"Impact and Recall of VHSC Training among VHSC members"

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

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F-76(1)/SIHFW/Internship/2011-12/388

TO WHOM IT MAY CONCERN

This is to certify that Ms. Shikha Gupta, a student of PGDHHM course from IIHMR-Delhi has successfully completed her internship as management trainee from Feb to April 2012 at SIHFW-Rajasthan.

During her internship she conducted study on "Recall and Impact of VHSC Training amongst VHSC members" under the guidance of me and my team at SIHFW.

Her work is satisfactory and her performance and conduct as a trainee was good.

We wish her good luck for her future assignments

Dr.Akhilesh Bhargava

Director-SIHFW

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Certificate of Approval

The following dissertation titled "Impact and Recall level of VHSC training amongst VHSC members" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

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Certificate from Dissertation Advisory Committee

This is to certify that Ms. Shikha Gupta, a student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision.

She is submitting this dissertation titled "Recall and Impact of VHSC Training amongst VHSC members " in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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ACKNOWELGEMENT

It is my esteemed pleasure to present this summer project report and whole heartedly thank each and everyone who helped me in this task.

This project was only possible with the generous hospitality, guidance and support of the organization-**SIHFW (Rajasthan)**. It has provided me with all the possible resources in terms of knowledge, exposure, guidance and support which have largely helped me to ingrain good knowledge of the subject and brought out the best from myself.

I would like to provide my sincere gratitude to the director of the organization, Prof. Akhilesh Bhargava for giving me the enriching opportunity to have such an experience. It is my honor to have worked under his critical appraisal and his pertinent suggestions have been of great help in shaping this report.

I am thankful to my project guide and mentor Dr. Vishal Singh (Associate Professor), SIHFW.I am extremely grateful for his keen interest, constant support and guidance throughout the training tenure and clarifying my doubts as and when necessary.

I would also like to thankful to BCMHO (Sirsi), Block accountant (Sirsi and Kalwad), Asha supervisor (Renu Jonwal) and the entire SIHFW family for their support.

I am obliged to my mentor Dr Sangram Kishor Patel**,** Assistant Professor at IIHMR, NEW DELHI for providing necessary suggestions and guiding me to complete the report.

Above all I thank the almighty and my parents for the constant support strength and everything.

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Acronyms used in the study

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWW	Aaganwadi Worker
DMHS	Directorate of Medical and Health Service
DWCD	Department of Women and Child Development
DPMU	District Programme Management Unit
GDP	Gross Domestic Product
HFWTC	Health And Family Welfare Training Center
IIHMR	International Institute of Health and Hospital Management
PHC	Primary Health Center
PRI	Panchayati Raj Institution
MPW	Multi Purpose Worker
NGO	Non Government Organization
NRHM	National Rural Health Mission
SC	Scheduled Caste
SIHFW	State Institute of Health and Family Welfare
SHG	Self Help Group
SPMU	State Programme Management Unit
ST	Scheduled Tribe
OBC	Other Backward Class
VHC	Village Health Committee
VHND	Village Health And Nutrition Day
VHP	Village Health Plan
VHSC	Village Health and Sanitation Committee

Introduction of the Organization

State Institute of Health & Family Welfare (SIHFW) Rajasthan is an apex level autonomous training and research organization in the Health Sector of the State. The institute was developed on April 19,1995 as a registered society (Reg No.25/Jaipur/1995-96) by the Government of Rajasthan under Societies Registration Act 1958.For the first time in the history of institute, the institute has a full time Director since April,2008

Mission

The mission of the institute is committed to improvement in health care through HRD, Health Research, Consultancy, and networking aiming at enhancement in the quality of life.

- Develop Human Resources for Health (HRH) through capacity building.
- Organizing Development (OD) through operations Research.

