

# Assessing Knowledge and Functionality of Village Health Sanitation and Nutrition Committees in India: A Mixed-Method Research

Shantanu Sharma<sup>1</sup>, Rohit Pandey<sup>2</sup>, Surendra Kumar Jena<sup>3</sup>, Sunil Mehra<sup>4</sup>

<sup>1</sup>Deputy Director<sup>1</sup>, Regional Manager<sup>2</sup>, Assistant Director<sup>3</sup>, Executive Director<sup>4</sup>, MAMTA Health Institute for Mother and Child, Delhi, India.

**How to cite this article:** Shantanu Sharma, Rohit Pandey, Surendra Kumar Jena et. al. Assessing Knowledge and Functionality of Village Health Sanitation and Nutrition Committees in India: A Mixed-Method Research. Indian Journal of Public Health Research and Development / Vol. 15 No. 4, October-December 2024.

## Abstract

**Background:** Studies have highlighted lacunae in the effective implementation of Village Health Sanitation and Nutrition Committees (VHSNC) in India. The present study aimed to evaluate the routine functioning of VHSNC in two districts of Odisha.

**Methods:** Our study included mixed-method research. The members of 467 VHSNCs were interviewed in two districts. The quantitative data was collected using a semi-structured questionnaire. Besides, we did 18 focus group discussions and 3 in-depth interviews to obtain the perceptions of the members of VHSNCs on the needs of the communities and the challenges.

**Conclusions:** VHSNC is an effective mechanism of health governance, but there are challenges, such as a lack of knowledge about the functioning of its members, irregular meetings, delayed funds or improper documentation, and ineffective supervision. A comprehensive model of VHSNC implementation needs to be developed and delivered with continuous monitoring to make them function effectively.

**Keywords:** Community-based participatory research, Community health planning, Health, mothers

## Introduction

Village Health Sanitation and Nutrition committees (VHSNC) execute the mechanism for community health governance in India. VHSNCs are expected to conduct monthly meetings, plan and monitor health and nutrition services, and use untied funds to spend on local health needs.<sup>1</sup> A VHSNC is represented by members such as the village head, frontline workers like Accredited Social Health Activists (ASHA),

*Anganwadi* Workers (working at mother and child day care centres), ward members, Self Help Group (SHG) members, school teachers, etc. Multiple studies in the past evidenced many gaps, such as the lack of information about roles and responsibilities among VHSNC members, lack of local collective actions and village health planning, etc.<sup>2-4</sup>

There have been multiple challenges in VHSNC functioning across the country, including delayed

**Corresponding Author:** Shantanu Sharma, Deputy Director, MAMTA Health Institute for Mother and Child, Delhi, India.

**E-mail:** shantanusharma@mamtahimc.in

**Submission date:** December 10, 2023

**Revision date:** January 22, 2024

**Published date:** September 20, 2024

This is an Open Access journal, and articles are distributed under a Creative Commons license- CC BY-NC 4.0 DEED. This license permits the use, distribution, and reproduction of the work in any medium, provided that proper citation is given to the original work and its source. It allows for attribution, non-commercial use, and the creation of derivative work.

or non-disbursement of untied funds and their timely and appropriate utilization for community activities.<sup>5,6</sup> Similarly, studies also reported that monthly meetings of the VHSNCs did not happen, and the attendance of the members was half.<sup>7</sup>

Though studies highlighted many lacunae and the potential of VHSNCs, there is a lack of data on its functioning from Odisha. Hence, the objective of the present study was to evaluate the routine functioning of VHSNC in Odisha.

## Materials and Methods

It was mixed-method research conducted across two districts of Odisha. The members of 467 VHSNCs were interviewed in two districts. Out of 467, 317 belonged to *Balangir* and 150 to *Nuapada*. We assessed the functioning of VHSNC through a quantitative survey and the perception of the VHSNC members through in-depth interviews (IDI) and focus group discussions (FGD)

The quantitative data was collected using a semi-structured questionnaire that consisted of questions related to VHSNC routine functioning on a paper-based format in the local language (Hindi or Odiya). The respondents for the VHSNC survey included frontline workers like *Anganwadi Workers*, ASHA or ANM members of the committees.

We did FGD and IDI to obtain the perceptions of the members of VHSNCs on the needs of the communities and the challenges. A qualitative data investigator conducted in-depth interviews with the village heads (*sarpanches*) and FGDs with other members of the committees. Purposive sampling was adopted.

