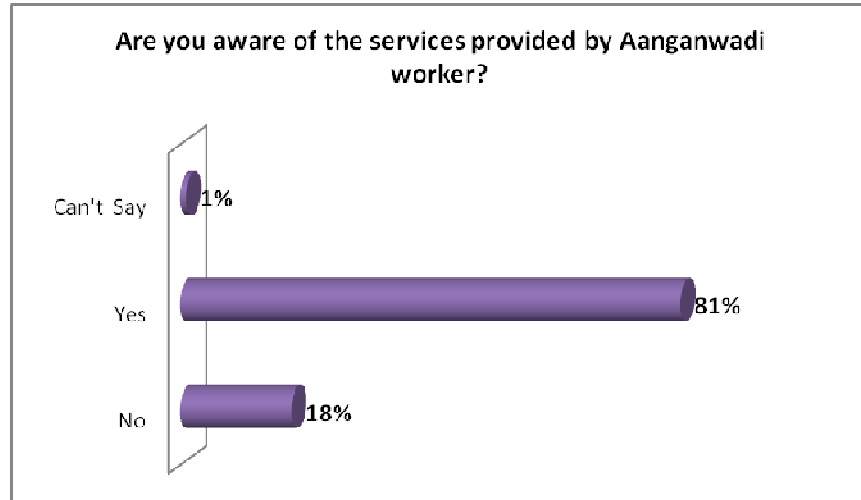
the Committee. Some of them

mentioned that their service delivery gets affected if they cover more than one village, as most of their time is then consumed in travelling from one village to another. They further stated that at times they receive insufficient medicines and other supplies and hence were not able to serve the villagers to the best of their satisfaction.

Integrated Child Development Scheme (ICDS) is one of the largest schemes of Government of India, being implemented all over the country. This scheme aims at providing food rations to children between 0-5 years and pregnant/lactating mothers and nursery education to children. It also aims to cater to the growth needs of children in the age group of 3-6 years. Pre-school education aims at ensuring holistic development of children and providing a learning environment to children, which is conducive for promotion of social, emotional, cognitive and aesthetic development of the child. Anganwadi centers are a part of the Integrated Child Development Scheme. In every village, there must be one Anganwadi center, operated by an Anganwadi Worker and a helper.

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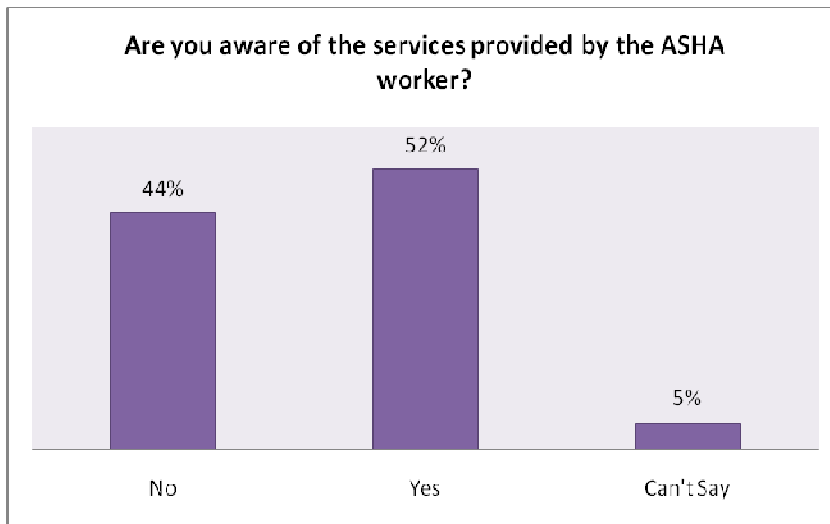
The members' level of knowledge about the services provided by the Aanganwadi centers was investigated. About 81% of the members are aware of the services provided by the Aanganwadi centers (Graph 9). Further



Graph 9: Knowledge about services provided by the Aanganwadi

investigation during the FGDs revealed

that the members were more concerned about the distribution of food rations in the center and not so much about pre- school education. As was observed in the case of ANMs, the members were not aware of the role of the AWW in the VLC-cum-VHSC. Even the Aanganwadi workers themselves were not clear about their roles.