Strategy

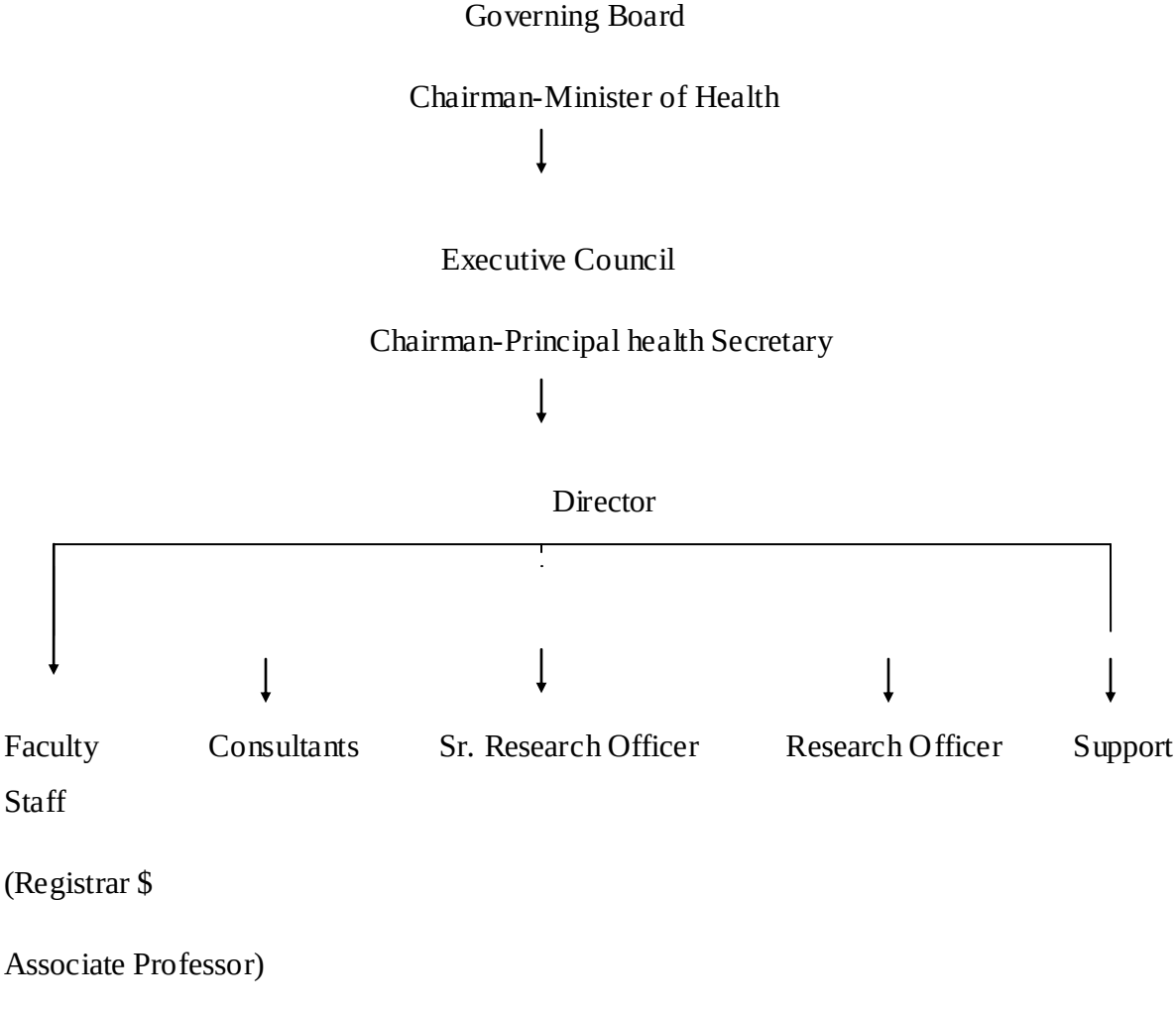
- Enhancing the capacity of the HFWTCs
- Enhancing the capacity of ANM training center
- Developing a pool of trainers through Training of Trainers (TOT)
- Developing training program and modules on the basis of Training Need Assessment
- Contributing to organization development of Medical, Health and Family Welfare of the State Government through operational research
- Providing consultancy on issues related to health
- Conduct studies related to evaluation and impact assessment of various interventions by Health Care Delivery System

Governance

A. **Governing Board** –Governing Board is chaired by the Honorable Minister of Health and F.W. The Director, SIHFW is the Member Secretary.

B. **Executive Council** is chaired by the Principal Health Secretary, Medical Health and Family Welfare, Govt. of Rajasthan, with Director, SIHFW as the Member Secretary

Faculty- Beside the Director, there are five faculty positions in the institute. These positions are of faculty (Registrar and Associate professor), Consultants, Sr.Research Officer, Research Officer and support staff.



Funding

To begin with SIHFW was fully funded by IPP-IX Project till Dec. 2001. Thereafter, UNFPA supported it between 01.01.2002 to 30.06.2003. Subsequently, Institute has been carrying itself through Projects, studies and consultancies on its own.

