

# Village Health Sanitation and Nutrition Committees: reflections on strengthening community health governance at scale in India

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## ABSTRACT

India's National Health Mission constituted Village Health Sanitation and Nutrition Committees (VHSNCs) as a key mechanism for community health governance. Health committees provide citizens with the opportunity to shape health systems and policies. Yet much remains to be learnt on how best to sustain health committees as vehicles for community health governance at scale. This paper reflects on the authors' experiences of introducing revised guidelines and an institutional support package for VHSNCs in two pilot settings in India and outlines lessons we learnt for sustaining community health governance at geographic scale. We describe the importance of ensuring norms for equitable participation, aligning committee rules with existing forms of decentralised government and providing key supports in terms of engaging NGOs as key implementation facilitators. Integration with rigid and unresponsive government administrative structures however remains a persistent challenge for scaling up health committees. With sustained financial support and strategic deployment of key personnel, VHSNCs could pave the way for more equitable and effective community participation in health governance at scale.

## Summary box

- ▶ India's nearly 550 000 Village Health Sanitation and Nutrition Committees (VHSNCs) are a key mechanism for community health governance, yet they have been poorly functional.
- ▶ Revised guidelines and an institutional support package were introduced to strengthen VHSNCs' functioning in two pilot settings in India.
- ▶ Some of the key strategies improving VHSNC functioning were: (1) ensuring norms for equitable participation, (2) aligning VHSNCs with decentralised government and (3) providing implementation support through non-governmental organisation facilitation.
- ▶ While revised guidelines and training and support for facilitation are crucial in strengthening VHSNCs, deeper social reforms, health systems change and decentralisation are also needed to sustain VHSNCs as key mechanisms for community health governance.



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## INTRODUCTION: INDIA'S VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

Community governance in health provides citizens typically left out of the ambit of health systems and policy processes the opportunity to shape these systems and policies. There is substantial experience globally of people's participation in health governance through the creation of committees at various health system levels.<sup>1–3</sup> Yet much remains to be learnt about how best to support and sustain health committees as vehicles for community health governance at geographic scale.

The National Health Mission (NHM), launched in 2005, currently accounts for over half of the Ministry of Health and Family Welfare's (MoHFW) annual health budget.<sup>4</sup> Within NHM, Village Health Sanitation and Nutrition Committees (VHSNCs) and female

community health workers, Accredited Social Health Activists (ASHAs), were constituted as key mechanisms for community health governance. ASHAs serve as member secretaries convening VHSNCs, whose membership include community members, frontline health providers and locally elected representatives. VHSNCs are expected to convene monthly meetings, conduct local health planning and monitor government health and nutrition services. VHSNCs are also to receive a yearly 'untied fund' of Rs 10 000 (US\$150) to spend on local health needs.<sup>5 6</sup>

While the MOHFW developed guidelines in early 2006 on the structure and functions of these committees and provided funding and support for training from national to state levels, subsequent evaluations reported that many of the 500 000 VHSNCs across India were poorly functional.<sup>7–9</sup> In 2013, based on lessons from state-level experiences and

### Box 1 Activities undertaken in the Strengthening Village Health Committees for Intensified Community Engagement at Scale (VOICES) piloting of the revised guidelines and institutional support package for Village Health Sanitation and Nutrition Committees (VHSNCs)

- ▶ Revised Guidelines and Training Handbooks for VHSNCs making it available for all the committees
- ▶ Formation, training and deployment of dedicated support team for VHSNCs
- ▶ Social mobilisation processes through meetings and public participation/awareness events
- ▶ Expansion of existing VHSNCs based on the revised guidelines, making them inclusive
- ▶ Regular training and capacity building of VHSNC members in core functions of the committee/office bearers and other pertinent issues
- ▶ Continuing support to all VHSNCs by the dedicated support team
  - in conducting regular committee meetings
  - in organising Village Health and Nutrition Days
  - in implementing their decisions
  - in addressing various problems and challenges that they faced
- ▶ Regular meetings of VHSNC leaders at Sector and Block Levels
- ▶ Supportive review, planning and troubleshooting by the support team

challenges,<sup>7 10</sup> the MOHFW revised its VHSNC guidelines to include an institutional support package to strengthen the constitution and functioning of VHSNCs.<sup>11</sup>

This paper reflects on the authors' experiences of the introduction and implementation of the revised guidelines and institutional support package in two pilot settings in North and South India, as part of a collaborative, 2-year implementation research project called Strengthening Village Health Committees for Intensified Community Engagement at Scale (VOICES) (box 1). The VOICES study was undertaken by research organisations and a parastatal technical agency, with community-based organisations as implementing partners. The location of the states and names of the community-based organisations are kept confidential to protect the identity of the community-based organisations and field workers. Rather than testing interventions by measuring health impacts, the emphasis on these pilots was to learn from implementing in conditions as close as possible to government operations at geographic scale. The two states were selected to ensure contrasting regional perspectives. Fifty villages in each state were involved in the pilot, resulting in 50 VHSNCs in one state and 17 in the other where VHSNCs were convened at cluster rather than village level.