All the interviews were recorded in Dictaphone, which were transcribed and written later. The

transcripts were coded inductively using thematic analysis in Microsoft Excel (Excel v.2007, Redmond, WA, USA). Content analysis was done. The data-driven themes that emerged consistently related to the health and nutritional needs of the villages and the ways to effectively address those needs. The data from the FGDs were categorized into four major domains, namely overall health, WASH practices, employment opportunities, and functioning of the VHSNCs. The ethical clearance was obtained on 7<sup>th</sup> August 2020 (MERB/August-2020/001) from the institutional ethical committee. Informed consent was obtained from the participants of the qualitative interviews and discussions.

## Results

### Functioning of VHSNC:

On average, there were 10 members in each VHSNC. In nearly 15% of the VHSNC, there was no fixed date for holding a meeting. Most of the VHSNC organized meetings monthly (82%), followed by once in two months (15%), half-yearly (1.1%), or quarterly (0.6%). The average amount of funds received since 2017 remained the same, i.e., INR 10000. The number of major activities that have been taken with the untied funds in the last 12 months included 2-3 meeting for preparation of village health plan, organizing *Jan Samvads* (community dialogues), and events like cleaning drives, vector control, etc. Most of the participants denied using money out of VHSNC funds for organizing VHNDs (70%), while 21% said yes, and 4% did not know. Of those who used, INR 500 (100-1200) (median (interquartile range)) was spent in organizing VHND from the VHSNC funds. In the past 6-months, 6 VHND meetings were organized. The frequency of the attendance of the members of VHSNC in the monthly meetings is shown in Fig 1.

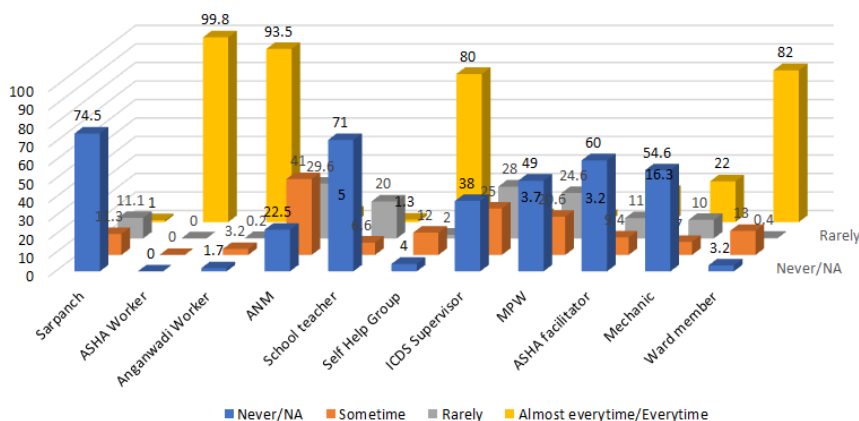


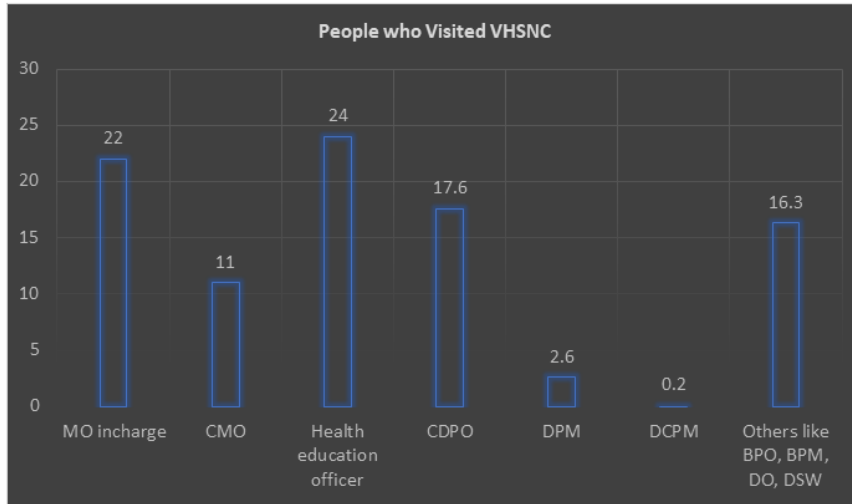
Fig 1. Frequency of attendance of the members of VHSNC in the monthly meetings

\*All figures are in percentages

Abbreviations: ICDS: Integrated Child Development Service Scheme; NA: Not Applicable

The figure shows frequency of the attendance of the members of VHNSC in the monthly meetings.

In 292 out of 467 VHSNCs, officials from state/district/block/PHC/CHC level visited VHSNC. The percentage of different officers who visited VHSNC is shown as Fig 2.



