UNDERSTANDING COMMUNITIZATION WITHIN THE NATIONAL RURAL HEALTH MISSION (NRHM): A CASE OF VILLAGE HEALTH AND SANITATION COMMITTEES (VHSC) IN JHARKHAND

A Dissertation Submitted to Jawaharlal Nehru University in Partial fulfillment of the requirement for the award of the degree of

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By

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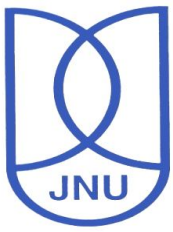

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DECLARATION

I declared that the dissertation entitled **"Understanding Communitization within the National Rural Health Mission (NRHM): A Case of Village Health and Sanitation Committees (VHSC) in Jharkhand"** submitted by me in partial fulfillment of the requirements for the award of the degree of Master of Philosophy of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work.

Minashree Horo

CERTIFICATE

We recommended that this dissertation be placed before the examiners for evaluation.

Prof. Ritu Priya Mehrotra (Chairperson, CSMCH)

Dr. Rajib Dasgupta (Supervisor)

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LIST OF ABBREVIATION

ANM	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
ACMO	Assistant Chief Medical Officer
BPM	Block Program Manager
BPL	Below Poverty Line
BTT	Block Training Team
CBM	Community Based Monitoring
CHC	Community Health Centre
CMO	Chief Medical Officer
CS	Civil Surgeon
CINI	Child in Need Institutions
CHW	Community Health Worker
CRM	Common Review Mission
CBO	Community Based Organization
DHAP	District Health Action Plan
DPC	District Program Coordinator
DDO	Drawing and Disbursing Officer

DDT	Dichloro-Diphenyl-Trichloroethane Insecticide
EAG	Economic Empowered Groups
FRU	First Referral Unit
GPELF	Global Programme to Eliminate Lymphatic Filariasis
GNM	General Nurse Mid-Wifery
GOJ	Government of Jharkhand
HCMC	Health Centre Management Committee
IEC	Information Education and Communication
IMR	Infant Mortality Rate
IHP	Indigenous Health Practioners
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
MMR	Maternal Mortality Rate
MTA / PTA	Mother Teachers Association/ Parent Teacher Association
MOs	Medical Officers
MPW	Multi Purpose Worker
MIS	Management Information System
MNREGA	Mahatma Gandhi National Rural Guarantee Act
MOIC	Medical Officer In-Charge

MoHFW	Ministry of Health and Family Welfare
NRHM	National Rural Health Mission
NBJK	Nav Bharat Jagriti Kendra
NHAK	Naga Hospital Authority Kohima
NGO	Non- Governmental Organization
NRC	Nutritional Rehabilitation Centre
PHC	Primary Health Centre
PESA Act	Panchayat Extension to the Scheduled Areas Act
PRI	Panchayati Raj Institution
PMGSY	Pradhan Mantri Gram Sadak Yojana
PCC	Pre-stressed Cement Concrete
PDS	Public Delivery System
PEI	Polio Eradication Initiatives
RKS	Rogi Kalyan Samiti
RCH	Reproductive Child Health
ST	Scheduled Tribe
SC	Scheduled Caste
SHC	Sub-Health Centre
STT	State Training Team
SHG/ WSHG	Self Help Groups/ Women Self Help Groups
SOE	Statement of Expenditure

SHRC	Sahiyya Health Resource centre
SAP	Structural Adjustment Policies
SPHC	Selective Primary Health Care
TFR	Total Fertility Rate
ToT	Training of Trainers
UHC	Urban Health Centre
UPA	United Progressive Alliance
UNDP	United Nation Development Program
UNICEF	United Nations International Children's Emergency Fund
VHSC	Village Health and Sanitation Committee
VHSNC	Village Health Sanitation and Nutrition Committee
VHP	Village Health Plans
VSRC	VHSC-Sahiyya Resource Centre
VHND	Village Health and Nutrition day
VEC	Village Education Committee
WHO	World Health Organization

LIST OF MAPS

CONTENTS

INTRODUCTION

A new approach was introduced in the International Conference on Primary Health Care in Alma-Ata (1978), concerning the disheartening situations in most of the developing countries to fill up the gaps between the ideal and the actual situation of the health among the people, was first of its kind. This conference came up with the Primary Health Care Approach a bridging up strategies that emphasizes on the equitable distribution of all the health resources to the people of the world echoing the slogan of "Health for All by 2000 AD" freezing the goal of achieving primary health care to all. This newly found approach comprised of promoting comprehensive health care with underlying principles of the community participation so as to ensure self-reliance of the people by assuming more responsibility and the ownership for their own community making themselves instrumental in taking care of their own health care needs and decisions, actions, steps and initiatives taken around them.

In the light of above mentioned commonly shared goals, in 2005 the National Rural Health Mission (NRHM) was launched by the government of India to reinforce the new approach and meet the desired goals of its own native citizenries being aware of countries own prevailing scenario of primary health care of common people and the socio-economic realities. NRHM prescribed to bring architectural corrections through systemic reforms and strategic management in the public health care system by making it more equitable, affordable and effective, with an enhanced capacity to absorb the increasing outlay in the country. In the country like India it was realized that the said goals can't be achieved unless rural community is brought strategically at the locus with a missionary vision and approach under sound policy framework. Thus the NRHM accentuates the 'communitization' of the rural health institutions through strong community participation as an integral element of functionaries and institutions providing primary health care. Under this concept village health committee (VHSC), urban health committee (UHC) and Rogi Kalyan Samiti/ hospital management committee (RKS/HMC) were constituted in order to facilitate and strengthen the process of 'communitization'. So, it can be said that the NRHM places significant focus on creating and supporting Village Health and

Sanitation Committee (VHSC) which is envisioned as key actors to promote decentralization receiving cooperation and support of communitized health institutions. Increased stake of the community both in the institutional set up and at the people's organization dealing with health care was perceived as a two way process of communitization that will potentially enhance the accountability, transparency and accessibility of these institutions and simultaneously help the community to own these intuitions for their increased stake in decision making, processes, awareness and empowerment. This approach appears to generate a win-win situations (for both the community and the government) if implemented in true spirit despite ambiguities that persists in policy understanding and existing perceptions of some core ideas, terminologies and definitions (e.g. communitization, ownership, community participation etc.) that has been adopted uncritically.

The present study is focused on the model of communitized institutions so adopted at the primary/ village level i.e. Village Health and Sanitation Committees (VHSC). It will explore the communitization process through the VHSCs in Jharkhand a newly formed state emerged in adverse initial conditions with the little social development including health. After the separation of state from Bihar the implementation of programs has improved, but still the state faces significant challenges in overcoming the growing weaknesses of the implementation capacity. The weak institutional performances, the newly formed local government/Panchayati Raj Institutions, inequalities in health status that exists across districts, between ethnic and social groups, and the poor and non-poor, inadequate rural primary health care services all translates into the poor service delivery including the healthcare. Despite of this situation, there are some early signs of turnaround in Jharkhand in several respects such as the decline in poverty and the improvement in social indicators such as in health, like dramatic improvements in the coverage of child immunization, and Vitamin A and Iron supplementation, also made significant progress in reducing the prevalence of leprosy and, to a lesser extent, in the spread of communicable diseases such as tuberculosis (TB) (World Bank, 2007). With these improvements in the health indicators it can be assumed that the Government of

Jharkhand (GOJ) is aware of the challenges it is facing and seems to be committed to overcome them to improve state's outcomes.

So the study will explore the communitization process in the villages of the Jharkhand as a government initiative for addressing the problem of poorly developed health systems, by exploring and developing an understanding about the communitization model (VHSC), designed under the NRHM to achieve the good health status in the tribal dominated state (comprises of 28 percentage of the total population as per census 2001).

Organization of Chapters

Chapter 1: The first chapter is the literature review done by the researcher to understand the underlying ideas of the evolution of the concepts and contrasting them with the real situation in the contemporary framework and situations. The chapter is divided into four consecutive sections.

First Section deals with development of the Primary Health Care approach. It follows the historiography of the health services growth and development in India up to the emergence of the National Rural Health Mission that carries forward certain old legacies and adopts newly found primary health care approach.

Second Section deals with communitization, as an alternative approach and a way towards creating the shared responsibility. It follows the bringing up the essence of its embedded key ideas, their components and definitions on board for further discussions viz. Community Participation, Decentralization, and symbiotic relationship between the community participation and the decentralization, and the social mobilization approach which is taken as a tool for strengthening communitization components.

The last section deals with the understanding drawn out from the literature review by the researcher.

Chapter 2: The chapter deals with the conceptualization of the research problem and discusses the methodological approach used in the study.

Chapter 3: Approach of Communitization: Experiences of different States in India. This chapter is divided into two sections. The first section deals with the process of communitization as illustrated under NRHM and the issues that generated after the implementation. Later it is followed by the case of the communitization in the state Nagaland for analytical field mapping. The section concludes with the current scenario of the communitization process as under the NRHM in India.

Chapter 4: Communitization: A case of Village Health and Sanitation Committees (VHSC) in Jharkhand, deals with the findings emerging out from the field study done by the researcher in the State of Jharkhand in relation to the Village Health and Sanitation Committees. The findings are divided into the broad themes that emerged out from the field study. Different sections deals with the different broad themes such as community participation, decentralization, social mobilization and the outcomes of the communitization and its effects contrasting between - the Village level health institutions and health intervention process in two distinct sets of strategically and methodologically selected sample areas for the added advantage it gives for developing critical understanding. The control and non-control village samples are taken from Khunti block of Khunti district (hereby to be referred as Intervention Area) and Ghaghara block of Gumla district (hereby to be referred as Non-Intervention Area) in the state of Jharkhand.

Chapter 5: This chapter discusses on the findings through critically analyzing it and bringing out the new emerging factors or issues as a part of the research on behalf of the research

CHAPTER 1

LITERATURE REVIEW

LITERATURE REVIEW

A new approach, Primary Health Care was introduced in the first Global Health Conference of Alma-Ata in 1978, concerning the disheartening health situations in developing countries realizing the existing huge gaps between ideal or desired and actual situation of health across the third world countries. The gap was intended to abridged, basically through emphasizing on the equitable distribution of all the health resources to the people across - the world to the reach the desired destination equivocally targeted under the proclamation - of "Health For All by 2000 AD" to attain the universal goal of Primary Health Care (WHO, 1978: 17). The World Health Organization (WHO) in 1978, defined the Primary Health Care as "…essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system of which it is the central function and main focus, and part of the overall social and economic development of the community" (WHO, 1978: 3). This approach emphasizes on the active community participation and for their self-reliance so that they can be more responsible and have ownership for their own health. Lesley *et.al* (2004) & Shoutz and Hatcher (1997) said that it is based on the principles of promotion of health and disease prevention with its essential primary health care such as health education, proper nutrition, maternal and child health care, family planning, immunization, prevention and control of locally endemic diseases, a treatment of common diseases and injuries, parallel to the major goals and objectives. This clearly gives thrust on the need for the multi-sectoral or intersectoral approach to health by addressing many of the health determinants through the six major sectors such as economics, environment, agriculture/ nutrition, health care, education/communication and politics by presuming that these are all interlinked and have impact on each other, either positive or negative, and may lead on the outcome of "Health for All". Thus, primary health care through the collaboration of health professionals, community

members, and others working in multiple sectors, emphasizes health promotion, development of healthy policies and prevention of diseases.

1.1 Health Service Growth and Development in India

Prior to the primary health care approach initiatives, the country India has already witnessed many phases of growth and development of health services with their own distinctive features and peculiarities across the temporal and spatial locations. Banerji (2005) clearly outlines some major trends and features of health services through his writings. He traces historical developments to identify the first such steps taken involving community in health care service provisioning right at the time of the conception of the Community Health Workers (CHW) scheme for every 1000 of village population that was prescribed by the National health (Sokhey) sub-committee of the national planning committee of the Indian congress in the year 1940. After few years the Bhore Committee in 1946 gave a distinguished authorship around the idea of access to equitable health ensuring community involvement through its proposals and recommendations that remains unchallenged and valid even in the contemporary period. The Bhore Committee rationalized that "nobody should be denied access to health services for his inability to pay" and that the focus should be on the rural areas with the emphasis on preventive measures and training to the community itself. Though author foresighted an approach given by the committee which fell prey to the stigma of so called 'principally idealistic approach' as it was referred by his contemporary writers, it realistically touched upon the cords of basic human right and dignity issues in present third world health situations. Never-the-less inspired by Bhore committees vision since the first five year plan (in 1950s) till the seventh year plan (in 1970s) the government set for the establishment of the primary health care structures such as PHC, CHW, CHC and with the referral systems and supervisory and supportive structures arranged at all the tiers: from the grassroot locals' right up to the national level. During that period also providing the health services to the population was considered a primary responsibility of the parenting government by offering these services free of cost. Here it is very much evident that the country had well

in advance visualized the essence of the approach what has resurfaced equivocally and precisely at the Alma-Ata Declaration on Primary Health Care in 1978.

Between the decades of 80's to 90's several health reforms were brought such as adoption of Alternative approach to the Alma-Ata by promoting the Selective Primary Health Care approach in 1979 (SPHC), introducing National Health Policy in 1982, and Structural Adjustment Policies in 1990's (SAP). Unfortunately these programmatic approaches were biased with the preoccupations like targeting specific goals like family planning that lead to gross neglect of the holistic and integrated health care of an individual, on the other hand it blindly relied on the promotion of the ill-conceived techno-centric vertical program that were imposed on the poor countries like India through structural adjustment policies which encouraged massive scale privatization of the health services. The major shift that took place due to these health reforms was in the notion of the health care from 'service for all' to the 'healthcare as a commodity' (Dasgupta and Qadeer, 2005). These developments and policy decisions can be viewed as a departure from the Alma-Ata Declaration of entrusting "people's health in people's hand". It seems that an antithesis was developed and strategically orchestrated by invisible hands (possibly Eurocentric interest groups driven with market) that negated the basic premises of life and well being related philosophy concerning health care as proposed in the said declaration of 1978 and recommended by Bhore Committee in 1946. The fact can be deduced from the Structural Adjustment Policies (SAP) that left quality health care of the common people at the mercy of private actors with the state being asked to withdraw from its welfare role for its citizenry (departure of welfare state). It raised the whole range of issues like affordability and access of quality health care services for vast rural population and have-nots in the third world countries like India. In 2002 the National Health Policy came which tried to focus on involving the community into the health service with believes that services should leave to the community itself and the responsibility of the provisioning of the services must be shifted to the private sector or NGOs.

1.1.1 National Rural Health Mission a way forward to the Primary Health care

The NRHM was launched by the UPA government in 2005 as the part of the socially progressive Common Minimum Programme. Sinha (2008) in his paper asserts that the NRHM is one of the largest global programs for regenerating primary health care systems in India. A time an attempt has been made under the National Rural Health Mission to view health as a totality by considering the non-health determinants of health like education, water supply, sanitation and communication emphasizing in the mission as an important attributes along with the other important initiatives such as decentralization, intersectoral co-ordination and accountability (Pandav *et.al,* 2005). National Rural Health Mission is a strategic framework which provides details of the strategies to be adopted to achieve major goals set in the National Health Policy 2002 and thus adopted its key guidelines e.g. equity, decentralization, involving Panchayati Raj Institutions (PRI) the local bodies in owning health care managements, strengthening of primary health care institutions and suggestions for generating alternative source of financing (Taneja, 2005). NRHM also replicates the focus on the rural population as recommended by the Bhore Committee in his reports, by prioritizing rural areas to the top in the developing countries as they account for the bulk of the population and having higher incidence of poverty. Gill (2009) argues that the NRHM believes in the fact that health inequity i.e. unfair, unjust and avoidable causes of ill health can result in the breeding inequalities in the health functioning that influences the well being of individuals, social groups and national populations. According to Hota and Dobe (2005) the NRHM attempts to provide health care to the rural population, especially in the remotest and the disadvantaged groups (including women and children), by improving access, enabling community ownership and demand for services. It also seeks to strengthen public health systems for efficient services delivery for enhancing equity and accountability and promoting decentralization. The plan of action includes decentralization and district management of health programme, community participation and community's ownership in taking care of public assets.

According to the NRHM framework the program aimed to undertake 'architectural corrections' of the public health system to enable it to effectively absorb increased expenditure to provide accessible, affordable and accountable primary health care services to poor households in remote parts of rural India. The major objectives of the program is to raise public spending on health with the improvement in the community financing and risk pooling, to provide access to the primary health care services for the rural poor, with universal access for women and children, to see a consequent reduction in IMR/MMR/TFR, to prevent and control communicable and non-communicable diseases and to revitalize local health traditions. Gill (2009) and Taneja (2005) observed that the mission is not a new program but integrates various health and welfare program and converge various programs on the basis of major determinants of health in the country viz. water supply, sanitation, hygiene and nutrition and in its spirit the program do not differ from health plan goals adopted by India over the last sixty years.

1.2 Communitization: An Alternative way towards shared responsibility

To address the different developmental issues, a new concept 'Communitization' has been adopted to support the program for the better services delivery and for creating a strong institutional mechanism for ensuring community participation through forming community organizations at various levels. Communitization has been explained differently by the different researchers but keeping the core idea of community involvement at it centre. Yhome (2010) describes it as "an alternative approach in governance to improve public delivery systems at the grassroots or local level when the govt. system failed and the privatization is unviable alternative, then to invest the funds, the expertise and regulatory power of the government with the social capital of the user community"**.** Hadenius (2004) explained communitization as a person's will and ability to shoulder the responsibilities entailed by popular government. He suggests 'social capital' as an extended dimension of citizenship where the individuals are not main interest rather the relation between them are more important. He asserts that these relations leads to the feeling of the solidarity which further lead into the form of collaboration and cooperation as an effective way to exert influence and brings a positive

change in attitudes and behaviours of the community. So according to Author this could be the better way to include people not only for their own development rather to see the development of all as each of them assumes a complementary role to each other. Hadenius proposition drives us away from the individual centric focus and argues for stressing on the groups in fulfillment of the individual needs as well as to attain the overall development of the society. But in doing so he misses out the concerns of the individual or segregated disadvantaged groups of individuals who all in the name of solidarity groups gets neglected, or become scapegoat or suffer isolation especially in a society stratified on the basis of caste and creed. Where few dominant individuals or social groups take benefits of their advantageous social positioning to divert the common poor of resources through manipulating relations on which Hadenius have absolute reliance for social change and development.

According to Yhome (2010) against the conventional notion of community participation, where the government engages the community resources in development and management process, communitization process lies in transferring 'real ownership, powers and resources' to the community that are managing and utilizing the government institutions and their assets. Here the government invests itself as an active partner in the development process, assisting them in managing and utilizing the resources by building their capacity and monitor and supervise the resource utilization by the community. All of these with the belief on the principle of trust the community by delegating the responsibilities train them for empowerment and transfer the power and resources in respect to day-to-day management to the user community. It shows that government lastly look forward to the community believing that, they have the better understanding of their own problems and instead of imposing outsiders to take care of them they themselves are capable enough to visualize and act in a better way. The only support should be given is to assist them wherever required in the process of the development. Here there is an agreement with Yhome to a great extent provided one could find and illustrate 'what a true transfer of ownership' is to be called and through what process it could be achieved? He does not provide us with the indicators to suffice the fact that look

this is how the real transfer of ownership should happen. To what extent the state and its functionaries are willing to shed their power in favour of community keeping intact its authority and say in the people's life? And also preparedness of the community to take charge of their lives is the issues which he never discussed.

Leading to this Abraham (2000) explained communitization as a process of facilitating creative interaction between community and institutions. The expression has been preferred to words like 'linkage' because communitizing is the symbiotic relationship envisaged between government institutions and community. In such a relationship, one flows into the other, and it envisaged that such relations culminate in 'partnership in development', rather than that of a donor and recipient relations. Though his approach is quite expressive and admirable one has to look into other relations the same community shares with the state for e.g. is the community in consideration is socially mobilized around other agendas or in ideological conflict with the state apparatus as seen in the case of separatist movements or insurgents infested tribal belts in India. There is no indication of what differential dialogue intention level is required between the state machinery and the local people who suffer from the feeling of alienation. Under these circumstances we cannot blindly rely on what the author is saying.

Before getting into the relationship of both the components, first we have to understand the concept of community and institutions. Author has cited the definition of community given by the UN Report – "a group in face-to-face contact, bound by common values and objectives, with a basic harmony of interest and aspirations". The most important dimensions are the personal relationship and a specific locality. The face-to-face community that inhabits the village and semi-urban areas in the localities forms the vast majority of Indian population, and they are the people who ought to benefit from any process of communitizing the government initiatives. Whereas, community came together for the common purpose of the development of the society and initiate new ways to achieve their development could be understood as an institution. So, the concept of communitization is said to be underpinned by the idea of relationship between the community and the institutions. The healthy relationship lies when the institution has

trust on the community by having respect for the intrinsic value of the community with the belief that common people can make the development initiatives possible. Here the institution recognizes that it has to learn from the community or people and adopt an attitude of not imposing to them as they know their problem and also have the survival strategy. The institution accepts the sustainable development is 'endogenous' where the development of the people spring out from its own cultural roots and native genius, and avoiding impositions of the foreign model prepared by the outsiders who does not have any proximity from the concerned area and the situations of the people living around there. The relationship is also strengthened when institutions acknowledge its strength and limitations and tries to understand the community, their problem and possibilities to cross match the resources for the benefit of both the parties. The author explained that relationship sustains when institution's is above the party politics and it is demonstrated in all its words and deeds. And it acts as a catalyst to strengthen the bonds of relationship within the community to promote collective empowerment of the people, as well as between the community and institutions to promote synergistic environment for creative action. Here the institution's strategy is to educate community to get away of the oppressive structures which can hamper the development of healthy and productive relationships through including them for the greater participation in the decision making. So, the more the relationship is healthy more the communitization takes place in the institutions and it moves forward for development with the more community participation. To a great extent such explanations by UN suffice with the core idea of communitization where both the parties are at par with each other in every respect. But in practical terms the government has its own rationales that may or may not conform to the counter-rationality (logic) which the community imposes. In such precarious conditions the desired outcomes thought superficially seen is satisfactory but the relationship remains problematic hampering true course of development.

Abraham (2000) had clearly pointed out the lacuna in the concept of communitization. He rightfully pinpoints that "communitizing developmental initiatives are not a value-free concept". It is not a mere package of strategies and methods for producing a set of socio-

economic benefits. He explained it as a matter of relationship; it is a matter of reaching out from the centre to the periphery, from the position of advantage to positions of disadvantage and want. It involves organizing the people into self-help groups or co-operatives or committees, strengthening the bonds among themselves. Promoting participation and empowerment through people's organization become important instrumental goals in the process.

Sandham (2009) argued that in communitization the kind of decentralization and delegation has been attempted to be attained through empowerment with the belief that the sense of responsibility will come that will enable release of creative forces which are latent in the community. He said that the success is possible, because of the abundance of social capital available with the community which sought to be invested by way of communitization. Once the community owns, the government institutions set up for them, the functioning of such institutions is bound to improve. Thus, it can be said that the communitization approach itself can ensure by the community participation and decentralizing the powers to enhance it. This could leads to the success of the any institutions and ultimately towards its prime objective.

1.2.1 An Essence of Successful Approach: Community Participation

The NRHM also re-emphasizes on the due importance given to community participation as one of the important pillar of the comprehensive health care programme. The Alma-Ata Conference emphasized on the community participation and ultimate self-reliance with individuals, families and communities assuming them to take more responsibility for their own health to help achieve the primary health care to all (Welschhoff, 2006). Community participation in health believes in the basic premise that the people themselves play an important part, both in the identification of the problems and finding appropriate and cost-effective solution to them. Community participation being an inevitable and uncompromised agenda needs to be further discussed. Different authors tried to define community participation through different approaches. DeKadt (1982) says that the concept is derived from the concept of community development and

conscientisation. The basic assumption behind the community development is the consensus on needs and aspiration in the communities. Another approach of community involvement is through conscientisation- a concept described by Friere (1967) as the organization and mobilization of the masses so that consciousness could be translated into a change. Both approaches indicate towards the greater involvement of the community by getting freedom to choose their own way to achieve 'health for all'.

Rikfin (1996); Morgan (2001); Welschhoff (2006) tried to define it with the two models namely 'utilitarian model' which talks about an efforts on the part of donors or governments to use local resources (land, labour and money) to offset the cost of services provision more efficiently, effectively or cheaply by collaborating people voluntarily or as a result of some persuasions or incentives in return of some expected resources. It is also known as target-oriented frame of reference or termed as 'top-down approach' where planners decide the objectives and then try to convince people to accept them. This utilitarian approach subsumed the idea of manufacturing consent at the bottom around policy decisions taken at the top. Another is the empowerment model also known as 'Bottom-up approach' which beliefs in enabling the community through giving education or information and through involving and experiencing them which further leads to gaining access and control of health care resources. Different participatory methods are used as a tool through which people could be facilitated to take responsibility for diagnosing and working on their own health and developmental problems.

At the conference to promote primary health care the community participation was given a special focus with due emphasis and acknowledgement of the fact - that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care"(WHO, 1978: 23). The recommendations that came from the conference to ensure - community participation was through emphasizing on the effective propagation of relevant information summing up with the increased literacy and most importantly the development of the necessary institutional arrangements giving space to the individuals, families and communities so that they could assume responsibility for their health and well being. The WHO report on Primary Health Care

(1978) clearly states that community is the essence of any developmental interventions as they are the development seekers and for sustenance of any program and when initiatives are taken by the developmental task happens to become a huge success.

The central idea of the participation is the initiative should be taken by the community themselves. The community consists of people living together in some form of social organization and cohesion, with the varying degrees of political, economic, social and cultural characteristics and powers, as well as interests and aspirations, which includes health. Apart from these, they also vary widely spread in the size and socio-economic profile, ranging from clusters of isolated homesteads to more organized villages, towns, city and districts. Recognizing these factors in ensuring participation is helpful in assuring full participation of the community. And community participation is the process that develops the capacity into them to contribute in their community development, helps in knowing their situations in a better way and gives motivation to solve their common problems. It also enables them to become agents of their own development instead of passive beneficiary of the development aid. Here the government is expected to play the role of the facilitators when community is willing to learn by explaining and advising for the clear information about the favorable and adverse consequences of the proposed interventions as well as the relative cost to be anchored by the community. Various committees recommended community participation in the planning implementations since different time period. The Bhore committee (1946) has recommended inclusion of community through the formation of health committees at village level. Community participation in the development literature has become an important issue since the early 1970s and from 1980s and it is perceived almost as a mandatory feature in most of the programmes for their success. And it is viewed as a vital or an important device to enhance the effectiveness of any programme (Manikutty, 1998). On the line of these thoughts different such initiatives were taken by including community's participation element in various programmes like Integrated Child Development Scheme (ICDS, 1975) and Community Health Volunteer Scheme (CHVs, 1977) in which volunteers were

selected from the community to serve their village for the improvement of their health status and service delivery systems (Welschhoff, 2006).

Manikutty (1998) asserts that the community participation in the development process is viewed as a vehicle for decentralization, capacity building and empowerment of the people at the grassroot level. With the increased beneficiary commitment that happens through achieving empowerment consequently improves the sustainability gradient of any program. It further serves as a vehicle for achieving positive outcomes of the other projects or programs due to the capacity building done at the grassroot level. And lastly it provides an effective learning mechanism for the better program design and planning in future. Another essential pillar of communitization i.e. Decentralization is conceived as an essential component for the success of any such developmental initiatives.

1.2.2 An Essence of Successful Approach: Decentralization

The National Health Policy of India that came in the year 1983 was introduced during the period when the greater emphasis was being given on the community based health systems. It emphasized on a preventive, promotive and rehabilitative primary health care approach with the decentralized system of health care. The key features of this were low cost, use of volunteers and paramedics, and ensuring community participation to achieve the universal, comprehensive primary health care services relevant to the actual needs and priorities of the community at an affordable cost (Duggal, 2005). Before moving further, it is necessary to understand evolution of concept of decentralization and its needs in the provisioning of the health service systems.

Decentralization: A Historical Perspective

Decentralization of health care was one of the recommended features the Bhore Committee in 1946. All the five year plans have given impetus to decentralizing of health care using the Panchayats Raj Institutions (PRI) for community participation. India moved from a decentralized village based governing entity to centralized colony under British Raj. After Independence, Indian Government established Panchayats Raj

Institutions under the 73rd and 74th Amendments Acts of the constitutions to give power to the local people in the villages. Health sector decentralization has become appealing to many because of its several advantages like unified health services which caters to local preferences, improved implementation of health programmes, minimize inequalities between urban and rural areas, cost effectiveness due to streamlined and targeted programs, involvement and financing of local communities, integration of public and private activities, and promoting intersectoral coordination and coordination particularly between local govt. and civic bodies for development activities (Shah,1998).

The health system in India is centralized at the central level where the central government is responsible for the health policy and planning for the country. However, the state government has been given autonomy for the first time in the 1919 under the Montague Chelmsford reforms (Shah, 1998). Since then each state has its own health care delivery policy. The structure of decentralization in the India is like principle unit of administration is the district under the Collector, which has further divisions; the lowest level is being the Panchayats at the village level. Despite of these defined units it was found that, each of the departments is functioning in the alienation. And there was neglect and inadequate emphasis of public health principles and planning in tackling the determinants of health particularly nutrition, water supply, housing, literacy and poverty alleviation. Here each of these departments was functioning in isolation culminating in wastage of resources and overlapping schemes meant for attaining the same goal. Twenty-nine sub sectors and eighteen departments running at the district level often used the funds in haphazard manner without an integrated scheme of planning giving out low results. Thus the success of health intervention that logically depends on intervention in other sub-sectors (e.g. drinking water and sanitation, primary school education, sub-sectorial intervention in livelihood for income generations etc., which were otherwise interdependent) lost its vigour. During that phase there was an inadequacy in the preparation to empower Panchayati Raj Institutions (PRI) to ensure community participation in the health decision making at the community level and cumulative result of it was overall failure. The health intervention had fallen prey to lack of political will

expressed through poor planning and policy framework. Author cited that to address these problems the National Health Policy 1983 was formulated identifying a major cultural gap between the aspirations of people and their culture, personal aspirations, attitudes and work ethic of health care systems where health professionals were insensitive and ignorant to the people and were in need of experience and knowledge through capacity building.

Decentralization: An Approach

Different researchers defined and explained decentralization differently. Decentralization has been explained by Mills *et.al*. (1990***)*** by comparing decentralization and centralization with a movement between two poles and stressed upon the essentiality of both the elements in any health system. Mills *et.al* (1990); Venkatesan (2002); Welschhoff (2006); Duggal (2005) sees it as an important theme for the health systems which works by transferring the authority or dispersal of power in the public management and decision making from the national level to the sub-national level to achieve the universal, comprehensive primary health care services at an affordable cost. Leading to the similar thought of line Agrawal and Ribot (1999) defined it as any act in which a central government formally delivers the powers to the actors and institutions at the lower level in a political administrative and territorial hierarchy. In this process government completely deprive it from certain duties and responsibilities and devolve them to some other authorities like PRI, and reserving its role only for the functions of providing guidance, supervision and higher level planning (ibid). It is a mechanism to disperse power, to ensure stability, to bring representative government closer to citizens, and to improve the accountability and responsiveness of local leaders (Shah, 1998). Author further illuminates that it has been undertaken because of the dissatisfaction with the efficiency of centrally provided public services. According to Smith (1997) it is widely accepted in the government health service provision to sub-national levels the necessity to produce an optimum combination of top-down and bottom-up planning. Mills *et.al.* (1990) explained that decentralization policies are concerned with changing power relationship between levels of government. They also put forward the ways of visualizing

the decentralization into two levels. The first one is on the 'philosophical and ideological level' in which it has been seen as an important political ideal providing the means of community participation and local self-reliance, and ensuring the accountability of government officials to the population. The second is on the 'Pragmatic level' in which this is seen as a way of overcoming institutional, physical and administrative constraints on development with the assumptions that with an increase of local control the results can better response to the local needs, improved management of supplies and logistics and generating greater motivations among the local officers and thus ultimately facilitating and speeding up the implementation of the development initiatives or any programs.

Decentralization depends upon the nature of the functions that are decentralized. Accordingly there are different types of decentralization and explained by the different authors differently.

The 'Deconcentration' or Administrative decentralization in which the powers and the responsibility for planning, financing, and managing certain public functions are devolved to the appointees of the central government, sub-ordinates units or levels of government, semi-autonomous public authorities or corporations, or area wide, regional, or functional authorities (Agrawal and Ribot, 1999). According to Mills *et.al.* (1990) the local administration set up under deconcentration can be of two different types namely the 'vertical' pattern of local administration where the local staff of each ministry is responsible to their own ministry. The other one is the 'integrated' form called to be an extreme version, a local representatives of central government accountable to the central agencies such as ministry of the interior or a ministry of local government, is made responsible for the performance of all government functions of his/her area. This form of decentralization is being set up in developing countries, such as in India where the District Collector is responsible for the overall functions of their respective area and accountable to the central government.

Hutchinson and Fond (2004), Mills *et.al.* (1990) explained the other types of decentralization. The 'Devolution' provides greater autonomy to decentralized bodies and

involves the transfer of responsibilities from the central government to lower levels of government which is empowered by the statutory or constitutional provisions. Here they have the clear legal status, recognized geographical boundaries, and a number of functions to perform, and statutory authority to raise revenue and make expenditures. The type of responsibilities devolved and the level of autonomy granted to the local authorities are broadly categorized into the political, administrative and the fiscal decentralization. Agrawal and Ribot (2004), Hutchinson and Fond (2004), Mills *et.al.* (1990) explained the political decentralization of devolution that the power in this case are devolved to actors or institutions that are accountable to the population in their jurisdiction. With presumptions that the decision made with the greater participation will be better informed and more relevant to diverse interests in society than those made only by the political authorities. Its success generally depends upon the key components, including constitutional or statutory reforms, pluralistic political parties, strengthening of legislatures, and local political units. Absence of some of these can lead to capture of the electoral system by local elites, who might pursue policies and actions favoring to themselves and the members of their preferred groups. 'Fiscal' decentralization of devolution refers to the local government control over financial resources, either in terms of expenditure assignments or revenue generation.