Networking

SIHFW has established formal linkages with IIHMR, IIPS, IIHM, ASCI, VHAI, FRCH, TISS, PRB, PFI, EPOS, NACO, NIHFW and other institutes.

Functions

- Training
- Research
- Monitoring
- Recruitments
- Consultancy
- Documentation

INTERNSHIP REPORT

Task assigned to me for internship was to review the Development of State Institute of Health and Family Welfare, Rajasthan

To review the development of the Institute, the timeline from its inception to present was divided into five year intervals.

- **Phase 1: 1995-1999:** SIHFW was established under the India Population Project IX, funded by the World Bank. With the principle of providing a formal institute to provide quality trainings for strengthening the in-service training programmes of all categories of health care providers and by providing technical support to other training institutions in the state.
- **Phase 2: 2000-2004:** In 2001 when IPP ended, SIHFW faced a crisis. The funding for the entire establishment expenditure including salary of the faculty and support staff, office expenses and other contingency expenditure ran dry and the institute had to find alternative sources of funding to function from January 1st, 2002.
- **Phase 3: 2005-2009:** Under the NRHM it was proposed to set up a State Health System Resource Centre. The objectives of the SHSRC were almost same as envisaged in the MOU of SIHFW society of Rajasthan, therefore a proposal was developed, whereby in Rajasthan could be located within SIHFW albeit maintaining its own identity.
- **Phase 4: 2009 to Present:** New reforms were introduced in SIHFW. Staffing pattern as per the recommendations of SHSRC was implemented. As it became a growing organization, employee motivation and retention also became areas of interest to administrators. The focus, which was earlier only on completion of trainings, now included to in-house capacity building and growth.

Major developments during different phases:

- **Phase 1:** SIHFW was assigned the responsibility of developing a training policy for the State in 1997. Training programmes for various cadres were conducted. Technical

support and backstopping to Regional Health & Family Welfare Training Centers located at Jaipur, Ajmer & Jodhpur and 15 District Training Centers & 12 ANM Training Centers was provided. The institute conducted several research assignments for international donors such as UNFPA, UNICEF and CARE India. The institute utilized more than 85 % funds received under IPP-IX. The Institute also contributed in developing Population Policy for the State.

- **Phase 2:** It submitted proposals for short-term and long term sustainability to the Government and requested the State Government to allot funds in the State budget. It was recognized that the Institute had a potential to become self sustainable in due course of time, if it functions at full capacity with full staff contingent and is given complete autonomy to raise and retain funds by organizing trainings and carrying out research & consultancy. A new process of induction of faculty and initiating the training activities from a new end and taking up relevant operational studies for the state was started. SIHFW became a resource center for RCH Projects. UNICEF funded Border District Cluster Strategy provided SIHFW an opportunity to initiate a special project of capacity building of service delivery system in three border districts. For the capacity development, collaborations with agencies like IIHMR and EPOS Health Consultants were formed.
- **Phase 3:** SIHFW got approval of creation of Health System Resource Centers (SHSRC) in Rajasthan. This meant a new lifeline for the institute with new funds and additional posts. The honorarium paid to the trainers was raised from the earlier level. The trainings which were held only in 3 districts, gradually increased and after NRHM an increasing number of districts were covered.
- **Phase 4:** Various new changes were introduced in the Institute. Including:
    - Appointment of a full time director
    - Introduction of an appraisal system
    - Increase in remuneration package
    - New strategies and mission were adopted
    - ISO 9001:2008 certification was obtained
    - Became a fully self financed organization
    - A documented HR Policy was developed

- A Quality manual endorsed by BSCIC was adopted
- Paperless and energy efficient office
- Staff was covered with Med-claim
- Website Developed (http://sihfwrajasthan.com)
- Uniform was introduced
- Evaluation of trainings was done on regular basis and feedback was obtained
- Establishment of Communications Resource Centre

Human Resource Development Initiatives

Phase 1:

- As all of the staff was invited as guest faculty, much emphasis was not given to staff development.

Phase 2:

- Faculty Development Programs were initiated and members attended various workshops/ seminars/ conferences nationally and internationally on various topics like:
  - RCH program
  - Immunization
  - Home Based Post Natal Care
  - Neonatology
  - Pediatrics
- Various publications in this period were produced covering topics like:
  - Reproductive and Child Health
  - IMNCI
  - Enhancing Vitamin A coverage: Process Evaluation.