Graph 10: Knowledge about services provided by ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist –or Accredited Social Health Activist, 'ASHA'. Selected from the village itself and accountable to it, the ASHA is an interface between the

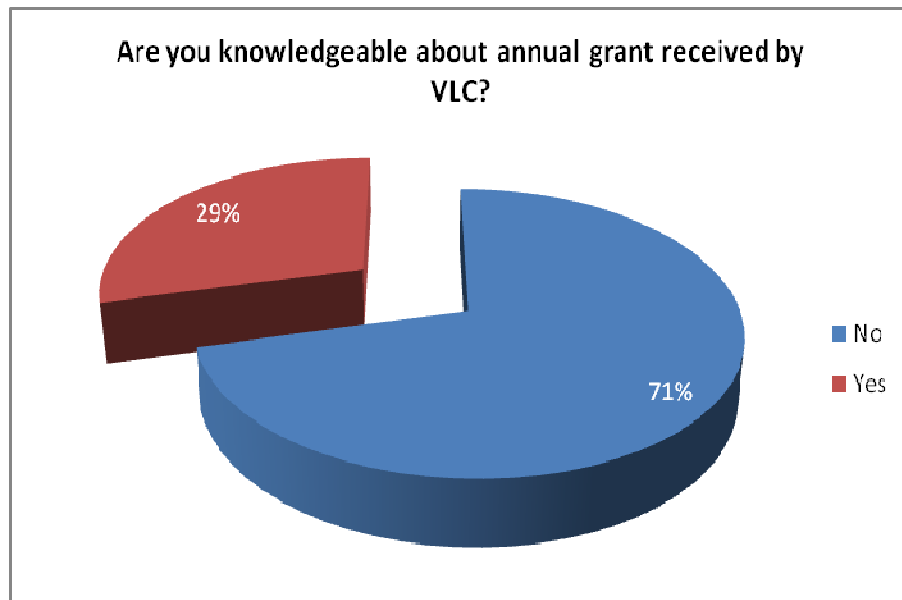
community and the public health system. ASHA is a health activist in the community who creates awareness on health, its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of the existing health services. Awareness of services provided by ASHA was assessed. A majority (52%) of the members was aware of the services, and only 44% of the members had no information about the work done by ASHA (Graph 10).

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Members' level of knowledge about the Funds

Every VLC-cum-VHSC is entitled to an annual untied grant of Rs. 10,000/- to enable local action and to ensure that public health activity at village level receives priority attention. The funds should be used for community activities that involve and benefit more than one household. The funds are transferred into the bank account of VLC-cum-VHSC from the district office of Civil Surgeon. VLC-cum-VHSC has to maintain a separate cash book for funds provided by the Health Department and has to nominate one members for the purpose. This member is paid Rs 100/- per month for maintaining the cash book out of the untied funds available with VLC-cum-VHSC. The accounts are available for public scrutiny and should be inspected from time to time by the Gram panchayat.

The members' level of knowledge on the annual grant received by VLC-cum-VHSC was investigated. About three fourths of the members are not aware of the grants received by the VLC-cum-VHSC (Graph 11).



Graph 11: Knowledge about Funds

During FGDs it was further observed that the members who knew about the grant amount were ignorant about the manner in which the amounts were to be spent. This suggests that there is a need to educate the members about the funds received by the VLC-cum-VHSC and the manner in which the monies are to be spent. This will not only assist the members in smooth implementation of the activities but will also help in bringing about transparency in the system.