While other papers report on research findings drawn from in-depth interviews, focus group discussions, ethnographic observation and process documentation,<sup>12–14</sup> this paper in addition draws on the authors' tacit and experiential knowledge based on multiple review meetings with project stakeholders to reflect on the lessons learnt on supporting community health governance at geographic scale. In particular, we reflect on three strategies in the revised guideline and institutional support

package that respectively targeted three key groups of actors involved.<sup>11</sup> They include:

- ▶ An explicit focus on equitable community participation, through expansion of VHSNC membership and articulation of norms for representational membership that were inclusive of women (50%), ensuring representation of marginalised groups (caste) and beneficiaries such as pregnant women, lactating mothers, mothers with children of up to 3 years of age and patients with chronic diseases who are using public services.
- ▶ Alignment of VHSNC jurisdiction and functions with constituted forms of decentralised government or local elected bodies such as the Gram Panchayat.
- ▶ Support to VHSNCs through government contracted non-governmental organisations (NGOs) for mentoring and facilitation at the subdistrict level.

### GUIDELINES FOR EQUITABLE PARTICIPATION: GETTING THE NORMS RIGHT

Expanding the membership and in some instances reconstituting VHSNCs in accordance with guidelines led to the inclusion of community members belonging to marginalised caste groups and women in the VHSNCs. In the North Indian state, support and facilitation provided by NGOs was critical in expanding membership to these previously excluded groups.

Notwithstanding more representative community participation in VHSNCs, exclusion related to caste-based discrimination and representation of inhabitants from small hamlets within larger villages remained a concern in both states. Furthermore, although membership and participation of women increased, existing social and gender norms, more stark in the Northern state, sometimes prevented women from taking up leadership roles.<sup>13</sup> Our work indicates that while these reforms are essential, sustaining representation from marginalised populations requires greater advocacy, support and facilitation, as well as a longer time frame to alter the deep-seated power relations that define who has voice in communities.

### ALIGNING VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES WITH GRAM PANCHAYAT RULES: CONFORMING TO THE CONSTITUTION OF DECENTRALISED GOVERNMENT

The Gram Panchayat is the unit of local government in the constitutional framework for decentralised rural governance in India and is composed of one or more villages (depending on administrative divisions in a particular state). Gram Panchayat members can, as elected representatives, demand action from functionaries of various government departments, and if required petition higher level government authorities at district or state levels to take remedial action.<sup>15 16</sup> Current government guidelines specify that VHSNCs are chaired by Gram Panchayat members at village level and federated at higher levels.<sup>11</sup>

In the North Indian state, health service providers were more regular in attending the cluster meeting (which

brought together a group of VHSNC from a Gram Panchayat) rather than individual VHSNC meetings. More importantly, the pressure created by the constitutionally mandated status of Gram Panchayats helped enhance the presence of the frontline service providers including the medical officer at the nearest facility, the Primary Health Centre, to attend the Gram Panchayat level meetings. In the Southern state, given that the VHSNC was constituted not at the village level but at the same level as the Gram Panchayat, the VHSNC and its facilitators' actions were further able to sustain the responsiveness of the administration to health needs on several local issues, including health. The key learning here was that alignment of the VHSNC with the Gram Panchayat enabled a form of constitutional legitimacy that in turn invoked accountability from health service providers, although varied across the two states to community demands. Future reforms will need to balance forums that enable village/community level organising for health, which may be different from those that govern community health at the Gram Panchayat level.

#### **NON-GOVERNMENTAL ORGANISATION FACILITATION: NECESSARY FLEXIBILITY AND LEADERSHIP**

NGOs engaged subdistrict level facilitators to support VHSNCs; these facilitators played a crucial role in building capacity of and facilitating VHSNCs to develop as viable community platforms taking up action around local priorities and issues, including environmental and social determinants of health. In some instances, this entailed improvising local solutions to address bottlenecks that blocked the representation of community voice. It also entailed flexibility and leadership in brokering relationships with various stakeholders with whom VHSNCs needed to advocate community demands.