Phase 3:

- Faculty Development Programs continued and members attended various workshops/ seminars/ conferences nationally and internationally on various topics like
  - RCH program
  - Immunization

- Home Based Post Natal Care
- Neonatology
- Pediatrics

➢ A new library was established and a large number of books and journals were made available to the faculty and staff for enhancing their academic acumen

Phase 4:

➢ Faculty Development Programs continued and members attended various workshops/ seminars/ conferences nationally and internationally on various topics

➢ A practice of welcoming and orientation all new staff members was started

➢ Birthday parties and festivals celebrated in the organization

➢ In-House development programs are organized weekly where presentations were given by staff members

➢ National and International exposure was provided to faculty members for attending various conferences and workshops related to topics of Public Health, IT, Capacity Building, Demography, Epidemiology, HIV/ AIDS etc

Trainings Scheduled during dissertation period

1.	ICTC Team Training	Training	RSACS	24	Feb 1-3	ICTC In-charge/ Counselor/ Lab. Technician	Ms.Nishanka
2.	Consultation Workshop on Pre School Curriculum	Workshop	UNICEF	13	Feb 6-7	Officials from Education dept	Ms.Poonam
3.	ToT for WASH	Training	UNICEF	29	Feb 13-14	Officials from Education dept/ SIHFW staff	Mr. Ravi Garg
4.	Workshop on Prison Visiting	Workshop	CHRI	13	Feb 14-15	Officials from different depts./ businessmen/	Ms.Divya

	System					private firms	
5.	Review Meeting of Focus District Coordinators and Divisional Coordinators	Workshop	UNICEF	17	Feb-15	Focus District Coordinators and Divisional Coordinators	Ms.Poonam
6.	ToT on Supervisory module for delivery of HBPNC	Training	NIPI	26	Feb 15-17	DMCHN/ BMCHN/ BCMOs/ MOs/ RO & Consultants - RCH (SIHFW)	Ejaz Khan
7.	ICTC Team Training	Training	RSACS	32	Feb 20-22	ICTC In-charge/ Counselor/ Lab. Technician	Ms.Nishanka
8.	Workshop on Developing Training Manual for CCE	Workshop	UNICEF	15	Feb 21-22	Officials from Education dept	Ms.Poonam
	Training on Appreciative Inquiry	Training	UNICEF	25	25	Free Lancers/ FDC/ SIHFW Staff	Ms. Poonam
1.	ICTC Team Training	Training	RSACS	41	41	ICTC In-charge/ Counselor/ Lab. Technician	Ms.Nishanka

BACKGROUND

The National Rural Mission (NRHM) was launched by the government of India on 12th April 2005 to carry out necessary architectural in the basic health care delivery system, with a plan of action that includes a commitment to increase public expenditure on health. The Mission envisages an additionality of 30 percent over existing annual budgetary outlays every year to fulfill the mandate to raise the outlays for public heath from 0.9 percent of GDP to 2-3 percent of GDP. Under the mission, multifarious activities have been initiated to strengthen the rural health care delivery system for improving the health of the rural population.

Under the NRHM framework, one of the strategic interventions is to support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into all the revenue villages.[4]

VHSC has been constituted with the overall aim of development of village and strengthening the community at the grass root level. The VHSC is the key agency for developing Village Health Plan & the entire planning of village Panchayat. Every village with a population of up to 1500 has to receive an annual untied grant of up to Rs. 10,000, after constitution and orientation of the VHSC. The untied grant is to be used for household surveys, health camps, sanitation drives, revolving fund etc. The Mission envisaged setting up of a revolving fund at village level by the VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization.[1]

Capacity building of VHSCs for making them functional in terms of developing the Village Health Plan, monitoring of the health activities and to ensure the access and utilization of services by all villagers is the key objective of the training of VHSC. State has decided to organize the Training of VHSC in a cascading model, the monitoring of which is as assigned to SIHFW besides coordinating trainings with the help of SPMU, DPMU and Nodal NGOs. It is very important that the members of the VHSC should know about their roles and responsibilities and what they should done for the better functioning of the VHSC.[1]

CHAPTER 1: INTRODUCTION

Concept of Village Health and Sanitation Committee

Village Health Committees are the first step towards communitization of health care services and for making health as a people's movement. The Village Health Committees are constituted in all the habitat villages with elected member of Panchayati Raj Institution of the village as Chairperson. Village Health Committee facilitates in addressing the health needs of the entire village with the help of health providers and health institutions. VHCs play an important role in planning and monitoring of the health care services through community monitoring mechanism.