'Delegation' involves the transfer of responsibilities from central agencies to the semi-autonomous entities operating independently or semi-independently from the government. Here government may see delegation as a way of avoiding the inefficiency of direct government management, of increasing cost control, and setting up an organization that is responsive and flexible. The ultimate responsibility remains with the government but its agent has broad discretion to carry out its specified functions and duties (ibid).

The forth type is 'privatization' where the responsibilities are transferred from the government to the private entities. Under this the responsibilities even devolved to service providers themselves, as has been evidenced in some efforts to separate the financing of service provision from the actual service provision. Alternative forums of

privatization might also include contracting out non-essential services. Many developing countries government have long depended on voluntary organization for the provision of health services. And despite of many suggestions regarding the alternative source of financing as a solution of it, privatization does not remove from the government's all burden of health management. But as a solution it requires a strong regulatory authority to monitor the supply and quality of both health services and supply industries such as pharmaceuticals, and to ensure the coordination of services on a geographical basis. So among all these the most important type very much in use is 'devolution' which involves elected local government signifies local autonomy (ibid).

As explained by Welschhoff (2006) that such inter-governmental transfer of powers and responsibilities known as 'devolution' is the conventional concept of decentralization in public administration. She also explains Panchayati Raj Institution (PRI) as a devolved local body having three-tier structure which depends upon the states that transfer the power and authority. Baru and Gopal (2006) admit that many debates took place during this period to decentralize health services through Panchayati Raj Institutions (PRI). The primary motivation behind this was to reduce the fiscal burden on the state and also to make them more responsive to the needs of the community. As a pilot step the health services have been brought under the control of panchayats in very few states. Authors add that the concept of decentralization is applied in selective primary health care approach that introduces a new perspective that meant to be a package of low-cost technical interventions to tackle the main disease problems of the developing countries by involving different local institutions and community in different health programs to help achieve the underserved community to the proper health care.

Hutchinson and Fond (2004) citing the advantage of the health sector decentralization asserts that it helped in promoting greater political stability and local government responsiveness through larger democratization and good governance. It also attempts to remove inefficient levels of bureaucracy, allowing for local government for decision making that is both faster and more appropriate for the local circumstances. And also for the economic rationales which may permits efficiency gains by reducing the costs i.e. by

removing the diseconomies of scale assuming that the local health officials may have greater knowledge of local health situation, to the central government coordinating activities across large population or geographic areas. Agrawal and Ribot (1999) said that this is the process which has been frequently imposed upon a country's health sector by political and social forces which aims at increasing democratization, political stability and community participation.

Decentralization Approach: A Need

Developing countries face a variety of obstructions in addressing their many health problems and most common among them are extremely limited and often inequitably distributed resources, shortage of institutional infrastructural and/ or human capacity, inadequate accountability mechanism, absence of risk pooling, inefficient and wasteful service delivery, inequitable access to care and often poorly designed public health to respond to the need of the population (Hutchinson and Fond, 2004). World Bank argued for the decentralization strategy of government service system to be considered as one possible way to improve efficiency in countries like India where managerial resources are scarce, communication is difficult, transportation is slow and many people are isolated (Shah, 1998). These obstacles stake the health and utilization of health care for developing countries population, in greater extent to the certain population sub-group of the poor, women, children and members of historically disadvantaged cultures (Hutchinson and Fond, 2004). Shah (1998) cited that the other rationale behind accepting and adopting this health reform strategy was the inefficiency in coordinating disparate activities from a central location, particularly in geographically larger or more heavily populated countries. The author asserts that the centralized system probably requires additional levels of bureaucracy and management, led to diseconomies of scale and longer decision-making times.

1.2.3 Community Participation and Decentralization: A Symbiosis

Community participation shares a symbiotic relationship with the decentralization. In order to decentralize the local government participation is necessary to respond to local

needs and information flow between citizens and the local government and state exist inevitably (Shah, 1998). Author said that decentralization could be a 'means' or an 'end' for the successful decentralization process. The community participation is a pre-condition for broad decision-making and decentralizing. However, lack of participatory mechanisms could not evolve decentralization which potentially could create responsiveness and demand. He asserts that the participatory processes can generate a learning action and innovation wherein the community takes ownership to achieve a common goal. Hence, the community behavior changes to make their priorities work in a good and efficient manner. The greater participation and ownership helps the stakeholders to remain committed to the program or projects that run into difficulties.

Thus, decentralization and people's participation have been considered key strategies for making health care services effective and this has been repeatedly said in all significant documents articulating people's rights to health with their involvement such as the Alma Ata declaration, the Bhore Committee Report and most recently, the documents pertaining to the National Rural Health Mission (Public Health Resource Network, 2008: 8). The main thrust is on establishing a fully functional, community owned, decentralized health delivery system, with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition and social and gender equality. Ownership and control is an important element for maintaining the effectiveness and quality of services and it can only truly be brought about by their participation and control over all processes leading to the delivery of services, starting from the planning itself (ibid). So the supporting mechanism that has been emerged out to ensure the community participation and decentralization was the idea of social mobilization.

1.2.4 Social Mobilization: A tool for strengthening the communitized components

In the decades of 90's the focus was shifted to the social mobilization as a core strategy to fulfill the immediate needs of the people. As the primary health care approach endorse community participation, the selective primary health care pushes social mobilization of

communities for technology adoption and dissemination (Chen, 1988). Social mobilization is defined as "a process of bringing people together to pursue a common interest among them by creating a sense of unity, ownership and self-control. It is also driving force for the people to overcome their differences to begin dialogues on an equal basis to determine issues that affects their community" (USAID, 2003: 17). It is a process of bringing all feasible and practical intersectoral allies i.e. decision and policy makers, opinion leaders, NGOs, media, private sector, communities and individuals to raise awareness and demand for a particular program, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance (Kim, 2006).

Many programs have used social mobilization as a strategy to achieve their goals such as the Annual Report on Lymphatic Filariasis (2002) also acknowledges that social mobilization plays a central and critical role in the Global Programme to Eliminate Lymphatic Filariasis (GPELF); it is a planned process vital to political advocacy, generate national resources and stimulate local public and private partnership in order to obtain specific changes in the behavior (healthy behavior at all levels – in home, neighborhood, community) the elimination programme seeks to achieve. The best example of the collaboration of the institutions for certain programme objective achievement according to Obregon and Waisbord (2010) is the Polio Eradication Initiatives (PEI) bringing together , National Immunization Programme, National UNICEF offices, Rotary Club, Red Cross and Various donors funded contractors. It reaches in the area where heath services are weak. Mobilization of the volunteers and health workers contributed resource intern of labour or cash and to address the cases of local needs and the reaction, both the acceptance and rejection, of the programs. They discussed the two distinct perspective of the social mobilization, the first one is 'activist' approach which views community participation and local empowerment when - community discuss needs and objectives, decide intervention and are engaged in the implementation of programs. It offers the 'bottom-up' understanding where community expresses their need for demands and accordingly defines the goals and decisions to

reduce disparities. It is all about communities gaining control over their lives and planning and implementing strategies for collective action. Another perspective is 'pragmatic approach' which views to strengthen health services and achieve critical goals by involvement and actions of community mobilizers, professional associations and political and religious leaders. Here it is not necessary to consider local empowerment as the core element of the social mobilization. It adds significant human and monetary resources to accomplish program goals. Pragmatic perspective of social mobilization is concerned with providing response to the immediate needs of the communities and the population groups by empowering them by the catalysts. This view is the means to reach an end more efficiently for e.g. in Polio Eradication Program education and staffing immunization teams to deliver vaccines helped in drastic reduction of the surveillance of the disease. Thus, Social mobilization could be a catalyst for the communitizing process to make people act upon their efficiency and capability which otherwise is unrealized and are latent.

Summing up the idea that have been developed by reviewing the literature is that the primary health care approach was introduced to address the health problems of the developing countries for more equitable, affordable and accessible healthcare for all the citizens of the country. This was done with the joint collaboration and participation of all the developing countries joining at a big forum of global health conference held at the Alma-Ata in 1978. It was the pioneer initiative which was later influenced many other health initiatives of the country to involve community in their health planning. This approach gives emphasis on the community participation where community themselves identify their health needs and plan and demand accordingly.

Based on the same line of thought in 2005 the National Rural Health Mission (NRHM) was introduced by the Indian government. The NRHM has tried to incorporate the basic goal of the primary health care approach by bringing up with a package of strategies helping in ensuring people's participation in the grassroot level. For achieving the mission has integrated the new concept of communitization in the health system. The concept incorporates decentralization and the community participation by using social

mobilization as a tool for awaking the urge for their own development latent in the community. The literature helps to find out the definitions and underlying connotations of these essential components of communitization concepts. The essentiality of the community participation was recognized by many researchers for achieving the main goal and success of the development interventions. Among the two ways of the community participation namely the utilitarian model of top-down approach and another is bottom-up approach. To relate it to the ground reality the bottom-up approach of the community participation is required for the country like India that can brings the real participation to achieve the sustainability of any developmental initiatives. In the country people are struggling for their basic necessities such as proper housing, education, food and health so while doing all this they hardly focusing on uniting for the common cause and thus top-down approach may not be able to ensure the sustainable development as it is based on the manufactured consent despite of sensitizing and motivating them for their own development. Here the government's prime responsibility is to take care of their citizen by ensuring their needs through involving them in their development plans, by imparting educations and enhancing their capability so that they can gain access and control over their health care resources with their own rationales. For this the government has adopted the approach of decentralization where they partially divest them with some of their responsibilities especially the management and planning part and basically plays the role of the facilitators and supports for achieving this.

All the literatures talks about the ways of decentralization and hardly came up with the idea that in what extent the decentralization has been able to bring community participation in the ground reality. Many literatures put forward the reality that though the government has decentralized the power to the local bodies at the grassroots level but still it is very less visible in the general practices. The authorities are not interested in giving their power to the local people and thus the community withdraw themselves by losing their faith in such concepts as it does not seems as a reality to them. And ultimately, decay the basic idea of the concepts of decentralization at the ground level. The devolution a type of decentralization was not gained much in our country because of the

fiscal, administrative and political devolution is in lackadaisical in the ground practices. Though it should be devolved in real manner but it seems as deconcentration at the local level by controlling the local bodies and their decisions. And raising the environment where the accountability is much more towards the government instead of the community. In such case it is very difficult to ensure the real participation of the local people without the proper decentralization as both carries symbiotic relationships with each other. It has been found that the concept of social mobilization is used as a driving force for the success of any such developmental initiatives by enhancing knowledge of the community in a particular area of work in which they have to intervene. But what if other such linked components equally important for the development as a whole is ignored for e.g. the education, knowledge regarding government entitlements, livelihoods. So instead of mobilizing community for the single purpose that can leads to the wastage of time and money, it would be better if community is mobilized for the whole development process keeping in mind that development cannot be achieved in isolations. The contribution of the target-oriented 'pragmatic approach' through involving and actions of community mobilizers cannot be denied but this approach is leaving behind another perspective of social mobilization 'activist approach' where community themselves express their needs and demands instead of the government who probe community to uptake their planning and act upon them as per their requirements. The pragmatic approach is good for achieving the targets but for the sustainability of the developmental initiatives it is very hard to assure it for the long period.

Many researchers came up with an explanation of the concept of communitization that it could be achieved by decentralizing the power and resources with enhanced community participation at the local level. Here government is keen interested in devolving their power with the belief that community ownership will enhance the better functioning of the health institutions set them and it will be cost-effective and much need based planning grounded by the people themselves. Though communitization is seems to be very attractive approach to reach the health of every citizen of the country but in the whole literature review it is very hard to find the actual process of communitization and it extent

which is underlying some apprehensions that is it going to be helpful in the country such as India where there is lots of inequalities in terms of caste, class, gender, geography hindering the equal accessibility of the services including health provided by the government. So the doubts is whether the concept of communitization is only used as a strategic tools or a package to achieve the primary health care focusing on the health related interventions without giving much concern to the factors such as power practices in the other local level institutions by the community. Here the relationship between the community and the government is to be as a development partners instead of donors and seekers. But at what base it can be fulfilled because the extent and the decentralization are not ensured at the local levels. Real communitization can be achieved only by the people's real ownership on the resources and assets set up by the government and it is possible only when the community is trusted by them with a great extent. So the trust is the main ingredient of the communitization process to develop a healthy relationships between the community (represented in a form of institutions where people come together for the common goal and interests) and the government institutions (that have set up by them for providing better facilities and ensuring entitlements to each of its citizenries). Apart from the government's position the trust by the side of community for the government is equally important in the communitization process. If there is lack of trust by the community for their existing government or other factors that make them to disbeliefs on them then it is very hard to reach out to the relationships that are call to be the healthy partners. And later it looks like any other initiatives taken by the government for its citizen decided by them from the central. This can raise the question of sustainability of the development and negates an idea of 'people's health in the people's hand' in a right manner concerning community's own perspective instead of the donors or givers perspective which generally end up with the absorption of their initiatives without ensuring its sustainability at the ground level.

Systematically going through the vast literary work do not helped to figure it out to what extent the government or the state enjoys authority over the life of its citizenry and at the first place why should it be interested to surrender its authoritarian stance so as to come

on the dialogue level of the rural community to achieve specific development goals. This aspect is pertinent to be discussed as the concept of communitization remains a quite recent conceptualization. State theories suggest that it always prefers assuming more power than its common citizenry and this is how the modern state functions. Another fact of discussions that still remains unanswered is that to what extent the state can hijack the all spheres of day to day life of its citizenries? Is the state actor acts as a value free entity? For example at one place state is not keen to acknowledge the local self-governing village institutions in schedule V areas and at the other proclaims its reliance of communitization of health institutions and services then it sounds double standards. Where traditional forest rights are infringed in tribal areas how come the government expect that the community will take full ownership in management of forest resources through joint forest committees at villages levels? What repercussions these advantageous positioning of the state over the life of the people bears on the true process of communitization around specific developmental intervention areas and not the other spheres of normal national life? The researcher would like to explore these critical aspects that remain implicit in overall discussions around communitization generated through contributions of these writers.

Moving further with this understanding gained out from reviewing the literatures can be summed up with that communitization in the implementation level is an attractive approach despite of some ambiguities which can helps in ensuring the developmental process especially the health initiatives by involving the community for taking care of the health institutions set up for them by indulgence in the management and utilization, and with the government's facilitations in building their capacity for up taking such actions with full confidence to reach health for all the people. So, here the reviewer bothers to find out the answers that what does real communitization means and what is the process of achieving it, and how does government see this approach and practice it in the ground reality. And so the inclination is towards studying the communitization model- VHSC that has been introduced under the NRHM as their core strategy for involving the village

level committees for ensuring the participation of the grassroots level units in the planning and implementation process of the people's health by them.

CHAPTER 2

Methodology

Methodology

The chapter divided into two sections. The first section discusses the research problem and second section followed by the research methodology of the study.

2.1 Conceptualization Framework

The Primary Health Care Approach is for addressing the health problems of the developing countries like India where the health status of its people is very poor. This approach has concern for the poor people who don't have the accessibility and affordability to the health care services. The major contributing factors to this that have been identified were the inequity that is existed within the society such as within the community, among the people and the geography. The rural areas and its people are seen as more disadvantaged group in terms of having good health care services as it hardly or improperly reached out to them. The main factors that are taking the rural areas and the poor people away from the better health care was because of the model that is techno-centric, expensive and mostly the urban based health care system. So the approach came into existence for ensuring universal accessibility of the better health care to every individuals and the community through making it more responsive by practical, scientifically sound and socially acceptable methods and technology. Thus the approach has basic thrust upon the full community participation and the reasonable cost that community can afford and for ensuring this the approach emphasizes on giving people the responsibility of their health in their hands with the spirit of self-reliance and self-determination.

The moment health responsibility came into the hands of the people the components such as community participation becomes pivotal. And in ensuring this the governance system was approached by devolving them the powers to get the full involvement of the local people in the managements starting from the planning to its implementation. The local governance system creates a space for addressing the local health issues by involving and ensuring every individuals and the families concerns and needs. This ultimately enhances their participation and results in the fulfillment of people's health needs by the people

themselves. The whole idea was conceptualized as the new approach known to be the 'communitization approach' in which government trust the community and allow them to participate in their health developments. They believe that people value health more and the returns are immediate and the sufferings are intense so they will keen to participate in the process of improving the quality of services and accountability through the political control such as with the local governance. In the communitization process community is seen as partners with the government where they handle the management parts of the health institutions and resources setup for their use and the government looks after the skill development part for enhancing their knowledge and confidence in taking care of these institutions.

This concept was not new in our country. Since the Bhore committee's recommendation of 1946, it has been suggested to involve communities in the healthcare services. Many initiatives such as CHW, VHW schemes has been introduced in 1970s and 80s but seen to be the major failure and being vulnerable because they were not seems to be firmly embedded in the communities themselves due to the lack of ownership and not driven by the community. So the greater urge for ensuring the community participation risen and it was integrated in the health care delivery system by institutionalizing and mainstreaming it for the managements and community financing to sustain the local resources as a necessity for the country where the people are poor and the environment is not so conducive for the easy accessibility of the health care services. This ultimately pointed towards the need of the political leadership, substantial and consistent financial, technical and material support.

The NRHM came into existence with the same line of thoughts and adopted the same approach for ensuring the primary healthcare for all the citizens of the country. The Mission adopted the communitization approach as per the demand of the situation by advocating the institutionalization of local health committees by giving them resources and powers for its management and utilization. VHSC is seen as an important tool for the communitization process under NRHM. It has the potential to ensure the community participation in the health planning and could increase the health demands from the

community itself. Though there are many other components under NRHM that have been used for the communitization process such as ASHA's, RKS but the VHSCs are seen to be the most important component in terms of ensuring participation straight from the grassroots level. It is capable of achieving the health goals through the collective efforts that underlying with the social capital and bonding within it, with the involvement and by representation from all the sections of the community. There is no apprehension that the collective efforts can help in making the development journey much smoother by ensuring and providing platform for the communities to address their issues and grievances related to health and other health related activities and enhance the accountability and control for better quality of health services. By undertaking this architectural correction in the health system the mission intends to ensure the better delivery of healthcare services through increased community ownership, decentralization of the programmes to the local level, inter-sectoral convergence and improved primary health care. It can be possible only if they are given much space for decision making that increases ownerships for the resources leading to the full participation, and enhancement of their skills through capacity building on a regular basis. After reviewing the related literatures concord with the idea that the VHSC an important model for the communitization to enhance people's participation and accountability at the grassroots level healthcare services.

So the study is keen to look upon the communitization process through the VHSCs in the newly formed state of Jharkhand with adverse initial conditions with low average income, high incidence of poverty and little social development. At the situation where the state is at its primordial stage of development initiatives, already with the existence of the local governance system recently replaced by the PRIs as a forum to discuss the developmental issues that are subsist, the study will try to look upon how VHSC will help in revamping the value of the health system in the Jharkhand.

2.2 Research Methodology

Moving further with the conceptualization of the research problem the questions that arises was became the researcher research question to get into the depth of the problem and bring up the issues behind helping in developing in real understanding of it.

2.2.1 Research Questions

1) How does NRHM visualize communitization – what approach does it follow?
2) What is the design of the communitization Model?
3) What are the outcomes of communitization within the NRHM?

2.2.2 Objectives of the Study

To explore the process of communitization within the VHSCs under the NRHM through analysis of its conceptualization, implementation and community involvement.

Specific Objectives

1) To review the various approaches of communitization in Health.
2) To critically examine the designs of communitization model – Village Health and Sanitation Committee (VHSC).
3) To contrast the outcomes of communitization in the intervention and non-intervention areas of two districts of Jharkhand.

For the purpose of understanding the implementation of the VHSC at the village level and explore its functioning, coordination with the stakeholders such as ANM, AWW and Animators and the outcomes of their functions.

2.3 The Study Area

2.3.1 Selection of the State

The field study was carried out in the state of Jharkhand due to its newly formed status and the Economic Empowered Groups (EAG) state where the developmental initiatives are in its primordial stage. Fieldwork was conducted in the two districts of the state based on the intervention where the NGO is intervening and the non-intervention area where there is only the government's interposition.

2.3.2 Selection of the District

The Gumla District was selected purposively as the non-intervention area where there is no other developmental agency apart from the government present those working for the development of the VHSC. This was one of the oldest districts of the state which was established in 1984 (Singh, 2006: 334) and already having an established health delivery health services system. This was also purposively selected because of the researcher's convenience of familiarity with the local dialects and the availability of transportation and accommodation facility which helps in carrying out the research in good manner.

The Khunti District was selected as the Intervention area for the study because of the NGO implementations. Though the NGO was intervening in both the Khunti and the Gumla district but the district was chosen purposively by the researcher according to her convenience with respect to the transportation and accommodation facility and also because of the familiarity with the local dialects. The district is a newly formed district in the year 2007 after the formation of the state. The district was on its primeval stage establishing its health institutions and systems. So the researcher also chose it for having a clear understanding the effects of the NGO intervention in the newly formed district without government prior inputs for the VHSC developments.

2.3.3 Selection of the Block

The Ghaghra Block of the Gumla district and the Khunti Block of the Khunti district was selected purposively by the researcher as per the convenience of the transportation and accommodation facility and the familiarity of the dialect.

2.3.4 Selection of the Villages

The four villages of the Ghaghra block of the Gumla District (non-intervention area) were selected on the basis of the distance from the Block PHC/CHC. The four villages namely Salgi village of Adar Panchayat within the distance of 18 Km, Sirkoat village of Puto Panchayat within 8 Km, Sarango village of Sarango Panchayat within 12 Km and the Ranhe village of Kugaon Panchayat within the distance of 3 km belongs were selected by the researcher.

Another four villages of the Khunti block of the Khunti District (Intervention area) were selected on the basis of the NGO intervention villages. The villages namely Fudi village of Fudi Panchayat, Kalamati village of Kalamati Panchayat, Manhu village of Siladone Panchayat and Chikor village of Hesahatu Panchayat were selected.

2.4 Area Profiling

2.4.1 State Profile

Jharkhand is a newly formed state created as 28th state of the Indian Union by the Bihar Re-Organization Act on 15th of November 2000. It shares it borders with Bihar on North, Orissa on South, Uttar Pradesh and Chhattisgarh on the West and West Bengal on the East. The State covers 79.714 Sq Km[1] (Census 2011). According to the census 2011the total population of the state is 3.29 (in crore) and this accounts for 2.72 percentage of the total population of the country. The state has the sizeable population of 0.70 crore constituting about 26.3 percent of the Scheduled Caste is 0.31 crores (Census 2001).

[1] According to the census 2011 the total area is 2.42 percent of the total geographical area of the country.

At the time of formation the administrative set-up of the state had 18 districts and later six districts were carved out by reorganizing these districts. Presently 24 districts of Jharkhand are grouped in Five Divisions viz. South Chotanagpur Division, North Chotanagpur Division, Palamu Division, Santhal Pargana Division and Kolhan Division. Both Gumla and Khunti Districts come under the South Chotanagpur Division (http://jharkhand.gov.in/new_depts/pland/Jharkhand%20Overview.pdf; Accessed on Sep 13, 2011). According to the RHS 2010 as cited in the 5th CRM report the state has 37 Sub-divisions, 251 Development Blocks comprising of 4, 423 Panchayats, 32, 615 villages, 149 towns, 3 corporations and about 37 Parshads or Nagar Panchayats.

The Baseline of the health system i.e. the health institutions in the state are 21 District Hospitals (DH), 188 CHC (Block PHC), 6 Sub-District Hospitals, 330 PHC (Additional PHC) and 3985 Sub-Centres. It serves a much higher number of populations as compared to the norms that has been set up (MoHFW, 5TH CRM Report Jharkhand -2011; pp-13).

2.4.2 District Profile

a) Gumla District

b) Khunti District

a) Gumla District Profile

The Gumla district came into existence on 18th May 1984. It was a large district and it consisted of 18 districts in erstwhile Bihar. But soon after the separation and the creation of the new state Jharkhand the district was divided into two parts in 2001 viz. Gumla and Simdega. At present the district has only one Sub-Division and eleven administrative blocks. The district lies between 22° 35” to 23° 33” north latitude and 84° 40” to 85° 1” east longitude (Singh, 2006; pp- 333-334).

Map: 1; Sources: www.mapsofindia.com; 2009.

The total geographical area of the district is 5320.94 Sq Km. The total population of the Gumla district is 1,025,656 comprises of 514,730 male population and 510,926 of female population. The total rural population is 93.57 percent and the urban population id 6.43 percent (Census 2011) depicting that it is predominantly a rural district.

The district institutional set up comprises of the 90 clusters of Sahiyyas with the total number of 1622 Sahiyyas. The total number of the Health Sub-centres in the district is about 242 and the total number of Anganwadi Centre i.e. 1670. There are around 944

revenue villages in the district and about 943 VHSCs has been formed as almost in every village. The total number of Panchayat in the district is 159.

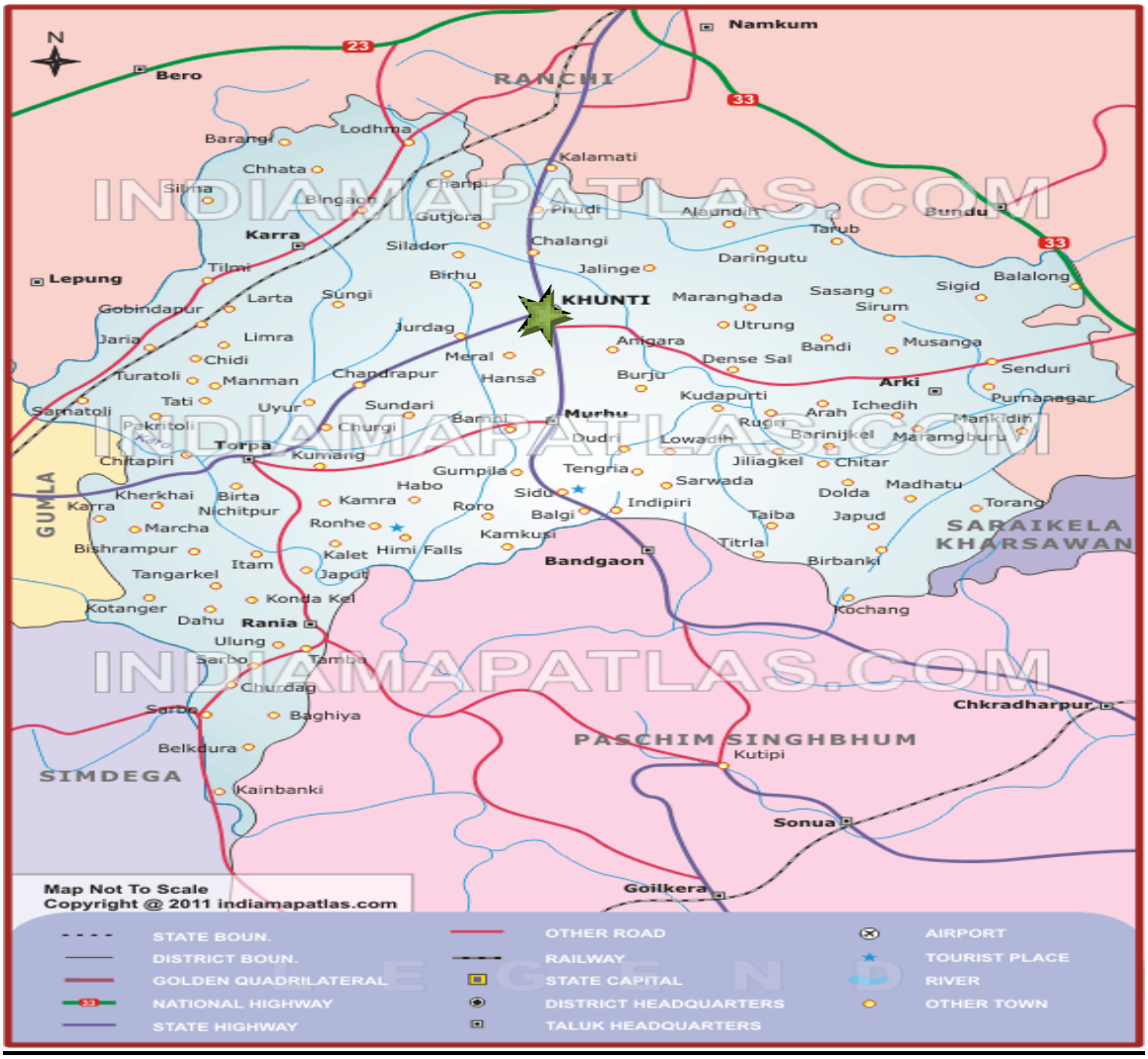
The district has a variation amongst its inhabitants in terms of religion and caste. The district is predominated with the tribal population with the total population of 893,661(census 2001). There are also primitive tribal groups such as Birhor are living in the forest area. The languages primarily spoken are Sadri as for the interaction language of the district. Some other tribal languages like Kurukh are also spoken in many of the areas. Mostly the Oraon group of tribal resides in the district. And other tribal's such as Munda, Kharia are also present in the district.

b) Khunti District Profile

The Khunti District is one of the twenty fourth districts in South Chotanagpur division of the State Jharkhand. It was carved out of Ranchi District on 12th of September, 2007. The head quarter of the district is the Khunti town comes under the Khunti Block. Khunti District is characterized by the undulating topographical features with the low hills featured with the valleys.

The Khunti district is comprises of 6 community development blocks viz. Arki, Karra, Khunti, Murhu, Rania and Torpa. It has 159 villages covered in 23 Panchayats. Despite of the proximity to the State capital, Khunti District is considered among the poorest districts in Jharkhand with lesser developed infrastructure. According to the census 2001, the tribal population in rural areas of Khunti is 66% as opposed to about 27% in the overall state. And it is the tribal dominated district with the total population of 3.49 Lakhs (census 2001) particularly by the Munda Tribe and other primitive tribes in the district are Pahariya, Asur, Birhor, Dwijiya and Nagesia (http://www.sameti.org/RKVY/SAP/Agri%20Plan_Khunti.pdf; Accessed on Feb 9, 2012). The houses are made of mud-walls and used tiles for roofing. It was reported under the census 2001 that the total number of the houses made up of mud wall in the districts is 78.67 percent and the tiled roofing was in an average of 83.88 percent. The

language primarily spoken are the Mundari and for Sadri is been used as a ‘link’ or interaction language.



Map: 2; Source: www.indiamapatlas.com ; 2011.

Khunti District have a population of 530,299 comprises of 265,939 males and 264,360 females respectively as per the census 2011. The decadal growth reported for the districts were 21.96 percent in the population compared to the population as per the census 2001. The population density is about 215 and the total area under the Khunti District is of about 2,467 sq km.

The health status of the Khunti District in the six administrative blocks the can traced by the health institutions performing in the district that are the total number of the Health Sub-centre is 108, with the 4 additional PHC and the total CHC is 6 in the district and the total number of the Sahiyya in the block is about 805 and the total revenue village in the districts is about 752. And almost in every village the VHSCs has been constituted as per the data available at the District Management Unit.

2.4.3 Block Profile of the District

a) Ghagra Block of Gumla District

Ghagra Block of the Gumla District has been selected for the study the VHSCs in the Non-Intervention area. The Ghagra block of Gumla District has the total population according to the census 2001 is 87,309. The category wise population of the Ghaghra block is about 1,955 the total population of the SCs and the ST population is 64,611.

In Ghagra Block there are 120 revenue villages comprises of 18 Panchayats. The health support system comprises of the total number of Sahiyyas are 233 and constituted around 10 clusters of it. The total numbers of PHC are around 18 and with 1 Additional PHC, Health Sub-Centre is 27 in the blocks and the Anganwadi centre is about 183 in total numbers. And the total number of VHSC is 120 almost in every village.

Majority of the village in Ghagra block have approach roads, the main roads having tar roads and the interior of the villages have Kachha roads but the main road around the village is having PCC roads under the scheme of PMGSY. The small buses, Auto rickshaw and jeeps are modes of public transport available to the people. In some villages which is situated within the route of the Bauxite mines people use them for the transportation to reach the block town. The buses are not very frequent and ply only on the main roads. The jeeps and auto rickshaw also run on the main roads but are more frequent.

The main economic activity of the people is agriculture. The main crops are paddy, Mahua[2] and pulses. The important minerals like Bauxite and Laterite (Aluminum ore) are found in Harup, Serengdag and Jalim in Ghaghra block. The total number of Bauxite mines is Twenty one in the Gumla District. Other mining activities like stone crusher, Brick kiln and stone chip mining lease are also available in different part of the Ghaghra blocks.

Most of the houses in the villages were mud or semi pucca houses with tiled roofs and some thatched roofs. Almost all the houses had a small verandah, a backyard and small land known as the 'bari', in which vegetables are grown. Tube wells are the main source of drinking water for the village and for other purpose water is used from the well and pond.

The Ghaghra block has mixed caste groups with both tribal and non-tribal but they are predominated by the tribal population mainly with the Oraon tribe. The villages have different hamlets, but not strictly according to caste lines but mostly seen as the clan lines. There are hamlets, which had mixed castes, especially the hamlets that have come up recently. Where there are mixed castes in the village the schedule castes are in minority and stay on the village outskirts.

b) Khunti Block Of Khunti District

Khunti block of Khunti district has the total population according to the census 2001 is 69,449. The category wise population of the Khunti block is about 3841 the SCs total population and the ST population is 52,923.

The total number of the revenue villages in the block is about 140 and the total number of the VHSCs is 140 along with the 140 Sahiyyas.

[2] Mahua: Scientific name is M.longifolia used as the non-timber forest products for the use of alcohol consumptions and edibles.

