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Assessing engagement of scheduled tribe communities in the functioning of Village Health Sanitation & Nutrition Committees in India

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India is home to the largest population of indigenous tribes in the world. Despite initiative of the National Rural Health Mission, now National Health Mission (NHM) and various tribal development programmes since India's Independence, disparity in healthcare for Scheduled Tribes (STs) prevails. The constitution of Village Health Sanitation and Nutrition Committees (VHSNCs) in 2007 by the NHM is a step towards decentralized planning and community engagement to improve health, nutrition and sanitation services. VHSNCs are now present in almost all States of the country. However, several reports including the 12th Common Review Mission report have highlighted that these committees are not uniformly following guidelines and lack clarity about their mandates, with no clear visibility of their functioning in tribal areas. Therefore, this review was conducted to assess the participation of the VHSNCs in tribal dominated States in order to know in detail about their functioning and gaps if any that require intervention. Several deviations from the existing guidelines of NHM were identified and we concluded that in order to sustain and perform well, VHSNCs not only require, mobilization and strict monitoring but also motivation and willingness of its members to bring in a radical change at the grassroot level. With continuous supervision and support from both the Government and various non-governmental organizations, handholding, strategic deployment of workforce, community participation and sustained financial support, VHSNCs would be able to facilitate delivery of better healthcare to the indigenous population.

Key words Community engagement - decentralization - healthcare - indigenous tribes - VHSNCs

In 2005, Government of India launched the National Rural Health Mission (NRHM) in order to bring significant reforms to India's health system, including increased financing and decentralized planning to improve the accessibility, affordability and quality of healthcare services, particularly for the rural

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poor and vulnerable sections of the society. In addition, it aimed to strengthen maternal and child healthcare across the country[1]. Enhancing the availability, accessibility, quality and usage of the public health system requires involving the community in planning and monitoring of health service delivery. Through involvement of *Panchayati Raj* Institutions (PRIs), the NRHM has placed considerable emphasis on addressing local challenges and finding local solutions, making it community centric. In this process, the Village Health Sanitation and Nutrition Committee (VHSNC) of the *gram panchayat* (village-level self-governing body) has been charged with the responsibility of developing village health plans (VHPs), implementing them, reviewing their effectiveness and bridging gaps between a community, healthcare provider and the decision maker. VHSNCs are constituted at the revenue village level, which are established through a participatory process, and are in-charge of village-level decentralized planning and monitoring. VHSNCs were thus established to make sure that no section of the village community remained left out of service reach. Ensuring effective utilization of untied funds (UFs) in the community to improve maternal and neonatal health was a major focus of this initiative[2].

In India, tribal population accounts for 8.6 per cent of the total population. Among these tribal groups, Particularly Vulnerable Tribal Groups (PVTGs) are most at risk of different health hazards. According to the 2011 Census[3], there are 75 PVTGs among 705 Scheduled Tribes (STs), spread over 17 States and one Union Territory. Further, there are exclusive tribal States, such as in the north-east (NE), which are listed in the Sixth Schedule of the Constitution. The States of Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, Maharashtra, Gujarat, Rajasthan, Andhra Pradesh, West Bengal and Karnataka account for 83.2 per cent of the total tribal population of India. Within these States, there are exclusive tribal districts, taluks/blocks and villages/hamlets. The governance of the scheduled areas in these States, is planned to be executed through a single window Tribal Development Department (TDD) with a distinct Tribal Sub-Plan (TSP). Tribal development work in these scheduled areas is formulated through Integrated Tribal Development Projects and administered by Rural Development Department at the *gram panchayat*, *panchayat samiti* and *zila parishad* levels[3]. The Human Development Reports of various States clearly indicate that the tribal districts and talukas are at the lowest levels on the Human Development Index (HDI), as compared to the non-tribal revenue units. Despite large budgetary outlets of the TDD, the STs after seven decade of Indian Independence have majorly remained on the fringes of growth, forming a marginalized population. Due to the difficult terrain, where villages and hamlets are spread over a large geographical area, group *gram panchayats* and committees under these are not effective functional entities.

Owing to the above reasons, it is important to assess the gaps and challenges like social exclusion of tribal communities and identify access to information with the benefits of different schemes and entitlements to these groups. It is also necessary to undertake studies in tribal populations with a particular focus on public health administration in these areas.

The current review was thus aimed to understand the functioning of VHSNCs, as a unit for decentralized health planning in rural, underserved areas of India. We reviewed studies particularly focusing on the functioning of VHSNCs and identified social inclusion of tribal communities in their capacity building initiatives and planning community action in health, nutrition and sanitation. The databases PubMed, Google Scholar and Scopus were searched for all articles published on the respective topic upto November 2021 using the keywords 'VHSNCs', 'scheduled tribes', 'community engagement' and 'India' in different combinations. Few articles were obtained by manual search or cross references of selected articles. Studies reported primarily on VHSNCs, engaging scheduled tribes were included. The search was restricted to the articles published in English. Based on the search it was evident that the studies do not refer exclusively to tribal areas.