Guidelines regarding constitution of VHSC

The detailed Implementation Framework of the NRHM approved by the Union Cabinet in July, 2006 provides for the constitution and orientation of all community leaders on Village Sub Centre, PHC and CHC committees. The NRHM implementation has been planned within the framework of PRIs at various levels. The VHSC envisaged under NRHM is also within the overall umbrella of PRI.

Composition of the VHSC

To enable the VHSC to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

1. At least 50% members of the committee should be women.
2. Every hamlet within a revenue village must be given due representation on the VHSC to ensure that the needs of the weaker sections especially SCs, STs, OBCs are fully reflected in the activities of the committee.
3. A provision of at least 30% representation from the Non-governmental sector.
4. Representation to women's self-help group etc. on these committees etc. has enabled the committee to undertake women's health activities more effectively.

5. Notwithstanding the above, the overall composition and nomenclature of the VHSC is left to the State Governments as long as these committees were within the umbrella of PRIs.

Thus VHSC has been formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat) [1]

Members of the VHSC

- Gram Panchayat members
- ASHA, AWW, ANM
- SHG leader
- Village representation of any CBO
- User group representative
-

Role of Village Health and Sanitation Committee

Activities

- Create Public Awareness about the essentials of health programmers.
- Discuss and develop a **Village Health Plan** based on an assessment of the village situation and priorities identified by the village community.
- Analyze key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. **Present annual health report of the village in the Gram Sabha.**
- **Participatory Rapid Assessment**: To ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping is also taken into account the health resources and the unhealthy influences within village boundaries.
- **Maintenance of a village health register and health information board/calendar**: The health register and board put up at the most frequented section of the village should have

information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc.

- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW.
- Get a bi-monthly health delivery report from health service providers during their visit to the village.
- Take into consideration of the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
- Discuss **every maternal death or neonatal death** that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
- Managing the **Village health fund**.
- **Village Health and Nutrition Day**: The VHND is to be organized once every month (preferably on Wednesdays and for those villages that have been left out, on any other day of the same month) at the AWC in the village. The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.[2]

Number of VHSC constituted in Rajasthan: 43,440

Village Health Fund (Untied Fund): An untied fund for VHCs- There is a provision of Rs.10, 000/- as untied funds for each VHSC per year. This untied fund is to be deposited in concerned Sub centers Account which is jointly operated by ANM and Sarpanch. The untied fund is utilized for demand generation for health care services, sanitation drives, emergency health care needs, rewards for exceptional work in health sector, publicity of MCHN days, RCH camps etc. The untied funds are to be used for the community actions for improvement of health status of the community, for any of the following activities: -

a. As a revolving fund from which households could draw in times of need to be returned in Installments thereafter.

b. For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.

c. In extraordinary case of a destitute women or very poor household, the Village Health & Sanitation Committee untied grants could even be used for health care need of the poor household.

d. The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education & Sanitation, Environmental Protection, and Public Health Measures shall be key areas where these funds could be utilized.

e. Every village is free to contribute additional grant towards the Village Health & Sanitation Committee. In villages where the community contributes financial resources to the Village Health & Sanitation Committee untied grant of Rs.10, 000/-, additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention. [2]

Orientation & Training

Every Village Health & Sanitation Committee after being duly constituted by the State Governments needs to be oriented and trained to carry out the activities expected of them. The members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities at the village level.

Training of the members of the VHSC in Rajasthan: Capacity building of VHSCs for making them functional in terms of developing the Village Health Plan, monitoring of the health activities and to ensure the access and utilization of services by all villagers are the key objectives of the training of VHSC. State has decided to organize the Training of VHSC

in a cascading model, the monitoring of which is as assigned to SIHFW besides coordinating trainings with the help of SPMU, DPMU and Nodal NGOs. It is very important that the members of the VHSC should know about their roles and responsibilities and what they should done for the better functioning of the VHSC.

As per the NRHM framework for implementation, all the members of VHSCs are to be trained. The objectives of training are –

- To develop VHSC as strong Vibrant Group which will be responsible for improving the health status of fellow villagers
- To develop understanding on Health Issues, Health Problems, Health Services, Health Programmes
- To empower the VHSC members to plan, demand and monitor the health services
- To strengthen the group to work as active participants of society for the cause of Health.