Majority of the village in Khunti block have approach roads, the main roads having tar roads and the interior of the villages have Kachha roads but the main road around the village is having PCC roads under the scheme of PMGSY. The small buses, Auto rickshaw and jeeps are modes of public transport available to the people. The buses are very frequent and ply only on the main roads as the national highway passes by this block. The block is very proximate to the capital Ranchi as the distance is only 31 Km the jeeps and auto rickshaw also run on the main roads but are more frequent.

The main economic activity of the people is agriculture. The main crops are paddy, Mahua and pulses. The people also go to the nearby town for the daily wage earnings as the capital town is very much proximate to the block. People also rely on some industrial activities that have come up like the stone quarries on account of the proximity to the Ranchi Town.

The Khunti block has a tribal dominated block comprises of Munda tribe population. The villages have different hamlets, but not strictly according to caste lines but instead according to the clans in the village. The hamlets that came up recently had the settlement of the mixed caste and the settlement shows that Scheduled Caste lives on the village outskirts. And it has found that there is no further scope for the village expansion in the Khunti blocks. The villages provide almost a similar picture.

2.4.4 Village Profile

a) ***Villages of Ghaghra Block*****:** The villages were selected by the researcher on the basis of the health care accessibility in terms of the distance of the village from the Block PHC/CHC. The four villages were selected viz.

The Salgi Village is the about 18 Km from the Ghaghra PHC/CHC at the block headquarter. The total population of the village is 1153. It comes under Adar Panchayat and it is the most remote village nearby to the hilly areas as some of its hamlets are in the forest. The total number of the households in the village is about 371 comprises of 588 male and 565 female. The total Scheduled Tribe population is about 692 and the total

Scheduled Cast population is about 46. So it is very much evident that the Salgi is the tribal dominating village. It has been observed that in terms of facilities such as road, electricity, school and basic amenities like water, markets it is very underprivileged. This village also lags behind due to the active activism of extremists.

Sirkoat village is a small village with the population of 685 people of which comprises of 349 are males and 336 females and the distance of the village from the Block is about 8 Km. it comes under Badri Panchayat. The total number of the households is 84. The category based population of ST is about 411 and the total number of SC population is about 27 in the village.

Sarango village is about 12 km from the block PHC/CHC. It has a total population of about 960 people comprising of 490 males and 470 females. And the total ST population is about 576 and the SC population is 38 in the village and the total number of the households is about 286. It comes under Sarango Panchayat. And it is nearby to the Serengdag village the Bauxite and Laterite minerals mines.

Ranhe village is the nearest village situated in the distance of around 3km and the total population in the village is about 726 comprises of 370 males and 356 females. It comes under Kugaon Panchayat. The total household in the village is about 212. The total ST population is about 436 and the SC population is about 29 in the village.

b) Villages of Khunti Block

The Fudi Village situated in the boundary of the Ranchi town. It is beside the national highway NH 33 of the state. The total population of the village is about 226 and the total households are about 180**,** Kalamati village of the Kalamati Panchayat is the next to the Fudi village and is comprised of the total population of 1796 with the total households being 293.The Kalamati and the Fudi village people residing over have adopted Christian religion as the area have the old churches since the British Period. Apart from this religion people belonging to Sarna religion, and also very few of them are Hindu in the village. Manhu village of the Siladone Panchayat is about 18 km from the block head

quarters and it is the remotest village from the main town of the district. The total population is about 495 and the total households are 80, Chikor Village of the Hesahatu Panchayat is also the remotest village of the Khunti block and it is affected by the activism of extremists. The total population of the village is about 593 with the total number of the household of 105. The similar picture of the settlement pattern in the all of these villages was found in all the studied villages. Each of the villages has clean premises and the central meeting place known as Akhara. And have the infrastructure such as one primary school with good building, 1 sub-centre with building in a good condition and houses with thatched roof but few of the houses are in well–off families are having toilets and the pucca buildings. It has been observed that the area of this block was surrounded by the Cobra Battalion[3]'s settlement nearby to the villages which makes the people feel safe in the conflict zone of Extremist groups but in a disguised manner. The block is disturbed with the activities of the extremist groups.

2.5 Data Sources

The researcher collected both secondary and primary data for the study.

2.5.1 Secondary data: The secondary data was collected from reports available with State VHSC-Sahiyya Resource Center VSRC, evaluation reports of VHSC, Common review missions of NRHM and other articles, books and journals related to VHSC. And also at the field level documentations such as VHSC Registers, Log Books, SOE copy of the VHSC.

2.5.2 **Primary data:** The primary data was collected through semi-structured interview schedule and observation. The interviews were conducted of the respondents and the key respondents that have been selected purposively by the researcher.

[3] COBRA Battalion: Acronyms – *Commando Battalion for Resolute Action* is a specialized unit of the CRPF (Central Armed Police Force) created to counter the Naxalite problem in India.

a) ***Respondents:*** The stakeholders in the study are village level Health functionaries such as ASHAs, AWWs and ANMs, VHSC president, VHSC members, PRI members, SHGs members, Technical supporters like Sahiyya sathi (ASHA facilitator), Block Training Team, Animators, NGOs (CINI) representatives and Block & District-level officials.

b) ***Number of Respondents:*** The total numbers of the respondent interviewed are 74. The Key Informants interviews were conducted with the 8 VHSC presidents, and the In-depth Interviews were conducted with the 12 ANM, 8 AWW, 15 Sahiyya (ASHA), 12 SHG Members**,** 8 PRI Member, 2 BTT**,** 2 Sahiyya Sathi (Sahiyya Supervisor), 2 NGO Animators. Using the Semi-structured interview schedule the Key Informant Interviews was conducted with 2 District Program Coordinator (DPC), 2 Block Program Manager (BPM) each from both the blocks, and 1 NGO Nodal Officer at state level.

2.6 Data Collection Process

The different techniques used were In-depth interviews, key Informant Interviews, questionnaires, semi-structured Schedules and observations.

2.6.1 Interviews

The Key Informant interviews were conducted with the VHSC President and government and development agencies' nodal officers. They were interviewed in detail. The VHSC presidents were interviewed in their respective village. And the officials were interviewed in their offices. The VHSC's other members were such as Sahiyya, PRI members and other health functionaries of the village were interviewed in their villages, at their home and also at the AWC of their village using as the centre meeting place by the villagers. An interview guide meant for interviewing them was designed for pre-test. The broad questions to meet the objectives of the study were asked. In Early Dec 2011, the interview guide was tested with the few VHSC and required changes in the tool were made. Certain questions were replaced with somewhat more relevant questions that

emerged up during the pre-test. Also, the pre-test helped in clustering a few related questions under a broad theme. Also, pre-test helped in identifying certain broader themes, which could be explored in-depth among various respondents.

Interviews were not recorded during the pre-test, and short notes were made while conversing with the respondents and later incorporated with necessary details. The process of researcher often posed interruption on part of the respondent's in terms of enquiry about the details being noted down which often disturb the free flow of information. As later the whole interview were recorded as due to the researcher's may face problem in recording the interviews that were taking place in the local dialects. But later it is being run smoothly without any interruptions as the whole interviews were recorded and later transcribed.

The interviews were recorded by taking notes with the official respondents and also some of them agreed to record the interviews.

2.6.2 In-Depth Interviews

The interviews conducted during this were recorded. Before recordings, the consent of the respondent was taken and the purpose was distinctly clarified. In case of refusal, the interviews were sought to note down the necessary details. None objected on recordings the necessary details. At times memory based additions were made.

2.6.3 Conducting the Interviews

The respondents chosen for the study were the members of the VHSCs of the respective village and the blocks and intervention area. The time taken by the respondents to complete one interview would vary from 40-45 minutes to 100 minutes. Since the respondent has a busy schedule, meetings were fixed as an appointment so that they can give interview when they have with ample time. At the village level it was difficult for them to convince them for a long interviews session. Moreover, ethically it is unfair so the interviews were re-scheduled for the next day to continue with the other phase of the interviews with the same respondent.

2.6.4 Other key-informants Interviews

Apart from the interviews conducted with the VHSCs members at the village level, frequently the health officials were also interviewed in order to understand the Village health institutions and the linkages of the members with the governments and the officials. At the same time interaction with the officials responsible for the block health activities, the villagers, the headman of the village and with the PRI members were done often; give an insight of the life in the village and the institutions dynamics. Field notes about the experiences of researcher in the village were also made.

2.6.5 Observations

Observations were an inherent part of the study often yielded valuable information on areas where sufficient data could not be collected through interviews. For instance, the meeting regularities, the discussions on the health issues, record keeping and the sustainability of the activities that were conducted, and the power relationships and bonding between the committee members, the conflict between the members were all observed by the researcher. Apart from that the condition of the village, its people, their clothing, concern for hygiene, eating habits, social relations, beliefs etc. were also observed.

2.6.6 Methods used in processing and analyzing Data

The recorded interviews were transcribed and translated. The qualitative data was analyzed separately for each category of respondents and then re-arranged to assess similarities and differences. The domains identified after reviewing the literatures and data were collected on the basis of domains such as on community participation, decentralization, social mobilization and the communitization processes. Under these broad domain the sub-domain were identified and those are formation process, composition, roles and responsibilities under community participation, powers such as political powers, administrative powers and fiscal powers and the power structure under the decentralization, the capacity building supports systems from the state, its structure,

facilitation by the NGOs, trainings under social mobilization, and accessibility, plan, implementation, monitoring, cooperation, collaboration, knowledge and awareness in VHSC and its output under the communitisation. During this the new themes were allowed to emerge through the constant connections of the sub-domains. The various qualitative data were cross studied in order to understand the inter-relation of the categories with each other. The best suited narratives were added at the times to bring the true picture that existed.

2.6.7 Problems encountered during the study

The problem of the fixed timing and appointments sometimes had hindered the interviews because the interviewees are eager to switch into the other activities that were appointed to them. The researcher took care of that the respondent does not get affected in their routine work. The distraction would often drag the respondent away from the researcher. The researcher had to try at times to bring back the respondents to the area being already discussed.

2.6.8 Limitations of the Study

The purposive sampling selection of the study area due to reasons of ease of the communication and familiarity with the socio cultural set up upto some extent has already been mentioned. Also, the study areas are having low accessibility as most of them don't have the good facility of the conveyance system. The most of the study area were got affected by the extremist (Naxal affected area) due to which researcher has to take precaution in terms of early completion of the interviews as to get her place back before late evening. Due to this many a times she has to leave the interview and postpone for the next day. Also the study deals with the VHSC of the Jharkhand with respect to various socio-economic and political factors prevalent in the area, the findings of the study cannot be generalized.

2.6.9 Ethical Consideration

The researcher took permission and introduced herself before conducting interviews to the respondent at the field. The informed consent was taken from the respondent before recording the data both in writings and recording with the help of voice recorder. At the village level the respondent allow researcher to use the recording device for recording the data. After the permission only she used the recording device so that he/she may not get offended.

CHAPTER 3

Approach of Communitization: Experiences of different states in India

Approach of Communitization: Experiences of different states in India

This Chapter is divided into four sections. The first section deals with the layout of the NRHM to understand the communitization process as intended within the fold of National Rural Health Mission (NRHM). And the second section present the communitization experiences in the different states of India. The third Section discusses the case of state Nagaland to bring ground level experiences of communitization in India. And the fourth section describes the current scenario of communitization in the country India.

3.1 Communitization within the National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM) is one of the largest global programmes for regenerating primary health care systems in India. It has been launched on 12th of April, 2005 throughout the country with special focus on eighteen states, including Eight Empowered Action Group states (EAG), the North-Eastern, Jammu & Kashmir and Himachal Pradesh. The programmatic thrust is on securing quality health services in remote and geographically inaccessible rural areas that are accessible, affordable and accountable. The basic assumption on which the NRHM works is that 'only securing people's health in people's hand will be able to craft a believable public system of health care by establishing decentralized institutions of local communities from village to the district level' (Sinha, 2008: 1). Such committees or local institutions are under the umbrella of the local government establishments (including elected bodies like PRIs) of the government and allow for the involvement of all those with the motivation to improve the lives of the people through health care interventions. Here this clearly brings the crux of the real involvements or inclusion by self instead of investing time and money to motivate those have to provide services, the motivated ones should involved in the developmental initiatives by organizing them. The NRHM advocates crafting of credible public platforms of health care by establishing decentralized institutions at all levels from village level health & sanitation committees to panchayat owned sub-health centres, PHCs, CHCs, Sub-district and District Hospitals through

supporting funding of multi-sectorial vertical schemes running as under the purview of the state and central sponsorships and flagship programmes. Country is imparting considerable flexibility to their states to come up with their own need based plans instead of forcing centrally designed schemes across all states. These health institutions are the core of the health service delivery.

To achieve the goal of health for all citizen the National Rural Health Mission (NRHM) adopted five main approaches to achieve its goal viz. through the communitization, flexible financing, and improved management through capacity building, Monitor progress against standards and innovations in human resource management (MoHFW, NRHM Framework for Implementation, 2005: 5). These approaches are incorporated to address the problems of health delivery systems assessing the real grassroots situations and related problems, and tried to solve it by making intervention strategies conducive and applicable to the ground situations. To improve financing, the Mission has brought all the schemes of health and family welfare arching under the one umbrella. For the better functioning of health programme, facilitation along with the financing through the NRHM budget head that provides the much needed funds to the districts through the funds allocated to the state based on the specific needs besides uniformities reinforced under its guidelines. The provisioning of untied funds at various local levels is also available under NRHM. Followed by the other approach in which the management skill at block, district and state levels were given emphasis, through creating post of public health management as well assisted with an accountant for the accounts work at block and district level. The health functionaries were strengthened by the continuous skill development harnessing the expertise through the involvement of the various NGOs. Though the mission urge for the decentralization through devolving the powers to the institutions at the local level for the managements and utilizations, on the other hand, it also rely on their management units for the managerial works. In practice the institutions are seems to be accountable more to the management units such as to the District Program Coordinators (DPC) or Block Program Managers (BPM) especially for funds and its utilizations. The contradicting factors is whether government is devolving or

doing deconcentration by devolving the power and responsibility for planning, financing, and managing certain public functions to their appointees or subordinates. The innovations in human resources management is very important to increase the pool of human resource to carry such a huge programme for the betterment of the facilities, and so additional manpower like nurse, Medical Officer (MO) are being provided at PHC and CHC. The provisioning of basic health services is done involving local residents of remote areas, who were trained and groomed accordingly. The multi-skilling of health functionaries especially of doctors and paramedics is being carried out so that a person could carry out multiple tasks of offering quality and diverse kind of services in the remote and outskirts areas (MoHFW, NLEP, 2009: xiv). But considering the ground reality, the local health functionaries at the local level were skilled up for multi-tasking as per the guideline are not so sound, infact their functions seems to be jumbled and hampered resulting into the improper functioning. The reasons realized were the professional orientations of the health professionals which skewed with the technical as well as the managerial works at a time together expected with a single person. And the base on which all the above approaches are based on is the communitization through institutionalizing the health institutions giving them the power and ownership to the formed local level health committees and volunteers in the health developmental planning and actions.

The institutional mechanisms have been created by giving much priority at each level to support national health programmes and improved delivery of health care services. The health programme may seek support of NRHM through the Village Health and Sanitation Committee (VHSC) a multi stakeholder at village level, create a public awareness about the programmes and ensure community involvement in partnership with ASHA, RKS and PRIs for the better implementation of the planned activities. The NRHM provides the flexibility to the state to direct funds to those areas where they are needed the most through the single budget head for activities with separate subheads for various programme. The fund allocation is on the basis of integrated state/district health action plans as approved annually. First the district health plans were drawn up followed by the

consolidated state health action plan based on that prepared and submitted for sanction of Government of India and it is drawn up with the consultation and approval of district NRHM authority. The formation of finance management group under NRHM at state and district level for release of funds from the states to districts and from districts to blocks, are suppose to monitor programme expenditure and maintain programme accounts. Under the mission there is availability of untied fund at the various levels which can be utilized by any programme based on the requirement wherever the convergence is rationalized to achieve desired outcomes (MoHFW, NLEP, 2009: xv). Here the mission's efforts is very much visible in terms of taking efforts to make the developmental process more decentralized by making different institutions as the platform or the medium and the mechanisms for ensuring the better people participations in their health planning.

The institutionalization of the public institutions including health institutions managing by the local people giving stress on the greater involvement of the community in a collective manner for their own developmental planning and actions. Here governments see the community as a 'partner' in the development process. But due to the negligence of assuring the important factor i.e. the local participation which may directly affect the core idea of communitisation. This seems to turns decentralized planning into the centralized planning present in a disguise manner. And ultimately negates the fact of an action of the community for their own health needs overshadowed by the planning done by the central in the name of the local needs. So it is also necessary to check the same attitudes and understanding of the management units responsible for the fund releasing about the objectives of the mission and the processes of the decentralized planning. Communitization is one of the most important priorities and strategy under the NRHM. And it is envisioned through the approach of decentralization through the transfer of Funds, Functions and functionaries to the community at the local level. The states have made significant progress in setting up of VHSC, opening of joint bank accounts of ANM and ASHA at the village level, ANM and Sarpanch at sub-centre level, setting up of RKS in PHCs, CHCs, Sub District and District Hospitals and in activating PRI at all levels. Several institutions at each level are expected to ensure full ownership of public

institutions for health care by the elected representatives of local governance such as bringing District Health Mission under the Adhyaksha of the Zilla Parishad and Block Health Mission as under the chairmanship of the Block Panchayat Samiti Adhyaksha and the role of the Gram Panchayat at the sub-centre level (Sinha, 2008: 3).

There are many instances and experiences of effective utilization of the untied grants are seen in a large number of states which have transformed public health facilities (ibid) .So for boosting up the confidence in the public institutions the massive trainings and orientation programme of the elected representatives at each level is required to undertake the responsibilities assigned to them. This will ensure service guarantee to the households. To meet the health needs of local communities and to ensure that referral services are available wherever is needed the expectations are from the key functionaries at the village level and gram panchayat level such as the Anganwadi Worker, the ASHA, the two ANMs, and the Male Worker. While NRHM recognize the umbrella of PRI, it also provides for the co-option of active members of SHGs and women committees at the village level with the clear intentions of having one common village level committee under the PRI that could look after water, sanitation, health, nutrition and education related issues. It was believed that through such convergence the health indicators would register significant decline and improvement in levels of well being.

NRHM has also focused on key activities at the village level like monthly Village Health and Nutrition Day (VHND) at the ICDS centres other than community institutions with the expectations to create greater awareness about health issues among local communities and the evidences shows that this has been succeeded effectively but the other aspect of this is that the venue, choices and issues that had adopted and were discussed sometimes unable or hinder the overall participation e.g. the male folk (Sinha, 2008:3). Though ideally the PRI and VHSC under them should organize and conduct such activities but generally it is seen as an isolated activity mostly conducted by the government appointed health functionaries without their participation.

The other important part of the communitization agenda of NRHM is community monitoring which allows for the setting up of monitoring committees at the PHC, Block, Sub Division and District levels to ensure that people health rights are rewarded at public facilities. It has the potential to improve the access to health services for the vulnerable groups and also expected to make local community institutions better aware of their roles and responsibilities. To ensure better health services for all households, the Ministry has urged states to set up community monitoring systems with the help of an Advisory Group on Community Action involving a very large number of very credible and independent NGOs working in Districts. Government initiatives in assuring the proper functioning through the monitoring process by committees were very appreciable. But at the local level the village monitoring committees needed to be strengthened so that the monitoring part does not flow from the upward from the government as per their needs for tracking the fund utilization rather it should be the need of the community and come from the downward from the people. This will help the community to trace the functionality and performances of the government officials and ensure the better decentralization of the services. It has been seen that the involvement of ASHA's in public health programme has had very positive results in terms of coverage of services as they are conceived as a social health activist to link households with the facilities. So it becomes important to ensure that ASHA and community organizations at various levels could able to seek service guarantees from health facilities (Sinha, 2008: 4). Therefore to seek hospitalized services the facilitation desks in the block and district level health institutions were established in the premises of health institutions to help community workers and community organizations. While for the effectiveness of the communitized institutions that mostly depends on the extent to which they are provided responsibilities and resources to carry out activities that meets people health needs. The communitization processes are very important beside a clear delegation of funds, functions and functionaries, so the government shown urge for the involvement of the civil society organization on a large scale at the state level for developing and building capacity in the community and its organization to manage their health needs in better manner (ibid).

3.1.1 NRHM Frameworks for Implementation

The NRHM recommends the states for promoting communitization in all its institutions and activities through the Broad Framework for Implementations and it call for looking at the current functions and responsibilities at various levels and incorporating detailed guidelines on power and functions of community organizations or PRIs. The illustrative structure was based on the assumptions that the structure of governance is different in different states and that systems needs to be evolved that address the diversity of the field reality.

Framework says that for the success of the mission of health for all, the reform process needs to touch every village and its people of the country because in the country nearly three fourth of the population that lives in the villages. This is very clear that it is possible only when the empowered community in a sufficient manner takes leadership in health matters. They gave thrust on the Panchayati Raj Institutions, right from the village to district level, by giving ownership of the public health delivery system in their respective jurisdiction. The positive gains of institutionalizing involvement of PRI in the management of the health system is been evident in some of the states like Kerala, West Bengal, Maharashtra and Gujarat where they have already initiated experiments in this regard. Apart from the PRI, other vibrant community organizing women's group also will be the associative part in the communitization of health care (MoHFW, NRHM Framework for Implementation, 2006: 29).

To achieve empowerment in community the NRHM seek to empower the PRIs at each level i.e. Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District) to take leadership to control and manage the public health infrastructure at district and sub-district levels. PRI members at time increase the accountability but at the other impede the efficiency and tempers with NRHM framework for vote banks and temporary/personal/political gains in their electorates. Thus empowering PRIs members under NRHM framework give out both positive and negative effect to the realization of need based health facilities. Under the purview of the Gram Sabha the Village Health and

Sanitation Committee (VHSC) is supposed to form in each village with the proportionate representation from all the hamlets, adequate representation from all the disadvantaged groups like women, SC/ST/OBC. The accountability of the Sub-health centre is suppose to be towards the Gram Panchayat and have local committee at this level with an adequate representation of VHSCs for its management (ibid).

The PHCs (not at the block level) will responsible to the elected representative of Gram Panchayat in their location. And for its management all the other Gram Panchayat covered by the PHCs would be suitably represented. The block level PHC/CHC has to involve panchayati raj elected leaders called as the ward members in its management even though Rogi Kalyan Samiti would also formed and present for the day-to-day management of the affairs of the hospitals. At the district level Zilla Parishad will be directly responsible for the budgets of the health sector and for planning for people's health needs. Under the effective leadership and control of the district panchayat with the participation of the block panchayats, the entire public health management at the district level will be devolved to the district health society with the development and capacities and through systems. It is very much clear that the framework has tried to devolve the power and responsibility at each level and for ensuring that it has sought amendments to acts and statutes in states to fully empower local bodies in effective management of the health system as pointing towards the institutionalized community led actions for health. The NRHM has visualized the village level health institution under the local bodies as the base of the apex level district health mission planning, so it emphasizes on the strengthening part of it by several capacity building mechanism (MoHFW, NRHM Framework for Implementation, 2006: 30).

The mission also recommends the concerted efforts of the NGOs through their involvements and other resource institutions to build capacities of elected representatives and users groups members for improved and effective management of the health system. For the social mobilization process to ensure its impact on the community action at the ground level by the facilitator agencies it ensures it through the evaluation mechanism. For the facilitation of the local action it has brought the provision of untied fund grants at

all level (Village, Gram Panchayat, Blocks, District, VHSC, SHC, and PHC & CHC). And also emphasizes on ensuring that the facilitation should be for the overall development of health instead of concentrating on the fund utilization part (ibid).

As already discussed the importance of community monitoring in the communitization agenda, in the implementation part with the participation of PRI representatives, user groups and CBO/NGO representatives in the monitoring committees needed to be formed at the various levels to facilitate through their inputs in the monitoring planning process and to enable the community to be involved in broad based review and suggestions for planning. Apart from these, the other various levels of events such as a system of periodic 'Jan Sunvai' or 'Jan Samvad' is recommended by the NRHM framework for the empowerment of the community members through engaging them in giving direct feedback and suggestions for improvement in public health services. Promoting equity is one of the important thrust given by the mission. It is seems to be the main challenges under the NRHM. In the community based monitoring system the framework says that there is a need of adequate representation from all the level and category of the community which is necessarily to be ensured through bringing up the voices of all the community for the better functioning of health services and suggestions for the betterment of the health institutions as well as the functionaries. The strategies outlined by the framework through which these are going to be overcome are like empowering the vulnerable through education and the health education, giving priority to area/ hamlets/ households inhabited by them with running fully functional facilities, exemption for below poverty line families from all charges, human resource development or capacity building, and most importantly recruiting volunteers from amongst them. It is expected that it should reflects in the planning process at every level. The framework says that the percentage of the vulnerable sections of society will be one of the benchmark for the performance of these institutions according to the use of the public health facilities (ibid).

3.1.2 Guidelines for Village Health and Sanitation Committee

Based on the above detailed framework for implementation the guidelines were prepared by the NRHM and approved by the Union Cabinet in July, 2006 which provides the constitution and orientation of all community health centre committees. As we already came to know that the implementation of NRHM has been planned within the framework of PRI at various levels and so the Village Health & Sanitation Committee envisaged within the umbrella of PRI. The guidelines suggests on the composition process of VHSC to enable them in such a way that it should reflects the aspiration of the local community especially the poor households and women. It says that there should be atleast fifty percent women as the committee members. Representation from every hamlet of a revenue village should ensure for the needs of the weaker sections especially ST, SC, and OBC with full reflections in committee's activities. But guidelines missed in detailing the socio-cultural aspects of the area as for instances the local influencing factors such as power structures, social structures and geography in ensuring the overall participation in a right manner. There should be the provision of atleast thirty percent from the non-governmental sector. To enable the committee to undertake women's health activities more effectively there should be the representation of women self help groups etc. in this committees. Every VHSC after being duly constituted by the state government needs to be oriented and trained to carry out the activities that are expected with them (MoHFW, Guidelines for Village Health Committee, 2006: 2)

<u>Roles and Responsibilities of the VHSC</u>

Administrative Roles

For the effective and better functioning of the VHSC few roles and the responsibilities have been laid down for the committees through the guidelines. According to it, the VHSC will be responsible for the overall health of the village. They should take into consideration of the problems of the community and the health and nutrition care providers and solve it through the proper suggestions. It will create public awareness about the essentials of the health programme focusing on the people's knowledge on

entitlements for their better involvement in the monitoring. It will discuss and develop a village health plan based on the village situation and identified priorities of the village community. The committee will analyze the key issues and problems and give feedback on the related issues of the village level health and nutrition activities to the Medical officer (MO) of the PHC. It will monitor all the health activities conducted in the village such as VHND, Mothers meetings etc. They are responsible to conduct household survey in the village along with the ANM. They will maintain health register and the health information board and will be put up at the most frequented section of the village along with the information about the mandate services in the sub-centre/PHC. They will ensure that the ANM visit the village on the fixed days and oversee their performance specified activity as per the sub-centre work plan. VHSC will discuss the ANM's bi-monthly village report submitted to them along with the plan for the next two month plans. And the formats and contents would decided by the committee itself. Committee will discuss every maternal or neo-natal death occurs in their village and suggest necessary action after analyzing it to prevent from such deaths. They also register these deaths in the panchayat. The committee will organize regular monthly meeting to discuss various issues in the village and keep the minutes of the meetings. They shall ensure public dialogue at regular intervals in the presence of Medical officer (MO) of the PHC. They also play an important role for selecting and supporting the ASHA form the community. The VHSC will also take care of the sub-centre and responsible to inform the community about the government schemes. Apart from the health issues they are also responsible for the development of the village (MoHFW, Guidelines for Village Health Committee, 2006: 4). Additional load of bureaucracy and setting up of numerous bodies has its own adverse effect in programme implementation e.g. duplication of work, wastage of manpower, burden on exchequers and it is needed to be sort out by the proper integration during the planning level to overcome the overlaps of the works and the activities.

Fiscal Roles

The guideline talks about the utilization norms of the untied grant a resource for community action at the local level and only to be utilized for community activities that involve and benefit more than one household. It will be utilized after the resolution in the VHSC monthly meeting and also the information will be shared regarding its utilization with the village meetings or public dialogue. The fund will not withdraw at one go by the committee. VHSC will be responsible for organizing village Health & Nutrition day (VHND) in the village by the ANM with arranging all the essential instruments such as BP instruments, weighing machine, examination table, and screen for maintenance of privacy during health check up and other supports required. And the procured instruments will remain under the custody of VHSC and returned to them after the use of it by the health workers. Committee will also provide Rs.100/- to ASHA for organizing the monthly VHND. The fund can be utilize for the village level activities leading to the better health such as cleanliness and sanitation drive, school health sanitation activities, building transport communication link for transfer of the patients, household surveys, for Anganwadi Centre facilities improvement and any other developmental activities for the village or community. The fund can also be utilized in the awareness generating activities for health and sanitation such as for the wall writing of slogans, making the signboard in the meeting place of the VHSC and during emergencies such as any epidemic for the relief camps or drug supplies, ORS, bleaching powder etc. committee will help or contribute half of 10 poor BPL families in a year @ Rs.300/- for the allotment of sanitary latrine under Total Sanitation Campaign. It is also written in the guidelines that the fund can be utilized in procuring bicycles for the ASHA's as in case the area was too distant to reach the households and provides health care services causing hindrance in the catering to all households. (http://www.nrhmassam.in/pdf/guideline/guideline_vhsc.pdf; Accessed on: Sep 1, 2011).

The maintenance of funds is also mentioned in the guidelines which talks about the amount of entitled annual grant of Rs. 10,000/- for village level activities under the VHSC. And there should be the maintenance of amount received and expenditure

incurred in a register along with the related activities undertaken by the committees. The committee will manage the village health funds for various health activities. They can use this fund as a revolving fund from which household could draw in times of need to be returned in installments thereafter. Every village is free to contribute additional grants towards VHSC where community can contributes financial resources to the VHSC and the additional incentives and financial assistance to the village could be explored. This is with the intention to enable local action and to ensure public health activities at the village level receive priority. They will have to maintain accounts and timely submission of Utilization Certificate and the Statement of Expenditure (SOE) for the money received to PHC. Along with this the committee has to maintain the registers such as Village Health Register, Birth & Death Register, Public Dialogue Register, Referral Register and the Untied Grant Register (ibid). Though the financial backups system is an essential requirements of the committees but in the country like India where the literacy among the people is in dwindling situation is very hard to ensure the perfection in the accounts related functions. And these managerial tasks could be one of the hindrances in the enhancement of the confidence in the community. So the simple formats with less paper works accounting is required for encouraging the community in the developmental tasks.

For the fund transactions the VHSC fund shall credited to a bank account and operated with the joint signature of ASHA/ Health Link Worker/ AWW along with the President of the VHSC/ Pradhan of the Gram Panchayat. The VHSC has the responsibility of the account maintenance especially ASHA. They shall maintain a register of funds received and expenditure incurred and the register be available for public scrutiny and shall be inspected from time to time by the ANM/ MPW/ Gram Panchayat. The review of the functioning and progress of activities undertaken by the VHSC will be done by the block level panchayat. And the information on the functioning of the VHSC are also expected to be done by the District Mission in its meeting through its members/ block facilitator supporting ASHA and the data base of the VHSCS are maintained by the DPMUs. (MoHFW, Guidelines for Village Health Committee, 2006: 3)

Based on the above Frameworks and the Guidelines for the interventions, the institutionalization of the health institutions has been started practicing by the government. So it is necessary to know the reality of the communitization at the grassroots level to have a clear picture about the similarities and the differences between the conceptualization and the interventions of the concepts at the grassroots level.

3.2 Communitization: Grassroot level Experiences

Rural health institutions are among the first to be taken up for communitization under the National Rural Health Mission that have been discussed in the previous sections. Under this concept Village Health Committee (VHSC), Urban Health Committee (UHC), Common Sub-centre Health Committee and Health Centre Management Committees (HCMC) were constituted in order to facilitate and strengthen the process of communitization. And leading to this it has been seen that most of the state in India, the panchayat members are involved in the facilities management provided through institutions at the district and the village level and in the selection of ASHA's. The core strategies are based on training and enhancing capacity of PRI to own, control and manage public health services and also promoting non-profit sector particularly in underserved areas.

To review and concurrent evaluation, the Common Review Mission (CRM) was set-up which has conducted the first appraisal in November 2007. This brings out the key findings that NRHM strategy talks about the involvement of the community in the health delivery services to improve the health system by emphasizing on the ASHA program which allows a space for communities to participate actively and creating awareness and facilitating people's access to services. To empower local health care providers and to close many critical gaps in service delivery the untied-funds is the another successful components at all levels from the sub-centres to district hospitals which was introduced. The best example of provision and its utilization of the untied funds are the Rogi Kalyan Samiti or Hospital Development Committees (RKS) which were acting as the enablers of facility development. It emerged as an alternative device to emphasize on minimal

affordable user's fee/ user charges collection as a cost recovery measure. Keenness was seen on coordinating with the ASHA's under the Mission for providing health volunteers for better service provisioning and the other community processes such as assistance in ANM and Dai trainings. Though NRHM also promotes NGO's participation but it is seen in a very limited manner. The First CRM (2007) reported that there is a widespread dissatisfaction in government divisions with the NGOs performance. The major development of NRHM is the district level planning where the village plans prepared based on household health data and with the involvement of PRI's are consolidated but in exception. It reported a number of important governance issues that are acting as program constraints at all the levels for example untimely release of funds to the states, active facilitation of VHSCs for the village level planning under panchayats leadership which is yet to achieve (MoHFW, First CRM Report, 2007: i-vi).