Village Health, Sanitation and Nutrition Committees (VHSNCs): A Community engagement unit

Conception of VHSNCs: The Bhore Committee[4] in 1946 proposed the formation of village health committee (VHC) as a way forward to enhance community engagement and address the local health issues. In the 1980s, the VHCs were implemented in India to support decentralization and empowerment of the locals to improve community health[5]. In 2007, the NRHM constituted the VHSC for village-level health planning and monitoring, and in order to include nutrition in the VHSCs, they were finally renamed in 2011 as VHSNCs[6]. The objectives were

(*i*) community engagement and sensitization, (*ii*) enabling community participation in the planning and implementation, (*iii*) facilitating voices of the community articulating local health needs, (*iv*) equipping *gram panchayats* with the understanding and mechanisms required for their role in governance of health and other services, and (*v*) providing support and facilitating the work of frontline workers[7]. The conception of VHSNCs was expected to bring several critical changes to India's health system, and these were formed within the framework of *gram panchayat*, which is a unit of local government. Each *gram panchayat* is composed of 4-10 villages and led by a 'sarpanch'. The elected *gram panchayat* members, community health workers, namely accredited social health activists (ASHAs), Anganwadi workers (AWWs), auxiliary nurse midwives (ANMs), representatives from community-based organizations (CBOs) like self-help groups (SHGs), forest management committees, pre-existing committees (if any, like school education committee *etc*.) and service users like pregnant women constitute the VHSNCs[8]. The VHSNC is aimed to plan and implement health, nutrition and sanitation targets for the marginalized and poor sections at the village level[9]. Although VHSNCs are envisioned to ensure community participation, their performances are also influenced by the factors such as accessibility of funds and preparedness of their members to perform.

Formation and composition of the VHSNCs: The NHM is mandated to have a minimum of 15 members in each VHSNC, with at least 50 per cent participation of women and an adequate representation of STs/Scheduled Caste (SC) and other minorities. However, several studies have reported that VHSNCs do not have the required number of members among them for proper functioning. Azeez *et al*[9] noted that <10 members were present in ~17 per cent of the committees. Srivastava *et al*[10] reported that VHSNCs were formed according to the State-level guidelines in both Jharkhand and Odisha. Sah *et al*[11] reported that majority of the members belonged to the other backward caste (OBC: 64%), followed by SC and ST (27%) communities.

Awareness about roles and responsibilities of VHSNC members: The 12th Common Review Mission[12], carried out by the Government, mentioned that only some VHSNCs were functional, and their members had ambiguity in their roles. Sah *et al*[11] in Wardha reported that the members were unacquainted with their roles and responsibilities, and had received no prior training. It was identified that the understanding about the role of VHSNC was highest among ANMs, AWWs and ASHA workers. Das *et al*[13] also reported that there was a lack of clarity about the roles and responsibilities among VHSNC members. Srivastava *et al*[10] noted that a detailed training was imparted to ASHAs and AWWs, while others received only a brief orientation, which many, did not consider as 'training'. Malviya *et al*[14] studied many villages in Madhya Pradesh, Raut and Sekher[15] in Gujarat and Odisha and Semwal *et al*[16] in Uttarakhand, and all of them described that VHSNC meetings were irregular, had insufficient trainings or even did not take place and that the involvement of *panchayat* was limited.

Regularity in meetings: As per NHM, each VHSNC should organize monthly meetings, as it is during the meetings that the problems are identified, discussed and plans charted out for their mitigation[7]. However, irregularities in the monthly meetings of VHSNCs were observed, where the committees struggled to organize regular meetings and with full attendance[9-11,13]. Semwal *et al*[16] mentioned that among all 18 VHSNCs, meetings were not organized regularly. At several places, meetings were only on paper, with no proper discussion and even the outcomes of the previous meetings' were not discussed. Pandey and Singh[17] informed that around 61 per cent of ASHAs, 53 per cent of community members and only 41 per cent of PRI members attended the VHSNC meeting. However, the involvement of ostracized and vulnerable section was in 45.8 per cent VHSNCs. Nongdrenkhomba *et al*[18] studied three NE States and observed that although the VHSNC guidelines were adhered to by its members, the percentage of VHSNCs holding regular meetings in different States of northeast India was variable; the frequency was reasonable in Tripura (68%). On the other hand, while the State of Manipur was good in holding regular meetings, which was to the tune of 84 per cent, Meghalaya was suboptimal (36%) in the frequency of meetings.