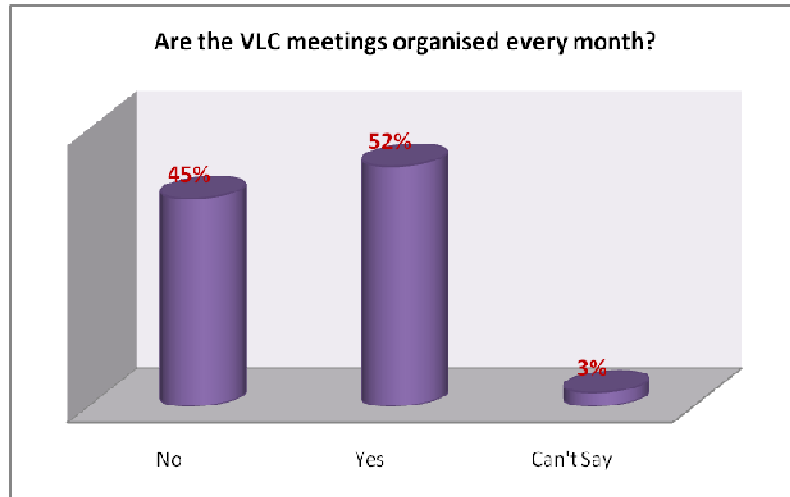
Members' level of knowledge and participation in Monthly Meetings

As per the guidelines of VLC-cum-VHSC, a meeting needs to be organized every month to review the work done by the Committee and the total expenditure incurred on the activities. This is a platform for the members to discuss their progress and make future plans.

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Whether the meetings are being organized as per the schedule was investigated. 52% of the members affirmed that the meetings were organized regularly (Graph 12).

However, in the FGDs the members had stated that not all members participate in the meetings. Either the members did not get information about the meeting schedule or they had other commitments. The members further mentioned that no expenditures details were



Graph 12: Are the VLC meetings organized every month?

shared during the meetings.

This clearly reveals that monthly meetings as a platform for the smooth functioning of the VLC-cum-VHSC are not being used in the desired manner. Hence, the capacity-building measures must aim to streamline the monthly meetings and also ensure effective participation of the VLC-cum-VHSC members. There is also a need to educate the members about the issues that needs to be discussed during the monthly meeting.

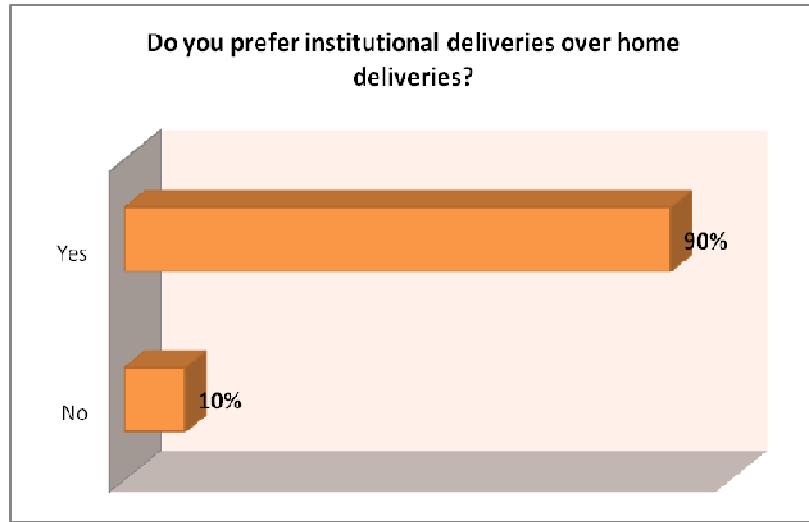
Role of Members in promoting Institutional Delivery and Immunization

In India, both child mortality (especially neonatal mortality) and maternal mortality are high. Seven out of every 100 children born in India die before reaching age one, and approximately five out of every 1,000 pregnant mothers die of causes related to pregnancy and childbirth. India accounts for more than one-fifths of all worldwide maternal deaths, from causes related to pregnancy and childbirth. It is well established that giving birth in a medical institution under the care and supervision of trained health-care providers promotes child survival and reduces the risk of maternal mortality. To address the issue of high maternal and child mortality rate, the Government of India has launched various schemes to promote institutional deliveries. However, the proportion of women giving birth in medical institutions remains low. A multitude of factors affects the utilization of health care facilities, personal beliefs being one of them.