The NRHM strategies for the implementation are well connected with all the four concepts of community participation, decentralization, social mobilization and communitization to achieve the goals for equitable, affordable and effective health services system. The implications of this in the health services can be visualize through the enhanced participation of the community (committees or PRIs) in the village to district health planning. It has been seen that people started recognizing and accepting the health workers such as ASHA's for their health needs. It increases the demands for the health services in the community and enhances the awareness among the people in bringing changes in the behaviours and practice in a positive manner by adopting healthy behaviours (ibid). Husain (2011) cited that in a study of the state of Uttar Pradesh it was found that the services delivery capacity of the public health system had increased at each level (Sub-centre, PHC & CHC) with the increase in the out-door patient. The main beneficiaries of indoor services at each level were always women followed by children and men respectively. Government was earlier fully dependent on the NGO's reporting as a part of the monitoring system for the better functioning of the VHSCs but later withdrawn support from them and not placed any alternatives for the monitoring since July 2007(Public Health Resource Network, 2008: 37-38). The reason was that

government established their own resource centres to strengthen their support system under the NRHM. The VHSC was tried to strengthened by the NRHM guidelines on the framework, functions and responsibilities and has provided by a flexible 'Untied Fund' of Rs. 10,000 per health sub-centre facility to support local actions. The NRHM guidelines for VHSCs talks about their role as a social mobilizers who creates awareness in the village about available health services and their entitlements. Under NRHM the village level health committees are expected to develop a village health plan based on an assessment of the situation and priorities of the community, suppose to maintain a village health register and health information, analyze the key issues and problems of the village level health and nutrition activities and provide feedback to relevant functionaries and officials and present an annual health report from the village to gram sabha. The NRHM guideline tried to address the inequality through suggesting equal representations from the panchayats, community based organization and NGOs, other representatives and village health and nutrition worker (AWW) and committee should include members from disadvantaged communities (e.g. SC, ST & minority groups) and suppose to oversee the work of the health functionaries such as ANMs, AWW and ASHA and were involved in managing the local sub-centre which is accountable to the gram sabha (USAID, Vistar Project, 2008: 1-4).

The NRHM has sought to encourage decentralization as a part of its core strategy recognizing the importance of involving the grassroots level organizations in the health care delivery system. The role of the gram panchayats is very crucial in attaining the objectives of the NRHM. The CHC and PHC involve the elected member of panchayati raj in their management through RKS. And the sub-centre is accountable to the gram panchayats through the local committee under the VHSC. The major objectives of the VHSC are to help ANM in preparing and helping in planning and implementing various program related to health, hygiene, nutrition, sanitation and drinking water (Husain, 2011). Some evaluation studies have noted that the constitution of the VHSC does not always follow the norms of inclusions of the entire category of the society. As for instance, the Jharkhand state's VHSCs formation was undertaken in three phases.

According to the norms VHSC are supposed to be formed through a process of identification of a facilitator in the first phase, who after receiving training were supposed to organized and conduct meetings in the gram sabha. They are supposed to provide all the necessary information related to VHSC, its function and role etc. In practice, the actual processes laid down in the guideline were followed only in the VHSCs formed in the first phase. The later formed VHSCs have not gone through all these processes. There was not any system in place from the side of government which could have ensured that the VHSCs have been formed and groomed as it should be because as of today all the VHSCs have been formed and the formation compliance was monitored by the NGOs. In Jharkhand Gram Panchayats election were held very recently at the end of 2010. So the VHSCs have been formed in such a way earlier that the committee could be linked with the respective gram panchayats when it is created. The VHSCs have been formed separately and is different from the hamlet level committees and the members of the committee are from within the village/hamlet itself. Function wise and constitution wise its roles is different from the other hamlet level committees such as Village Education Committees (VEC or Gram Siksha Samiti) and Mata Samiti (or Saraswati Vahini) and the members are also different (Public Health Resource Network, 2008: 37-39). Though they are different in nature but supposed to work for the one broad goal under the umbrella of the PRIs for the overall development of the village. So they need to work in a collective manner instead of working in isolation. Taking the instance of J&K where the representation of the village; socially backward classes or women representatives were not fulfilled while the formation of the VHSC. The another guidelines ensuring which was a failure on the part of the state health departments was to provide training through orientation program to the VHSC member, it thus has limited their role in helping the ANMs utilize the untied funds. It has been observed by CRM that meetings are not regularly held in many states and the role of the VHSC in preparing the district plans has remain limited. It has been mentioned that around 95% of ANMs had a joint bank account with the sarpanch of the panchayats and the funds were used for mostly or could said only to meet infrastructural shortcomings which is undesirable and against the spirit of its provisioning. Whereas, expenditure of the untied funds in some cases is planned by

the ANM in consultation with block medical officers, bypassing the panchayats members. The increasing accountability was expected through the establishment of the RKS which was also in the process of evolution and thus it has also fallen short of expectation. According to the CRM observes the role of RKS is limited by the tendency to view them as an alternative financing device and the consequent emphasis on user fees as a cost recovery. Other mismanagements are like irregular meetings, display boards stating member and decision about meetings are often not in order and proved futile measure to undertake the specific activities outlined in the NRHM document (Husain, 2011). The First CRM reports clearly showed the ground realities of the ideally designed program. The achievements have fallen short of what was originally conceptualized. "It did not adequately take into account the complexities of Indian rural societies characterized by gender disparities, and divided on the lines of caste, micro –politics and economics class" as quoted by Husain (2011). So it can be said that the social-cultural context in which social capital and health system is situated, and ultimately determines the success of policies and measures, including decentralization has not paid sufficient attention which can hinder the broad goal of 'Health for all' declared in the Alma-Ata to achieve the comprehensive health care with the community participation and self-reliance to the health care needs.

On the basis of the ground reality and the state experiences it could be said that though government has showed their keen interests in adopting the communitization for the betterment of the health institution's utilization and its management by involving the community itself, they could not able to achieve the expected level of communitization where people area able to visualize their own development by participating in the need based health planning and implementation.

The framework makes a great effort to bring each approach through the minute detailing of implementation at the ground level. Based on these framework and its guidelines this has been experimented in many states. Apart from not so acceptable outcomes of the communitization throughout the country, there is a state that is pioneering in the process of communitization. And the best practices could be seen in the health institutions of the

state Nagaland which is going to be discuss in the further sub-section for enhancing the clarity over its processes at the implementation level and its impact on the health status of the local people.

3.3 Communitization Experiences of Nagaland

Based on the above framework the VHSCs has been moving forward by conducting their activities at the local level. Many states are experiencing the communitized VHSCs through its activities and implementations. There are mixed experiences related to the communitization process in different states. Nagaland is the pioneering state to practice the communitization through inculcating it into the management of the essential public services like education, health, power etc. by the village and local users by delineating both administrative and financial responsibilities to the local bodies. This is trying to incorporate an idea of an approach to achieve a good primary health care that lays emphasis on the health care provision by the people, as it centre's on people's participation in their own activities.

Nagaland, got statehood on the 1st December 1963 and it is the 16th state of Indian Union. Prior to Independence the state with an expanse of tough terrain and full of greenery inhabited by the tribals remained isolated and neglected. There was only limited administration considered essential by the Bristishers to maintain law and order in this region. As a consequence, even little technological changes in other parts of the country did not bring any impact in this area and people remained economically and socially isolated from the rest of the country and semi-isolated pockets of development took place. After the Independence, the Government of India adopted the policy to bring the tribal to the mainstream of national life by opening up the avenues for their developments. Government formulated various development programme in such a way that there should be the minimum disturbance to the existing social structure and at the same time taking efforts to make the norms and social values responsive to the changes as a sustained efforts to develop these areas economically. The state of Nagaland is having an area of 16,579 Sq. Km. it is one of the North-Eastern states of India and

according to the census 2001 it comprises of 11 districts (including three new Districts of Peren, Kiphire and Longleng), 52 Community Development Blocks, 93 Administrative Circles and 1278 villages. (Govt. of Nagaland, SPIP: Nagaland, 2008-09: 6-11)

The state is predominated by the tribal population with an average population density per sq.km of 120 persons (Census 2011). The population density is highest having 333 persons in the Dimapur district to its peculiar topography and difficult terrain. Apart from the topography, the tribal customs also give in to widely dispersed settlement pattern of the population that applies to the whole state. There are seventeen tribes, most of them being Nagas, each of which has distinct customs, traditions and languages and inhabited in 1278 villages (census 2001). The sex ratio is 909 as per the census 2001 and the literacy rate is highest in Mokochung District (84.27%) and is lowest in Mon District (43.25%) of the Nagaland (ibid).

3.3.1 Genesis of Communitization in the State

The underlying health system was inherited at the time of statehood in 1963 itself. Over the year the Nagaland government established a network of health institutions throughout the state in various sectors in almost all villages. It was found that despite resource availability there are many unresolved problems such as many continues to suffer and die from the preventable diseases, pregnancy and child birth related complications and malnutrition and the increasing burden of the emerging threats and challenges like HIV-AIDS, lifestyle diseases, increasing age of the population and re-emergence of communicable diseases having the potential of undermining the health and developmental gains made so far (GOI-UNDP Project, 2011: xiii). However, the reasons were mostly underutilization of the health institutions by the community due to mismanagement and negligence, lackadaisical attitude of functionaries at all the levels and cursory job performance by the staff, high absenteeism from duty, decadent monitoring mechanism and supervision, lack of accountability and also because many of the community was hardly consulted or taken into confidence which makes them passive spectators in the development process and often become victims of inefficiency and

insensibility (WHO, HSR in India, 2007: 75; GOI-UNDP Project, 2011: 5). Yet, it leads towards the uneven sharing of the health gains with the health gaps between regions and among the different social groups. Hence, as a consequence the feeling of mistrust and alienation among the community developed which leads them to seek the services of the private institutions. Moreover, people see the government as an authority as the government institutions and its facilities were owned and managed by them and the sole responsible for the service delivery. Sue to these people were hardly had a sense of responsibility or belongingness to the public institutions and services and tend to disregard, even destroy the government property. Overall it can be said that these were the expressions of the resentment and frustration of the community at the perceived failure of government (GOI-UNDP Project, 2011: 5).

Under these circumstances, the government launched an enquiry process called "Imagine Nagaland" with an objective to engage community in the constructive dialogue to ensure the priorities of the community ultimately shaping up the priorities of the state (WHO, HSR in India, 2007: 75). Improving public service delivery at the grassroots level emerged out as one of the important priorities. The state government recognized the need for the community participation as an underlined requirement to achieve health and sustainable development and so the programme was initiated by transferring the power and responsibility to the community with the underlying measures of harnessing the state rich social capital by tradition and culture, strong tribal and village community bonds that is more organized, effective and participatory , and traditional village councils to vitalize the public institutions by launching the "Communitization Policy" with the enactment of Nagaland Communitization of Public Institutions and Services Act in 2002 (GOI-UNDP Project, 2011: 5).

The Communitization policy in the health sector gave thrust on three prime goals that community will take over ownership and management of health centres and the staff, they will promote/protects its own health through preventive actions and education and they will popularize/promotes indigenous health care systems & its practioners. So, the community based committees have been formed such as Village health committees

(VHSC) and Village Education Committees (VEC) under the communitization where the committees have been delegated the powers and responsibilities of management such as disbursal of salaries with power to enforce 'no work, no pay', control of attendance, grant of leave, maintenance of buildings and assets and purchase of essentials etc. To exercise these powers, the state government relaxed Rule 217 of Central Treasury Rules to allow drawl of advance salary up to three months by amending delegation of financial and cognate Power Rules, 1964 to give power to drawing and disbursing officers to sanction ' salary deducted amounts' to grant-in-aid; with new arrangements worked out for new arrangements (new formats, crediting drawn amounts into committees bank account and record keeping by committees) and two bank accounts opened per VHSC/village (current account to keep staff salaries and savings accounts to keep all other grant-in-aid). The State Bank of India also waived conditions of initial deposit to open the account. Later the implementation was started with intensive social mobilization process by the awareness campaigns, capacity building and training of VHSC members, Departmental officials, and the other stakeholders including trainings of trainers on the new roles and responsibilities to be taken. The periodic publishing of handbooks on updated systems, forms and norms was done on timely basis for wide circulation along with the separate training on financial transactions and records keeping were conducted for the cahiers/ accountants of all Drawing and Disbursing Officers (DDOs). The four types of committees at different levels were set up with representatives from all sections of the society viz. at the village level two committees were constituted by the respective village councils namely Village Health & Sanitation Committee (VHSC) and at the sub-health centre level the common health sub-centre committee covering more than one village (federation of VHSCs). In Town areas urban health centre were constituted by town ward/colony councils. And in the CHC/PHC level Health Centre Managing Committee (HCMC) were constituted by beneficiary village councils/town committee. The role of state and Health departments is as a facilitators, Guide and supportive supervisor. The Civil Surgeon carried out the function at the district like providing staff salaries and Grant-in- aid for other purposes, manpower posting in all the health centres, training and capacity building of health committees and technical support in all matters to sustain

communitization. The monitoring and supervision of the programme is carried out at the state level by the state communitization committee and district supervisors, at the district level the district coordination committee, at the CHC/PHC the civil surgeon and medical officer in-charge in their respective jurisdictions and at the village level by the village councils (WHO, HSR in India, 2007: 76). So here it is very much evident that the government made all the possible way to achieve the goal of handing over the responsibility to the community through the communitization process.

3.3.2 Communitization in Nagaland: A Case

In Nagaland presently there are 11 District Hospitals, 21 CHC, 86 PHC, 397 Sub-health Centres, 2 TB Hospitals, 1 Mental Hospital, 1 Nursing college, 2 General Nurse Mid-Wifery (GNM) School and 1 Auxiliary Mid-Wifery (ANM) school, 1 Paramedical Training Institute, and Naga Hospital Authority (NHAK) as state referral hospital. (MoHFW, 2009; GOI-UNDP Project, 2011: 3)

Since 2002, a total of 358 Health centres (including 350 sub-centres, 7 PHCs and 1 CHCs) were communitized (GOI-UNDP Project, 2011: 11). The health committees conduct their meetings regularly and take up work like cleaning, minor repairs, relocation of sub-centres, construction of staffs quarters and providing equipments such as furniture, gas stoves and fridge. They have undertaken health promotional activities such as cleaning of villages, arranging medical and awareness camps and also village issues like banning free roaming of domestic animals. The practioners of indigenous medicines/healing have been identified in the three sub- health centres and were promoted to practice at the health centres They are required to maintain patient registers both at health centre and at their homes. The seminars were organized for these practioners to provide trainings and activities are facilitated by providing the necessary financial and technical support (WHO, HSR in India, 2007: 77).

Involving Indigenous Health Practioners (IHPs) were one of the important reasons for the success of communization. At most of the places where these barefoot traditional health practioners were neglected or inception of modern health care techniques by the

government snatched their bread and butter these traditional healers turn into a major force of resistance pursuing community to become hostile and not to accept government health intervention. Thus integrating and acknowledging indigenous knowledge of health care under the communitization efforts proved vital for its success. Trainings and supervision are also providing to the health committees so that all the activities could be implemented through them. The government transferred the three months salaries and medicines funds to these committees and the health departments took initiatives for health promotional activities by designing folders of eight commonly prevalent diseases in local dialects, and also the VHSC and VEC converged for health promotion in school (ibid).

Despite of this smooth implementation, the communitization process faced problems during its implementation both from within the departments as well as the community. It has found that the department officials resisted giving up some powers and establishing an equal partnership with the community indicating towards the need for change in the mindset in the staff for greater commitment, professionalism, sincerity and discipline. As a surmount strategy a series of consultation was undertaken to drive home the concept and the benefits of the communitization to achieve the overall improvement in the health system and health status of the community through involving the actively in the planning and execution of activities. On the other hand, community felt that government is throwing its responsibilities and burdening to them leading to the lack of motivations in the community in accepting the new responsibilities without any remuneration which seems one of the major hurdle. The problems were tried to solve through the intensive awareness campaigns, close supervision and guidance, active involvement of political and socio-religious bodies in progress (ibid).

So the question is at what extent the government officials keen to deliver their power to the local people and how much they have trust on them as a partner. And if they are resisting doing so then what are those underlying factors and fears that taking them away from the basic understanding and needs of the communitization. It was evident that the problems tackled for ensuring the community's participation were addressed but what

about the clarity and understanding of the officials representing the government and the first hand contact between the government and the community at the grassroots level which were unaddressed. It is very important to deal with these problems to ensure the healthy relationship between the community and the government to achieve the notion of real partners.

Based on the above grassroot level implementation for communitizing of the local institutions the state had experience both the good as well as challenges in the whole process. Here we discuss the impacts of the communitization process in the state Nagaland.

3.3.2. (A) Impact of Communitization: Good Practices in Nagaland

a) The health facilities are now being fully run by the community with improved staff attendance, improved availability of medicines and redeployment and posting of staffs in all the health centres, enhancement in the dedication and sense of responsibilities related to their jobs in the health workers, and the jurisdictions were clearly defined. And the community contributions were enhanced in the regular cleaning of the health centres premises and contribution in cash and kind.

b) The outcome of community ownership leading towards their enthusiasm to develop the centre to meet all health requirements of the community even beyond the standard set by the department of health and family welfare through public contributions. And it has been found that the health facility became a ‘community asset’ and is central to the core activities of the village life in the village. This is depicting that the communitization is welcomed by the village community.

c) VHSCs improved the conditions of the health centres by voluntary contributions of materials. And there is an improvement in the staff attendance and attitude to work as well as towards patients, an increase in the attendance of the patients in the health centres and the medicines availability and also in its quality appreciated and a change in sense of ownership among VHSCs/ villages.

d) The Communitization Act has created space for the motivated ones those who desire to re-ignite community creativity and invent it for positive actions

3.3.2. (B) Communitization in Nagaland: Identified Gaps

a) Good health for all found to be far from the reality despite of the communitization policy in the state where the state has decentralized the management of the health units to the community for ensuring the good health delivery system. It is due to the lack of good quality of leadership in the community and lack of enabling environment mainly related to lack of capacity in terms of inadequate infrastructure (building, equipment, furniture, and medicines) and human development for functional redeployment of district staff.

b) There was lack of resources for constant supervision/ monitoring by field officers and there is also a need for intensive and focused trainings.

c) This also includes the strengthening and sustaining community involvement and dealing with the fatigue syndrome.

These cited problems seem as threaten to negate all the community's good will, confidence and motivation that have been achieved so far. It has been found that the community participation was limited to the infrastructural development such as constructing buildings, donations in cash and kind. In the communitization it was expected out from the community to contribute in cash or kind for the sustainability. But the question here is why community should bear such costs when the community is already paying tax to the government. It is clearly depicting towards the governments motives for the reduction of the fiscal burden or by cutting down the cost from the state and though it also makes the community more responsive to the health needs but development depends on this is apprehensive for its sustenance.

And it has been taken into consideration that the community participations should not only linked to the cost sharing but should also include other problems in health system such as developing capable community and effective leadership, health administrative

reform and the infrastructure development. The state government has undertaken measures to address these challenges as it envisaged that communitization along with the other changes brought under the NRHM will bring improvements in the public health system to meet the needs of the people (GOI-UNDP Project, 2011: 32). According to the UNDP report on Nagaland's communitization the institutions are meant to be more communitized when the committee is enhancing their participation and contribution in both their cash and kind. But the apprehension here is if the base of the evaluation is the contribution part of the community to ensure the level of participation then it raises the question that how long any program or health institutions will sustain for the public to run/contribute at their personal cost/ or community loss. And this will definitely bring the inequality in the performances due to the difference in different socio-economy among and within the country, states, districts, sub-districts and the Panchayats.

3.4 Present Scenarios of Communitization in India

The Communitization process in the state of Nagaland has a pioneering status with the good practices and experiments through the institutionalization of the health institutions and people's participation in its management and administration. The Nagaland gave a clear evidence of the communitization process in the state and leading further towards the present scenario of communitization in the whole country of India.

According to the Fifth Common Review Mission Report of 2011 it has came out that, the most essential part of the rural health service delivery system's through the ASHA's, which seems to be the driving force for enabling the increased access to the health system and providing community level care for mothers and child. Different states of the country overall brings out an understanding that there is a good progress in the delivery system through ASHA's by setting up of support structures for the capacity building and empowerment of the ASHA's, Active trainings based on these structured support systems elements, streamlining of incentives payments as an important motivational factors for the ASHAs, better regularity of them in their services and actions and the improvements in the collaboration with the AWW and ANM. Though many Non-high focused states

like Andhra Pradesh, Haryana, Karnataka and Gujarat are managing with the existing staff which is emerging as one of the barriers to effective outcomes due to no deployment, this leading in degrading the quality of performances as an ultimate results, still there is low detritions rate founded in most of the states and primarily on account of ASHA's moving into other career path's leaving their positions for a change or as a consequences of role ambiguities. The ASHA's role is more pronounced as a facilitator of services, taking care of the people health by doing the regular visits for the newborn and post partum care and it has been seen in the states like Uttarakhand, Odisha, Rajasthan, Uttar Pradesh and Chhattisgarh. And these states also initiated the ASHA training in Module 6 or equivalent for maternal and child health care for their further progress. ASHA's in the country are seen to be very active in most of the states and many good practices has been emerged such as grievances redressal systems for them was established and were seen practicing in the health systems of the states like Andhra Pradesh, Chhattisgarh, Assam, Odisha and Sikkim. The replenishment of drug kits in a regular basis is the problem of the all states. Report also brings out that, the Performance monitoring of the ASHA's support system from the few States such as Chhattisgarh and Rajasthan for keeping check into their performances. It is giving out a clear vision that ASHA's are still on the way to be progressed and lots of structural problems hindering her to be communitized in a real sense, but there is a vivid hope as they have amply accepted by the community for her service provisioning.

To ensure the better process of communitization in the health services system the NRHM emphasized in the preventive and promotive health services including nutrition along with the Inter-Sectoral convergence. And the major convergence in the state and at the grassroots level was between the field staff of ICDS and the health was founded to be interactive and effective. This was basically experienced in the state of Andhra Pradesh, Sikkim and Odisha. Moreover, the services or facilities adding to the convergence were the Nutritional Rehabilitation Centres (NRC) which was described in Bihar, Chhattisgarh, Gujarat, Jharkhand and Rajasthan. It has been seen that the nutritional factor have been considered as a essential requirements and given special focus by the government, and in

action tried to converge with different other departments as an assurance strategy in a special manner came out according to the fifth CRM report.

In most of the states Village Health and Sanitation Committees (VHSCs) have been renamed as Village Health Sanitation and Nutrition Committee (VHSNC) with the addition of the nutritional factors and its provisioning and assurance through the health committee. The total number of VHSNC established in the year 2011 was 483496 i.e. 76% of the total villages (RHS, 2011 as cited in Fifth CRM Report) reported for the total number of villages i.e. 638000 as per census 2011. The functionality of the VHSNC described was varied in different states but the effective health committee's founded according to the functions was of the Andhra Pradesh, Sikkim and of Odisha and the state like Bihar, Jharkhand and U.P the VHSNC was accounted to be in a primordial phase of development. The health committee in some states like Goa and Odisha undertaken the initiatives such as cleanliness drive to control vector borne diseases. And it can be said that the overall potential of VHSNC as a platform to address the social and environmental determinants of health (physical, community and /or economic/ financial conditions such as access to services and community, social support and isolation, quality of air, water and soil, housing, income, distribution of wealth, access to safe drinking water and adequate sanitation, disease vector breeding places, sexual customs and tolerance, racism, attitudes to disabilities, trust, land use, urban design, sites of cultural and spiritual significance, local transport options available, etc.) are remained inadequately untapped. But there are some progressive indications in addressing of both the nutrition and social determinations of health in few states such as Bihar, Jharkhand, A.P, Gujarat and Odisha with the involvement of the NGOs or program such as Mahila Samakhya (in A.P).

Apart from the convergence functions of the VHSNC there were more examples of Village Health Plan (VHP) whose functioning can replicate as a model for the others to emulate need to be built up. To understand the decentralization an important approach of the communitization in the health service system, the better way is through the local health actions in each level. It has been come out that in most of the district the District Health Action Plan (DHAP) are in place but with the varied degree of quality. The

quality differed due to the variation in the participation degree across the districts with the limited involvement of non-state actors and stakeholders in preparing DHAP. It has been found that in many states, in the planning process the use of the HMIS district reports has been improved but with the little evidence on the use of it in planning for intra-district difference. Now coming up to the VHSCs at the village level of the Districts, majority had functional VHSCs almost in every state with the co-signatories of ANM/AWW. The important function of the VHSC, preparing of Village Health Plan (VHP) is not yet institutionalized anywhere and there are no clear models or clarity has been found regarding its roles and utility in the states. There was an increase in the utilization of the untied fund for the village health and sanitation committee (VHSC) and Rogi Kalyan Samiti (RKS). But the important components in the composition of the VHSC the PRI members were seen with the very limited involvement on the health planning process and its function of VHSNC and RKS. The community monitoring was only happened was in the state Karnataka and it was going to be started soon in Bihar.

Overall the communitization process in India is in the rudimentary phase and apparently showing or brought the major changes in the ASHA programs, the VHSNC and the RKS in terms of strengthening of the community participation and mobilization. But still there was a scope of progress in the areas such as community participation of the community in each phase of the communitization such as planning, management and implementations of the interventional activities and increased NGO involvement which have not picked up yet for the better health care services. Here emerging issues are that the facility development to achieve quality of care remained yet a major issue due to poor baselines and in addition due to the internal institutional capacity to generate, recruit and train the human resources. Due to these weaknesses some of the focus states like Jharkhand, Chhattisgarh, U.P and Bihar are particularly lagging behind. At the end, it can be said that the status of communitization that have been used by the NRHM as an important approach is not found to be satisfactory. It seems to be dawdling with the lackadaisical community participation with the low ownership for the government institutions and the assets and decentralization with devolving the power but in improper way in each level of

the administration affecting in ensuring the better functioning of the intervening programs such as ASHA program, VHSNC and RKS an important component of NRHM to achieve communitization: a path towards primary health care by involving people's in their health care decision making and management. Despite of unsatisfactory progress of the communitization process still there is a hope that it will bring changes and betterment in the health delivery services as it is most admirable approach to reach out to every individual of the country through involving them and lending responsibility of their health in their hands.

CHAPTER 4

Communitization: A Case of Village Health and Sanitation Committees (VHSC) in Jharkhand

Communitization: A Case of Village Health and Sanitation Committees (VHSC) in Jharkhand

Jharkhand is one of the newly formed states and it has implemented the activities of NRHM and has transformed public health services delivery in the state. The status of the health institutions as reported in the 5th CRM report (2011) is of 24 *7 PHCs in the state is like out of 330 only 22 PHC are functioning on the 24*7 basis. There are 17 District hospitals and 7 CHCs that are working as FRUs. Around 40,964 ASHAs has been selected and 40,115 of them have been trained up to the 1st Module and about 40,964 ASHAs are trained up to 5th Module and no ASHAs have been trained in 6th and 7th Module. The status of the contractual appointments have been positioned under NRHM is about 478 Doctors, 576 paramedics, 862 Staff Nurse, 31 Specialists and the village level health functionaries are about 4098 ANMs and 50 Ayush Doctors. The institutionalize health committees in the villages under the NRHM is Rogi Kalyan Samiti (RKS) which is having 481 facilities that has been done by merging of 21 District Hospitals, 170 CHCs, 36 other than CHCs and 254 PHCs through registering with RKS. The Rogi-Kalyan Samiti is operational at 24 District Hospitals, 170 CHCs and 231 PHCs. The merger of societies is completed in 24 districts and out of 24 districts, 22 districts have started developing their own District Health Action Plan (DHAP). The village level health institutions VHSNC status is out of 32,615 villages only 30,011 villages constituted VHSNCs along with 10,000 joint accounts operationalized at sub-centres and VHSNC in the state. The meetings of State Health Mission which is held 3 times and District Health Mission meeting held 50 times have been reported as a regular meetings held in the state by the 5th CRM report. Moving further, knowing the current status of health institution in the state which helps us in developing better connections for the understanding of the overall status of communitization where the community utilize and manage these institutions for their health needs. It is done through the findings that have been emerged out from the study that have been conducted in the two district based on the intervention as per the field of the developmental agency CINI and non-intervention areas having only the intervention by the government in the state of Jharkhand.

Before heading towards the finding from the study done of the VHSCs, it is necessary to have a historical background of the health initiatives in terms of the community participation in the state. The ASHA's are not new to the state as it has been already introduced before the establishment of the NRHM as a concept of Sahiyya's in a mode of movements in the state of Jharkhand.

Historical background of Sahiyya scheme in Jharkhand

In the local dialect Sahiyya means the "Friends" and as per the background it has been discovered that they are the results of the "Sahiyya movements" taken place in the state. As Jharkhand is a predominantly rural state with a large tribal population living in highly inaccessible areas where there has been no tradition of Panchayati Raj Institutions (PRI) in the village before December 2010 which is resulting in little or no community organization (at least in the eyes of the government). In order to provide quality health care services to the 'Last person in the last household of the last village', the government of Jharkhand initiated the Sahiyya movement after a pilot in 2004 to encourage community to participate in delivering quality health care to the needy and with a motive of empowering women.

The programme aims to focus on women and children in marginalized sections of the community particularly in remote, inaccessible areas. The key activity is the establishment of community health workers called Sahiyya, democratically selected by the community and approved by the VHSC, in the pivoting role.

Since 2004, the Sahiyya movement is going on in the Jharkhand state for its advantages in empowering and encouraging the community to focus on their own health needs, acceptance for the health care and advice provided by a women- the villagers know and trust, cost effectiveness to ensure a wider reach of health services without great cost to the health departments and for wider reach to all the villages in the state irrespective of its location and culture.

The programme has been influenced by the programme of Women group leadership promotion programme namely Sanjeevani, Haryana and the Mitanin Programme of Chhattisgarh where the team from Jharkhand was sent for the study of their programme before the piloting of the programme.

Initially the programme was started in the 52 blocks as a pilot project but its large scale rollout was during the NRHM period and it was continued using the same Sahiyya scheme rather than adopting the ASHA scheme recommended in the GOI's NRHM (www.hsprodindia.nic.in/retopt2.asp?SD=25&SI=5&ROT=4; Accessed on March 6, 2012).

4. Findings of the Study:

Intervention Area: Four villages of the Khunti Block of the Khunti District namely Phudi, Kalamati, Chikor and Manhu where the NGO CINI. The development agency CINI intervenes in the basic thrust areas like on the sustainable development education, protection and care, health and nutrition of child, adolescent and women groups in need through adopting 'Child and Women Friendly Community' (CWFC) approach.

Non-Intervention Area: Four villages of Ghaghra Block of the Gumla District namely Sarango, Salgi, Sirkoat and Ranhe which fall within the distance of 3-8 Km from the block PHC/CHC are directly having a government intervention for the VHSCs.

4.1 Community participation

4.1.1 Formation of the VHSC in the two blocks:

4.1.1. A) Selection Process of the VHSCs

The Village Health and sanitation committees in both the intervention and non-intervention areas were formed on the lines of the Memorandum of Understanding (MOU) between the state government and the NGOs which were selected owing to their presence in different geographical/operational areas, area of intervention, expertise and

foothold in the targeted community. In both the District namely Gumla and Khunti, the VHSC was formed in the second phase falls under June 2007 to Dec 2008 –January 2009.

The responsibility of the VHSC formation and the selection of the Sahiyyas were on the shoulders of the NGOs. Both the VHSCs and Sahiyyas are the measures to enable the community members to have stake in decisions related to health related well being in their own hands, put forward demands and seek the institutionalized government services that are needed. The concept of female health extension workers (HEW) assisting the rural people in availing the health services in some of the blocks in Jharkhand is not new. Before the formal conception of the National Rural Health Mission, some NGOs successfully experimented with 'Sahiyya' a local word meaning 'Friend' or 'Saheli' in the state vernacular dialect. Sahiyya is a volunteer who is supposed to assist the villagers for their health needs and bridge the gap between the health care systems and community. The Formation of VHSC and the selection of the Sahiyyas are done in different phases excluding blocks covered by the NGOs earlier. In Phase -1 (Pilot project intervention) in 2005, Sahiyyas were selected and trained in 34 blocks. These blocks were falling within jurisdictional areas of six districts namely Ranchi, Hazaribagh, Jamtara, Dumka, East Singhbhum, Gumla and Saraikela-Kharsawa in the state of Jharkhand.

In the Ghaghra Block of Gumla district Vikas Bharti and in the Khunti block of Khunti district Nav Bharat Jagriti Kendra (NBJK) on the basis of their claims around operational areas approached to undertake the activities. They both agreed on the contents of the programme to implement the Sahiyya program in coordination with and or on behalf of the State health departments in the respective blocks of the above mentioned districts of the Jharkhand state. They agreed to undertake to facilitate the formation of the VHSC and mentor them in every village and identify, select and train Sahiyyas in every hamlets of the above mentioned area. The NGOs undertake the responsibility to follow processes for the selection, training and supporting the Sahiyyas as mutually agreed between them and the state health departments and as outlined in the operational guideline (Standard Operating Procedure). They were supposed to be instrumental in mobilizing people by orientation, facilitation, organize meetings prior to the formation and the selection of the

Sahiyya in the village. These development agencies were proclaimed to have expertise in the particular area of intervention, well acquainted with the geographical terrain and expected to have already developed considerable rapport with the clear understanding of the area.

But ironically it has been observed that the proposed steps and mode of disseminating and orientation of the villagers regarding the village health committees were not followed precedent in both the district's block. By the time the selections were made those who were selected, hardly had any idea regarding the motive and purpose of the formation of such committees and their role specifications. People were only informed that the females were going to be selected in their village for the health related activities to be conducted along with the ANMs. But no concept seeding around the ideas, purposes and the roles assigned to the VHSC members, village community and office bearers were given to them.

