Tied, Untied fund?

Assessement of Village Health and Sanitation Committee involvement in Utilisation of Untied Fund in Rajasthan

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BACKGROUND

The Government of India launched the National Rural Health Mission (NRHM) in April 2005 to carry out systemic corrections in the delivery of basic health care services and to commit to increase public expenditure on health and bringing health care closer to the people. Under the NRHM, each village or habitation with an Accredited Social Health Activist (ASHA) is expected to have a Village Health and Sanitation Committee (VHSC)[1]. VHSCs are the first step towards communitisation of health care services and for making health a people's movement. Within a community empowerment approach, the NRHM envisages the VHSC in charge of decentralised planning and monitoring at the village level.

The members of the VHSC include the auxiliary nurse midwife (ANM), panchayati raj institution (PRI) members, ASHA, anganwadi worker (AWW), community members, school teachers and members of non-governmental organisations (NGOs), community-based organizations (CBOs) and self help groups (SHGs). The VHSC's role include development of the Village Health Plan (VHP), monitoring of health activities in the village (e.g. actively participating in Mother Child Health and Nutrition(MCHN) Day and Kishori Balika meeting) and having a comprehensive understanding of health related activities.

To empower the VHSC and to address immediate health needs of the community, the committee has been given the authority to utilise "untied" fund of Rs.10,000/- per annum. The purpose of this fund is to stimulate local action towards raising health awareness and organising village level meetings, sanitation drives and other identified health needs.

Although guidelines have been laid out regarding the functioning of the VHSC and the use of untied fund, various studies found significant deviation from these guidelines in practice. A study by Public Health Resource Network in 2008, covering 5 villages of 2 blocks in Chhattisgarh, revealed that villagers were not aware of the funds and knew nothing about the processes involved in certification of accounts. Knowledge regarding roles and responsibilities was limited to committee meetings.

To address these issues in Rajasthan, trainings have been organised on VHSC constitution, roles and responsibilities and utilisation of untied fund. Despite these trainings, the decision of utilisation of untied fund is often taken at the district level and not at the village level.

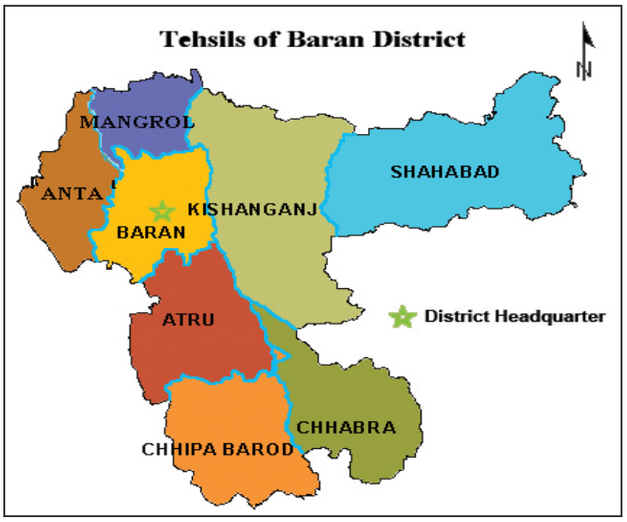
This study tried to understand the pattern of VHSC decision-making and the utilisation of the untied fund as compared to the guidelines.

STUDY OBJECTIVES

1. To assess the knowledge of VHSC members about their roles in the committee and utilisation of the untied fund.
2. To ascertain the level of involvement of VHSC members in using untied fund.
3. To examine the current pattern of allocation and expenditure of untied fund.

STUDY SETTING

District Baran was carved out of erstwhile Kota district in 1991, with its headquarters at Baran block. The district covers a total area of almost 7000 km², out of which only 35 km² are considered urban. The total population of the district is 1,223,921 as per the 2011 Census, with a decadal population growth rate of 19.83%. According to the 2011 Census, the sex ratio is 926 females to 1000



[1] VHSCs were subsequently revised to Village Health Sanitation and Nutrition Committee or VHSNC but for the purposes of this report the term VHSC is being retained since it was conducted before the change in nomenclature.

males and the literacy rate is 67.38%. As per 2001 Census data, the population was 21% scheduled tribes (STs) and 18% scheduled castes (SCs). As per the 2010-11 report of State Institute of Health and Family Welfare, Jaipur, on VHSC, 43,475 VHSCs had been constituted in the state of Rajasthan[2].

METHODOLOGY

The study was quantitative in nature.

Sample: Using simple random sampling method, 50 VHSCs were selected from the universe of 1114 VHSCs from 7 blocks of Baran district of Rajasthan. Three members (1 ASHA, 1 PRI member, 1 community member) were selected from each of the 50 VHSCs as per their availability.

Data collection: A total of 150 respondents were interviewed using a semi-structured questionnaire. The questionnaire was pretested in Govindgarh block of Jaipur district with 2 ASHAs and 2 VHSC members. Six investigators were given a 2-day training regarding the tools and processes and field work before they started data collection.The data was collected between April and June, 2011.

