VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE AND VILLAGE HEALTH PLANNING - THE CHHATTISGARH EXPERIENCE

Problem Statement

Since the launch of NRHM, about 18706 VHSNCs have been formed in the state at revenue village level. However in the initial four to five years the functionality of the VHSNCs was very limited. TO address this issue state has put in various efforts to support the VHSNCs and improve the effectiveness of the existing VHSNCs.

The state has, over the past four years worked to strengthen Village Health and Sanitation committees, and today it is perhaps the only state in which convergent planning of village level action on health, sanitation, nutrition and development issues is being undertaken at scale.

Programme Description

The focus of the monthly VHSC meeting is to identify gaps in health and health related areas and plan to resolve these gaps. The action-plan is defined in terms of the key tasks for the community, which also includes ensuring action by government at various levels. It is not a one-time exercise of drawing up a comprehensive plan for purposes of submission to the state. Utilising the untied grant is seen more as a facilitating factor, rather than as the sole purpose of the VHSC. The VHSC plans focus on gap assessment and resolution in health services, health status or health related behaviour, nutrition, food security, sanitation, gender, and livelihoods. In each monthly meeting, about two or three issues are discussed and plans for resolution are drawn up.

Inputs/support for Village Health Planning

Two rounds of five day trainings are held for the Mitanin and her facilitator. This includes three days jointly with PRI/VHSC members.

The facilitators (one for every 20 Mitanins) must attend and facilitate every VHSC meeting under her area (which is usually about 6 VHSCs), and the 'Fixed day plan of VHSC meetings' is matched and integrated with fixed day plan of the facilitators.

The Mitanin and female Ward level PRI representatives are joint bank signatories (and also the perceived leaders) of VHSC. This greatly helps the process.

The meeting process

Meeting of VHSC is held every month and apart from designated members of the VHSC, other residents are also encouraged to participate in these meetings. The discussion is facilitated by a facilitator (in the Chhattisgarh case it is the Mitanin Facilitator) by asking a series of questions to the assembly, and follows these steps:

Step1 - Identifying the problem: The facilitator leads the discussion by asking the group, "what are the main (health) problems in your habitation?". Sometimes there is an answer from some members, but in some meetings, no issue gets identified this way. In such cases the facilitator starts the discussion by using the list of 32 issues. (Table 1)

Step 2 - Identifying the habitation/s where the problem is more severe: The situation (with respect to the issue identified through the above step) of each hamlet in the village is discussed in order to finalize the habitations for which action needs to be planned immediately.

Step 3 – Analysing the problem - Identifying the main cause(s) of the problem: Thefacilitator asks further questions to enable the VHSC to identify the

causes which need to be addressed to solve the problem. E.g. if a habitation has a big gap in immunization, the cause may be irregular VHND, distance, non-functioning Anganwadi, lack of information regarding dates of VHND etc

Step 4 - Deciding the solution: The solution is defined in terms of actions that the community can take to steer progress in the direction of a solution. E.g. if a habitation has a gap in immunization due to irregular VHNDs, the VHSC may decide to talk to the concerned ANM to resolve the issue. When the related service provider is present in the same meeting, it is often the case that the service provider commits to corrective action, and the issue gets resolved.

Step 4 – Deciding who is responsible: For each action decided, volunteers are called

Gap (weak aspect)	**Weak habitation** (where the gap is severe)	**Cause of the problem**	**Action** (that village would take)	**Responsible Person** (Person who volunteers to lead the action)	**Time Frame** (for completing the action recorded in previous column)	**Review** (in the next meeting – on progress made)

Reviewing the progress on items planned in previous/earlier meeting: In the subsequent meeting of the VHSC, the progress made on the actions planned in the last few months is reviewed. Usually, if a VHSC plans for three issues is a meeting, around one issue is successfully resolved in a month. In some cases, the planned action is taken but the outcome is not successful. In such cases, further planning is done to decide on the next action required to solve the issue. There are situations when the action is not even attempted. In such cases, the steps of fixing responsibility and time-frame are reviewed/re-decided. The facilitator keeps the attention of the VHSC on the success rather than on failures. This helps in keeping the morale of the group high.

Impact

Most VHSCs of the state have completed the training and about 1.15 lakh VHSC members have been trained (5-6 members from each VHSC). One block coordinator has been placed exclusively to coordinate this planning process, in each of the 70 blocks of state (of the total 145 blocks of state). As of now about 10,600 VHSCs are regularly conducting this process of monthly village planning, and then process has reached a stage of maturity in about 5000 VHSCs where regular meetings are held and follow-up actions are undertaken on a sustained basis. In the remainder incremental gains are being made.

Scalability

Chhattisgarh's community processes programme provides many valuable lessons for the rest of the country. It shows that by building up adequate support structures for VHSC at all levels, focused capacity building of the VHSC members and handholding of the VHSCs in planning process can provide positive outcomes for the VHSCs. The initiative also shows the potential of scaling up across the state where such support structures exist and state programme management is committed for increasing the participation of the community in the health planning process.

Table1: List of issues discussed for Village Health Planning

1	Fully immunized children of 12-36 month	12	Effectiveness of Mitanins in Neonatal and Child Survival	23	Rojgar Guarantee Yojana
2	Ante-natal care	13	Effectiveness of the Panchayat health Committee	24	Malnutrition
3	Institutional delivery (in sub-health center, primary health center, community health center, district hospital)	14	Effectiveness of Women's Health Committee	25	Low birth weight
4	Delivery at home assisted by qualified health personnel (Doctors/ Nurse/ ANM)	15	Stagnant Water	26	Under-Age marriage of girls
5	Weighing of newborn on the day of birth	16	Safe Drinking Water	27	Spacing of birth
6	Breastfeeding within half an hour	17	Use of Toilet	28	Family planning/ Access to sterilization
7	Supplementary food to children of 6-18 months	18	Anganwadi Coverage(Children from 6 months to 6 years old)	29	Still Birth
8	Availability of chloroquine	19	Midday Meals	30	Infant death
9	Use of mosquito net	20	Functioning of the Public Distribution System	31	Outbreak of water borne diseases
10	Effectiveness of Mitanin in Maternal Health	21	Antyodaya Yojna	32	Malnutrition amongst Adolescent girls
11	Incentives to Mitanins	22	School Enrolment		