The majority of the VHSC president and Sahiyya talked about the formation day of the committee that villagers were scarcely informed and consequently they organized village meeting in the Akhara[4] where people from the few or centrally placed hamlets of the village were gathered. Mostly the women associated with some women self help groups (WSHGs) along with the influential persons of the villages like Gram Pradhan[5] and Pahan[6] or the local elites showed their presence along with few other males. Most of the women shared that prior to their selection as Sahiyya they were already approached by the facilitator NGO for their individual consent as they were already associated with the NGO in some or the other way and had worked with them in any of their projects in some

[4]Akhara: An important common meeting place in a village where political, social and cultural meetings take place.

[5] Gram Pradhan: A village head part of the local governance system looks after the village affairs and selected traditionally.

[6]Pahan: A local traditional priest of the village.

capacity. Apart from such identified women, NGO facilitators also approach the ANMs in their jurisdiction villages where they didn't know the villagers. In some villages there were more than 40 people whereas in other villages there were hardly 10-20 persons present in the meetings. In the presence of these many village attendees accompanied with the NGO facilitator, Sahiyya of the facilitator's choice got selected that was followed by the selection of the VHSC President and the committee members in the same day long meeting. The VHSC comprises mostly of the women with little of presence of the male folk. Though as per the guidelines the post of the office bearers other then Sahiyyas was not necessarily to be assigned to women only but preferably. It reflects on the low enthusiasm and participation of the male folk and their eagerness to take up health related responsibilities at community level as such roles are traditionally assumed to be taken up by women (nursing and caring role). On the other hand in the name of the community participation where ideally both the genders would have been involved the male members were discouraged to formally participate being an office bearer. The very fact is evident from the cases like as in a village namely Sarango (Ghagra/Gumla) earlier a male president was selected but he was replaced by a women according to the instruction got from the block PHC.

Whereas in Khunti block (Khunti) village like Manhu, Fudi are the villages where they were already late in the selection process and ANMs were instructed to form the Committee as early as it is possible. As a result after the Sahiyya selection in the presence of handful of people they themselves (Sahiyya) select the President and committee members by registering a minutes of the processes in the register signed by the Gram Pradhan and the 10-12 people present in the meeting and submitted it to the Block PHC office.

> *"Our VHSC was formed in April 2010. For this a meeting was organized in the village Akhara where all the villagers along with Nav Bharat Jagriti Kendra (NBJK NGO) member were present and they selected me as VHSC president. The bank account opening was done in the same year followed by the formation of the committee."* VHSC President, Khunti.

"For VHSC formation we got instructions to organize a meeting where we were asked to select the president but it doesn't happen actually in the manner it was desired to be done, because we were already late in the whole process. So, what we did was we prepared an application in which we mentioned it in the process recording register that we have selected Sahiya and president respectively and got it signed by Gram Pradhan along with 10-12 people of the village leaving the discussion part as prescribed. Then we submitted it to the block office. After that we have opened our bank account in 2009 under pressure duly created by the block office." Sahiyya, Gumla.

"Initially there was no such VHSC in our village. After the Sahiyya selection the block officials asked Sahiyya to open a bank account for the untied fund transactions. So she asked me to be one of the account bearers. Till then and even now I had no idea about the actual roles and responsibility except as account signatory being an office bearer." VHSC President, Khunti.

It has been observed that the representation in the whole formation and selection process of the VHSC was compromised by some dominant sections and interest groups of the community such as the village headman, Pahan, ANMs and SHG's presidents which already had a say in all village affairs. The attendees in the meeting held were comprising mostly of the male members, certain influential persons form PRIs or tribal Self Governing body heads, the local elites, women associated to certain community based organization - especially from Mahila Mandals (SHG) owing to certain kind of influence over the community and in the village during the entire process of formation as well as selection. Though all the decisions pertaining to select the Sahiyya and the VHSC presidents were taken in the open forum but still somehow it is hijacked by such dominance of influential people. Thus complete and ideal participation was severely compromised at the village level even if it happened in the full presence and view of all the villagers. The facilitation and acknowledgement of the perspectives, view points, consents, inputs and knowledge awareness of all the major sections such as all men, women hailing from rest of the village hamlets, differing clans and other pre-existing

committees of a village community at the entire village level were not equally present and accessible in the whole selection and formation process. Though the office bearers thus selected were suppose to represent the entire village. Apart from the internal intricacies in ensuring the community participation there is also an influence exertions and pressurization from the health functionaries at block level and others at PHCs such as Auxiliary Nurse and Midwives (ANMs) in the selection of the Sahiyyas and the VHSC president of the village and it was apparent that they were somehow already chosen prior to the village meeting.

As people were having impressions that the process is related to the health activities so the ANM's suggestions were preferred and counted as be more valuable without having any doubt over her individual discretion . So the decisions were taken by the ANMs with uncontested agreement by the community. But the major influential group or can be said that the manufactured consent for the candidates pre-decided to be selected was played by the NGO facilitators themselves. They approached to those who were already associated with their NGOs or having some prior experience by dint of their prior association with those NGOs and or working outside for some of the welfare activities that have been taking place around the village. There are also many cases where the selection process was just done for the formality on paper in a hurried manner due to the dropouts of the early selected office bearers of the committees. The various reasons being as reflected through different responses were community being ill informed, lack of roll clarity of the office bearers, household responsibility and husband's pressure on Sahiyyas, wide work coverage including frequent block visits and reporting's, monitory expenses anchored for frequent visits to block office for training at their own, low remuneration and incapacity due to neo literacy (low academic profile as they could not cope with the exhaustive training procedure), power equations of local elites as they selected them and the communities were unable to resist because of the social desirability and need of the time, attempt to manufacture consent by the facilitator NGO based on favoritism, block officials pressure. Thus the agencies that were expected to act as facilitators assumed the role of pressure groups and reinforced their choice in the process

of selections coupled with the dominance of certain sections in the very manner that departs from the core idea of community participation that was essentially supposed to be an essence of the communitization process.

4.1.1. B) Views on the selection of different stakeholders of the VHSC

At the most instances the Sahiyyas shared about the selection process of the members/office bearers in the formation of the VHSC revealing that in some of those village where the facilitator NGO already had a foothold in the course of their earlier project intervention for instance in case of Ghaghra block of Gumla District Vikas Bharti (NGO) identified women those were actively associated with them through Setu Vidhyalaya educational project for the Sahiyyas selection. On the other hand in Khunti block of Khunti District most of the Sahiyya who had already joined got replaced by new ones in significant numbers ostensibly due to some or the other personal reasons cited by the earlier. The new lot was already late for trainings so they were reproached by the ANMs and the other village women owing to their pro-activeness in the village affairs and as they were much vocal, literate enough and able to give time for the work and transmit knowledge and information given by the block health departments. There were also some instances of false motivation was intentionally given convincing the candidates for the position of Sahiyyas as in the case of the Ghaghra block where women were told by the facilitator that they got information by the government bodies that Sahiyyas are going to be the permanent employee of the government in future. But in the Khunti block of Khunti district most of the Sahiyya were already aware of the job profile, nature of incentives given and engagement as they replaced those who left the job because of some reason or the other. They themselves took the responsibility of the Sahiyya with the hope that there may be some considerations around increment in their incentive/ remuneration in future despite any promises. The Sahiyya were told that they have to work in coordination with the VHSC as the fund will be disbursed though VHSC bank account, a joint bank account to which she would be a signatory. Further they were delineated to undertake health and sanitation related activities in cooperation with the committee

president and other members ensuring accountability of the proper use of the untied fund thus given to the VHSC.

> *"I have been selected as Sahiya in 2006. The selection was done through the gramsabha where villagers as well as people from the Vikas Bharti were present in the meeting. They nominated my name for the Sahiya because prior to this I have already worked with the Vikas Bharti in their some educational projects like Setu Vidhyalaya for one year. So this was the reason for which they gave preference to me. I am intermediate fail as far as my education is concerned but still wants to continue this job because it helps me as a source of income and people's respect.*" Sahiyya, Gumla.

> *"Yes, the Sahiya selection was done in 2008 in our village and two ladies worked at least for 2 months and then resigned. Lastly in the same year I have taken the responsibility. Before taking up the responsibility I asked Anganwadi Sevika to reproach other ladies who might be interested in taking up the task as the people might think that I am intended to grab all the opportunities that came to our village all alone. I asked them not to complain in the future because I have already been preoccupied with my engagement in the job of an NGO called 'Jan utthan' for around 12 years that I can't compromise in between. Later, all ladies agreed for me to hold the Sahiya position as we were already late for freezing Sahiyya position from our village to the block office and non were agreed to take the position."* Sahiyya, Khunti.

The observed instances here relates to the self perceptions of the Sahiyyas about themselves and their reflections around selection process. It was also evident that the job opportunity as Sahiyya was seen as an offering to someone who was economically weaker with no other fixed source of income (e.g. BPL or Antodaya Card Holders, spouse of farmers with small land holdings, spouse of physically challenged husband). This happened in the villages where unlikely intervention of NGO representatives or other pressure groups were least or absent. But such instances can be seen as a good

practice if other parameters of Sahiyya selection were not compromised at the same time. But there were contrasting observations as well. In the Gumla district most of the Sahiyyas are neo-literate whereas in Khunti district the Sahiyyas are mostly literate. Few of the Sahiyyas are already engaged with the other NGO's work/ activities for the sake of a source of income. As a part of observations if one looks at the socio-economic profile of the spouse of most of the Sahiyyas, their husbands were literate, running grocery shops in the village, working as Para-teachers in village primary schools, good daily wage earners in nearby town, PRI members, small contractors or having working experience in some NGOs. Possibly these attributes of the Sahiyya's husbands made their husbands to land familial support to Sahiyyas right from the selection process to the permission to these women to frequently visit block offices and PHCs outside villages without any apprehensions. Apart from this considering status of their husbands there are few Sahiyyas who are sole bread winners of the family as their husbands are either physically challenged or medically unfit (due to some chronic ailment) to take care of their family needs and in few cases are widower. Some of the Sahiyyas seemed to be opportunistic as no one were ready to take up the responsibility though they were already caught with some of the other kind of activities and apparently was not able to justify the desired roles and responsibilities as Sahiyya Almost invariably all of them seemed to work enthusiastically and ready to take new activities assigned to them as there was an excitement coupled with motivation and learning experience for most of the Sahiyyas to take part in village affairs and communicate with the world outside village. In almost all the tribal dominated villages the Sahiyyas are tribal but in few villages there are also non-tribal Sahiyyas representing their hamlets. It has been observed that in the villages where both the Sahiyyas are working together against common grounds and towards common goals, the decisions are generally influenced by the non-tribal Sahiyya. Though mostly the Sahiyyas were found to be self motivated to voluntarily work but they were usually pressurized to take decisions under the influence of government officials sitting at block or PHCs. The latter (government officials) claiming the Sahiyyas enjoy freedom in decision making with community consent at village level but reality differs from actual

scenario. The government apparatus thus in disguise of lending support, facilitation and training usually found to impose their own ideas

The VHSC president shared about their selection that during the meeting on the selection day they were present and added that with the consensus they were selected by the villagers for the said position owing to their proactive participation in the village affairs and required attributes like basic literacy to handle the accounts. But at many instances as in the case of the president of Chikor Village of Khunti block as she told herself that she was agreed because no one was ready to take the responsibility. Whereas in Manhu Village of Khunti block the president was agreed because she is friend of the Sahiyya and Sahiyya felt that she can accompany her in the meetings and in the paper work required in the bank. In Sarango village the previous VHSC male president was replaced by the female president as he was unable to give time for this activity or possibly he was having discomfort in being a member president of the committee predominantly comprising of females only which he realized latter. So the villagers along with the Sahiyya re-selected the president in the village meeting especially organized for this purpose.

"Initially I was not the president of VHSC. Some other man was the president. As Sahiyya told \you that she always has to wait for him in conducting any kind of work. Later he himself told that it is very difficult for him to manage and take responsibility of VHSC president. Then with the initiative of Sahiyya a meeting was organized in which the women folk of the village selected me for this post in her presence. Initially I was totally unaware of my responsibility but as the time passes on I got to know about my duties." VHSC President, Gumla.

"Our VHSC was formed in the year 2010. I was selected for the post of president in the gram Sabha where every villager was present. People selected me because no one is interested in taking such responsibility and I was little proactive in the village affairs. This was the reason they chose me for this post." VHSC President, Khunti.

"Yes, I was selected by the gram Sabha in a meeting held in the year 2008. But all was done in a bit hurry. Sahiyya felt that I can help her in her work lending support

and cooperating in going to the bank and attending the meetings regularly; this was the very reason why she has chosen me and preferred me for this post." VHSC President, Khunti.

The selection of the VHSC president was genuinely happened in the Gram Sabha in the presence of the villagers to some extent. But even in these selections attendance was low and almost all the attendees were from the same hamlet where the meeting has been organized. The selection process of the VHSC president was required to be in the consensus but the democratic consensual process was compromised as it was influenced by some dominant sections such as traditional tribal leaders known as Gram Pradhan, ANMs and Sahiyyas according to their convenience, as they were mostly the Sahiyyas friends, relatives and the neighbors. The selections were not questioned by the people as they themselves want to get rid of such responsibility and otherwise reasons being the improper information disseminations regarding the roles and the responsibility of the President. Taking responsibility becomes central issue as one cannot compel eligible person if he is not ready himself or herself. Otherwise the criteria followed were based on nomination by someone, status of the person, proven active participation in village affairs in the past, vocal behavior to represent villagers, articulation abilities and basic literacy to handle bank accounts and registers. Very few of the villagers actually fitted in such criteria and those who were fulfilling sometime used and sometime misused their power of negotiation for the post based of their eligibility. If the kind of eligible persons are few then the community usually has no choice but to choose them even if they were not self motivated and enthusiastic enough to take up responsibility in a serious manner. The similar was the case at many instances due to rampant illiteracy. Low self motivation has been observed as most of them were bound to undertake responsibility to maintain or sustain their relationships with the influential persons with whom they are somehow interlinked out of some interest. In the case of the male candidates they took responsibility because they had some stake in the community so in order to maintain that they got ready to take the positions. But there were many instances where they defaulted from the position of the president. This withdrawal of the male members can be attributed

to the misinformation from the Block PHC to the villagers to ensure the reserved seats of the female candidates for the post of president. Apart from these facts some have also defaulted because of the traditionally assumed role of the female members to conduct activities mostly around maternal and child care (e.g. sub-centres and PHCs running programmes such as routine immunization, Ante and Post Natal care, Pre-Natal Care, Family planning and routine contraception and consumption of the Iron Folic Acid tablets etc.) and the way women is defined with their role and systematically integrated institutionally in health services programmes. These gender specific construction of health schemes and programmes give out and impression to the male counterparts in the village that they often disqualify or unsuitable for taking part in such female related activities. The peer group comprising males could rebuke or humiliate males taking up such responsibility together with Sahiyyas. On the other hand roles and activities that they have been assigned along with the Sahiyyas are not much exciting to them as compared to nature of involvement males usually like due to stereotypes, e.g. contractual work or village level politics, where in males could satisfy their ego. As a part of observation one could investigate into these existing stereotypes to understand why males defaulted from the post of president in case of VHSCs. The president has no clear understanding regarding their roles and the responsibility and almost every VHSC presidents are preoccupied with the narrow understanding that they are the mere signatories who have to accompany Sahiyyas to go to the PHC, Banks for the transactions, meetings organized in the village, clusters and the blocks. It has been observed that the presidents were not happy with their positions in the VHSC as they were subjected to very insignificant roles and had limited opportunities to exercise power and thus loosing stake in the committees.

The VHSC members including the treasurer are mostly women affiliated to the Self help groups of the village. Most of them don't know that they are the members of the VHSC and identify only their SHG as a committee or better to say only women committee as VHSCs were ill conceived as women committees. They shared that they were asked only for the signature in the meeting register at the end of the meeting and hardly told about

their roles in the committee. Many of the members were not even present in the meeting and in the SHG meeting they were asked for the signature by the Sahiyya and the president. There were no membership overlapping in the VHSCs from the other important committee in the village like Van Vikas Samiti, Gram Siksha Samiti, Nigrani Samiti and Gram Panchayat signifying the fact that the VHSCs were not taken as a serious committee with lacking representation of most of the worthy and active people of the village contributing themselves to other committees. The District official even shared about the actual situation of the VHSC after its formation that the VHSC were not formed in well organized manner as many committee members were just enrolled on paper without following the process of orientation, facilitation and trainings. Many committee members were eventually selected without their consent as they were either absent in that meetings or positions were reserved for them by the influential members present in the meeting. Thus to our surprise in villages many VHSC members were neither aware of the fact nor conscious of it that they were the members of the Village health committee.

> *"The VHSC in our district started in 2007. This time it was just a paper work where the name of president, secretary and treasurer was given without having any orientation, facilitation and trainings. In most of the villages the members themselves don't know that they are the member of VHSC. This is because the people are absent in the meetings that usually takes place in the village. So in such cases those who were present nominated other members for different posts without his/her consent. If I would say it without paraphrasing in straight terms then we have to admit that VHSCs are not formed in well organized manner*" DPM, Gumla.

It is very much clear that the all the focus in the VHSC formation was given to the selection of the Sahiyya and the President. The other members of the committees were totally ignored in the whole process. The selections of the other VHSC members are done in a very informal manner usually only on paper. The facilitator NGO has completed their work in the target oriented manner just to complete the numbers that they were asked to achieve bound with the MoU. The full-fledged equitable participation is totally missing raising questions as even in the committees like Mahila Mandals that enjoys

maximum representation in the VHSCs by default the members were unaware of their roles in the VHSC committees. One could least expect them to must know whether they are the part of the VHSCs or not, but ironically they were not aware of this fact even. On the other hand male members were least aware of their presence in the committees if rarely they were selected through whatever process followed. The lack of interest has been very much visible in the VHSC member's views and remarks regarding the committee's activities as they have no clear role ever defined to them and were asked to participate in the activities of the committees without least orientation.

4.1.2 Composition of the VHSC

The VHSC in every village comprise of 10-12 members as registered in their resolution register of the meeting on the formation day. In Some VHSC like of Ranhe, Salgi (Ghagra/Gumla) and Kalamati (Sadar/Khunti) it exceeds to more than 19 members. The reason Sahiyya told was that during the formation those who all were present, in lack of awareness; put their signatures in the register though all 19 were not selected but merely present. According to the guideline there has to be mandatory representation of women (not less than 50%), from all the hamlets and all the other committees that exists in the village (MoHFW, Guidelines for VHSC, 2006: 3) like Mata Samiti, SHG, Nigrani or Purush Samiti[7], Van Rakhsha Samiti[8] and Gram Siksha Samiti[9]. Whereas in few villages in the health committees, members are the people who usually attend the meetings and those women who are the members of the self help groups (WSHGs) as these groups were informed that women representation was the most. .

[7] Nigrani or Purush Samiti: A group of male having agriculture as a main occupation. Do savings and invest in the agricultural activities like irrigation, seed purchasing and seed banks.

[8] Van Samiti: A joint forest group looking after the management of the forest falls into their area.

[9]Siksha Samiti: An education committee of the village comprises of the school teachers, principal, village members and NGO members looking after the school activities.

The VHSC comprise of office bearers that includes the President, treasurer and Sahiyya which also acts as Secretary of the committee along with the other VHSC members. The treasurer position of all the committees was spuriously present on paper. About 91 percent of the members are female in the said committee, most of the VHSC presidents are female and preferably from the schedule Tribe (ST) social categories. The villagers informed that this is because firstly, people had a notion that this was the health related village affair and therefore it should be conducted by the women folk as it is in practice in case of ANM, Anganwadi Sevika and also, they were suppose to cooperate and support Sahiyya, herself a woman, so most of the women were got selected by the community. Secondly, due to mandatory attendance in the meetings held frequently inside the village and also outside in the blocks essentially those women who stays in the village and don't migrate or go outside the village in search of their livelihood were preferably got selected. Third, both the district and their blocks are tribal dominated areas so the ST representations were already high. And fourth, most importantly the facilitators asked them especially for these two criteria during the formation time. All the members are above 18 years in age and the age group falls under the range between 20-55 years. There is also one VHSC of Manhu (Sadar/Khunti) having 70 years old president. And almost all the members are from the different family esp. the Sahiyya and other members. Invariably in every VHSC the representation of all the hamlets was not ensured by the facilitators as evident from the fact that these meetings were organized in the predominant hamlet of every revenue village and all the members in every position of the committee were eventually selected from the same hamlet. Other hamlets of the village still don't know that any of such committee does exist although they are also supposed to get the equal benefits from the VHSC and have stake in all kind of decision making pertaining to them in principle. No special considerations and preferences were given to the financially weak persons during the selection of the members, office bearers and specially Sahiyya. Except in the case of Salgi village where Sahiyya was selected because she has no other source of income and her husband is physically challenged. So she was offered this position as an opportunity for the sake of her livelihood sustenance.

"They selected me because I am literate; however I have studied only up to 8th standard and could not pass it. And mainly because my husband is a handicap and so we don't have any other source of regular income to sustain ourselves. Thus based on considerations for my financial and social deprivations they preferred me for the Sahiya". Sahiyya, Gumla.

Most of the VHSC female presidents are agriculturist who look after their farm and home whereas the male president are mostly the daily wage earners usually going to the nearby town for their livelihood. All of them have BPL cards. And other VHSC members are also females who depend on the agriculture for their livelihood and belong to the BPL category. All the president and Sahiyya are invariably literate and mostly studied above senior secondary. But the other VHSC members apart from these two posts are mostly illiterate.

As a part of the major observation at the first place in order to fulfill the said criteria as per the guidelines regarding the committee's composition such as reservation for the women and ensuring the Scheduled Tribes (ST) category representation in the village other vital aspects were compromised. In some way these criteria proved as constrains in realizing the complete participation from every sections and residents of the village resulting in exclusion of males and other social categories. It appears as if the same guidelines were misused by the facilitators to avoid taking pain and smoothen their way for getting done with the work in their hand faster and in true spirit of communitization. There is vivid dichotomy between the practice and the principles on which these guidelines are based. For example generally the main hamlet of the revenue village in these blocks are inhabited by the key persons and local elites like traditional village head -Munda priest- Pahan who observes rituals and is religious head, petty local contractors, dominant clans of the village and mostly literate (or neoliterate) population. Facilitators have an easy access to them avoiding residents of other hamlets difficult to access due to tough tiresome terrains with low connectivity and illiteracy of the marginal clans residing in those so called unimportant hamlets. Besides this the settlements are of mixed type of social group but otherwise dominated by schedule tribes of dominant clan type. These

minor groups such as OBCs, SCs and in some cases like in Salgi Village (Ghaghra/Gumla) the endangered tribes namely Birhor, often contests with the dominant tribal populations for their say and stake on village resources and schemes that comes to the village. Thus the facilitators not taking much pain directly accessed the people residing in major hamlet among the rest. The approach of ensuring full participation was further negated when they only approached and informed the women self help groups (WSHGs) already running in the villages to organize such meetings for VHSC formation keeping others including males in oblivion. The guidelines generalize scheduled tribe and caste categories within which even many marginal clans and endangered populations exist in these villages. Again inclusion and say of women being ensured by the guidelines do not take much care of the fact that women too hails from marginal or dominant groups. And though few of them who reside in the same hamlet attend the meetings but due to their prior information of the major criteria they were lacking interest in participating as they felt already excluded with the programme. Thus homogenizing nature of the said guidelines was realized as constrains in ensuring communization in true spirit wherein these marginal groups within the stratified village should have given proper representation by design. The other excluding factors were that the members are supposed to be a women so the only committee were approached was the Mahila Mandal's of the hamlet/ village because they more accessible for organizing the meetings, easily available and traceable for the signatory works and the other committees such as Nigrani Samiti, Purush Mandals were instantly ignored. So the VHSC in many villages perceived as the women oriented groups headed by the Sahiyyas.

4.1.3 Roles and Responsibilities of VHSC

4.1.3. A) Understanding of the VHSC Program

According to the guideline the broad objective of the VHSC is to work for the better health care of the villagers and to perform as a link between the community and the health care institutions (GOJ-NRHM, VHSC-1: 1). As we move further with this

guideline it attempts to capture the Stakeholders engagement patterns and their understanding for achieving the main objective of the program.

The VHSC president shared about their understanding regarding the VHSC that they have to spend the fund in their hamlet/village given by the government in the health and sanitation activities ascribed by the officials. It is just like other government funded health program. The Sahiyya's opinion on this was that the VHSC program is very useful in terms of fund granted by the government for the village. They can use this fund for their health emergencies and also as a revolving fund without any interest. Few Sahiyya do not have the clear understanding of programme motives and knowledge apart from its execution part like utilizing VHSC untied fund for meeting infrastructural shortcomings and their role in all the village level decisions. Sahiyya of Manhu village sees it as a medium through which she can easily disseminate health related information to the community. Whereas the other VHSC members see this as a source of government fund for the activities related to drinking water and sanitation and like pit filling, insecticides spray and for the institutional delivery cases. Here is has to be noted that this programme is perceived as just another source of fund by the villagers reducing other more important components designed in principle.

The Gram Pradhan or Munda is the head of the Gram Sabha and he has been selected through the '*Aam Sabha*[10]' in the village and only the Munda Caste people can be the Gram Pradhan of the village. It has been observed that the Gram Pradhan hardly knows about the VHSC of the village and only knows the activities conducted from the fund for hand pumps and sanitation drives under the supervision of the Sahiyya. He hardly participates in the VHSC related work as they don't have any idea about its functioning. They only remember the meetings held for prioritizing the activities which was organized by the Sahiyya to freeze the work plan. It has also been observed that after the PRI election they become little inactive as their most of the power has been transferred or it

[10] Aam Sabha: Village meeting that takes place in the presence of village headman and the villagers.

can be said that there is a redistribution of their power wherein he contests it with the PRI members falling on the losing side. Power seems to tilt in favor of PRI members leaving traditional leaders administratively in limbo. Though they are still the part of the gram Sabha and have to be present in the meetings and were invited by the PRI members in various meetings, they most of the time took personal initiative in organizing the meetings for the village affairs. This tension between traditional leaders and the PRI members consequently tampers with the functioning of VHRC owing to various power equations forming around contesting domains and the interest groups the tension creates and recreates. Traditionally the self governance has been the driving force of village life and decisions and the tribal populations predominantly inhabiting in these areas are yet to adjust and harmonize with the state guided PRI structures under Panchayati Raj scheme of governance.

The Block Program Manager (BPM) talked about VHSC program as important one for the operation of certain health related activities in the village through the supervision of Sahiyya along with the VHSC president and its members. They see it as an easy and reliable channel through which they can disseminate their information related to any health program or activities which was otherwise very difficult and time consuming. And this is the way to ensure greater participation of the community in any program. The most important thing is that the members in the VHSC along with the community collectively decide the activities for the welfare and the development of their village at least in the principle and to be considerable extent in practice.

> *"For the proper information flow regarding any kind of health related programs the best way is to give first information to the VHSC apart from the ANMs. Then the information will disseminate properly to the village level as the VHSC will inform it to the villagers in their meetings. It is very important to pass on knowledge to the people about the programs and its benefits and about its beneficiary. The people should know about the program and its benefits for the greater participation in any program".* BPM, Khunti.

"The VHSC president is itself from the village along with the Sahiyya as a secretary with the villagers as other VHSC members. They all with a consensus take decision for the activities to be conducted in the village for the welfare of the villagers". BPM, Ghaghra.

The District level officials like District Program Coordinators (DPC) had an opinion that VHSC enhances the community participation which is the main ingredient for the success of any program. This is an important part of the village as it helps in betterment of the health of the people through the need assessment which is only possible by them as they can decide for their need and accordingly prioritize the activities to be spent on. Both the DPM emphasizes on the strengthening of this village level institution for generating their own fund through enhancing awareness and capacity among the village people to meet their health demands through the VHSC.

"*VHSC is very important for the health care of the village people because need assessment of villager is only possible by them. They only can decide well that in what health activity they need to spend this money. Our prime objective of strengthening the VHSCs is for making them capable for generating their own fund to meet their health requirements through the VHSC*". DPM, Gumla.

"Community participation is very important for making the program get run smoothly. So there is a requirement for strengthening its base institutions". DPM, Khunti.

The understandings of the VHSC program by the VHSC members are perceived which revolves around the funds which were granted by the government in the name of the VHSC and its utilization. Different stakeholders seek it differently but very useful as the Sahiyyas see it as an important medium or source of information dissemination through the SHG or Mahila Mandals. As earlier discussed that most of the VHSC members are from the Mahila Mandals itself. The Munda or the Gram Pradhan hardly seems interested in the VHSC activities. The reasons being were firstly, the funds granted to the VHSC for the Sanitation drives in the village which earlier granted in the Village funds under the

supervision of the Gram Pradhan himself. Secondly, the role conflict in maintaining the gravity or stake in the decision making in the village affairs after the recent emergence of the PRIs (Panchayati Raj Institutions Members) in the village. This works as an agent to develop ego problems in the traditional leaders which led them to withdrawal from participating actively. Whereas the government officials or can be said as the extension workers see the VHSC as an tool for spending the untied fund through the proper and traceable channel which able to give an impression of the collectivity in the community decisions. The DPM perceive the committees as an important factor to ensure the community participation for the smooth functioning of the programme indicating towards the proper follow up of the guidelines.

Nature of fund with VHSC: Generating own corpus fund at village level to meet health emergencies still seems to be a distant dream as the committees are concerned with only utilization part of untied fund and not generating surplus at their own at village level. Self sufficiency of the VHSC in terms of having their fund besides disbursed untied fund is an element completely missing out in the programme design. It increases the dependency of the community on the government apparatus and thus controlling of their decisions and prioritizations by petty bureaucracy at block and Panchayat level government establishments. Finally such dependent relations subsumes VHSC and make it a puppet and a medium to smoothly implement government schemes on health and not fulfilling communities own health well being demands. Often the counter rationality of the community may differ from the rationales given by the government around health intervention programmes including the mode of their implementation.

4.1.3. B) Role Perception of the VHSC Members

The VHSC role and their work in the village will be determined by the way they visualize themselves. According to the guidelines most importantly the VHSC has to maintain the minutes and information in the Village Health register so that they can share activities and plans with the villagers pertaining to health care of the pregnant women and the infants, the information related to the government schemes for the small kids especially

the girl child and maintaining the list of the severely diseased patient and other potential beneficiary group. Likewise, they can consult and discuss these with the ANM and Anganwadi Sevika for the activities they expect and intend to do through the village health register (GOJ-NRHM, VHSC -1: 6).

From the interviews of VHSC presidents of different committees responses leads towards their perception regarding their role which are mostly as a signatory of the bank joint account along with Sahiyya a secretary of the committee in the name of VHSC. He/she is required during the withdrawal of the money. They have to coordinate and help Sahiyya in executing activities which were decided to be conducted in the village meeting. In the case of Sirkoat village, VHSC President doesn't even ask Sahiyya about the details of the expenditure as every time she denied discussing it.

> *"I don't have knowledge about its total expenditure. Sahiyya never told me anything about this. Yes, the work is visible but I never got any details regarding its expenditure".* VHSC President, Gumla.

It has been observed that the VHSC members especially the Sahiyya keep all the records regarding the formation of the VHSC and the selection of its members. Records comprise of the minutes of the discussions and signature of the members and people present in the meetings. In almost every VHSC the meeting registers were not up-to-date and mostly having only the records of the formation day.

The financial records have been seen in the same register in many of the VHSCs and the activities and their expenditures mostly recorded are to overcome infrastructural shortcomings. In the Intervention area few VHSCs also spend the fund in the miscellaneous activities like for organizing meetings and in the Salgi Village of Ghaghra/Gumla it shows expenditure anchored on the purchasing of Sahiyya's saree. All the expenditures were recorded briefly in every VHSCs in both intervention and non-intervention area.

In almost every VHSCs new meeting register was seen provided by the health departments but the entry was not yet started practically into them as it is very new for

them to understand the format and also hardly such meetings were held due to unavailability of funds. The register is already in a format design consisting of the details like Recapitulation of the previous meeting, Sahiyya's reporting, issues of health care providers (ANM & AWW) functionality, discussion on health and sanitation issues, issues of Health sub-centre/ AWC/ PDS system, Drinking water and sanitations, discussion on the utilization of the untied fund (VHSC/Sub-centre), discussion on Janani Suraksha Yojana (JSY), new work proposals, and others such discussions related to village health are printed in the format as a guideline for the meetings.

All the VHSC presidents are aware of the fact that they have to attend the meetings and trainings organized in the block PHC. They responded as they remembers all the activities which they have conducted with the Sahiyya like repairing of hand pumps, cleaning and maintenance of the wells and pit filling before rainy season. The major work of them is during the submission of the statement of expenditure (SOE) where they help Sahiyya to get it prepared. In few VHSC of the Khunti block of Khunti for e.g. the VHSC president of Chikor Village can able to visualize their future activities apart from the above one by utilizing this money as a revolving fund without charging an interest especially for the poor family of the village during the health emergency.

> *"VHSC is very important for the village. Apart from the above activities we can use this fund as revolving fund during the urgency and health emergency of the very poor family in the village. They don't have to pay an interest over this debt and they can go for their treatment. But not yet we have used this amount for this purpose. But in future when the next lot of money will be sanctioned then we will definitely use this money for such purposes".* VHSC President, Khunti.

Ideally the role of the President is to implement, monitor and evaluate the VHSCs annual/ half yearly activities planning, expenditures, discussing VHSC activities in the meetings, encouraging more people's participations and control the conflict raising situations but the scenario is that the president is inactive in all the VHSCs and all the activities and responsibilities were taken up solely by the Sahiyya of the concerned VHSC.