**Fig 2. Percentage of different officers who visited VHSNC**

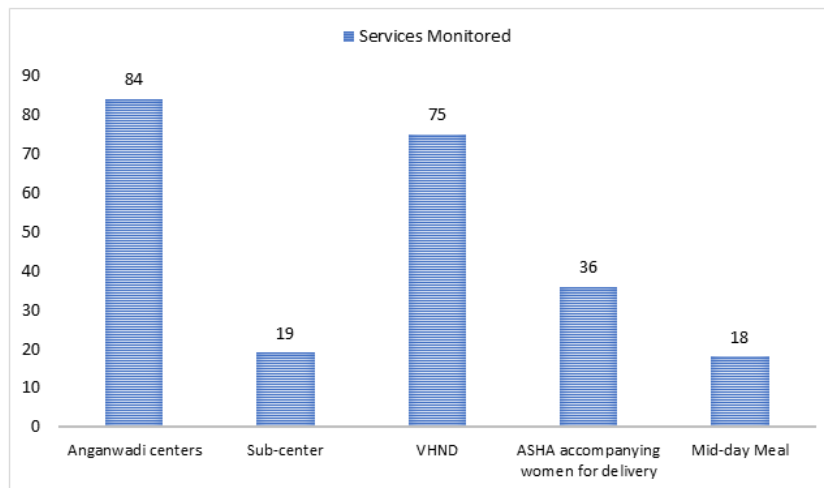
\*All figures are in percentages

Abbreviations: CMO: Chief Medical Officer; MO: Medical Officer; CDPO: Child Development Project Officer; DPM: District Program Manager; DCPM/BPO/BPM/DO: District and block level officers

The figure shows the percentage of different officers

who visited VHSNC.

Around 83% of respondents informed that they made a village health plan. Similarly, 92.5% said that they made a list of vulnerable populations. The percentage of respondents who monitored various services in the villages (Fig 3).



**Fig 3. Percentage of respondents who monitored various services in the villages**

\*All figures are in percentages

Abbreviations: VHND: Village Health and Nutrition Day

The figure shows the percentage of respondents who monitored various services in the villages.

## FGDs

In total, 18 FGDs were conducted. The average duration of the FGDs was 1 h 15 minutes, and the average number of participants per FGD was 11. The FGDs were conducted mostly at the *Anganwadi* centers and at the center of the village.

## Overall health, specifically maternal and child health

Medicines like oral rehydration solution (ORS), paracetamol, zinc, and iron folic acid (IFA) tablets were available with ASHA, but these medicines were not available sufficiently. The members felt that some alternate health service mechanisms could be done that the villagers could easily access and a free medicine distribution center should be opened where all the villagers could access the services during emergencies. The villagers used to depend upon the traditional village healers or quacks due to a lack of doctors or medicines near their villages. Ambulances 102&108 were irregular and not sufficient; hence, they suggested to have another ambulance.

The immunization sessions were held regularly once a month (usually on 3<sup>rd</sup> Wednesday), but the quality of the cold chain management was very poor. Due to migration, it was too difficult to track both mothers & children. Village Health and Nutrition Day (VHND) was not conducted regularly, and VHND sessions had not been held in the past 4 months. Adolescent girls were getting IFA tablets, sanitary pads, and zinc tablets from ASHA. The pregnant women were getting take home rations.

Diseases like fever, diarrhea, headaches, cough, stomach problems, cold, and allergies were very common. Drinking alcohol was common among the male members of the villages and this created gender violence in the villages. Villagers were taking advantage of housing schemes like *Indira Awas Yojana*.

Primary health centers were not in the villages, and the villagers had to go to community health centers, which were 12 km from their respective villages. The services of ANM had been reported to be irregular by some of the members.

## WASH practices

There was an issue with toilets; though toilets had been constructed, they were small and many had never used them. They went for open defecation. Safe drinking water was a problem for the village. The quality of water was not good (excess fluoride levels).

## Employment opportunities

In daily wage labor work, villagers normally receive Rs 303 per day. During the month of October, they started migrating and returned after 6-7 months. Due to irregular payments by the contractors, and limited job availability from MGNREGA (employment generation scheme), the villagers were forced to migrate.

## Functioning of VHSNCs

Self Help Groups (SHG) prepared mid-day meals for schools. As per the community, 'the *Gaon Kalyana Samiti* GKS (alternate name for VHSNC in Odisha)' has been formed on the instruction of the Department of Health. Untied funds were used to refer malnourished people, to purchase mats, weighing machine, and chairs, etc. However, the GKS meetings were not conducted regularly. Some perceived that even the activities of the GKS were not carried out in a proper way and demanded training on the utilization of the untied funds.