During our experience of working closely with the community, we have observed that villagers prefer home delivery to institutional delivery. This section analyses the faith of the VLC-cum-VHSC members in institutional delivery.

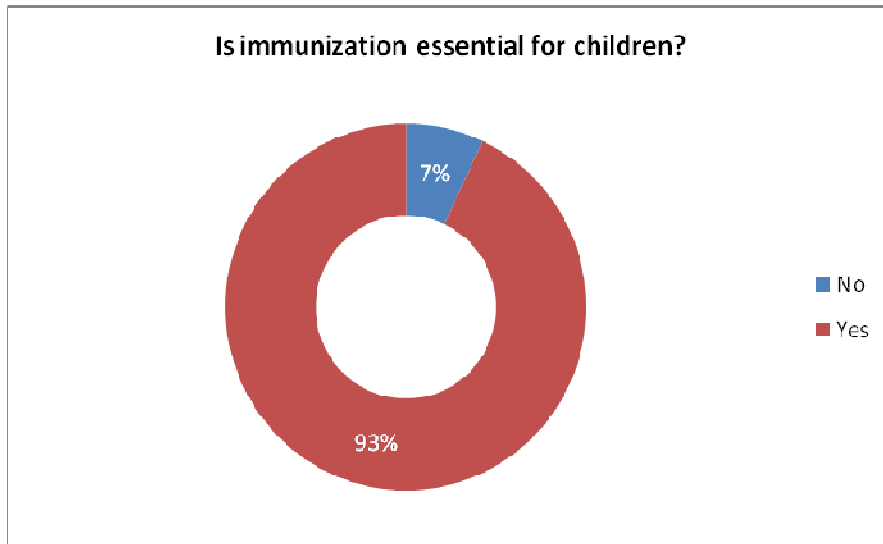
Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

The analysis reveals that 90% of the members prefer institutional deliveries over home deliveries (Graph 13). In the FGDs, the members opined that institutional delivery was safe, especially in high risk cases. This suggests that VLC-cum-VHSCs in the villages can play an active role in promoting institutional deliveries.



Graph 13: Preference for Institutional Delivery

Immunization is one of the most cost effective public health interventions to reduce mortality and morbidity caused by vaccine-preventable diseases. India has a Universal Immunization Program focused on preventable diseases like Diphtheria, Tetanus, Pertussis, childhood tuberculosis measles and Polio. The program aims at covering all infants with primary



Graph 14: Is immunization essential for children?

immunization schedule and pregnant women with Tetanus. Owing to the importance of this program, it is essential for the VLC-cum-VHSC members to ensure that there is 100% immunization coverage in their village. For this the members must believe in the need for immunization for children. Members' opinion about the immunization program was sought. A majority (93%) believes that immunization of a child is very essential to keep the child protected from various diseases (Graph 14). This implies that, it would be easier to mobilize the VLC-cum-VHSC members to work for complete immunization coverage in their villages.

Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

9. CONCLUSION

In the thirteen villages (covered in the study) the efficiency and impact of VLC-cum-VHSC appears to be very limited. More than 50% of the VLC-cum-VHSC members have inadequate knowledge about the constitution of VLC-cum-VHSC, their roles and responsibilities and entitlements and Government schemes on Health. No formal training has ever been provided to them before being made VLC-cum-VHSC members. Some of them are not even aware of their membership.