Sahiyya is seen as a most important part of the VHSC according to the health officials in conducting all the health related affairs of the village from its planning till its execution. They said that the only link that can easily be traced by them was the Sahiyya so they were assigned with all the responsibility to handle the funds and utilize it according to the village priority. The Sahiyya who are heading as a secretary in the VHSC themselves see it as their prime responsibility. They talked about their roles primarily in terms of utilizing the untied fund of Rs. 10,000/- given to them by the health department. They said that they have first opened a joint account with the President in the name of the VHSC. Though she is the second signatory in the bank account still she has all the accountability towards all the responsibilities. When funds were sanctioned they have to withdraw money from the bank, organize a village meeting, inform through *Hakua*[11] to every VHSC office bearers along with the members to decide the activities, make a consensus over the decisions, handle conflict situation during a meeting, handle the activities and monitors its timely completion, organize a meeting to discuss the work and the fund status, prepare a SOE and submit it to the BTTs or in a block, regularly attend the trainings organized by the block health departments, conduct the meetings of VHSC on a regular basis, attend the cluster meetings with the *Sahiyya sathi*[12] to discuss their issues regarding VHSC functions.

> *"At the time when all the VHSC was dysfunctional and then all the responsibilities were given to the Sahiyyas because this was the link which is easily traceable to us to monitor the expenditures".* DPM, Gumla.

> *"The Sahiyya are responsible for making Plans for the village and execute it with the untied fund of the VHSC".* BPM, Gumla.

[11] Hakua: A person is assigned by the locals as a messenger whose basic responsibility is to inform their village about the village meetings or get-togethers.

[12] Sahiyya sathi: A Sahiyya facilitators looks after a cluster consists of 15-20 Sahiyya at the block level.

"Before planning the activities we conducted the gram Sabha where we decided the activities and the entire village member agreed and participated. Mostly the person from those hamlets whose hand pumps and wells are needed to get repaired was present in that meeting. Most of the work has been done in the two big hamlets of the village. In between the work, villagers again conducted the meeting to have knowledge about the status of the VHSC fund". Sahiyya, Khunti.

Apart from the office bearers the other VHSC members said that they don't remember that they are the members of the VHSC. They are mostly from the self help groups. In response to their roles and responsibility answers came that they don't have any work to do in the committee. In most of the VHSC all recognizes the Sahiyya but not as a secretary and no one recognizes their VHSC president. They said that they haven't assigned any kind of responsibility because the prime responsibility is given to the Sahiyya. In the meetings we use to sign at the end in the participant list. One of the members of Sarango VHSC told that she usually did not stay in the village so it is hard for her to know about the committee affairs.

"Are you asking about the SHG? No, I don't remember that I am the member of such committee. In the first meeting they asked me to sign in the register so I did it." VHSC Member, Gumla.

"I hardly stay at my village because I have to go outside for my daily earnings. After 2-3 months I use to come back. So I don't know about the committee meetings and their works." VHSC, Gumla.

"We haven't worked or asked to work for the VHSC in the village then how do we know about what we are supposed to do in the committee. So we don't have knowledge regarding VHSC work details". VHSC Member, Khunti.

The actual situations in terms of the role functioning of the VHSC members ironically differ from the said guidelines. The president's roles and responsibilities were totally overshadowed by the roles and the power that have been assigned to the Sahiyyas in the

VHSC. The Sahiyyas are more powerful in terms of the decision making and through direct linkages or contacts with the government officials at the block level health institutions, directly approached for the information and regular knowledge up gradation through the meetings and the trainings related to the VHSC in the block. This creates a wide gap in terms of the knowledge and information between the other VHSC members of the committees and leads to the lack of interest among the VHSC president and the other members in the VHSC and its activities. And in the case of any problems related to the fund utilization the Sahiyyas are blamed by them as she is the only person taking responsibility of all the VHSC's activities. It was clearly observed that the Sahiyyas are seen as a link between the community and the service providers and was given the whole accountability of the VHSC related activities. Though most of the Sahiyyas are not much efficient to take up such tasks as they are neo-literate, over burdened with the other assignments, unable to articulate information and knowledge and lack supports from the community and other VHSC members. It has been also observed that the other VHSC members don't have any such role clarity and the orientation regarding the VHSC functions. And also the fact added to this was that she herself does not have much clarity about the role of the other members due to which she was unable to seek the cooperation from them. All the VHSC stakeholders perceive that the VHSC is got to do with the Sahiyya and the Sahiyyas are the sole player in the VHSC. This could be the reasons due to which the VHSC untied funds are termed as a Sahiyya fund in most of the villages and by the community.

The ANM and Anganwadi Sevika[13] are the permanent invited members of the VHSC according to the guideline (GOJ-NRHM, VHSC -1: 5). The ANM of Ghaghra block told that they hardly know about the committee. Among them one ANM of Ranhe told that she apparently did not know about such committee but was once asked by the Sahiyya to attend the meeting as they are going to decide about the fund utilization in the village. But she was so busy with her own job that she couldn't find the time to attend that meeting. Whereas in the Khunti block of Khunti district the ANM said that they are

[13] Anganwadi Sevika : Anganwadi worker

aware of the functioning of the VHSC in the village and many of them were also engaged in the formation of the committee and selection of its member. But after that they were hardly involved in the meeting of the VHSC. Regarding attending the separate meeting of VHSC they were never invited by the members but they are present during the talks which were done by the Sahiyya for the villagers regarding health and sanitations for the daily life practices in the VHND. In both the intervention and Non-Intervention area the Anganwadi Sevika responded that they don't remember about the formation of the VHSC in their village and also don't know about the committee and its office bearers. Most of them were not present in that day. They recognize the committee as a Sahiyya fund of Rs.10, 000/ annum which was allocated to the Sahiyya for the sanitation work of the village. They told that they were never invited or informed about the VHSC meetings and also don't get any kind of official instructions from the block to attend such kind of meetings. So due to this they hardly have any information regarding details of the fund utilization and expenditures. Some of them responded that they are happy that they were not invited to attend the meeting because they don't want to get more burdens as they are already overburdened with their tasks.

> *"I intentionally don't want to attend the VHSC meeting because I don't want to take more responsibility as we have already so many works to do. I am overburdened with the works."* Anganwadi Sevika, Khunti.

> *"We were never informed and ordered by the block health officials to attend such meetings so how do we know about VHSC and its work".* Anganwadi Sevika, Gumla.

The ANMs of the non-intervention area hardly have the knowledge regarding the VHSC, its activities and its office bearers whereas; the ANMs of the intervention area were involved in the formation as well as in the selection of its members in their concerned villages. But after that they never attend the VHSC meetings and have any information regarding their activities. It has been observed that the functions of the VHSCs were not structured in the manner that the health functionaries involved in their meetings to give some kind of consultations and information related to the concerned and prevalent health

issues of the village. Though all of the health functionaries meet during the VHND day and they do health related discussions but the problem is that it only ensured the presence of the women who are seeking the health care services like immunization and the rations delivery. Not only other women but also the men are also excluded in gaining and benefiting from the piece of information important for the health of the individual. The ANMs and the AWWs have little information regarding the functional status of VHSC and its activities although they meet Sahiyya very frequently. The reason could be that the Sahiyya don't perceive the other health functionaries as an important part for the consultation for discussing major health requirements in terms of identifying the major health needs of the village and also because they are not supposed to plan or discuss it for the fund utilization activities. The major observation done was that the ANMs and the AWWs are not interested in taking the responsibility or attend more meetings of the VHSC as they were unable to manage time for the activities of the committees due to their hectic work schedule, tasks and the coverage area due to which they never or least desired to be the part of the village committees.

4.1.3. C) Coordination among different stakeholders of VHSC

It has been observed that the Sahiyya and ANMs seem working in very cordial manner with each other. The ANMs are privileged to have the assistance of the Sahiyya in the work. The Sahiyyas helped them to inform and ensure the presence of the people to be immunized and helps in recording. The ANMs doesn't require going to each and every doorstep that saves time and energy and also helps in achieving the targets. But the ANMs hardly seen as working for the VHSC and the Sahiyya never involved her in the consultation of VHSC fund. The VHSC are in very primordial and struggling phase which cannot prove to be efficient enough to monitoring the stakeholders as Sahiyya herself bears the sole responsibility for the VHSCs functioning.

The Sahiyya and Anganwadi sevika both only meet in the VHND day to work together. They hardly interfere into each other's work and also don't have much knowledge regarding the role of each other.

Both the Sahiyya and the president are working together at par level but president was seen working as the subordinate of the Sahiyya and the whole responsibility was carried out by the Sahiyya.

It has been observed that the Sahiyya and the ANM work in a cordial manner. It is very much visible that the Sahiyyas has been used by the ANMs for her whole extension and outreach works as a workforce and fully utilized by her for the assistance. The Sahiyyas bear all the responsibility alone and hardly interfere in the work of the AWW. The reasons could be that they both are in the same positions as an extension workers from the same village and most importantly having no clear role clarity of each other and seems as an competitors in terms of the community acceptance. It has also been observed that the Sahiyya and the president should work as a team but the president was seems to be the subordinate of the Sahiyya.

In the intervention area the NGO's Animators attends the village meetings on a regular basis to improve the awareness of the community about the VHSC of the village. The Animators are from the same locality, educated and paid well by the NGO in comparison to the Sahiyyas. The Animators used to create awareness among people through organizing Nukkad Natak in the villages and discuss the need of the VHSC in the village. But in these Nukkad Natak, the performers are outsiders' hired by NGOs who are not acquainted with the local vernacular dialect and touch the cords of local issues and problems at village level. Thus, to what extent these are effective in knowledge dissemination, sensitization, motivation and awareness generation remains questionable from the point of view of the community. Animators also organize the meetings and trainings for the other VHSC members in the NGO headquarters to do capacity building. But it has been observed that there was a conflict issues in the coordination between the animators and the Sahiyyas. The reasons being: the Sahiyya doesn't want to be interfered for the VHSC activities as she alone is to answerable to the Government officials and solely prepared the whole accounts. There is a visible ego clash because of the comparison with the amount of work load and the remunerations rewarded against them which is considerably low in case of Sahiyya. Animators are merely involved in capacity

building but getting higher remunerations from the NGOs though they hails from the same locality. Sahiyya feels like because of the animators' undesired intervention her situation becomes more difficult to cope with as she has to be answerable to both community and the government officials alone regarding the whole accounts of the VHSC funds and thus should enjoy short of freedom to take decisions. "If animators are not willing to take any responsibility or accountability in their hands why they interfere with our work" is the basic sense of discomfort with Sahiyyas which seems to be logical to a great extent. Who exercises authority on whom and who is vested with what power makes things more complex then it appears at community level building up stress most of the time and working harmoniously rarely. This observation can be extended to the fact the these animators who otherwise represent NGOs have differential intentions to intervene at different levels which is often in conflict with the practical roles of the Sahiyyas to carry out her tasks or /and may be Sahiyyas have assumed themselves in the centre stage of VHSC and do not like to share their authority and power with the animators or dislike their own village committee to fall puppet of these animators.

The BPM and DPM rely on the Sahiyya for the VHSC activities like for the meetings, executions, preparing of SOE and also for the trainings. They never approach other VHSC members for the accountability.

There is also an over dependency of the programme officials on the Sahiyya for tracing and the follow-up of the fund utilization in the village. They don't trust or rely on the other members supposedly due to their inefficiency and direct connections with Sahiyyas only.

4.2 Decentralization

4.2.1 Powers (planning & decision making) in the Intervention Area & Non-Intervention Area

4.2.1. A) Political Powers

For the purpose of facilitation and formation of the VHSC in the Khunti block of Khunti district the Intervention Area was basically defined for the two NGOs namely Karra

Society for Rural Action and Nav Bharat Jagriti Kendra (NBJK) under the MOU signed with the state government. And in the case of Ghaghra block of Gumla district, the Non-Intervention area, it was given to the NGO named Vikas Bharti. The basic responsibility of these agencies is to facilitate the formation process in the village through sensitizing the people, organizing meetings, regular visits in the area and information disseminations related to the health committees. But during the process the whole sensitizing process was compromised as sharing with the VHSC members of both the area reveals that they were asked to arrange the meeting on the day of formation and selected the VHSC and Sahiyya at the same day without following the prescribed ideal process. As they said they don't have any prior knowledge about the committee and its works. The state government was associated with the NGOs only till the formation part of the VHSCs was over and the Sahiyya selection was ensured and later in 2009 the state formed their own State health resource centre for the capacity building and strengthening of the VHSCs named as VSRC at the state level. It has been observed that the NGO exerted their influence over the formation of the VHSC and Sahiyyas selection through approaching the people whom they knew earlier, to the Munda and the Pahan of the village and in the decision making also.

In the composition of the VHSC around 91% in all three key positions are acquired by the women. The total members are 10-12 and 8 out of 12 in the group are women. Most of the representation was from the SHG members of the village and many are also the members of the other committee like Mata Samiti and Siksha Samiti of the village. Whereas in the non-intervention area all the members are from the SHG and the other committees in the village are in the hibernating stage. In both the intervention and non-intervention areas all the VHSC members are from the same hamlet as representation from all the hamlets of the revenue village was not ensured. The people of other hamlets responded that they don't have any idea about such committees and only heard about the Sahiyya fund for the sanitation drive in their village. All the members in the committee are Schedule Tribes as the study area comes under the scheduled area (Scheduled areas as notified in the Schedule V of the constitution of India).

At present there is no representation from the PRI in the VHSC. According to the Government of India guideline the women ward member of village should head the committee and incase of no wards the SC/ST person will head the committee (PHRN, 2008: 8). As the PRI elections were held in December 2010, the re-formation of the committee will start from the March 2012. The written order from the government has not yet received to the health officials. The wards members are still not clear about their role in the committee and they are not sure whether they should attend their meetings or not. In the non-intervention area the ward members said that they don't know about such committees and they were not even told by the block officials to attend the meetings. They said that still they lacks clarity about their roles and responsibilities so it is hard for them to know about all the activities going around the village and in addition to it, they exclaimed that they might have ever been told by the officials they would have attended the meetings.

As different responses that came from the ward members of the village of intervention area indicates that they were not assigned with the responsibility from the government, so their words could not be valued through perceiving weightage by the people and they hesitate to say anything to any of the village health functionary. PRI members are still not acting upon their roles in full fledged manner because they were not oriented and instructed by the block officials although they want to work on some health issues.

"*VHSC is the important one along with the other four committees in the village. And the members can ask questions regarding the functioning of the ANM, Anganwadi Sevika and Sahiyya in the sub-centre*". PRI Member, Khunti.

"No legal authorities were given by the Block officials to us. So I don't feel that I have the right to ask questions to anyone. Still if I say anything then people don't give weightage to my words."

"We don't have any instructions or orders by the block officials to attend the meetings of VHSC in the village. The day we were told we will start giving attention to it." PRI Member, Khunti.

It has been observed that the PRI members still don't own the VHSC as an important committee of their village and so they wait for the instructions or the permission to intervene or involve into the committee. In fact it seems that the PRI members themselves are struggling to develop a stake among the village and the community.

4.2.1. B) Administrative Powers

In both the Intervention and Non-Intervention area the VHSCs were already provided by the Block health officials with the list of sanitation drive activities via the Sahiyya of the respective villages. The block enlisted the activities according to the guidelines and mainly concentrated to fill in the infrastructural shortcomings of the village. Apart from this villagers had also done some sort of situational analysis and prioritization of the activities at their own in the meeting organized in the Gram Sabha. The decisions such as to whom and what should be given the first preference, how much should be spent on each activity, how to execute are all decided in the meetings by the committee. At the village level all the decisions were taken by the President and Sahiyya along with the influential persons of the village. But in many VHSC there is an absolute monopoly of the Sahiyya in the decision making of the activities to be carried out.

The VHSC apart from the assigned tasks of utilizing the untied fund don't do bidding with the health officials for the locally appropriate health care services. In intervention area the members are aware of the health needs of the village but don't have knowledge about whom to consider for it. The Non-intervention areas are totally unaware of the fact that they have the rights to bid for the appropriate facilities from the health departments because they are not given information related to their entitlements and rights through the trainings and the workshops. It can be said that in the area there were no such social mobilization efforts have been taken by the agencies or by the government agencies

There is no such coordination between the VHSC and the other health functionary of the village. The VHSC never check the attendance register of the AWW, Mid-Day meal sanchalak or Anganwadi Sahaika, MPW and ANM. So the signature of the VHSC convener is never done in their registers maintained at Anganwadi and sub-centers.

Likewise, the health functionaries are also never accountable towards the committee and never submit their Bi-Monthly village report to them along with the next two month plan. According to the guideline the VHSC are suppose to decide for the desired formats and contents of the Bi-monthly reports of the ANM and MPWs. Thus instead of achieving convergence and coordination these health functionaries are working in isolations.

The VHSC monitoring through the prescribed tools and indicators at the village level are not done in both the intervention and non-intervention area. Village health register were prepared by the Sahiyya but almost in all the VHSC it was incomplete. The details of the village survey, total numbers of the infants, total numbers of the children and patient infected by severe disease are not prepared properly. The VHSC individually don't have the copy with them. The records of the ANM in the sub-centre were never kept by the VHSC. The Village health calendar is never prepared by the committee in any of the area. And the infant and maternal death audit was not done exactly by the committee but it was done by the Sahiyya and ANM. But the VHSC collected the information as their monitoring part. In the Intervention area in some villages the community based monitoring was organized by the government officials where they discussed the functioning of the VHSC, utilization of the untied fund and functioning of the health functionaries working in their villages under their health sub-centres. They also participated in the Public Dialogue organized by the district officials but not participated proactively. One of the reasons behind all the governmental officials' visits in the intervention areas villages being the Khunti block of the Khunti district is very near to the state capital Ranchi. The distance of district headquarter from Ranchi headquarter is about 35-37 km. They said that though they haven't organized these meetings at their own but through attending it they got lots of information regarding their roles and responsibilities. Whereas in the Non-intervention areas the steps for the monitoring process of the VHSC and health activities by the health functionaries in their village were never conducted. .

"No other activities we do apart from the utilization of the fund in the sanitation activities told by the block officials. We submit the SOE to the block and write down into the register for the future use." Sahiyya, Gumla.

"We together work with the ANM and Anganwadi Sevika in the village and we all are doing our own job. So we don't have any problem and questions regarding each other's work." Sahiyya, Khunti.

"I have attended the CBM meeting organized by the block officials where they are asking about the utilization of the fund by the VHSC. And also once in few months back in the block Panchayat the meeting was organized where the collector was present and talking about the village developmental work progress." VHSC President, Khunti.

The whole administrative power of the VHSC revolves around the fund utilization of the committees. Hardly the office bearers interfere into each other's work as they are not able to question because of the low information or no information regarding the roles and responsibilities of each others.

4.2.1. C) Fiscal Powers

In both the intervention and non-intervention area the sole responsibility of the finance was given to the Sahiyya, the secretary of the VHSC. So the Sahiyya is only accountable towards the whole finance related work. Sahiyya discusses the fund while deciding the activities and its allocation but the transparency was lacking behind the decisions to the other VHSC members including the VHSC president in many villages. So the public are unaware of the amount of fund sanctioned and its expenditures details. In the intervention area the Sahiyya and president together deal with the fund expenditures in most of the villages but in the case of non-intervention area most of the villages are unaware of its details and whole accounts settlement was done all alone by the Sahiyya without consultation with the other members.

In the intervention area four of the villages were allocated the untied fund of amount 10,000/- in the year 2009 for the first phase. And two out of four were again sanctioned the amount of the second phase in the year 2011. The funds were utilized as per the discretion of the VHSC but according to the activities guideline given by the block officials. In the Non-intervention area fund were allocated to the three VHSC out of four VHSC in the first phase in the year 2008 in the installment basis of Rs. 5000/- and again the next installment of Rs.5000/ after few months of the same year. In the next financial year of 2009-10 two out of four were given the fund of Rs. 10,000/- and one VHSC got the amount of two financial year. The utilization of the fund was done discretionally by the committee on the decided activities. But in many villages of the Intervention area like Fudi they deposited 70% of the whole amount and rest 30% of the fund's utilization activity were already decided and was deducted by the officials. Though they wanted to spend this money on some other activities but can't do this because of the instruction given by the officials as said by the Sahiyya.

"*The first untied was sanctioned in the year 2008. The fund was disbursed on the installment basis. So, almost in every village it was given in two phase. Initially 60 VHSCs were given and in the next phase another remained 60 VHSC were provided. In this process some VHSC were got two financial year fund and some only got single financial year fund. This was the only reason which creates problem in fund regularity."* DPM, Gumla.

"The VHSC fund first came in 2009 in the joint account of prior VHSC president and Sahiyya. The untied fund is the whole amount of Rs.10, 000/-." Sahiyya, Khunti.

"We got fund of Rs. 10,000 for the activities like repairing of Hand pump, cleaning up of wells, pit filling. We use to do all the activities here. We both of us, Sahiyyas plan the activity and submit it to the Block PHC. Then once the activities were done we submitted all the bill vouchers to the block through the BTTs. The next fund of same amount we got for another phase in 2011." Sahiyya, Gumla.

"They deposited around 7000/- in our bank account and the amount of 3000/- was deducted for the DDT machine which they promised to provide us for DDT spray in the village. But till date we haven't got that machine." Sahiyya, Khunti.

It has been observed that though the fund is known as the untied fund wherein in principle a flexible amount should be spent on the priority of the community but in the actual practice the VHSCs were given an activity list and asked to ensure that they must spend on the particular activities although they want to spend on other prioritized activities, to meet local requirements. It seems that they are bound to spend on the activities told by the block officials. If it is so then there is no meaning of provisioning "untied fund" to meet community based demands that potentially could meets infrastructural shortcomings as per the community and not the government officials.

4.2.2 Power Structure and Sahiyya in the VHSC

The Sahiyyas are the personage of the VHSC events taking place in the village.

Powers of Sahiyyas in the VHSC

It has been observed that in both the intervention and non- intervention areas Sahiyya has a great acceptance in the community as she has already been introduced since 2004 well before the inception of NRHM and these Sahiyyas hail from the same community and are selected democratically by them. She plays a role of linkage between the officials and the community and gets visibility as a social worker who contributes for the welfare of her own community. The trust and belief of the community remains on her evident from the fact that like the gram Pradhan and religious preacher -Pahan of the village respects. She also receives their respect due to her knowledge around health issues and her work which is strong enough to place her as an influential person in the community. The influential status of the Sahiyya and her acceptance level makes her a significant actor among the health officials for the executions purpose at the grassroots. Sahiyyas also acts as a link between the community and other service providers and work alongside with the Anganwadi sevika and ANM which promotes her to get identified as a direct person to

whom approach for the health needs of the village by the community. The education level brings difference in the gravity of their existence regarding their knowledge and help community many times for the payment in kind like people helps her during the hectic period of harvesting season.

The responsibility related to the financial management is upon the Sahiyya of the VHSC. The health officials approach her for the details of the expenditures and the utilization certificates of the untied fund of the committee. It has been observed that Sahiyya is the key office bearer who have been actively involved and done the work from the account opening, withdrawal to the fund utilization of the untied fund of the VHSC.

But the power of Sahiyya cannot be seen in disguise of the programmatic structure that essentialize her role and hence her positioning in the community as a key person. Because of the fact that Sahiyyas are also struggling to create her identity on day to day basis within the tensions that inherently exists in rural community. Much of the predicament she usually faces makes her work a real challenge. There are various interest groups and ethnic subjugation and dominance imposed by these groups that makes it really difficult for them to provide the desired services to the beneficiary community in true spirit. The contestation among other key members/other influential groups and Sahiyyas within the rural community for power and acknowledgement is an ongoing and never ending process. The realization of power and authority by the government officials and NGO representatives crumbles the aspiration of the Sahiyya to bring out positive change and thus the community whom she represents. There are some pros and cons of centrality of Sahiyyas in the project which at times seems to help the community to avail health services and simultaneously given with much importance to Sahiyya in practice refutes the motive of communitization wherein everybody is desired to play the same important role. Again placing Sahiyya in the key role reduces the project to a women centric project that negates the idea of everybody's involvement but supports empowerment issues and leadership of rural women.

4.3 Social Mobilization

4.3.1 Capacity Building Supports from the State

Before the formation of the VHSC the facilitators never used the methods and tools of social mobilization (community organization) as emphasized by the committee members. After the formation of the VHSC the social mobilization part still remains missing as the members are still involved in the strategies of the strengthening of the committee itself. The state government withdrew the support of the NGO after the formation process ended and later setup their autonomous institution called State Health Resource Centre (SHRC) as an additional technical capacity and resource institution. The major task of the SHRC in the VHSC programme was to design, implement, monitor and support the programme. SHRC is established as under the state Ministry of Health & Family Welfare (MoHFW) is the apex body for the task of trainings and capacity building. The support from the NGOs having an experience in the programmatic implementation at the community level interventions in the health sectors were chosen by design. And CINI a non-governmental organization is also one of the advisory members of this SHRC. SHRC is carrying out the state and district level trainings and providing supportive supervision for the block/PHC level trainings what they term as training of trainers (ToT). The NGOs are also directly involved in the trainings of member of the committee at village level and laid provisions for the logistics and support for such trainings.

The State Program coordinator of the VHSC-Sahiyya Resource Centre (VSRC) which is a part of SHRC at the district level talked about SHRC at the state level that they provides technical backstopping to the programme. The training modules, learning materials, development of resource pool, state level trainings, supportive supervision for district and block level trainings are provided by the SHRC. The supports are also provided in the monitoring of the program from the state level. State Coordinator told that there are 8 Regional coordinators in the state for the facilitation and grooming of the village health committees.

4.3.2 The structure of the support system

4.3.2. A) District Programme Coordinators

There is District Programme Coordinators (DPC) at the district level and their prime responsibility according to the guidelines is to facilitating the components like constitution of the VHSC, making data base and profile of the VHSCs, facilitation of development of village health plans (VHP) and block health plans and their integration in the consolidated district health plans and addressing the issues by the VHSC and work for the friendly solutions.

It has been observed that the District Programme Coordinators are very much aware of the objectives of the NRHM and its strategies, and very importantly the grandness of the VHSCs to achieve the prime goal of the programme. They are really keen to work according to the orientations they got through the trainings but unable to practice the same at the ground level due to their contractual status. They really seems to be unhappy to share that they are bound to perform according to the instructions from the apex body and are overburdened with lots of other engagements like reporting, organizing trainings and preparing training calendars assigned to them by the Chief Medical Officers. They blame the red tapism inherent to government functioning for their not up to the mark performance. Though they wants to focus on the VHSCs but due to above reasons they are unable to do regular visits to the blocks, faces problems for regular field visits due to transportations problems, and lots of other assignments and targets to discuss with the Sahiyyas sidelining the prime activities of the VHSC related discussions and issues at the district level meetings. They shared that somehow the VHSCs are not given priorities by the CMOs as mostly they are engaged with the activities of conducting RCH-1 and RCH-II family planning camps, Routine Immunization, School health programmes and NRHM – Sahiyya program.

4.3.2. B) Block Programme Manager

The Block Programme Manager (BPM) is responsible for the intervention related to VHSC. They have the responsibility of consolidating all the village level health plans at the block level and block level plan to the district through Medical officer (MOs) who sits at the PHC and or MOICs. To ensure distribution of/communication of resource envelope (along with physical and financial targets) of all health schemes to all the health functionaries in the block with the support of the block accountant, review the physical progress exclusively and financial progress with bank accountant in the monthly meeting under the guidance and supervision of MO, compile and submit monthly report in the prescribed format, BPM has to visit at least 3 PHC in a month and at least 7 sub-centre in a month and report to MO about the VHSC meeting achievements/progress as per resource envelope, coordinate and deal with all correspondence related to NRHM at block level, BPM has to make the physical progress available to the block accountant for the reporting on Health MIS portal, coordinate the collection and distribution of NRHM supplies to the block and all health institutions in the block and also maintain the record related to these supplies.

> *"We BPM along with the other members of the structure use to do a monthly meetings at the district level and at the block level there is monthly as well as weekly meetings with the BTTS, Sahiyya and the ANMs. And the Sahiyya and BTTs attend the meetings at the village level, PHC and CHC level." BPM, Khunti.*

The total number of BPM in the state is about 204 in Administrative blocks level. In the Non-Intervention area Gumla district the number is around 11 in each block and in the Intervention area Khunti district have 6 BPM.

The BPMs are totally oriented to the managerial works at the block level. Remarkably they have low awareness regarding the objectives and motive of the NRHM programmes. They are appointed very recently in the year 2010 and were in the primordial stage to handle all the responsibilities efficiently. In the Ghaghra block of Gumla the BPM find difficulties in the reporting as due to the lack of the basic facilities like Internet and they

have to go to the nearby town for accessing it and to report which is online reporting. Whereas the Khunti block BPM don't find problem related to the reporting as there is accessibility of these basic facilities. They are primarily oriented for the managerial tasks and so having low awareness regarding the prime objectives of the VHSC programme and its importance to the NRHM.

4.3.2. C) State Training Team

The total number of the STT in the state is about 48 comprises of 2 in each district. The composition is one male and one female as STT. The SHRC's state training team gives training to these STT, at the state level at Ranchi. They have the responsibility of selection of the Sahiyya Sathi by selection of block training team (BTT) and then to the Sahiyya Sathi through BTT. The training of the Sahiyyas and Sahiyya Sathi's by creating a cadre of trainers and train them for the orientation and training of the Sahiyya Sathi. Monitoring and support by providing the necessary support through the trainers and evaluation of the training programme.

> *"We have to regularly attend the Cluster meeting of Sahiya sathi. In meeting we generally guide and train them about their roles regarding conducting meetings, talks about the guidelines of Sahiyya formation, about conducting the cluster meetings, and to elucidate Sahiyya about their roles and responsibilities regarding health issues at the village level."* STT, Gumla.

4.3.2. D) Block Training Team

The number of Block Training Team (BTT) in the state is about 848 consisting of 4 BTTs in each block. The composition should be of 2 Sahiyas and 2 others including 1 male and 1 female. And the numbers of BTT were decided as per the guideline given by the state health department. In the Khunti district there are total 24 BTTs and in the Gumla district it is total 44. The responsibility of the BTT is to monitor the activities of Sahiyya by taking reports from them and discuss about the problems and limitations during the implementation to the concerned Sahiyya Sathi of that cluster.

"*4 BTTs divide their clusters according to their convenience. They prepare reports. They attend 1 day VHSC meeting, 1 day block level BTT meeting every month. In BTT meetings they give their VHSC meeting date in the Forthcoming meeting Planning report (Agrim Report) through getting informed by the village Sahiyas sathi. And the cluster meetings of Sahiyya sathi are being fixed by them to maintain coordination. They plan accordingly to attend the VHSC meeting and in the meeting there is the presence of Sahiya sathi, Sahiyya, VHSC members (All the CBO- like Krishi committee, Nigrani committee, and Education committee, Mata Samiti, Van Samiti, and SHGs) and villagers. BTT takes information regarding the involvement of Sahiyya in the VHSC; they monitor and ask about the tasks performed by the Sahiyas such as their regularity, whether they tell the villagers about the information dissemination regarding the health services by the health departments, roles and responsibility of Sahiya sathi to the VHSCs."* BTT, Gumla.

4.3.2. E) Sahiyya Sathi

The Sahiyya Sathi's are the supervisors of the Sahiyya and selected by the BTTs and STTs according to the experience and performance efficiency. She looks after the clusters that comprises of 20-30 Sahiyya. The total number of Sahiyya sathi in the Khunti block is 4 in each cluster comprises of 35 Sahiyya each at the village level and in the Gumla district the number of cluster is 10 and the Sahiyya sathi is 13 consists of 23 Sahiyya in each. The cluster is decided according to the geographical distance or panchayats of the village. The Sahiyya sathi meeting takes place at the two levels, firstly, at the cluster level and secondly, at the block level. They primarily do the supervision of the Sahiyya by documenting their activities and reporting to the PHC level. She is supposed to land support by looking after the activities of ensuring and organizing the monthly meeting regularities, provide support in training, facilitation in the development of village health plans, facilitation in conflict redressal and other issues related to the VHSC.

The other components of the support systems such as STT, BTT and the Sahiyya Sathi's are the representatives of the community. They are the influential persons in the

community due to their affiliations with the governmental activities, knowledge regarding the contents of the VHSC and the Sahiyyas activities, and authority of monitoring the tasks or the performances of the Sahiyyas and the VHSCs. They are the key resource persons who are directly to be contacted with the community and community also directly approach them for any issues related to the executions. Though they are the resource person who trains the Sahiyyas and the VHSC office bearers but they are the persons who are trusted most by the BPM for the getting the first hand information regarding the work progress of the different VHSCs and the reports of the VHSC trainings and the fund utilizations. They are also the first contacts of the Sahiyyas to discuss over the issues and the problems related to the executions. They are regularly given trainings around the capacity building at the district level so as to disseminate it I in turn to the lower tiers i.e. form cluster to the village level.

4.3.3 Facilitation by CINI in the Intervention Area

Child in Need Institution (CINI) joined VSRC for strengthening of the Sahiyya and VHSC programme in the year 2009 under the frame work of the NRHM in the entire state of Jharkhand to improve community awareness and action for Child health and nutrition that is the prime objective of the organization. The activities are technical support in the form of capacity building material development, documentation and inputs to all ongoing communitization related activities of Jharkhand Rural Health Mission. The settling up of Jharkhand State Health Society, Appraisal of state programme Manager Unit and District programme Unit under NRHM have been completed. The guideline and other materials for the state school health programme were also provided. The other programme known as 'Janta ka Swasthya Janta ke Haath' initiated with an objective of capacity building of CBM team and VHSC members on village health planning, schemes and services and CBM tools (http://www.cini-india.org/cini.pdf; Accessed on: Dec 3, 2011). The activities are through mapping of villages from clusters of each block, Training, need assessments of the members of the VHSCs, formation of CBM teams, capacity building of CBM team and VHSC members on VHP, schemes/services, untied

fund, CBM tools and conducting CBM exercise, Kala Jatha teams formed and sanitation activities has been carried out.

All the activities are carried out through the field workers appointed by the organization known as *Animators* whose basic responsibility is to work with a cluster of SHG covering an average population of 10,000. She facilitates a dialogue within the SHGs on health and present morbidities and causes of mortalities. And then the SHGs through the participatory mechanism share experiences, attempts to understand the causes of ill health and prepare action plan for limiting ill health and promoting health.