The GKS has been utilized to purchase baskets, brooms, soaps, bleaching powder, masks, oxygen machines, hand gloves, and sanitizers to raise awareness on COVID-19 and conducting awareness programs malaria, *Swachh Bharat* (Clean India), and T.B. The male members thought that the GKS committee had been formed only for females. So, they never attended any GKS meetings. VHSNC members faced difficulties in fund management and documentation.

## In-Depth Interviews

Three IDIs were conducted in the two districts of Odisha. Two out of three interviews were women and one man. They were aged 42, 32, and 26 years.

The members suggested having regular health check-ups of the people with proper counseling sessions on health and hygiene using different educational materials. The primary health centers

(PHC) did not have anything, and they ought to be provided with weight machines, lab facilities, and at least essential medicines. It was also suggested that door-to-door campaigns be carried out with the support of the primary health center of the concerned area. The need for a proper micro-level plan of separate programs for mothers, adolescents & children was highlighted.

The members said that village health sanitation and nutrition days, mobile health units, sub-centers, or *Anganwadi* centers were active in villages. It was perceived that the male members were not well-informed about maternal or child benefit schemes. ANM/ASHAs regularly visited the households and invited people to the VHND meetings.

*“Being a male, I cannot attend these meetings as all the participants over there are mostly women. So, I am unaware of the govt schemes in detail”*, said a male PRI member.

ASHAs, ANMs, and *Anganwadi* workers were perceived to play an important role in building awareness among the community and had regular meetings at *Anganwadi* centers. ANM performed antenatal check-ups of women and did immunizations of children in villages.

A shortage of health professionals was perceived. There was a lack of gynecologists and child health specialists in the community health centers. Pregnant women and their families faced financial and mental problems. There was a lack of respectful maternity care by the medical staff. Traditional beliefs prevented couples from using family planning methods and breastmilk. People did not practice early initiation of breastfeeding as they thought the first milk was not good for their child and, hence, discarded milk for the first few days. Also, the belief that immunization would make children feel sick, and hence, communities stopped their children from being immunized; however, counseling by healthcare workers motivated them.

*“People think it would be disrespectful to their deity if they use any of the family methods. A person using the family planning method is not allowed to attend most of the rituals, and it is the disrespect shown to the deity. Our god becomes angry with us. This is what people think”*, said the PRI member.

One of the PRI members was aware of schemes like *Janani Suraksha Yojna*, JSY; *Janani Shishu Suraksha Karyakaram*, JSSK; and MAMATA scheme. People

were perceived to be availing of the benefits of the schemes.

*“In the JSY scheme, Rs. 1400 was given for the institutional delivery of the first two children. About JSSK, I did not know much. But in the MAMTA scheme, as far as I know, women were given Rs. 5000 for the loss of wages to ensure that the woman gets rest after delivery during her postnatal period and lactate her child on time”*, said a PRI member.

Lack of staff was highlighted in the interviews, and as a result, ASHA, ANM, and *Anganwadi* workers were overburdened all the time.

*“I can help these workers (ASHA, ANM, and Anganwadi workers) by sharing whatever I know about the schemes or things. People should spread about these things more and more so that more and more people should be using these schemes”*, said the PRI member.

## Discussion

Our study highlighted that there was a lack of complete knowledge about the functioning of VHNSC among its members and many operational challenges like delayed receipt of untied funds, no fixed date of meeting, correct use of untied funds, effective monitoring of the VHNSC by supervisors, etc. The study is crucial from the lens of improving community health governance at the village level and deliver universal health coverage.

Studies found that despite the guidelines of ensuring 50% women participation in the VHNSC membership, the same was not followed at many places due to social and gender norms.<sup>1</sup> Also, the representation from school teachers or NGOs was limited in VHSNCs (2). Our findings concur with the findings from other studies suggesting that VHSNC meetings were held irregularly and documentation of the meetings and other records were poorly maintained.<sup>2,8,9</sup> Lack of knowledge about the activities of VHSNCs among their members have been reported in other studies.<sup>2,10</sup>

VHSNCs have broader roles than just organizing health activities, such as monitoring services, addressing health needs of the communities, and improve the nutritional status of the villages. However, most of the studies, including ours found a lack of clarity in roles among the members and a lack of proper training could be attributed to the same.<sup>5,11,12</sup> Sanitation and cleanliness drives were the

major health issues addressed adequately or known to VHSNCs members, as found in our study and the study by Dhiman *et al.*<sup>5</sup> VHSNC members did lack clear understanding of making fund utilization certificates.<sup>13</sup>