For example, in the northern state, the NGO designed official stationery for all VHSNCs. All petitions and letters to the government were sent on such stationery, increasing legitimacy, enhancing status of members within the VHSNC and in the community and thus building up an institutional identity for VHSNCs. The NGO support staff worked closely with the VHSNC members in filing petitions with various authorities, attending monthly VHSNC meetings and ensuring follow-up. Notable successes in the Northern State included working with health authorities to deploy additional frontline health workers; working with other sectors to lay water pipes; and working with political authorities to grant one of the informal migrant settlement area the formal recognition of a 'revenue village', a formal administrative unit for which the state is mandated to ensure civic services.<sup>12</sup>

Demonstrating the important role of subdistrict facilitators in strengthening community health actors and platforms was critical to convince policy makers at state and national levels that vacancies for facilitators needed to be filled to enable both ASHAs and VHSNCs to realise their potential. In addition, integrating the support structures

for the VHSNC with those for the ASHA programme was also necessary. The NGO role in supporting the ASHA was particularly important as it built her capacity to undertake one of her key roles, which was to enable VHSNC functioning by convening regular meetings and discussion of health and related issues.

#### **INTEGRATION OF GOVERNMENT SUPPORT STRUCTURES: A PERSISTENT CHALLENGE**

Despite the MoHFW recognition of the need for further support structures and facilitation, made possible through NGOs, not all support processes were realised. Provision of an amount of Rs 10 000 annually as untied funds to every VHSNC was intended to facilitate local action.<sup>6</sup> While not in itself a large amount, it allows the VHSNC the ability to leverage action and was expected to trigger a sense of accountability in the leadership of the VHSNC, as it had done previously in other states.<sup>17</sup>

In the North Indian state, despite opening of bank accounts, non-release of funds by authorities was demotivating for committee members, and this remained unaddressed throughout the intervention period.<sup>12</sup> In the South Indian state, although the annual funds were transferred, village health nurses and village heads continued to manage the funds with no change in the pre-existing pattern and without a significant role for lay members in determining how grants would be used. Despite multiple follow-up by field-level facilitators and NGO staff, both these experiences also indicate the limits of NGO facilitation in overcoming systemic barriers in government responsiveness.

#### **LESSONS FOR SUSTAINING VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES**

The VOICES implementation research study demonstrated operationalisation of revised guidelines and an institutional support package to strengthen VHSNCs within the context of government operations at scale. This led to important gains - the initiation of inclusive VHSNC membership and leadership, the creation of community health platform with better linkages to political governance structures and an understanding of the support needs required for enabling citizen-led approaches for improving health. At the same time, the sustainability and geographic scale up of community health governance require further social reforms, larger scale health system change and deeper decentralisation efforts.

Strengthening VHSNC at scale is a process-intensive effort since the components are complex and require a high level of facilitation. Perhaps the most significant finding of the VOICES experience is the importance of ongoing support in implementation to making VHSNCs effective. The support structures for the VHSNC and other community processes rely on a strong state and district mechanism, whether for capacity building and monitoring for programmatic interventions or for fund releases and auditing utilisation. The VOICES

intervention demonstrated that even with the bureaucratic constraints that can bind local action, community action addressing social health and environmental health determinants was possible. Furthermore, NGO facilitation flagged attention to ensuring marginalised voices in communities were heard and demonstrates that such facilitation is needed to ensure an equity focus while operating at scale. Nonetheless, the NGO-led facilitation of VHSNCs while supportive in both contexts is likely a limiting factor in scaling up in areas with limited availability of suitable NGOs. Further implementation research is required to study alternative institutional mechanisms to support and mentor such committees.

Strengthening institutional capacity at state and district level is critical to implementing and monitoring VHSNCs at scale. Tools such as guidelines, standardised training modules and capacity to train and monitor can be useful to scale up support to VHSNCs. However, to address large-scale systems change, the orientation and ownership of state and district officials and elected representatives of local government is essential. Adaptability is key to the scaling up of VHSNC, yet it requires the capacity to learn from implementation and develop a cycle for feedback and correction, which is often not well established. It relies on strong systems and well-capacitated programme managers. Where one or the other is lacking, implementing a standardised package of guidelines, training material and predefined models may help effective geographic scaling up only to a certain extent. Finally, the expectation of scaling up community committees within a context where governance and particularly decentralised governance is still evolving needs to be tempered. Nonetheless, the strategic deployment of funds and existing NHM personnel could pave the way for improved and more equitable community engagement and, ultimately, to positive health outcomes.

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