It has been observed that the Animators are well educated and belongs to the well off family from the same locality. They regularly attend the SHG meetings and the VEC meetings and slowly have started influencing the community with her regular presence in the meetings.

4.3.4 Trainings of VHSC members

The guideline says that the VHSC members should get orientation training designed to equip them to provide leadership as well as plan and monitor the health activities at the village level. All trainings were organized just prior to the fund allocations in the year 2009-10 and 2010-11 to the VHSCs of both the district. There was two days orientations program reported by the respondents esp. the PHC officials for the office bearers of the VHSC basically for the fund utilization. All the trainings were imparted by the handholding supporters like Block Training Team (BTT) at the PHC level.

After the PRI election, held on December 2010, the special one day training for the office bearers along with the PRI members for the roles and responsibility were organized in the year 2011.

For the better roles clarity and functioning of the VHSCs members the SHRC has taken up responsibility and thus has prepared VHSC module. The module is a printed book module in a simplified version using pictorial and simple language was distributed in all the VHSC where everything is printed regarding the roles, responsibility, functions, how to spend the money and how to keep the records of the village in terms of their

population, their health issues, school going children, drop out children, birth and death registration, the prominent members of the village and many more so that if any of the people want to have any information then they can see the register and have it from there. At the same time for ensuring the meeting regularity VHSC printed meeting registers were also provided and one day training of account keeping at the block level in both the district was imparted.

The trainings imparted were clearly focused on the capacity building of the office bearers for the fund utilization and the SOE preparation. The trainings were focused on the funds and its related activities despite of the need and the roles & responsibilities of the VHSC as a whole. Although there were initiatives for providing the format of the meeting register to be maintained by the VHSC to ensure the meetings, its minutes and the discussions on the health related issues documentations but in the actual situation hardly any VHSC started utilizing it. The office bearers are still confused about its application because the meetings were never taken since the completion of the funds. It has been observed that though the PRI members were invited for the orientation programme organized by the VSRC regarding the roles in the VHSC along with the Sahiyya and the VHSC president but they show low participation and in fact the proxies which indicate towards their prioritization of the activities apart from VHSC. The PRI members are mostly interested and involved in the other schemes and programmes related activities such as MNREGA, Antodaya Card, BPL cards, PDS, Seeds distribution during cultivation seasons and arranging MLA funds for their village and also observed that they are still striving for their stake in the panchayats as no clear responsibilities were assigned to them and the whole decisions were taken by the Mukhiya of the panchayats. These are the reasons due to which they don't feel confident about taking up the activities and giving priorities to the health related activities in the village.

4.3.5 Social mobilization Activity in Intervention Area

In the intervention area of the organization CINI the capacity building initiatives were taken besides the state intervention and other social mobilization activities were also

followed rigorously to ensure people's participation in the community. The implementation was done with the help of the Animators the so called organizational field workers under the supervision of the field coordinator who carried out the activities like Nukkad Natak/ Kalajatha for creating awareness in the community, organizing Sahiyya Sammelan where all the Sahiyya meet together and share their experiences in solidarity, Sahiyya Sandesh Yatra for generating awareness at the village and the cluster level with the unity, and community based monitoring (CBM) to discuss the VHSC functioning, its achievements and challenges, and organize 'Jan Samvad' a medium through which community can interact and have a dialogue with the government officials.

"I think that the officials are aware of the concept but not able to put the knowledge into practice at the ground level. This is what they are lacking so we are trying to show by different social mobilization activities like in last year we have organized a Sahiyya Sammelan, Sahiyya Sandesh Yatra, community based monitoring (CBM), Jan Samvad etc. All these things are happening and so they are now realizing that this is very important. If I talk about the Jan Sunvai or Janata Durbar then it is such a medium where the community comes and interacts with the officials directly. One side the officials are sitting and the community at the other side where they show their concerns and officials are responding to it and they are also taking corrective decisions and measures. If they find that something is not good for the community then they will go back and try to make the system in such a way that they will meet the community need and resonate with their voices eliminating scopes for grievances, addressing problem and they trying to short it out . Jan Sunvai has been initiated in at least one block of all the 24 districts and this year it is going to be started in the two blocks each. Later we have plans for replicating it in at least four blocks in all the districts. So apart from all the paper and the written thing there is direct communication between the two for the better establishment of the linkage between them. We also sensitized the block program manager and the block finance mangers at the block level to make them aware of their responsibility. So we are trying to train

these community members and on the other hand to the officials to generate common awareness regarding the common purpose. When they expend their money and come to show SOEs to them then there won't be any communication gap." Nodal Officer, CINI (Jharkhand)

The whole social mobilization activities were to emphasize on the total awareness among the community members through information dissemination through different activities such as Nukkad Natak, Sahiyya Sammelan, Sahiyya Sandesh Yatra, Jan Samvad and the CBM to motivate people and to enhance awareness. Though there was a slight changes or difference comes through the whole mobilization process in the community as for the instance the CBM was organized by the health officials in the presence of the VHSC office bearers, NGO members and the CBM team consist of Civil Surgeon, ACMOs, MOIC, MOs and the ANMs and the basic agenda discussed were the fund utilizations of the VHSC. This event slightly brings the difference in the awareness level of the VHSC members and the villagers as they came to know about the facts related to the functioning of the VHSC in the village but the major objectives or expected advantages were not gained through the process as it provided very low opportunity and space to put forth their complaints regarding health services and give their opinion about the health services they need in the CBM meetings held in the Block PHC and as consequence leads to the low participation of the community in the analysis, planning and implementation for their entitlements and their contribution in terms of labour and kind is still not so much evident. In the village the VHSC members are not negotiated yet with the service providers for them and the overall community demands.

4.3.6 Personnel's View on the training procedure

The DPC of Gumla discussed about the quality of training admitting that it was not up to the mark according to the training providers and organizers due to the logistic and accommodations problem for the residential trainings of more than one day which leads to the transitory loss of the main body of information. Apart from this the trainings also faces problems like low participation in the trainings of the VHSC members and also the

irregular presence of the same members in the continuous trainings of the VHSC members except Sahiyya. There is no proper follow-up of the trainings due to the time constraints which ultimately leads to the low quality of trainings and thus its outcomes.

> *"The orientation and trainings were done but the gap in between is very wide. And whenever we called a meeting then it is very difficult to accommodate the large group of around 50-60 members which reflects in their training. And if we do it in a small group then it will be a time consuming process."* DPC, Khunti.

> *"Sahiyya now in the true sense are involved and working. But the condition of president involvement is still poor i.e. up to 50%. It reflects the quality of training."* DPC, Khunti.

The NGO Nodal Officer said that it is true that all the trainings and capacity building activities were focused on the strengthening of the Sahiyya's whereas VHSCs were initially ignored and this is one of the reason that Sahiyya is gone ahead than VHSC in acquiring skills which ideally would have been in a way that VHSC must have lead the institution and Sahiyya should be accountable and responsible towards them. The other reason added by him for all the attention given to the Sahiyyas was that she looked upon as an active volunteer of the village and according to the state guidelines she is the mandatory office bearers in the committee in the position of secretary. So the focus was given to her in the hope that she will take the committee forward.

The reason behind the low quality of the trainings is majorly the time and the financial constraints faced by the officials. And during the participation among the VHSC members in training was basically owned by the Sahiyyas and it is because they are directly traceable and expected to be accountable to the government officials. Though they are attached with the activities voluntarily but somehow they are facing the pressure from the officials to perform and as results they were overly rely and focused in the belief that they will take forward the VHSCs of the village.

4.4 Communitization

Village health and sanitation committee (VHSC) is responsible for the complete health care of the community in the village.

4.4.1 Accessibility of VHSC at the village and Panchayat level

According to the guidelines the VHSC is one of the important committee among other eight committees in the Gram Sabha. As both the intervention and Non-intervention area comes under scheduled area so the formation of the committee was done in the Gram Sabha. According to different respondents the health agendas were discussed in the gram Sabha during the fund utilization period of the VHSC. The agendas were basically about the health related activities to prioritize for the sanitation drives like cleaning of wells, maintenance of hand pumps and cleaning its surrounding, pit filling, repairing of sewers, and maintenance of village roads during rainy season to avoid water logging as preventive measure for the malaria endemic. In the Salgi Village of Ghaghra/ Gumla the villagers decided to ensure the village as Malaria endemic free village. The village is the remotest village of the block based on the foothills and identified as a malaria prone area of the district. For this, with the help of the malaria department they provided Mosquito nets and asked people to use this and also utilized some amount of the untied fund for the DDT spray in entire village. Apart from it the sanitation drives committee also decides for the beneficiary of the health emergencies and in most of the cases emergencies were met by anchoring cost of hiring the vehicle during the delivery and helping expecting mothers for purchasing of the essential medicines.

At the Gram Panchayat level the VHSC is not so develop to undertake the activities like approving the activities of the untied fund of the sub-centre given under the joint account of ANM and the Sahiyya. Infact the VHSC at the village level is in the initial phase and did not have the role clarity at the Panchayat level.

The VHSC members don't participate regularly in the Gram Sabha meeting and in case they attend it, it rarely happens that the health agenda's were discussed there except few.

After the elections the new formed Gram Sabha are irregular and only takes place during the programme or schemes implementation. The Sahiyya alone discusses the health issues of the hamlet level in the SHG meetings along with the village people and also in every VHND day along with the ANM, Anganwadi Sevika and enlist it and give information related to better health practices for a good health.

It has been observed that the meetings of the VHSC are not regular and it has not taken place separately after the fund completion. All the discussions were done in the VHND in the presence of the mothers and their child who came for the immunization and the ration. Sahiyya also conduct their meetings in the SHG meetings and in the Anganwadi centre. The bank pass books are in the name of the VHSC of the particular village and the signatories are Sahiyya and the president of the VHSC. And the third signatory was the SHG members. Most of the bank accounts in the non-intervention area were opened in 2008 and in the Intervention Area the bank accounts were opened in 2009 and in the following year they all were disbursed with the untied fund. And most of the activities were conducted for the sanitation drives and for the infrastructural shortcomings. And the Sahiyyas good relationship with the gram Pradhan in the village make the VHSCs accessibility very easy to be discussed about the health related issues and information to transmit it through the Gram Sabha.

4.4.2 Plan of VHSC

Plans are the process outcomes that are collectively done with the participation of all people by identifying the village problem and solving it taking different steps required therein. The VHSC is supposed to make the Village Health Plan (VHP) at the village level and it is the primary role as an important stage of planning that goes for consolidation in the final step of District Health Planning to include marked problems and its solution in the activity planning and mapping. In both Intervention and Non-Intervention areas the second phase VHSC exists and they were in the grooming stage so no Village Health Plan (VHP) has been prepared by any of the VHSC. But during the

utilization period of the untied funds, all the VHSC has plans for their proposed activities in the presence of the community in the gram Sabha.

The VHSC mostly planned the Preventive/Promotive Activities like sanitation drives, DDT spray, Sewers, hand pump and well repairing and maintenances. The Curative activities as a part of measures were basically planned like promoting institutional deliveries, helping in the immunization in the VHND, and taking severely diseased patient to the hospitals by hiring a vehicle by utilizing the fund. The promotive activities such as creating awareness by the VHSC member regarding the health by doing wall writings, information dissemination in the SHGs and VHND was done by the Sahiyya and VHSC. No such instances of the rehabilitative activities like use of fund as a revolving fund were taken in both intervention and non-intervention area studied.

The beneficiary of the plan was centered on the women who are expecting mothers and delivery cases in the village. Other than this the fund was given to the very poor family identified by the community during the health emergencies. The criteria for the preventive activities for common benefits were decided according to their utility for the community in general and not on the individual basis like for the well and hand pumps etc.

The decisions should be taken in a collective manner but initially during the first allotment of fund the activities were decided by the community but later in many cases for the second installment of the fund in most of the VHSC, in both the intervention and Non-intervention area, the activities were decided by the VHSC president and the Sahiyya without discussing it in the community forum. And many of time both the office bearers gets influenced by the influential persons of the village or the local elites and decide for the beneficiary as in the case of Sirkoat village Ghaghra/Gumla.

4.4.3 Implementation by VHSC

In the implementation process all the VHSC members are non- participatory and involved in the execution of the activities. The scenario in both intervention and Non-Intervention

area is that all the VHSC members are inactive except the Sahiyya and the President. The sole activities were acted by the Sahiyya from the decision making level till its implementation followed by the reporting and SOE submission to the block accountant and BPM. The implementation is not ensured in a participatory approach.

During the implementation period the community participates in the activities related to the sanitation drives. Though the motivation is for monetary gains, as admitted by the Sahiyya that people do participates in time when required for lending out labour but only for credit. Like in the case of Sirkoat village Ghaghra/Gumla the people worked in credit for spraying the DDT in the entire village. Likewise happens for the most of the sanitation drive activities in many villages.

The impacts of the implemented health activities in the community are directed towards improvement in the infrastructural shortcomings in the villages which was remarkably done by the community. The awareness level enhanced among people about the fund grants for the activities like sanitation drives. After the first installment of the untied fund there is an increase in the utilization of the funds in the VHSC which was not visible during the first allotment of the fund. The VHSC activities are driven by the funds and its functionality also directly driven by it, as in almost every VHSC of both the area meetings were irregular or not taken place after the completion of the monetary support. But due to the promotive activities by the Sahiyya in the Anganwadi centre, SHG and in the VHND the women are very much aware of the better health practices and the behavioral changes can be seen in the village people in their daily works such as keeping their premises clean, don't wash their clothes and utensils nearby to the drinking water surroundings, and also ask others to maintain and ensure such practices. There is very much visible increase in umbers of the institutional deliveries in the village and rational approaches taken by the Sahiyya and the president for providing monetary help in case of health emergencies. In the intervention area now the community has started demanding for their health needs such as asking about the information related to the health schemes, facilities and started questioning the roles of the health functionaries working in their area.

4.4.4 Monitoring by VHSC

According to the CBM guidelines the community monitoring process involved conceptualization, stimulation, sensitization and motivation of community based groups, capacity building at the different levels and mobilization of the community to provide direct feedback on the Govt. health services and its functioning, which includes improved planning and action at all levels (CBM of Health Services under NRHM Jharkhand – A Report; 2008).

The main responsibility of the CBM team is to reviews the VHSC functions, the performances of the ANM, AWW and Sahiyya and the communities own experiences about Govt. health services.

In the Non-Intervention area no such CBM was initiated till date. Whereas, in the Intervention area the CBM at the PHC level known as 'Jan Samvad' was organized in 2011 at the block level where the presentation of the information by the CBM team was done in the presence of Civil surgeon (CS), MOs, ANMs and VHSC members (President). Here it was organized for examining the VHSC function, and utilization of the untied fund.

4.4.5 Cooperation to the VHSC

It has been observed that the accountable health officials such as DPC, BPM and the technical supporters like STT and BTT are very much cooperative to the VHSC and its activities. Though the state did come up with a guideline for the VHSC and Sahiyya but at the grassroots level the BPM and BTT are not aware of the contents of the guideline thoroughly which hinder them in co-operating the committees in the full-fledged manner.

The field level health functionaries such as ANM and AWW work with the Sahiyya but due to the lack of role clarity in the VHSC they are hardly able to support the VHSC in their fund executions. Apart from the fund utilization they come forward to help in the curative activities.

Cooperation of the other village committees- There is no such evidence of cooperation of the other committees of the village like Education committee, Nigrani committee, Mata Samiti, SHG and Gram Van Rakhsha Samiti. They all work as a separate entity though the members are overlapping coincidently in many VHSCs.

4.4.6 Collaboration

In both the intervention and non-intervention area it has been observed that though the VHSC has done a kind of collaboration such as with the malaria departments for distributing the mosquitoes net and the DDT spray in the block level implementing through the VHSCs yet there is hardly any evidence of the collaboration with any of the other departments such as Village drinking water departments.

4.4.7 Knowledge & Awareness Level in VHSC members

In the Non-Intervention area VHSC members are not much aware of their roles and responsibilities. The Sahiyya and president are performing the tasks of utilization of funds as given by the block PHC. The awareness level in the community is also low regarding the functions of the VHSC as many of the people from the same village or hamlet don't even heard about the committees. The reasons behind this could be said that there are no other initiatives other than the state efforts that were initiated in this area. The geographical constraints with the distance and accessibility to the block headquarters are very much prominent that it is very difficult for the VHSC members for the purpose of attending the meetings or trainings and for the block officials to visits the area regularly.

In the Intervention area the awareness level among the VHSC members and the community is better with the initiatives taken by the Animators of the NGO that imparts information through the 'Kalajatha' a street play in the community regarding VHSC, Sahiyya, and their entitlements under NRHM and about the rights of the people almost once in few months. This was found as an effective tool for the community for sensitization and motivation for the community. This played an important role in the

process of sensitizing people around community based monitoring of the health services also and consequently many people have started raising their voice for the details of the fund utilization. On the other hand, attending the 'Jan Sunvai' at the block level also helped in enhancing knowledge among villagers related to the Village level organization. The NGO conducts the meetings with the community people in the Gram Sabha in different villages for imparting same; develop understanding about the purpose of the initiatives sensitizing the community about the need based community groups like VHSC. This brings a tremendous difference in the awareness level in comparison to the Non-Intervention area. Apart from the NGO intervention the other reasons could be the geographical proximity of the community as the Block is very nearby to the state capital, the distance of the Khunti block headquarters to the Ranchi State capital headquarter is about 35-37 Km. and most of the officials visits are organized in the villages of the Khunti block as Khunti itself is a Sub-division. This ultimately brings difference in the accessibility in the facilities.

4.4.8 Outputs

Both in intervention and non-intervention areas the positive impact of the programme has been evident such as increase in the fund utilization in the villages mostly spent on the sanitation drives, increase in the awareness level among the community regarding the immunization, increase in the awareness level among the mothers to send their children to the Anganwadi centre and also to the school in their village. In the intervention area due to the high awareness level owing to the intervention made by CINIs the attitudinal changes among the people are very much evident.

> *"If we see the basic thing of VHSC like guideline, meeting register, impact of the trainings, the awareness level of the VHSC, there is a definite change in relation to the responsibility of the office bearers of the VHSC, there. I find there is a meeting regularity, they are vocal in keeping their issues and when they visit for any facility demand, overall in the capacity building part they are much capable in our intervention area. And they are also very much eager to know once they are*

sensitized and oriented, in terms of meeting they are very regular and about to ensure proper utilization of the untied fund, knowing about their rights, they go and visit AWC (Anganwadi Centre) and monitor AWW work like children enrollment of their village is properly done or not, also aware their community regarding VHND, look after the children should go to their school by attending their village education committee meetings and also started learning the village health course and the PRI members have also started showing their interest in the community health program. They are regular in their meetings and write the minutes properly." Nodal Officer, CINI (Jharkhand).

CHAPTER 5

DISCUSSION

Discussion

The introduction of primary health care approach comprises of comprehensive health care emphasizing in community participation and ultimate self-reliance presuming more responsibility for the own health to achieve the primary health care to all. All the significant documents articulating people's rights to health such as Alma Ata Declaration, the Bhore Committee report and most, recently, the documents pertaining to the NRHM considered the community participation and decentralization as the key strategies for making health care services more effective.

It is widely understood and accepted that people's ownership and control is essential to maintain quality and the effectiveness. The people's participation and the control are required in overall process leading to the delivery of services, starting from planning itself.

The Village Health and Sanitation Committee is one of the modes of allowing local village level planning for health care, ideally, an informed body that comprises of village level health workers such as Sahiyya, ANMs, Anganwadi Sevika, the representatives of PRI known as ward members and CBOs representatives such as members of Women Self-help Groups, Village Education Committees, Nigrani Samiti, Mata Samiti, Purush Mandals and Gram Van Suraksha Samiti and specially including groups who are otherwise marginalized, having the capacity and competency to do an adequate situational analysis of the local status of health and plan for it, with the power and leverage to bid for locally appropriate health care services and with the ability to monitor them. The process also includes, ideally, control over finances and budgets with built in systems of transparency to the public at large.

The roles of the VHSCs are expected in providing the drift for the positive and sustainable change through various instruments and investments. Therefore, the National Rural Health Mission acknowledge these processes as essential to the 'architectural correction' required for the health sector reforms and spells out many details of institutional arrangements for local health planning at the village level. The mission seeks

to empower local government to plan, facilitate implementation, manage, control and be accountable for public health services at various levels. The idea behind this is to realize that the decentralized planning, facilitation of implementation, supervision and monitoring through community involvement will likely to be more responsive to the healthcare needs of local communities and will be a step towards 'communitization' an authentication of the NRHM.

The whole VHSC is visualizing as a simple and effective management structure at the lowest level, comprising representatives from the village to initiate the community-led action. The key function of VHSC is to prepare the village health plan, implement it and manage the fund which ventured as per the need of the community. The committee is the facilitating body for the village level development program relating to health and sanitation and reflects the aspirations of the local community.

The present study was an attempt to explore the Village Health and Sanitation Committee (VHSC) – a Model of Communitization at the level. For this purpose the study looks at the Village Health and Sanitation Committees (VHSCs) in the intervention and non-intervention area. The four villages of the Khunti block of the Khunti District was studied as the intervention area where there is the intervention of the implementing agencies CINI (Jharkhand) and the four villages of the Ghaghra Block of the Gumla District as the non-intervention area where there is only the governmental intervention without any other implementation of the other developmental agencies. The time period of study conducted was December 2011- February 2012.

In both the district namely Gumla and the Khunti, the formation of VHSC is done in its second phase which falls under June 2007 to December 2008-January 2009.

The NRHM framework for the implementation clearly emphasizes that the VHSC will form under the Gram Sabha of each revenue village with the proportionate representation from all the hamlets, disadvantaged categories such as women, ST/SC/OBC and the minority groups. In case of Jharkhand, the scheduled areas the VHSCs are supposed to form in the area where Gram Sabha exists and so it could be possible to have more than

one Gram Sabha in one revenue village and hence the VHSCs too. At the Gram Panchayat level the sub-Health centre with an adequate representation of VHSCs will be responsible for the managements and they are accountable towards Gram Panchayat. The VHSC are supposed to make the village health plan, village health survey, and the maintenance of the village health register. The framework specifies that every VHSCs will get an annual untied grant of up to Rs. 10, 000/-. In addition to the VHSC fund, each sub-centre will also have an untied fund for the local action of Rs.10, 000/- and will be deposited in a joint bank account of the ANM and Sarpanch or in the case of Jharkhand with ASHA/ Sahiyya and operated by the ANM in consultation with the VHSC. They have to ensure the fund utilization provided by the government for the health related activities such as revolving fund, IEC, household survey, preparation of health register, organization of meetings at the village level. The frameworks has the provision of the skill development of the VHSC through the orientation training to enhance the leadership quality for the better planning and monitoring of the health activities of the village.

Based on these implementation framework the study tries to get the information and in the process of the study some of the issues emerged through the research in the intervention and non-intervention areas at the implementation level are:

In contrast to the guidelines the formation process was not followed by the proposed steps and mode of dissemination and orientation. It has been done without any concept seeding around the ideas, purposes and the role assignments to the VHSC members, village community and office bearers. The male members were seems to be discouraged to participate being an office bearers which ideally, needs to be the involvement of both the genders to ensure the better participation of the community. The whole formation and selection process of the VHSC was compromised by some dominant sections and interest groups of the community which already had a say in all the village affairs. This leaving behind the core idea of equal presentation and accessibility led towards the community participation with the facilitation and acknowledgement of the perspective, view points, consents, inputs and knowledge awareness of all the major sections such as all men, women hailing from rest of the village hamlets, differing clans and pre-existing

committees of a village community at the entire village level. Apart from the internal intricacies in ensuring the community participation there is also an influence exertions and pressurization from the health functionaries at block level and the PHCs such as ANMs in the selection of the Sahiyyas and VHSC President of the village and it was apparent that they were somehow already chosen prior to the village meeting. Thus, agencies that were expected to act as facilitators assumed the role of pressure groups and reinforced their choice in the process of selection coupled with the dominance of certain sections.

The ownership and control is seen as the major criteria for the services to maintain quality and its effectiveness. And the roots of the ownership is basically based on the self motivation of the people to undertake the activities and owned it for its sustenance. But in practice, taking responsibilities by the person for being the part of the VHSCs becomes the central issues as one cannot compel eligible persons without their interests. The criteria followed for the selection process were based on nomination by someone, status of the person, proven participation in village affairs in the past, vocal behavior to represent villagers, articulation abilities and basic literacy to handle bank accounts and registers sometimes leads towards the scarcity of the kind of eligible persons. Then community usually does not have any choice but to choose them. And if they were not self motivated and enthusiastic enough to take up responsibility in serious manner then it affects in their ownership level and thus negating the core idea of the communitization that to 'empower the motivated one instead of wasting time and money on unmotivated empowered one' this ultimately led towards the lackadaisical of the ownership an important step to achieve the participation. The male counterparts in the village got an impression of often disqualify or unsuitable for taking part in the activities basically for the females due to gender specific construction of the health schemes and programmes. The VHSC presidents were subjected to very insignificant roles and had limited opportunities to exercise power and struggling for marinating their stake in the committees. The lack of interest was very evident in the views and remarks of the VHSC's members due to the role obscurity and involvement in the committees functions.

The VHSCs were not taken as serious committee with lacking representation of most of the worthy and active people of the villages contributing themselves to the other committees. It is very much clear that the facilitator NGO has completed their work in the target oriented manner just to complete the numbers that they were asked to achieve bound with MOU. The full-fledged equitable participation is totally missing leading towards the low ownership building and control over the overall process of services delivery starting from the planning in the absence of real ownership.

The other vital aspects were compromised at the first place in order to fulfill the said criteria as per the guidelines regarding the committee's composition such as reservation for the women and ensuring the ST category representatives in the village. There is vivid dichotomy between the practice and the principle on which these guidelines are based. In many ways these criteria proved constrains in realizing the complete participation from every sections and residents of the village resulting in exclusion of males and other social categories. Facilitators have an easy access to the local elites, dominant clans of the village, petty local contractors and mostly literate (or neo-literate) avoiding residents of the other hamlets difficult to access due to tough tiresome terrains with low connectivity and illiteracy of the marginal clans residing in those so called unimportant hamlets. The guideline generalizes scheduled tribes and caste categories within which even many marginal clans and primitive/endangered population exists in these villages were bypassed who in reality often contests with the dominant tribal populations for their say and schemes that come to the village. Again the guidelines unable to take much care of the inclusion and say of women by focusing on the fact that women participating hails from marginal or dominant groups and due to the prior information of the major criteria few of them who resides in the same hamlet lack interest in participating as they felt already excluded with the programme. It appears as if the same guidelines were misused by the facilitators to avoid taking pain and smoothen their way for getting done their work in their hand faster. The other excluding factors were that the members are supposed to be a women and to ensure this the only committee were approached was Mahila Mandals of the hamlets/village by ignoring the other important committees of the

village, giving an impression of VHSC as a women oriented groups headed by the Sahiyya. Thus homogenizing nature of the said guidelines was realized as constrains in ensuring communitization in true spirit wherein these marginal groups within the stratified village should have given proper representation by design.

The state health policy is totally focused on strengthening the Sahiyyas for ensuring the better healthcare delivery system at the local level and undervaluing the strength of the VHSCs. It seems that they are patronizing Sahiyyas by making them sole player in the VHSCs at the village level. At the ground level the roles, responsibilities and power of decision making of the Presidents and the other VHSC members were totally overshadowed by her. The Sahiyyas are more powerful in terms of decision making and through direct linkages and contacts with the government officials at the block or PHC level, and by the regular knowledge up gradations through meetings and trainings. This creates a wide gap in terms of the knowledge and information between the VHSC members and the Presidents of the committee which leads towards the lack of interest and ownership for the VHSCs in them. It develops an impression that the VHSC is got to do with the Sahiyya and she is the sole player in the committee giving a backup and proof to the emerged nomenclature of VHSC untied fund as a 'Sahiyya fund' from the community itself. It seems supporting the people's perception and gives a glimpse of centralization of the power and resources against the decentralization a basic approach of communitization at the institution level. The VHSCs and the Sahiyyas role into it are seen as a separate entity by the other health extension workers of the village such as ANMs and AWW. Both of them shows least interest in taking responsibility pertaining to the VHSCs because it was found that the village level health functionaries are already overburdened with the health related tasks assigned to them from the block health departments which make them to see this responsibility as the additional task. Though the AWW are they themselves belong to the same place and could help the VHSC with her valuable inputs but it was very difficult to ensure their full participation here due to petty information regarding roles and responsibilities of each other and also by sharing the status of competitors in terms of community acceptance. It also between the Sahiyya and

president, that despite of working as a team the president seems to be the subordinate of the Sahiyya. The overall impressions received from the government strategy of taking shortcuts to strengthen the VHSCs by focusing on Sahiyyas due to over dependency of the programme officials for tracing and the follow-up of fund utilization in the village. And ignoring the other valuable elements comprising the committee due to low trust or rely upon them supposedly due to their inefficiency without considering the problems or constrains of the other stakeholders in ensuring their full participation.

At the village level though Sahiyyas seem to be more powerful, patronized and sole player in the VHSC raising towards the questions related to the proper space of decision making at the local level but the other side of the coin say something else about the conspiracy. Though mostly the Sahiyyas were found to be self motivated to voluntarily work but they were usually pressurized to take decision under the influence of government officials sitting at the block level or PHC. The power of Sahiyya cannot be seen in disguise of the programmatic structure that essentialize her role and hence her positioning in the community as a key person because the fact that she is also struggling to create her identity on day to day basis within the tensions inherently exists in rural community. The contestation among the key members/ other influential groups and Sahiyyas within the rural community for power and acknowledgement is an ongoing and never ending process. Placing Sahiyya in the key role reduces the project to a women centric project that negates the idea of everybody's involvement but supports empowerment issues and leadership of rural women.

The other forms of decentralization in the VHSC also give an idea of the degree of space of decision making of the VHSC member at the local level. The political decentralization that allows to devolved power to the VHSC as an actor and though its success depends on the components such as statutory or constitutional reforms as well. And though the study area falls under the administration of the fifth Schedule constituted with the clear objectives to assist the tribal's in enjoying their existing rights without any hindrance by others and to develop the Scheduled Areas and protect and promote the interest of Scheduled tribes. In the Study area the Traditional tribal council plays an important role

in the society. The institution of traditional tribal council is as old as the tribal society. Their functions has been primarily to decide social and religious matters, in some areas to determine judicial matters on the basis of the consent of the people as a whole and also decide economic questions as the part of their social responsibility in the light of the customary laws. Tribal councils are not elected bodies; infact heredity was often the basis of it. But many times character and the personal life of the individual elevated a person to this coveted position. Inspite of this, every adult had equal rights to argue and put forth any question and thus issues used to be settled through consensus. The decisions of the councils are the law of the tribals because they are based on their social customs and religious rites (Hasnain, 2007: 347-348). Recently in year December 2010, there was an advent or an introduction of statutory panchayati system throughout the state, which seems to have weakened the traditional tribal councils at some places, but generally speaking these statutory bodies have adopted almost all the functions of the traditional tribal councils with the added responsibility of implementing development work too. But the tension between traditional leaders and the PRI members consequently tampers with the functioning of the VHSC owing to various power equations forming around contesting domains and interest groups, the tension creates and recreates. Traditionally the self governance has been the driving force of the village life and decision and the tribal population predominantly inhabiting in these areas are yet to adjust and harmonize with the state guided PRI structures under the Panchayati Raj Schemes of governance. But in the current scenario the PRI in its primordial stage, their members still are not acting upon their roles in full-fledged manner due to lack of orientation and instructions by the block officials. This seems to cause the low ownership leading towards giving an importance to the village health committees as an important committee of their village. As mentioned earlier that they are in their primordial stage themselves and struggling to develop a stake among the village and in the community.

This programme is perceived as just another source of fund by the villagers reducing other more important components designed in the principles of the VHSC. This is seen as a tool for spending the untied fund through the proper and traceable channels which able

to give an impression of collectivity in the community decisions. The self sufficiency of the VHSC in terms of having their fund besides disbursed untied fund is an element completely missing out in the program design. It increases the dependency of the community on the government apparatus and thus controlling of their decisions and prioritization by petty bureaucracy at block and panchayat level government establishments. Such dependent relations consider as a part of this general rule and make it a puppet and medium to smoothly implement government schemes on health and not fulfilling communities own health well being demands. This is substantiating the fact that the fiscal decentralization is very low in the VHSCs as the untied fund is based on the principle of the flexible amount spent on the priority of the community rather in actual practice the VHSCs were given a activity list and asked to ensure that they spent on the particular activities. This indicates the non flexibility and boundary to the VHSCs in spending of the funds negating the meaning of provisioning of 'untied fund' to meet the demands of the community.

The fatigue syndrome is very evident in the VHSCs. As due to the disrupted fund flow the VHSCs members are seems very enthusiastic in up taking the health related activities and meeting irregularities, no role clarity and very less space to practice innovations at the village level spreading poor presentation of the committees. Apart from this major issue the other reasons which lead towards this are the content of the training programme which seems to be very iterative. The activities related to the infrastructure shortcomings and sanitation drives done for the utilization of the fund though they wants to spend the fund in the some other health needs make them less interested and hinder their ability to spend it with some innovations. Apart from the VHSC members the community also does not find the committee interesting due to no innovations and less active in the development initiatives. Thus, overall local people have very low expectations from VHSC in the progress of their village except confined or approach the Sahiyya for the institutional delivery purposes.

The administrative decentralization in the VHSC is very low and it can be said on the basis of the decision making space given by the government officials to the VHSCs

which seems to be very limited at the ground level. Government show that they are keen to promote decentralization through the statutory or constitutions by devolving their powers and responsibility in terms of authority and the functions from the central government agencies straight to the community present in the form of lower level autonomous units but in reality the real devolution is seems to be diluted. Here in the absence of the statutory body (PRI or Gram Sabha members) involvement in the VHSCs actions, the Sahiyyas are confined with the roles and responsibilities of the VHSCs. Though she has the sole responsibility but the space given for the decision making seems to be very low and thus can be realized that at what extent the power have been devolved within the health committees to create a space for the control and the decision making for the Sahiyya as a representative of the community through the health committees. So it can be said that the government apparatus VHSC in a disguise way of lending support, facilitation and the training which is usually found to impose their own idea. As indicating towards the delegation form of decentralization which is seen confined only to the transfer of the managerial responsibility for certain functions pertaining to health to the VHSCs.