NGOs can be a mediator to facilitate the effective functioning of VHSNC.<sup>1</sup> Supportive supervision and monitoring are critical to ensure VHSNC utilize their transformative potential to the fullest.<sup>7</sup> Village health planning is a critical responsibility of VHSNC that help them address community health and nutrition needs. However, 20-25% of VHSNCs were found not making the plans in our study. Our findings are in congruence with the findings from the study by kumar *et al.*<sup>14</sup>

### Conclusions

VHSNC can effectively ensure people's participation in planning and delivery of health and nutrition services. However, there are multiple challenges in VHSNC functioning. A comprehensive model of VHSNC implementation needs to be developed with continuous monitoring to make them function effectively.

**Ethical Clearance** was obtained on 7<sup>th</sup> August 2020 (MERB/August-2020/001) from the institutional ethical committee.

**Conflict of Interest:** The authors declare that there is no conflict of interests.

**Source of Funding statement:** The study is a part of a project funded under Corporate Social Responsibility.

### References

1. Ved R, Sheikh K, George AS, Raman VR. Village health sanitation and nutrition committees: reflections on strengthening community health governance at scale in India. *BMJ Global Health*. 2018 Oct 1;3(Suppl 3):e000681.
2. Semwal V, Jha SK, Rawat CM, Kumar S, Kaur A. Assessment of village health sanitation and nutrition committee under NRHM in Nainital district of Uttarakhand. *Indian Journal of Community Health*. 2013 Dec 31;25(4):472-9.
3. Kumar V, Mishra AJ, Verma S. Health planning through village health sanitation and nutrition committees: a qualitative study from India. *International Journal of Health Care Quality Assurance*. 2016 Jul 11;29(6):703-15.
4. Azeez EA, Siva PS, Kumar AS, Negi DP. Are village health, sanitation, and nutrition committees functional? Evidence from Chhattisgarh and Madhya Pradesh. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*. 2021 Jan;46(1):80.
5. Dhiman A, Khanna P, Singh T. Evaluation of village health sanitation and nutrition committee in Himachal Pradesh, India. *Journal of Family Medicine and Primary Care*. 2020 Sep;9(9):4712.
6. Sharma S, Rawat S, Akhtar F, Singh RK, Mehra S. Assessing community health governance for evidence-informed decision-making: a cross-sectional study across nine districts of India. *International Journal of Health Governance*. 2021 Dec 24;27(1):8-20.
7. Scott K, George AS, Harvey SA, Mondal S, Patel G, Sheikh K. Negotiating power relations, gender equality, and collective agency: are village health committees transformative social spaces in northern India?. *International journal for equity in health*. 2017 Dec;16:1-2.
8. Pandey A, Singh V. Tied, Untied fund? Assessment of Village Health Sanitation and Nutrition Committee, involvement in utilization of untied fund in Rajasthan, CHEERS Rajasthan. (Last accessed on 2013 29th July). Available from: <http://www.chsj.org>.
9. Prasad V. An Assessment of the status of VHSNCs in Bihar, Chhattisgarh, Jharkhand and Orissa in March 2008. *Public Health Resource Network*: (Last accessed August 2nd 2013). Available from: [www.shsrc.org](http://www.shsrc.org).
10. Village Health Sanitation and Nutrition Committees (VHSNCs) in Chhattisgarh: An Assessment. State Health Resource Centre. Raipur: Chhattisgarh; July 2013.
11. Fund U. Assessment of Knowledge and Utilization of Untied Funds by Stake Holders at Village Health, Sanitation and Nutrition Committees in Udaipur District, Rajasthan. *Healthline, Journal of Indian Association of Preventive and Social Medicine*. 2016;7(2):74-80.
12. Purohit B, Singh R. Limitations in the functioning of village health and sanitation committees in a north western state in India. *Int J Med Public Health*. 2012;2:39-46.
13. Nongdrenkhomba, H.N., Prasad, B.M., Shome, B.K. et al. Community-based health committee initiatives in India: a descriptive analysis of village health sanitation and nutrition committee model. *BMC Proc* 6 (Suppl 5), O29 (2012).
14. Kumar V, Mishra AJ, Verma S. Health planning through village health sanitation and nutrition committees: a qualitative study from India. *International Journal of Health Care Quality Assurance*. 2016 Jul 11;29(6):703-15.