The involvement of VLC-cum-VHSC members in the activities laid down in the VLC-cum-VHSC guidelines is negligible. They hardly approach Government departments for health entitlements, primarily owing to lack of information. Most of the members are not aware of the kind of services provided by Sub-Centers. There is very limited or no involvement of VLC-cum-VHSC with the community. However, the members are aware of the importance of Institutional deliveries and Immunization for the children.

There is no involvement of members in budget planning and subsequent expenditure. The members are not involved in any budget tracking activities. They are not even aware of the annual grant given to the Committee for various activities. The VLC-cum-VHSC meetings and activities are not organized as stipulated in the guidelines and the participation of members in these meetings and activities, whenever conducted, is insignificant.

Across all parameters, as the level of education of members increases so does their knowledge and involvement in the stipulated roles of VLC-cum-VHSC. The unlettered members are reluctant to participate in the affairs of the VLC-cum-VHSC. There is a need to break this resignation and inform and motivate them towards effective participation. Across villages, the level of knowledge and participation of VLC-cum-VHSC members varies and hence the capacity-building program needs to be designed in a manner to incorporate these variations.

10. RECOMMENDATIONS

To ensure effective functioning of VLC-cum-VHSC in the villages as stipulated in the guidelines, it is envisaged to design and conduct a capacity-building program to capacitate and empower VLC-cum-VHSC members and ensure their participation. Simultaneously, awareness generation activities about the functions of the Committee would be conducted in the villages to make the Committee accountable to the village community. The program would aim at reviving and strengthening the VLC-cum-VHSCs in the villages to empower them to access health entitlements for the community and ensure quality health for all in the villages.

Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

From the analysis, it is evident that the capacity-building priorities vary across villages and education levels and hence the training program will be designed to accommodate the different needs of the members. The training would specifically focus on increasing the participation of illiterate members of the VLC-cum-VHSCs and organizing activities as per the guidelines and utilization of funds allotted. The training would be administered following the “Clinical Methodology” wherein the participants, during the training, will take up real issues and work with the community and the administration to address health issues.

The following would be the content of the training program.

- Constitution of VLC-cum-VHSC
- Roles and responsibilities of VLC-cum-VHSC members
- Guidelines of VLC-cum-VHSC: activities & budget
- Information about health entitlements, Government health schemes, health services.
- Preparation of village health action plan and Budget Planning and Tracking
- Community engagement by the VLC-cum-VHSC
- Promotion of women and child health
- Involvement of VLC-cum-VHSC in planning, decision making and monitoring and evaluation
- Regularity and participation by all members in VLC-cum-VHSC meetings
- Linkages with District administration
- Participation of illiterate members in the affairs of the VLC-cum-VHSC
- VLC-cum-VHSC as an effective health Committee at the Village level

Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

11. REFERENCES

- ◆ National Rural Health Mission (2005-2012), Mission Document
- ◆ Implementers handbook for Community Monitoring to Improve Health Services-NRHM
- ◆ Guidelines regarding entitlements & utilization of united funds –VLC-cum-VHSC, Mandhikhera Hospital, Mewat.
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- ◆ <http://mohfw.nic.in>
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- ◆ <http://www.haryanahealth.nic.in>
- ◆ <http://india.gov.in>

Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

Annexure 1

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Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

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Table 5: Religion and Roles and Responsibilities of VLC-cum-VHSC

Table 6: Highest Education and Roles and Responsibilities of VLC-cum-VHSC

Table 7: Village and Roles and Responsibilities of VLC-cum-VHSC

Table 8: Village and Health Entitlements

Table 9: Education and Health Entitlements

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Report on Capacity-Building Needs: Village Level Committee-cum-Village Health and Sanitation Committee

Annexure 3

Training Needs Analysis for Capacity-Building of VLC-cum-VHSC- Focus Group Discussion Guide

Are VLC members aware of the purpose behind the constitution of VLCs in the village?

Are VLC members aware about their roles and responsibilities?