Data analysis: The data was entered and analysed using Epi Info statistical package.

Ethical review: Ethical clearance for the study was obtained from the Institutional Ethics Review Committee of School of Public Health, SRM University. Consent was taken from each respondent and confidentiality of information was strictly maintained.

FINDINGS

Background of the respondents

Out of the 150 respondents, 50 were ASHAs, 51 were community members and 49 were PRI members. The constitution by caste was as follows: around 27% were SCs, 28% were STs, 21% were other castes and 24% belonged to the other backward castes (OBCs). Women constituted 64% of the VHSCs in the 50 districts that were surveyed.

For female respondents, mean age was 34 years with a standard deviation of ± 9.9 and for the males, the mean age was 39 years with a standard deviation of ± 5.1.

Knowledge and awareness of VHSC members

Existence of VHSC: The study revealed that although all the respondents were members of the VHSC, only 80% were aware of the existence of the Committee. All ASHAs were aware of the VHSC, but 24.5% of PRI members and 27.5% of community members were not aware of the existence of the VHSC.

Membership: More than half the respondents have been members of the VHSC for over 2 years. Three out of four respondents reported learning about their membership after being recruited as a member and not during the formation of the VHSC. Around 80% of the respondents reported knowing about their VHSC membership through the ANM, while 11% reported learning about their membership through the medical officer.

More specifically, over half the ASHAs in the VHSC have been members since 2 or 3 years and over 84% of them reported learning about their membership after being recruited. Over 80% learned about their membership from the ANM. Community members and PRI members showed the same trend in learning about their membership. A possible reason for more VHSC members being aware of their membership than knowing about the existence of the VHSC could be that they know they are a member of some committee, but do not know it by name.

Roles and functions of VHSC: More than half of the ASHAs that were interviewed responded that raising health awareness, helping the ANM with health services and tracking infant mortality rates (IMR) and maternal mortality rates (MMR) were her key roles as member of the VHSC. After probing they added that making VHP was also one of their functions.

Community members (35%), when queried about their roles, readily responded that raising health awareness was the VHSC's key responsibility, while after probing almost half (45-53%) the respondents added that their work also included village development work, tracking IMR and MMR, helping ANM in her health services, making the VHP, and monitoring health services and health related problems.

PRI members responded that their key functions and roles included monitoring health services, followed by raising health awareness. After probing they said that their key functions included village development work, followed by preparation of Village Health Plan, helping the ANM with her health activities and addressing health problems/issues.

Untied fund: Almost 84% of VHSC members did not know their role in planning and implementing the untied fund. And around 95% of the respondents did not know that they have to track and record utilisation of the untied fund. Around 51.3% of the community members were not aware of the exact amount allocated as untied fund for the VHSC and one fifth of the members believed that the ANM is the sole person who receives the untied fund.

[2] http://sihfwrajasthan.com/VHSC%20Consolidated%20Report.pdf

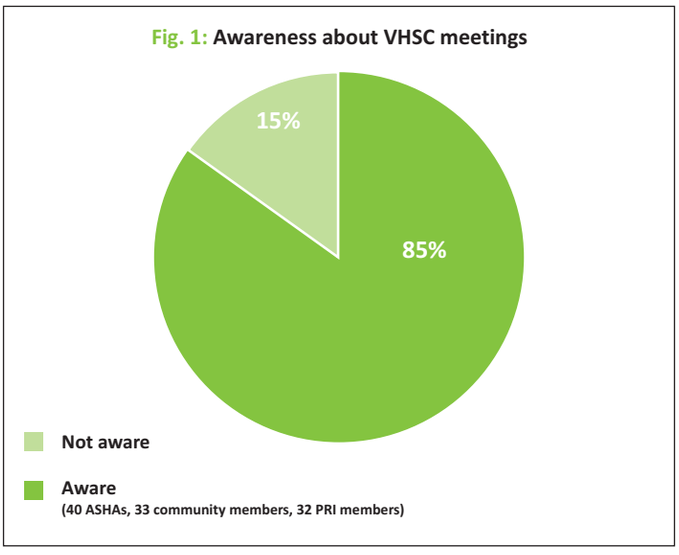
Respondents were asked what the priorities were in spending the untied fund. Their responses changed significantly after probing which can be seen in Table 1.

Table 1
Priorities for spending untied fund

	Priorities before probing	Priorities after probing
ASHAs	1. Sanitation 2. AWC development 3. Public health 4. Education	1. Environmental development 2. Other village work 3. Support to poor families 4. Health awareness 5. Construction 6. Education 7. Public health 8. Sanitation
PRI members	1. AWC development 2. Sanitation 3. Public health	1. Other village work 2. Environmental development
Community members	1. Public health 2. Sanitation	1. Other village work 2. Environmental development 3. Supporting poor families 4. Construction

Participation and involvement of VHSC members

Around 61% of ASHAs, 53% of the community members and 41% of PRI members reported having a VHSC meeting every month, whereas 37% of ASHAs, 44% of community members and 59% of PRI members reported that meetings took place on MCHN Day. It can be concluded that most of the VHSC meetings take place in the aanganwadi centres as reported by 70% of ASHAs, 88% of community members and 91% of PRI members. Members are informed about the meeting by the ASHA, according to 93.6% respondents, and by the ANM according to 6.4% respondents.