Village health plan (VHP) and record keeping: VHSNCs are mandated to prepare an annual plan on issues that affect the health of a community. Sah *et al*[11] reported that none of the VHSNC members knew about VHP, except for the ANMs. In fact, as per this report, the VHPs were not being prepared and the members also failed to do any budgeting for the coming year.

Further, the monitoring also seemed to be weak. Other independent studies[14,16,19-23] found that the VHSNC members had no formal training and guidance on monitoring or preparing VHP and the high-level health system functionaries provided insufficient support to them.

According to NHM, the VHSNCs are further required to maintain records of the meetings with attendance signatures, cashbook, passbook, statement of expenditure along with birth and death registers. However, the studies reported improper maintenance of the records. Azeez *et al*[9] reported that 37 per cent VHSNCs did not maintain proper records, while 35 per cent VHSNCs did not keep a register. Sah *et al*[11] reported that majority of the VHSNC members revealed that neither minutes were recorded nor any village health, birth or death registers were maintaining. Srivastava *et al*[10] reported that AWWs were exclusively responsible for maintaining VHSNC records in 90 per cent of the VHSNCs in Odisha, while in 10 per cent VHSNCs, AWWs and ASHAs maintained such records. In Jharkhand, almost all the VHSNCs reported to have a meeting register maintained by ASHAs workers. Further, while 64 per cent VHSNCs maintained a cashbook for fund utilization, 22 per cent of them kept a survey register and included information on village demographic, health and nutrition status[10].

Utilization of funds: As per NHM, every committee that is constituted and oriented is entitled to an annual UF of ₹ 10,000, which can be used for health planning. The health of a village and the decision regarding utilization of funds should be made during the VHSNC meeting. Srivastava *et al*[10], in 2016, mentioned that 91 VHSNCs in Odisha had a bank account, while 17 per cent VHSNCs evaluated in Jharkhand did not have so; 97 and 57 per cent VHSNCs with bank accounts in Odisha and Jharkhand, respectively, reported spending of their UF within the same year. On an average, those VHSNCs, which had an active bank account and reported expenditure in Jharkhand, spent 83 per cent of their UF received last, while the VHNCs in Odisha spent only 53 per cent of these funds[10]. Singh and Purohit[20], in 2012, found that many VHSNCs failed to utilise the budget in the same year. The UF for a given financial year was normally being issued in the next year, due to which many payments and disbursements could not be done on time and also several expenses could not be made. As per Singh and Purohit[20], these funds were not properly utilized due to lack of awareness of the VHF. Sah *et al*[11] reported that in most of the VHSNCs, the members were uninformed about the guidelines for utilization of UF, although some of the AWWs, ANMs, *panchayati* members and few ASHAs knew about the UF-provision for VHSNC. Dixit *et al*[24] studied utilization of the UF in the areas of Madhya Pradesh, and Raut and Sekher[15] in Gujarat and Odisha found that members of their VHSNCs did not know about the existence of such fund, while some were aware but did not play a part in fund allocation. In an assessment initiated by the Regional Resource Centre for North Eastern States in Manipur, Meghalaya and Tripura to understand the performance of VHSNCs as well as various challenges faced by VHSNCs, it was observed that these committees did not receive these funds properly, while some districts constituted a greater number of VHSNCs than the approved number, leading to sharing of their respective UF. In Manipur, out of 140, 118 VHSNCs received fund and the remaining 22 (15.7%) never received any fund since their formation. In Tripura, out of 57 VHSNCs, six (10.52%) never received funds. In Meghalaya, out of 104 VHSNCs, 46 (44.23%) received funds, while the remaining 58 (55.77%) had not.

Co-ordination and supervision: As per the underlying concept of VHSNCs, there should be community and non-governmental organization (NGO) involvement in monitoring the activities of VHSNCs, and their members must be given due support[1]. However, we identified lack of evidence of supportive supervision of VHSNCs by the higher authorities. According to an assessment of *Rogi Kalyan Samiti* and VHSNC in Sikkim, while monitoring at the State level was conducted just six times in the 63 VHSNCs reviewed, it was 12, six and 42 times at the levels of district, Community Health Centre (CHC) and Primary Health Centre (PHC)[25], respectively. There was also a dearth of capacity building programmes for VHSNC members. Singh and Purohit[20] reported that meetings of VHSNC staff with higher authorities for providing supportive supervision to the staff were not organized regularly. Srivastava *et al*[10] had similar findings from Odisha; only 5.5 per cent VHSNCs reported any visit by district- or block-level officials.