Do the members know who all can be the representative of VLC?

Are VLC members aware of the various health entitlements and Government schemes available in the village?

Does ANM Visit the village? If yes, what is her name?

What are the services provided by the ANM?

Does ANM submit village report and a plan to the Committee?

Is Anganwadi functional in the village? What are the services provided by AWW?

Is there any ASHA worker in the village? If yes, how many ASHAs are there name them and what are the services provided by the ASHA worker.

Has VLC ever participated in selecting ASHA worker in the village?

Are there any Male Health Workers at the Sub-centre? What are the services provided by them?

Are there any sub-centers in the village? Whether it is functional, if yes, what are the timings and what are the services provided? If no, where is the nearest sub center situated from the village (in which village, distance and timings?)

How far is the nearest PHC from the village? What are the services provided in the PHC?

How active are the VLC members in terms of:

- Organizing development activities (cleanliness and sanitation drive, health awareness activities etc.)

- Conducting Household Surveys

- Maintaining Village Health Registers

- Organizing School health activities

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- Ensuring Aanganwadi facilities
- Monitoring health activities in the village of ANM, AWW, ASHA, Sub-Center

Are members aware of the amount of annual grant received by VLC and how it can be spent?

Has the VLC ever developed a Village Health Plan?

Has the VLC ever done wall writing of slogans? If yes, How many and on which topics.

Have you ever conducted any public awareness programs in the village? Health day, Nutrition Day, Mothers meeting etc)

Do the members know about the maternal and neonatal deaths? Do they report about these events to any government health worker? What do they do about it?

Where do generally deliveries take place in the village (Home or Institutional)?

Are members sensitized to vaccination, care of pregnant women, immunization, injections?

Do VLC meetings happen? If yes, what is the frequency? How often do the members participate in the VLC meetings?

Has VLC member ever visited a Sub-Center, PHC, CHC or any government Official for their health entitlements?

Are VLC members aware of the number of BPL card holders in the village? Have they ever contributed any amount in building toilets for BPL card holders?

Where do people generally go in case of ill health?

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Annexure 4

Training Needs Analysis for Capacity-Building of VLC-cum-VHSC- Individual Questionnaire

Assessment Indicators	Response		
Do you have knowledge about the formation and membership of VLC	Yes	No	Can't say
Do you have knowledge about VLC's roles and responsibilities	Yes	No	Can't say
Do you have knowledge about health entitlements and Government schemes available in the village?	Yes	No	Can't say
Do you have knowledge about health annual grant received by VLC and how it can be spent?	Yes	No	Can't say
Does ANM Visits the village?	Yes	No	Can't say
Are you aware of the services provided by ANM?	Yes	No	Can't say
Are you aware of the services provided by ANM?	Yes	No	Can't say
Is Anganwadi functional in the village?	Yes	No	Can't say
Are you aware of the services provided by AWW	Yes	No	Can't say
Is there any ASHA worker in the village?	Yes	No	Can't say
Are you aware of the services provided by ASHA worker?	Yes	No	Can't say
Have you participated in selecting ASHA worker in the village?	Yes	No	Can't say
Are you aware of the services provided at the sub-centers?	Yes	No	Can't say
Have you ever participated in any Health activities(cleanliness and sanitation drive)	Yes	No	Can't say
Are the VLC meetings organized every month	Yes	No	Can't say
Do you participate in the meetings	Yes	No	Can't say
Have you ever visited PHC, CHC or Government Office for their health entitlements	Yes	No	Can't say
Do you think that immunization for children is essential?	Yes	No	Can't say
Do you know about the immunization schedule of a child?	Yes	No	Can't say
Do you think immunization (TT) and IFA is essential for pregnant women?	Yes	No	Can't say
Do you know about the immunization schedule of a pregnant Woman?	Yes	No	Can't say
Do you feel that institutional deliveries are Safe & better?	Yes	No	Can't say