The content of the training is developed with focus on the following issues-

1. Concept of Health and determinants of health.
2. Health institutions and health programmes
3. Social aspects impacting health status like child marriages, son preference etc.
4. Demand generation for health care services
5. Planning and monitoring of health care services
6. Team Building and networking
7. Operational issues - Constitution, monthly meetings, funds management, reporting
8. Roles and responsibility of VHC in improvement of health status of the community

The training has been imparted at PHC/Block level and all the committee members of the cluster of villages have been trained in one batch. State Institute of Health and Family Welfare is the Apex body for the task of trainings. The support has been taken from the NGOs which have an experience in implementing the community level interventions in the health sector. [6]

The pool of trainers has developed at State, District and Block level. The cascade model is used for these trainings. The trainers team has included identified and experienced trainers from DMHS, DWCD, NGOs and some free lancing trainers. SIHFW has carry out the state and district level trainings and it provide supportive supervision for block/ PHC level trainings. NGOs have been involved in the trainings of members of the committee and provision of the logistics support for the trainings.

Training of trainers

a. State level- 20 selected trainers at state level has been identified who are involved in the development of training module and reading material. The support of the NGOs who are involved in Community Monitoring Programme has sought for development of reference material and state trainers group.
b. District Level- 6 selected trainers - 2 DMHS, 1 Panchayati Raj, 1 DWCD and 4 NGO and free lancer trainers- Total 10 per District will be trained at state level by SIHFW.
c. Block Level - 6 trainers per block- Constitution same as District Level Trainers- 6* 237 = 1422 trainers. These trainings will be conducted at District level, simultaneously in all the districts

Training of VHSC members

The total training load is of approximate 2,50,000 members. The trainings at grass root level have contracted out to the NGOs which were selected at district level to carry out the trainings. State level SIHFW has monitor and provide supportive supervision for the trainings.

Training Load: 2, 50,000 members

Training Agency: Identified NGO in the district

Time Span- One Year

Batch Size – Minimum 49 members (7 VHSC in one batch)

Training Duration: Two Days

Minimum attendance- 70%

Training material

Two Books- Trainers Guide

- Reading material for members

Content of training module and reading material

• Determinants of Health

• Burden of disease on families, community

• Causes of diseases

• Health institutions, Health Programmes, Service guarantees

• Village Health Committees- Constitution, Roles and Responsibilities

• Untied Funds for VHSCs

• Monthly meetings

• Development of Village Health Plans

RATIONALE OF THE STUDY

Capacity building of the VHSC members is very important for the smooth functioning of the VHSC and the overall development of the village. It is very important to assess the impact and recall level of the VHSC training amongst the VHSC member's .As at the village level VHSC plays a very important role and without the development of the village the overall development of the nation is not possible.

VHSC training started with the aim of empowering the members of the VHSC so that they can perform their function efficiently and effectively. In VHSC training, training had been imparted to the members about the various issues, about the roles and responsibility of the different members, about the composition of the VHSC, about the untied funds and to many other issues which is directly or indirectly related with the VHSC.

The study helps in knowing that whether VHSC training is useful for the VHSC members or not. And. The study also analysed that whether same type of VHSC training is equally beneficial for the different participant of the VHSC and if there is the need of the different training programme for the members of the VHSC.[3]

CHAPTER 2: OBJECTIVES

✓ **General Objective**

- The main objective of the study is to evaluate the outcomes/impact of the VHSC training.