Role of NGOs in community-led interventions and community engagement: NGOs play a powerful role in developing and promoting community participation in the health system. NGO-led interventions (training and facilitation) to strengthen VHSNC functionalities,

based on government requests noted that VHSNCs were marginally functional or non-functional at the commencement of the intervention, but the community-based monitoring ignited vibrant community action in VHSNCs[26,27]. Integration of tribal youth into public health interventions had shown good programme outcomes. Das *et al*[28] trained village volunteers in Koraput district of Odisha to enable distribution of chloroquine to malaria patients and filling of the fever treatment sheet. Another study by Vyas *et al*[29] reported that community-based active case finding helped in identifying more people with TB in tribal and rural areas. We included the available case studies[27] on the interventions undertaken by a German NGO, namely Welthungerhilfe, in the remote and underprivileged tribal districts (Khunti, Pakur, Sahebganj and Dumka) of Jharkhand in partnership with the Network for Enterprise Enhancement and Development Support (in Pakur district), Ekjut (acting as Technical Agency of intervention), Life Education and Development Support (in Khunti district), PRAVAH (in district of Dumka) and BADLAO Foundation (in district Sahebganj). In the villages of these tribal districts[30], VHSNC members were unaware about their roles and responsibilities and also their meetings were infrequent and irregular. Through the orientation programme conducted by the NGOs, amendments were made about the committee members and the members were made aware about both their roles and responsibilities as well as about the role of VHSNC through regular meetings. Through sensitization, VHSNC members started to conduct regular monthly meetings and discussions on health, hygiene and nutrition.

These NGO led interventions reinforced the grassroots-level functionaries like VHSNCs, in equipping them with information on schemes and entitlements and apprising them about the process to be followed for regular functioning. Such capacity building programmes tremendously improved the quality and access of public services to the communities. The NGO led interventions proved that community engagement could significantly improve various programmes at village level that otherwise demonstrated poor performances.

In India, with reference to community development since 1952, there is no conceptual or infrastructural difference between a tribal and non-tribal area or population groups. Tribals grouped together in a constitutional category of ST under Act 342, form a heterogeneous group with huge diversity. Translating special provisions in the constitution about ST, new tribal population dominant States, districts, taluks/blocks were formed by the Government of India. Although single window TDD with TSP, fortified with the *panchayats* (extension to Scheduled Areas) Act and Forest Rights Act are in place, as also the AWWs, ASHAs and the VHSNCs, their implementation varies in different States. Despite all these, the tribal States, districts and taluks are lowest on the ladder of HDI.

Our synthesis of studies presented grassroot situation, by way of evaluation of VHSNCs, which are expected to work as a fundamental entity of community engagement to address the issues of marginalized groups like STs and also bring them within the ambit of health services. Even after 15 years of the conception of VHSNCs, we found a dearth of studies from the tribal dominated blocks of India, where tribals are more than 50-90 per cent of the population and are generally poorer than the rest of the social groups. Despite substantial inequalities in health, nutrition and other aspects between ST and non-ST populations, only a handful of articles have assessed the functioning of the VHSNCs and that too from the villages with mixed populations of caste-peasantry and tribal people[8-11,13-21]. In such mixed villages, the committees were dominated by the non-tribal members, in matters of attendance, record keeping and usage of schemes and funds. Therefore, it needs to be ascertained whether there is a fair understanding among the members of VHSNCs about their roles and responsibilities. Village health planning, monitoring of community health services, regular monitoring visits by district block-level officials, local collective action for health promotion and adequate funding as well as timely utilization of the funds from the central and State budgets were other identified issues essential for the development of STs. There is not only a need to develop a system for regular reporting and their timely submission to the Chairperson; it is also important for the service providers to learn about the gaps through community feedback, apart regular training, monitoring and hand holding of VHSNCs, which is required to enhance their participation.

The studies and NGO led interventions revealed that the training imparted to ASHAs and AWWs had made them responsive to the functioning of VHSNCs. Similar interventions could work for 50 per cent women members of PRI by statutes as per the 73rd

Constitution Amendment, and CBOs like *mahila mandals*, SHGs and youth groups. What is desired is not the university style of academic research which ends up as evaluation research, but the intervention research, which requires the research team in collaboration with the NGOs, CBOs and PRI to select the areas and communities and provide training and monitoring services. Based on such approach, models can be developed to facilitate proper functioning of VHSNCs, which could be replicated at places with geographical variations, addressing micro-level situations[31]. Research bodies and tribal research and training institutes need to collaborate and provide funding for such participatory intervention research[31]. A judicious mix of qualitative and quantitative tools and techniques, would provide insights about the 'emic' perceptions of the people about health and development in such endeavours.

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