Almost all the ASHAs (97.6%) said that they participated in the meetings, whereas only 76% of community members and 79% of PRI members claimed to have participated in past meetings. When asked about VHSC members' attendance of the last meeting, there is a discrepancy among the numbers provided by the various respondents.

About 76.5% of respondents know that records of meeting proceedings are maintained by the ASHA, while 20% believe the ANM does it. Almost half of the PRI members and community members explained that the registers are sent to their homes for taking signatures, whereas 77.5% of ASHAs reported the registers are signed at the end of every meeting.

Among the people who attended the most recent meeting, 85% shared their opinion and proposed resolutions for utilisation of the untied fund and solving non-financial issues. None of the community members who attended the meeting shared their opinion or proposed resolutions.

Among respondents who participated in meetings mostly non-financial proposals were made for women and child development (87%), health awareness and MCHN Days (88%), followed by girl child development (76%) and other work (66%).

Expenditure and utilisation pattern for untied fund

Resolutions : The respondents claimed that the majority of the untied fund are being utilised for creating health awareness (76%), for sanitation work (74%), village development (53%) and health department work (51%). Most of the proposals made during these meetings involved ICDS (86%), sanitation (80%), health awareness (77%) and departmental work (64%). Most of these resolutions are passed by the ANMs.

Fund utilisation process: The status of utilisation of the previous year's untied fund is not known to nearly all (94.7%) of the respondents. Around 77.9% of the respondents did not know the actual date of grant reception. ASHAs generally receive support from the health department by being provided training and guidelines released for utilisation of funds, but PRI and community members did not receive any such support. More than 80% members reported that the withdrawal and expenditure of the fund money is done through ANM, even though this is not supposed to be the responsibility of only the ANM. About 29.2% even think that this expenditure is monitored by the ANM herself, but 50% believe that the medical officer does it and 21% have no idea who monitors it. Around 92.2% of respondents acknowledged that they have never monitored this process of expenditure.

CONCLUSION AND RECOMMENDATIONS

Findings from this study reveal that the majority of the respondents were not aware of their roles and responsibilities as members of the VHSC, especially in planning and

implementing untied fund. They were also not aware of the amount received as untied fund, who receives them, or how the tracking and recording of utilised funds is done.

It is very evident that the ASHA plays an important role as the source of information about the VHSC, which is one of her major roles. However, respondents reported that the ANM is the key person for the withdrawal of money as well as spending the same which, according to the NRHM, it is the ASHA's role.

According to community and PRI members, the medical officer monitors expenditures. Meanwhile, the ASHAs reported that the ANM is in charge of monitoring expenditures. This is where the autonomy of the VHSC is compromised because handling of untied fund is not in the hands of the local community, but rather in the hands of the ANM or medical officer. Decentralisation of authority for expenditure is critical for the success of local governance.

The study found a high level of involvement at all levels among the respondents although there are gaps in understanding how untied money is received, tracked and monitored.

It is essential to note the lack of transparency about the transactions related to untied fund. The proposals need to be formally made with consent from other members. All members should be kept informed regarding the expenditure and withdrawal of the funds through proper communication. The quality of meetings is poor.

Based on these findings, the following recommendations are made for better functioning of VHSC in terms of the untied fund:

Recommendations

- From the outset, it is critical that members of the VHSC are informed prior to their appointment to the Committee. An official document about their recruitment to the Committee by the local government would aid in making the process official, thereby ensuring ownership and authority to their roles and responsibilities in the committee.
- The official process of recruitment could include a training wherein the committee members are initiated to the VHSC's roles and responsibilities and taught about the utilisation of untied fund.
- It is essential that members of the VHSC are educated about the purpose and priorities for untied fund utilisation.

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Acknowledgements: We would like to thank CHSJ team for their help with the study and UNFPA for their technical and financial support. We are grateful to Professor Satish of SRM University, who was our mentor throughout the process. We owe a special thanks to the respondents who willingly gave their time.

About the Organization: CHEER Society (Community Health, Education and Entrepreneurship Reform Society) is a not for profit organisation, working in Rajasthan since 2007. CHEER Society promotes participatory development and governance through direct field action, capacity building, research and advocacy. CHEER Society strengthens civil society efforts to help the poor, the oppressed and the disadvantaged sections of society.

Mentoring: This study was mentored by Professor Satish, SRM University and the report was finalised by Dr. Abhijit Das and Ms. Shelley Saha Sinha.

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