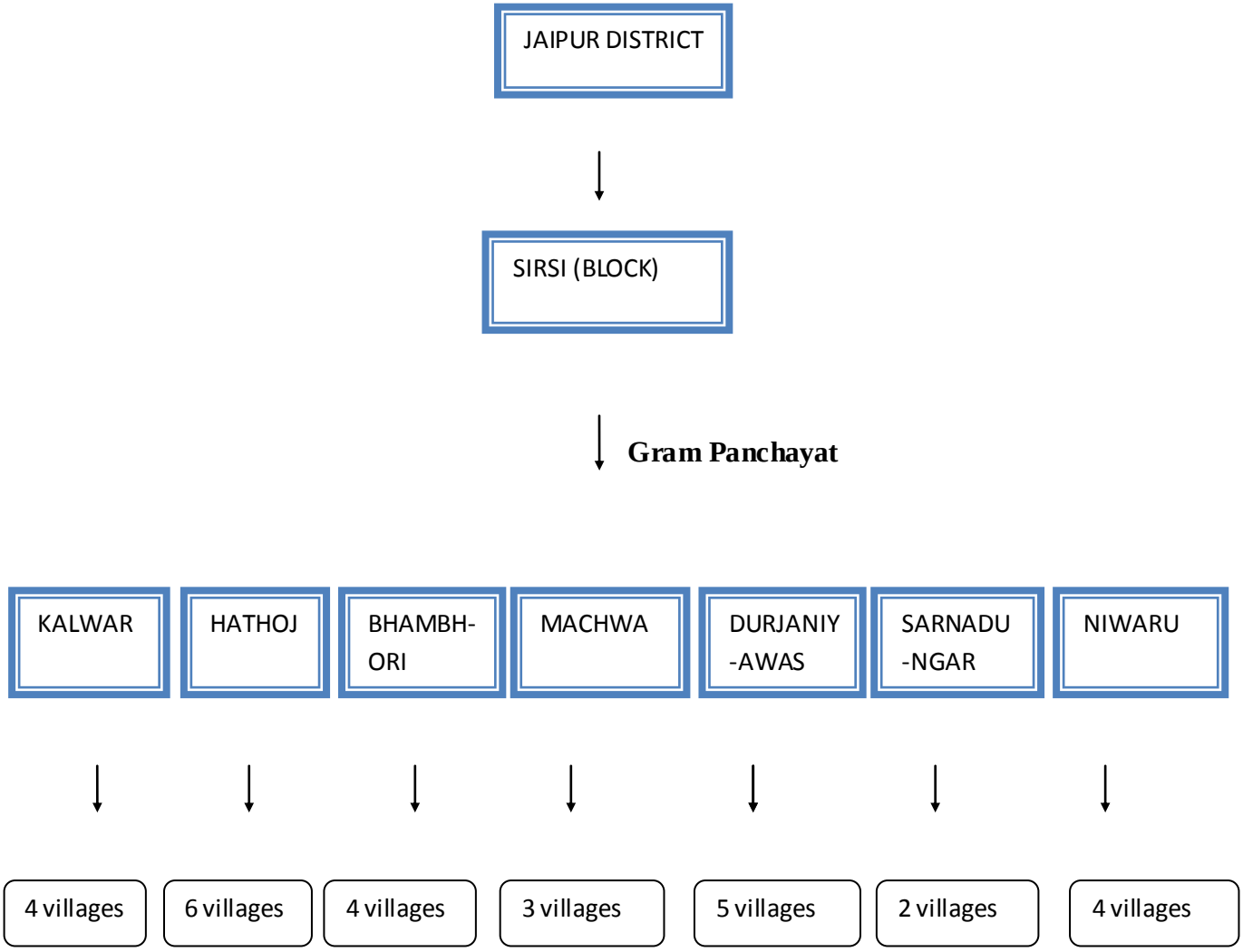
✓ **Specific Objectives**

- To check/monitor the training recall amongst VHSC members
- To compare the training recall level of different participants of VHSC members
- To evaluate the outcome of training of VHSC members in terms of enhancing their Knowledge, Skills and attitude.

CHAPTER 3: METHODOLOGY

Study Design: Descriptive cross sectional study

Study Area: Jaipur District. Sirsi block of Jaipur had been selected for the study.



Study Universe: VHSC members

Study Type: Qualitative

- **Study Tools:** Structured questionnaire. Structured questionnaire had been developed to check the recall level of different members of the VHSC about the VHSC trainings. All questions in questionnaire used for surveying and data collection were close ended .Most of the questions had 5 options. Each question was specific and related to the study .The members were interviewed on the following parameters;
  - Personal characters like
    - Age
    - Sex
    - Level of education
    - Caste
    - Category
  - Recall about VHSC Training
  - Knowledge of the VHSC member about the constitution of the committee, VHSC meetings and about the roles and responsibilities of the VHSC
  - Benefits of the VHSC Training

Sampling Technique: Convenient Sampling

Sample Size: 150 VHSC Members

Data: Primary as well as secondary. Primary data had been collected by going into the field where as the list of participants and the information about the VHSC trainings had been collected at the block level in the form of secondary data.

CHAPTER 4: RESULTS AND DISCUSSION

There was a questionnaire for the VHSC members which focused on the general profile, questions related to the VHSC training and assessing their recall level in terms of their knowledge related to topics covered during the VHSC training.

Responses of the VHSC members

A. **General Profile:** The general profile covered characteristics as age, gender, caste, education occupation, and category of the VHSC members.

Sex of the respondent: Out of the 150 respondents, 75% were women and 25% were men.