In the intervention area of CINI basically deals with the social mobilization process to strengthen the VHSCs at the local level through several strategies. Among the entire most important one is through Animators who are responsible for capacity building and awareness generation at the local level in the VHSC and its members along with the whole community. But there was a conflict in coordination between the Animators and the Sahiyyas. The reasons were the unwillingness of the Sahiyyas to be interfered by the animators and pretending her as an outsider due to her accountability to the NGOs. A visible ego clash between Sahiyya and the NGO animators because of the comparison with the amount of work load and the remunerations rewarded against them which is considerably low income in case of Sahiyya. The basic sense of discomfort of the Sahiyyas with the animators is that if they are not willing to take any responsibility or accountability of the VHSC in their hands then why interfere in the Sahiyyas work through raising question in a way of monitoring despite of solving their grievances and

implementation issues which seems to be logical to a great extent. It extended to the fact that the animators who otherwise represent NGOs have differential intentions to intervene at different levels which is often in conflict with the practical roles of the Sahiyyas to carry out her tasks or may be Sahiyyas have self assumed themselves in the centre stage of VHSC would not like to share their authority and power with the animators or dislike to fall puppet of these animators. One of the important tools of generating awareness they use is Nukkad Natak which they claim to be the most effective one seems to be doubtful as they were arranged in the time when all people cannot gather due to their daily work and it was done as the task based manner by the animators without ensuring and assuring that is it touched the cords of local issues and problems at the village level. Though such events like community based monitoring (CBM) organized by the government officials and developmental agencies slightly brings the difference in the awareness level of the VHSC members and the villagers. But in real sense it is unable to achieve the expected advantages, and thus provides very low opportunity and space to put forth their complaints and opinion regarding their needs of health services which results in a low participation of the community in the analysis, planning and implementation for the entitlements. And the VHSC contribution in terms of labour and kind is still not so much evident and to be said as a long way to go. Thus the question arises here is that to what extent the mobilization process of the NGOs are effective in knowledge dissemination, sensitization, and motivation and awareness generation from the point of view of the community.

The government initiative for the strengthening of the VHSC through grooming and facilitation seems to be done through the structured support system. But there are several constraints in the developing of the support systems lacking basically the intangible motivational part among the components of the systems. The contractual positions and the managerial orientation of the district and the block level officials complementing with the low prioritization by the CMOs and MOs, focusing basically on the national level health programmes with the overburdened work schedules leads towards the de-motivation among the health officials though they are keen to focus on the VHSCs. There

is proper need to acquaint the officials directly responsible for the strengthening of the VHSCs through their capacity and knowledge building regarding the need of such health committees apart from the managerial tasks based orientations. The capacity builders from the community itself are able to bring a difference in the VHSCs as they are acquainting with the knowledge and information and able to disseminate it well in the community. Their familiarity in the community, approachability, trustworthiness, and first hand contact ability to the VHSC members' helps in bringing out an evident change at the execution level. The most important part in the strengthening process is imparting trainings to the VHSC members. But it is evident that, mostly it is based on the objective of fund utilization and the SOE preparation, clearly indicating towards the narrowness of the ideas of the communitization process despite giving a clear orientation on the need and the roles and responsibilities of the VHSCs as a whole. The low sustenance of the training output with lot of transmit losses at the execution or at the practice level is points towards the low quality of the training due to time and financial constraints faced by the officials.

Overall the community mobilization part is basically based on the 'pragmatic approach' viewing to strengthen health services and achieve critical goals by involvement and actions of community mobilizers along with the professional associations. It was seen as the blessings for health program by adding significant human and monetary resources to accomplish goals. But in the practice level the approach unable to translate in a well manner as lacking their prime purpose to make VHSC itself into social mobilizers who create awareness in the village about available health services and their entitlements and most importantly evident in their executions. Though heavy fund and time is invested towards the social mobilization process including the involvement of both government and non-government agencies but the outputs in terms of capable VHSCs with the raised awareness and demands for a particular program, can assist in the delivery of resources and services and able to strengthen community participation for sustainability and self-reliance is yet a distant dream.

The outcomes of the communitization process could be seen in terms of various components which capture the real practice and experiences of the VHSCs in the village. The accessibility of the VHSCs in the Gram Sabha, an important governing body is very minimal as earlier discussed that it is not given much importance as an important committee of the village. The Gram Sabha themselves are struggling between the two systems of the local governance body namely the traditional and the PRI system, making them unable to undertake initiatives to incorporate each and every village level committees in the development process of the village as a whole. Due to this the VHSCs is definitely missing a reliable platform trusted most by the community for bringing or discussing on the health needs. This leads towards the weak or infact no development of the village health committees at the Gram Panchayat level. Ultimately leading towards the absence of village health plans (VHP) and panchayat level plans to support the district level development plans. The plans are the process outcomes that are collectively done with the participation of all people by identifying the village problems and solving it taking different steps required therein. And it is very evident that the degree of community participation is not up to the mark to achieve the greater degree of ownership and control over the institutions, which ultimately come up with need-based better developmental planning. Somehow it seems that the degree of community participation is in between co-option and compliance level refers to the token involvement of local people with the selection of the representatives but with no real input or power and latter with the glimpse of incentive based tasks assignments where outsiders decide agenda and direct the process giving an impression of very low degree community ownership and sustainability an essence of the communitization process. This also leads towards the non-participatory way of involvement in the implementation and execution process confined to the few sections of people. This only ensures the completion of tasks prescribed by the government with the fund utilization an ultimate objective by narrowing the broad objectives of the communitization process and deviating from the prime objectives of the VHSC model.

The VHSCs in the study area is at its primordial stage and there is much scope for being communitized as an institution. But we cannot deny the fact that its foundation is not so strong enough to support the communitization process. The essentialism of community participation with the good degree of decentralization along with the government support in the strengthening through the social mobilization for making an institution communitized in a real sense for achieving the goal of comprehensive health care supporting idea of 'health for all'. The approach supported here for ensuring the community participation ideally should based on the community involvement approach through conscientisation with the organization and mobilization of the masses so that consciousness could be translated into a change by supporting the empowerment model which beliefs in enabling the community through giving education or information and through involving and experiencing them further leads to gaining access and control of health care resources. It is a 'bottom up approach' used a tool through which people could take responsibility for diagnosing and working on their own health and developmental problems. But in the ground reality, in practice it deviates from this approach to the other approach of community participation known as the community development approach with the basic assumption based on the consensus on needs and aspiration in the communities through the utilitarian model. This generally known as target-oriented frame termed as 'top-down approach' where planners decides the objectives and then try to convince people to accept them with an effort on the part of government or donors to use local resources to offset the cost of services provision more efficiently, effectively or cheaply by collaborating people voluntarily or as a result of some persuasions or incentives in turns of some expected resources.

Communitization is supporting the devolution form of decentralization for giving more space for decision making in terms of political, administrative and fiscal authority and responsibility through the powers. In the study area the devolution form of decentralization is very rare and the delegation form is been practicing with the transfer of authority and responsibility delegated from the central agencies to the organizations such as local organization not directly under the control of those agencies. But in both the

case of decentralization the underlining question is that whether there is an appropriate mix of central control and local management or else there is much control of the central actors. And it could be said that the ultimate goal or output of the decentralization the responsiveness and the increase in demands is yet to be achieved due to the limitation by weak institutional base and dearth of efficient local level institutions compounded by the confusion on the concept and practice of decentralization due to lack of clarity for all the levels including those who gets benefits out of it.

The community participation and the decentralization have a symbiotic or mutualism relationships and both are the preconditions to each others for broad decision making. And the communitization is the matter of relationship as vital factors between the institutions and the community where the institution respect the intrinsic worth of the community, realize the potential knowledge to learn from by adopting an attitude of no imposition, and accept the idea of indigenous for the sustainable development with the cultural roots and native genius for avoiding the imposition of the foreign model supporting to the consideration of the counter rationality of the community such as much more important needs according to the geography and epidemiology of the area instead of the governments own perspectives and objectives of the interventions for the problems focusing on the few vertical programmes. And thus the more healthy relationship, the more is the communitization.

The suggestions that were grounded from the study field, basically brings out the expectations of the community and the Village Health Committees stakeholders from the health committees of their village. Most of the suggestions that came out from the VHSC members are for ensuring the meeting regularity of the committees with the full and active participation of all the members including the Gram Pradhan, other CBOs, PRI members and the health extension workers such as ANMs and AWW. They also bring an aspect of lacking the male folk participation in the health related activities that have been undertaken under the health programs. The basic tendency and the perception prevailed in the society that the activities related to the care giving and sanitations works are the domains of women and it could be the reasons that men hardly shows their interest in

participating in the committees that specifically deals with promotive health activities. So this was one of the important suggestions as ensuring male folk participation in the VHSC activities undertaken in the villages and to erase the build-in perception of VHSC as a female based affair conducted by the women folk considering only their health problems. The other important suggestions came out was the active involvement of the PRI members in the health related activities through ensuring their presence in the discussion of health related matters and unanimous decision making, through discussing it in the Gram Sabha as no such instance has been taken yet. So the VHSC members suggested that there is a need of streamlining the discussion on health related issues at the village centre level i.e. in the Gram Sabha and must be given the similar importance to the other developmental issues and programs in the village. VHSC member also suggested that there must be the regular fund flow from the government as it is one of the greatest motivational factors among the health committee to uptake the activities by regularizing their meetings and it creates an enthusiasm among the members as well as among the community for ensuring the funds related planning and its activities implementations. The important components of the VHSC the Sahiyyas suggested that there must be the regular payments of Sahiyyas on time as its works as an extrinsic motivations for them to work enthusiastically on the field. Other than the VHSCs members, the other stakeholders at the block and the district level working as the support systems suggested that the more focus should be given on the field based support systems such as to the Block Training Team (BTT), Sahiyya Sathi and also to the State Training Teams (STT). They are the closest link to the community and belongs to the same locals can be the better linkage in redressing the problems and hindrance of the field workers at the field level, and also the direct linkage with the government officials for transmitting the valuable information. The suggestions that came from the local health volunteers is by ensuring the remuneration in a regular basis can be able to ensure the sustenance of these support systems. Moreover to retain the quality and lessening the transmission loss for the betterment of the quality of trainings the suggestion are mostly for the enhancement in the fund allocation by the government for the training purpose for improving the logistics and accommodations facility which affects the training quality

directly. The encouragement for the village health plan (VHP) should be done in all the VHSC instead of influenced plans by the health officials with the underlying intensions of planning for target fulfillments of the village level health plan. Here they suggested that community must come up with their developmental ideas for their village which will later lead them to bid for it. These are the valuable proposal that came from the users themselves for the better functioning of the VHSC in their village. And giving an impression that community is not numb about the dysfunctions of the VHSCs infact they are facing some of the structural constraints and wanted to be unriddled soon with the proper initiatives and supports from the government and the people themselves.

Summary

The basic objective behind the study was to explore the communitization within the Village Health and Sanitation Committees (VHSC) under the NRHM through analysis of its conceptualization, implementation and community involvement at the grassroots level. The communitization process was understood by analyzing the major components of the communitization such community participation, decentralization and the government's initiatives in the social mobilization for helping in communitizing community. In the practice or in the implementation level it has been found that the NRHM tries to stress upon ensuring the fully functional, community owned, decentralized health system with the active participation of the community along with inter-sectoral convergence at all levels. It is by ensuring simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition and social and gender equality through giving the management power of the institution at the local level which is seems to be on the way but with the slow progress. Further raising the question that is there the transfer of real ownership, powers and resources to the community for the management and utilization of the government institutions and their assets, is being done in the presence of the top-down approach where decision were imposed in a disguised manner for the community participation. Here they are given minimal attention by the guidelines to the

various facts such as social dominance and authority in the peculiar areas such as in the tribal dominating areas, gender relations and socio-cultural context, political will of the community leaders especially in the area context where there is conflict situation between the traditional and the formal governing body and sharing of same goals among the government planners and community workers for the greater participation. The limited power is given to the institutions in devolution and delegation to the authority and responsibilities. And the role of the government as the assistor and partners in the strengthening of the community institutions was seems to be undermined due to the least incorporation of the 'activist approach' where community and local empowerment is done through discuss needs and objectives decides intervention, and the beneficiary involvement and engagement in the implementation with the underlying beliefs on the principle of trusting the community. Rather the instances show that much of the 'pragmatic approach' is in the practice. It exists in the form of capacity building that has been done to achieve the target based health achievements such as for the completion of fund and its utilization at the ground level that has allocated by the centre. Here the apprehension is that if government believes in trusting the community then at what extent they are able to show their trust, empower the community through trainings and transfer the power and resources in respect of day to day management to the user community for ensuring the real communitization in the health sector through the local institutions – VHSC. And if the government says that the community is being communitized in real sense as in the case of Nagaland then is it the rationales of the community or the government that are fulfilling the needs of the government by helping them in carrying the cost over the health needs. Many instances at the implementation level depicting towards the failure of the communitization process. The unsuccessful communitization process could be the consequences of the counter rationality that keeping away the community from its real need and the context overshadowed by the central's health objectives. Then the dubiousness related to the sustainability of the participation was strongly arises here. Moreover it raises question that how the communitization is possible only in the health sectors ignoring the other developmental activities and conflicts taking place around leading to the distrust towards the government by the community. And is it

possible to achieve without solving the other constraints prevailing in the society especially in the Scheduled Areas for gaining trust of the community for the real partnership. These are some of the questions that are anticipated to be answered like – Is the VHSC a model of communitization is only the medium of government program conducted from the central and the another way of controlling mechanism for the tribal community or is it really seen as a democratic way of ensuring people's program from the grassroots considering the needs of the community and ensure it endogenously.

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ANNEXURES I

KEY INFORMANT'S SCHEDULE

A) ***Respondents: VHSC Members***

(Sub-centre Level)

Major themes wise interview schedule

1) ***Existence***:

i) When did your VHSC formed?

ii) What is the Total number of members in your Committee?

iii) What is the nature of representation/composition of your committee? (Socio-economic, gender wise etc.)

iv) How frequently is the meeting being held of your VHSC? (Meeting regularity)

v) Did you get any kind of Orientation/ Process- Awareness trainings in the course of VHSC formation?

2) ***Formation***

i) How do you see your Roles and Responsibility being a VHSC member?

ii) Are you aware of the Guidelines for VHSC formation?

iii) What were the processes followed during formation of your VHSC? Would you call it a Participatory Process? If yes then why and if it was compromised according to you then how?

3) Composition

i) What is the composition of the office bearers in the VHSC? How do they represent distinct stratifications at your village?

ii) What is your group composition and affiliations within the VHSC? (Sub groups you or other's formed or represent in VHSC)?

4) Perceived Roles and Responsibilities of Office bearers

i) How do you see the roles and responsibility of each office bearer in your VHSC?

5) Capacity Building

i) Did you get any training around VHSC functioning?

ii) What kind of governmental support in terms of training assistance did you get for VHSC?

6) ***Activities***

i) What are the major activities undertaken by your VHSC so far?

ii) How do you coordinate with other stakeholders/ related institutions/ people/organizations around VHSC activities? How do you appreciate their role and alliance w.r.t VHSC?

iii) Do you see convergence happening and how this has been useful for the functioning of VHSC?

iv) What are the things you see as major Achievements of your VHSC?

v) What are the problems do your VHSC faces during its usual functioning?

vi) What kinds of accountability do you have towards government and community?

vii) What would be your suggestions for improving the function of VHSC?

7) ***Funds***

i) How much fund has been allocated to your VHSC? And who decides for the fund allocation's time-line and amounts?

ii) How do you maintain your Accounts/ book keeping?

iii) Did you get any kind of Accounts Trainings?

iv) Do you have Bank accounts? Who are the signatories? How they coordinate among themselves?

v) How your VHSC had been utilizing the allocated funds? How your VHSC do handles decisions around budget-expenditure issues and prioritizes activities?

8) ***Monitoring***

i) What is the Monitoring Mechanism in VHSC? Is there any formal Indicators fixed?

ii) What is the process of monitoring of a VHSC?

iii) How VHSC do gets monitored internally and maintain linkages with external monitoring committees?

iv) What are the general/ specified tools used for the monitoring of VHSC?

B) ***Respondent: DPM***

i) How do you find Village Health and Sanitation Committee (VHSC) scheme? How do you see if VHSCs are important for improving the health delivery system?

ii) How important do you find community participation in various stages of the VHSC?

iii) What kind of support does Village Health & Sanitation Committees (VHSCs) gets from the per-existing health service delivery systems?

iv) To what extent do you think community is contributing to the desired realization of this scheme?

v) What are the future prospects of Village Health & Sanitation Committee (VHSC) in strengthening district health care delivery system?

vi) How do you ensure (steps taken to ensure) quality concerns for ideal Village health committee (VHSC)?

vii) How do you see your role under this intervention scheme through VHSCs?

viii) How do you visualize (in short term and long term) the pros and cons of the VHSC scheme?

ix) What are your parameters to decide upon 'well functioning' and 'malfunctioning' VHSC'?

x) What do you think about the current status of VHSC performance in the district? (strength and weakness and opportunities lying in VHSCs)

xi) Do you have any suggestion around betterment of VHSC and its role as support system for the health functionaries?

C) ***<u>Respondent: BPM</u>***

xii) How do you find Village Health and Sanitation Committee (VHSC) scheme?

xiii) How important do you find community participation in this process?

xiv) What kind of support do Village Health & Sanitation committee (VHSC) gets from the pre-existing health service systems?

xv) To what extent community is contributing to this scheme?

xvi) How do you visualize the future prospects for Village Health & Sanitation Committee (VHSC)?

xvii) What is the supervision process for Village Health and Sanitation Committees (VHSCs) in your jurisdiction?

xviii) How do you find your role for under VHSC scheme?

xix) What are your quality concerns for VHSCs? How do you address these concerns in your capacity? What kind of vision do you have in this regard for future?

xx) What are the vivid pros and cons of the VHSC scheme according to you?

xxi) How will you characterized 'well functioning' and 'malfunctioning' VHSC'?

xxii) What do you think about the VHSC performance in your jurisdiction?

xxiii) What are the major challenges that need to be overcome for proper functioning of VHSC?

xxiv) Do you have any suggestion around betterment of VHSC and its role as support system for the health functionaries?

D) <u>Respondent: NGO Nodal Officer</u>

i) How do you find Village health and Sanitation committee (VHSC) scheme?

ii) What are your roles in strengthening of VHSC?

iii) What kind of governmental support do you seek for strengthening VHSC?

iv) What are your strategies to engage with village level VHSC?

v) What kind of accountability do you have towards the government with respect to VHSCs?

vi) What kind of accountability do you have towards the community with respect to VHSC?

vii) According to you to what extent community is contributing to materialize goals of this scheme?

viii) What are the pros and cons of the VHSC scheme according to you?

ix) What parameters do you suggest to characterize ‘well functioning’ and ‘malfunctioning’ VHSC’?

x) How do you see the current state of performance of VHSCs in your jurisdiction?

xi) What are the major achievements you figure out for VHSCs in your jurisdiction?

xii) What are the bottlenecks/ challenges that need to be overcome in short and long terms?

xiii) What do you suggest for the betterment of VHSC regarding its role in strengthening the health care service system?

xiv) According to you what are the core objectives of NRHM expected to be fulfilled through NRHM?

xv) Do you find that VHSCs are fulfilling the core objectives of NRHM

ANNEXURES II

Comprehensive Interview Schedules

A) Respondents: ASHA/Sahiya Sathi (considering the two as analogues)

1) Knowledge and Awareness about VHSC

i. What do you know about VHSC?

ii. Do you belong to the village having VHSC?

iii. Are you the member of VHSC?

iv. How do you see responsibilities you are entrusted to bear on your shoulder?

v. Are you aware of the core objectives of VHSC?

vi. Do you know and seek coordination with the other office bearers of VHSC?

vii. What do you know about NRHM?

2) Perceptions regarding adequacy of Capacity Building of VHSC

i. Have you received any training or orientation around NRHM?

ii. How useful are they in practical terms?

iii. Have you received any specific training or orientation on VHSC?

iv. Do you remember any training/ orientation contents on VHSC?

v. How did it help you to internalize its goals?

vi. For practical prepuces how useful they are?

vii. What is your perception about the usefulness of those trainings?

viii. Do you figure out any gape or think more detailed trainings are required/ needed?

3) Perception on Functioning of VHSC

i. How do you identify the specific role of your VHSC?

ii. Are you able to organize frequent meetings or it is called as per need of the time?

iii. Do you have something to say about meeting regularity?

iv. Do you think that monitoring system is in place?

v. Do you think that activities are being effectively monitored by seniors?

vi. Do you think external monitoring is useful or handholding exercise?

vii. What are the activities taken by your VHSC so far?

viii. Is there any Village Health Plan prepared by your VHSC?

ix. How did this plan emerge and what was basis of prioritizing different activities?

x. What role do you play in your capacity to realize those plans on ground level?

xi. What role expectations do you have from other members and office bearers for this?

4) Opinion on skill set/ Resources available with VHSC to formulate village health plan

i. Had any training been organized on how to prepare village health plan?

ii. Do you have any knowledge about the VHP guidelines in this regard?

iii. Do you and other members contributed effectively in planning process?

iv. Do you think members and you have acquired adequate skills to prepare plan?

v. What are the material conditions and practical hindrances for inability in implementing decided activities?

vi. From whom do you seek support in case of difficulties?

vii. How to overcome those difficulties/problems?

viii. Do you have an idea whether to take up VHP in the current year?

5) Activities undertaken by the VHSC

i. Have VHSCs created awareness about the health programs?

ii. Do they have undertaken a village health survey?

iii. Do they successfully engage villagers in cleaning of open drainages and tube-wells and their surroundings?

iv. Do they assist during routine immunization?

v. How do they use the sub-centre untied fund?

vi. Do they oversee the IEC activity/wall painting?

6) Role perception of ASHA

i. What is your role and responsibility in VHSC?

ii. How you have contributed in the VHSC?

iii. Can you briefly outline the expected role of ANM, AWW, SHG members, PRI members, NGO's and other users group in the VHSC? How frequently and in what terms do they interact and support each other?

iv. What are the major achievements of your VHSC according to you?

v. Whom do you think that they are more accountable to?

vi. Do you hold any accountability? If yes what is the nature of that?

vii. Can you outline the usefulness of the VHSC for the community? If yes then in what manner?

viii. What are the concerns that impede you in delivering the services in your context?

ix. Give your suggestion to improve the functioning of VHSC?

B) <u>Respondents: ANM</u>

1) Knowledge and Awareness about VHSC

i. What do you know about NRHM?

ii. What is the core idea behind this mission?

iii. What do you know about VHSC?

iv. Are you the member of VHSC?

v. Do you know about the objectives of VHSC?

vi. Do you know the office bearers of VHSC?

2) Perception on Capacity Building of VHSC

i. Have you received any training or orientation on NRHM?

ii. Have you received any specific training or orientation on VHSC?

iii. Do you remember any training/ orientation contents on VHSC?

iv. What is your perception about the usefulness of those training?

v. Do you think any gapes in those trainings in practical terms?

vi. Do you think that detail training is required/ needed around any specific domain or in general?

3) Perception on Functioning of VHSCs

i. How do you see the desired roles of VHSCs?

ii. Are you able to tell about the frequency of meeting in your jurisdiction villages?

iii. What is your opinion about the meeting regularity?

iv. Do you have something to comment upon the issues being discussed in those meetings?

v. Do you think that monitoring system is in place?

vi. Do you think that activities are being monitored by seniors or it is handholding exercise?

vii. What are the activities taken by the VHSCs?

viii. Is there any Village Health Plan prepared by the VHSCs?

ix. Do you have any role to play in panning exercise of VHSCs?

4) Opinion on skill set/ Resources available with VHSC to formulate village health plan

i. Is there any Village Health Plan made in your locality/ area of operation?

ii. Are you aware of specific tasks outlined in the village health plans in your jurisdiction villages?

iii. Have you any information about training that has been organized around village health planning process?

iv. Do you have any knowledge about the VHP guidelines?

v. Do you have an idea whether to take up VHP in the current year?

5) Activities undertaken by the VHSC

i. Have VHSCs created awareness about the running health programs?

ii. Do they have undertaken a village survey?

iii. Do they participate in cleaning of open drainage and tube-wells and their surroundings?

iv. Do they assist during routine immunization?

v. How do they use the sub-centre untied fund?

vi. Do they oversee the IEC activity/wall painting?

6) Role perception of ANM

i. What is your role and responsibility in VHSCs?

ii. How you have contributed in the VHSCs?

iii. How do you monitor and assist the VHSCs?

iv. What are yours accountability towards VHSC?

v. What do you see the expected role of ASHA, AWW, SHG members, PRI members, NGO's and other users group in the VHSC? How frequently do you interact with them and they among themselves?

vi. What are the major achievements of VHSC according to you?

vii. Whom do you think that they are more accountable to?

viii. Do you think this scheme is useful for the community? If yes then How?

ix. Give your suggestion to improve the functioning of VHSC?

*C) **Respondents: AWW***

1) Knowledge and Awareness about VHSC

i. What do you know about NRHM?

ii. What do you know about VHSC?

iii. Are you the member of VHSC?

iv. Do you know about the objectives of VHSC?

v. Do you know the office bearers of VHSC?

2) Perception on Capacity Building of VHSC

i. Have you received any training or orientation on NRHM?

ii. Have you received any specific training or orientation on VHSC?

iii. Do you remember any training/ orientation contents on VHSC?

iv. What is your perception about the usefulness of those trainings?

v. Do you think that detail training is required/ needed in general or around any specific domain?

3) Perception on Functioning of VHSC

i. What do you know about the role of VHSC?

ii. Are you able to tell about the frequency of meeting?

iii. What is your opinion about the regularity of the meeting?

iv. Do you think that monitoring system is in place?

v. Do you think that activities monitored by seniors?

vi. What are the activities taken by the VHSC?

vii. Is there any Village Health Plan was prepared by the VHSC?

4) Opinion on skill set/ Resources available with VHSC to formulate village health plan

i. Are you aware about the village health plan?

ii. Is there any Village Health Plan made in your locality/ area of operation?

iii. Have you been a participant member in the planning exercise?

iv. Any training has been organized around how to conduct village health planning exercise?

v. Do you have any knowledge about the VHP guidelines?

vi. Do you have an idea whether to take up VHP in the current year?

5) Activities undertaken by the VHSC

i. Has the VHSC of your village created awareness about the health programs?

ii. Do they have undertaken a village survey? Have they ever involved you and considered your inputs in such surveys?

iii. Do they participate in cleaning of open drainage, pits and tube-wells and their surroundings?

iv. Do they help during routine immunization camps?

v. How do they use the sub-centre untied fund properly?

vi. Is there any duplication of activities done by VSHCs and you?

vii. Do they oversee the IEC activity/wall painting?

6) Role perception of AWW

i. Have you any role to play in your VHSC?

ii. How it is distinct from the role of sahiyya?

iii. How you have contributed in the VHSC?

iv. How do you get monitored by VHSC?

v. What are yours accountability towards VHSC?

vi. What do you think about the role of Asha, SHG members, PRI members, NGO's and other users group in the VHSC? How frequently do you interact with Sahiyya, VHSC members and above mentioned people/bodies?

vii. What are the major achievements of VHSC according to you?

viii. Whom do you think that they are more accountable to?

ix. Do think that it is useful for the community and How?

x. Give your suggestion to improve the functioning of VHSC?

D) <u>Respondent: SHG Member</u>

1) Knowledge and Awareness about VHSC

i. What do you know about VHSC?

ii. Do you belong to the village having VHSC?

iii. Are you the member of VHSC?

iv. Do you know about the objectives of VHSC?

v. Do you know the office bearers of VHSC?

vi. How many of your SHG members are also acting in any capacity in VHSCs?

vii. What do you know about NRHM?

viii. Being a women group do you have any distinct role then your male counterparts in VHSCs?

2) Perception on Capacity Building of VHSC

i. Have you received any training or orientation on NRHM?

ii. Have you received any specific training or orientation on VHSC?

iii. Do you remember any training/ orientation contents on VHSC?

iv. What is your perception about the usefulness of those trainings?

v. Do you think that detail training is required/ needed?

3) Perception on Functioning of VHSC

i. What do you know about the role of VHSC?

ii. Are you able to tell about the frequency of meetings?

iii. What is your opinion about the regularity of the meeting?

iv. Do you think that monitoring system is in place?

v. What are the activities taken by the VHSC?

vi. Is there any Village Health Plan prepared by the VHSC?

vii. Are the issues concerning the women and child health care being considered by your VHSC?

4) Opinion on skill set/ Resources available with VHSC to formulate village health plan

i. Are you aware about the specific components of the village health plan?

ii. Is there any Village Health Plan made in your locality/ area of operation?

iii. Any training has been organized on village health plan?

iv. Do you have any knowledge about the VHP guidelines?

v. Do your SHG members have any stake in preparation of the village plan?

vi. Do you have an idea whether to take up VHP in the current year?

5) Activities undertaken by the VHSC

i. Do VHSC created awareness about the health programs?

ii. Do they have undertaken a village survey?

iii. Do they participate in cleaning of drained and tube-well surroundings?

iv. Do they help during routine immunization?

v. Do you SHG members participate in such tasks undertaken by VHSC?

vi. How do they use the sub-centre untied fund?

vii. Have you or your SHG ever proposed any specific activity to be integrated in village health plan?

viii. Do they oversee the IEC activity/wall painting?

6) Role perception of SHG Members

i. What is your role and responsibility in VHSC?

ii. How you have contributed in the VHSC?

iii. Does it increase the women participation in the local health activities planning and its implementation?

iv. What is your extent of participation in the decision making process and the preparation of village health plan?

v. What do you think about the role of Asha, ANMs, PRI members and other users group in the VHSC? How frequently do you interact with each other?

vi. What are the major achievements of VHSC according to you?

vii. Whom do you think that they are more accountable to?

viii. Do think that it is useful for the community and How?

ix. Give your suggestion to improve the functioning of VHSC?

E) <u>Respondents: PRI Members</u>

1) Knowledge and Awareness about VHSC

i. What do you know about VHSC?

ii. Do you belong to the village having VHSC?

iii. Are you the member of VHSC?

iv. Do you know about the objectives of VHSC?

v. Do you know the office bearers of VHSC?

vi. What do you know about NRHM?

2) Perception on Capacity Building of VHSC

i. Have you received any training or orientation on NRHM?

ii. Have you received any specific training or orientation on VHSC?

iii. Do you remember any training/ orientation contents on VHSC?

iv. What is your perception about the usefulness of training?

v. Do you think that detail training is required/ needed?

3) Perception on Functioning of VHSC

i. What do you know about the role of VHSC?

ii. Are you able to tell about the frequency of meeting?

iii. What is your opinion about the regularity of the meeting?

iv. Do you think that monitoring system is in place?

v. Do you think that activities being owned by community?

vi. What are the activities taken by the VHSC?

vii. Do the VHSC members approach you for any support?

viii. Is there any Village Health Plan was prepared by the VHSC?

ix. Do you have any stake/representation in the planning exercise?

4) Opinion on skill set/ Resources available with VHSC to formulate village health plan

i. Is there any Village Health Plan made in your locality/ area of operation?

ii. Are you aware about the specific activities included in village health plan? Do you think they are need based?

iii. Any training has been organized on village health plan?

iv. Do you have any knowledge about the VHP guidelines?

v. Do you have an idea whether to take up VHP in the current year?

5) Activities undertaken by the VHSC

i. Do VHSC created awareness about the health programs?

ii. Do they have undertaken a village survey?

iii. Do they participate in cleaning of open drainage, pits and tube-wells and their surroundings?

iv. Do they help during routine immunization?

v. How do they use the sub-centre untied fund?

vi. Do they oversee the IEC activity/wall painting?

6) Role perception of PRI Members

i. How you people have been selected as a PRI member?

ii. What are the activities do you perform related to health?

iii. What is your role and responsibility in VHSC?

iv. How you have contributed in the VHSC?

v. Do you have local governance system? If yes, then how useful do you find it in undertaking or conducting health related activities in the village?

vi. What is your extent of participation in the decision making process and the preparation of village health plan?

vii. What do you think about the role of Asha, ANMs, AWW and other users group in the VHSC? How frequently do they interact with each other?

viii. What kind of coordination do you find between the different Inter-sectors for providing health services in the area?

ix. How do you ensure community participation especially of the women folk in the VHSC and its activities?

x. What are the major achievements of VHSC according to you?

xi. Whom do you think that they are more accountable to?

xii. Do think that it is useful for the community and How?

xiii. Give your suggestion to improve the functioning of VHSC?

F) <u>Respondents: BTT and STT</u>

i. What is your roles and responsibility for VHSC?

ii. Have you received any training or orientation around NRHM?

iii. How useful are they in practical terms?

iv. Have you received any specific training or orientation on VHSC?

v. What are the training/ orientation contents of VHSC?

vi. How did it help you to internalize its goals?

vii. For practical prepuces how useful they are?

viii. What is your perception about the usefulness of those trainings?

ix. Do you figure out any gap or think more detailed trainings contents are required/ needed?

G) ***<u>Respondents: Animators</u>***

i. What is your roles and responsibility for VHSC?

ii. Did you get any Training for the capacity building of VHSC?

iii. What are the major activities you carried for the strengthening of VHSC?

iv. What are the things you see as a major achievement of VHSC in your area where you work?

v. What kind of accountability do you have towards the community and to the NGO?

vi. What would be your suggestions for improving the functions of VHSC?