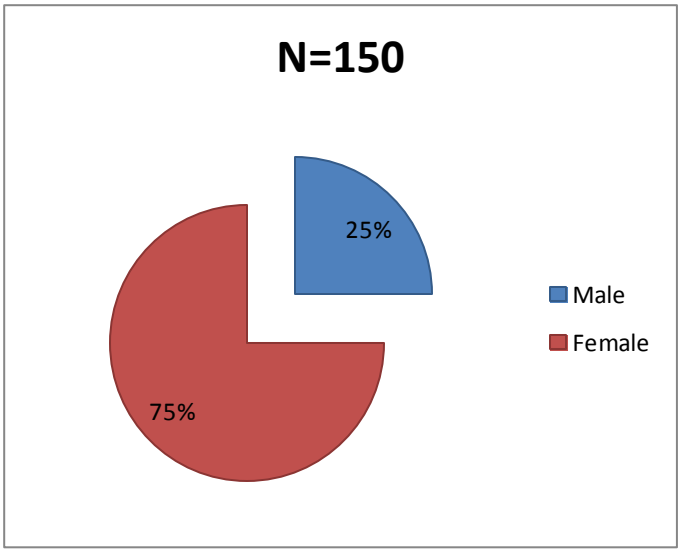


Table 1: Sex-wise distribution of the Respondents

Age Group of the respondent: 73% of the respondents belonged to the age group 25-45 yrs, 18% of them were below the age of 25 yrs and 9% were above the 45 yrs.

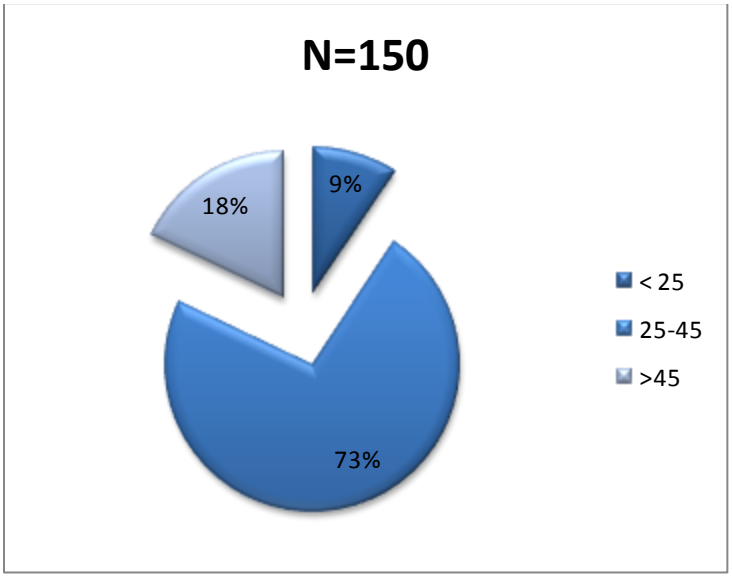


Table 2: Age-wise distribution of the Respondents

Caste of the Respondent: Out of the 150 respondents, 42% belonged to general category, 38% were OBC, 15% were ST and 5% were SC.

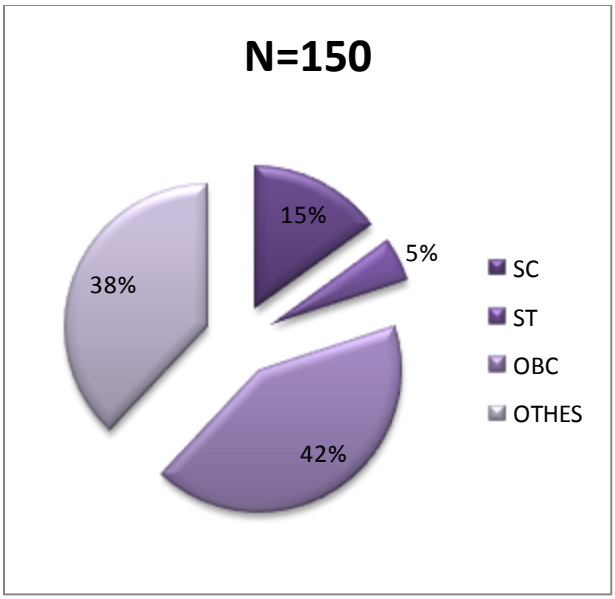


Table 3: Caste-wise distribution of the Respondents

Educational level of the members: 44% of the members were educated up to the primary level followed by 25% educated up to secondary level. 11% of the respondents were illiterate while 9% of the members can read and write only. 7% respondents were educated Upto the graduate level.

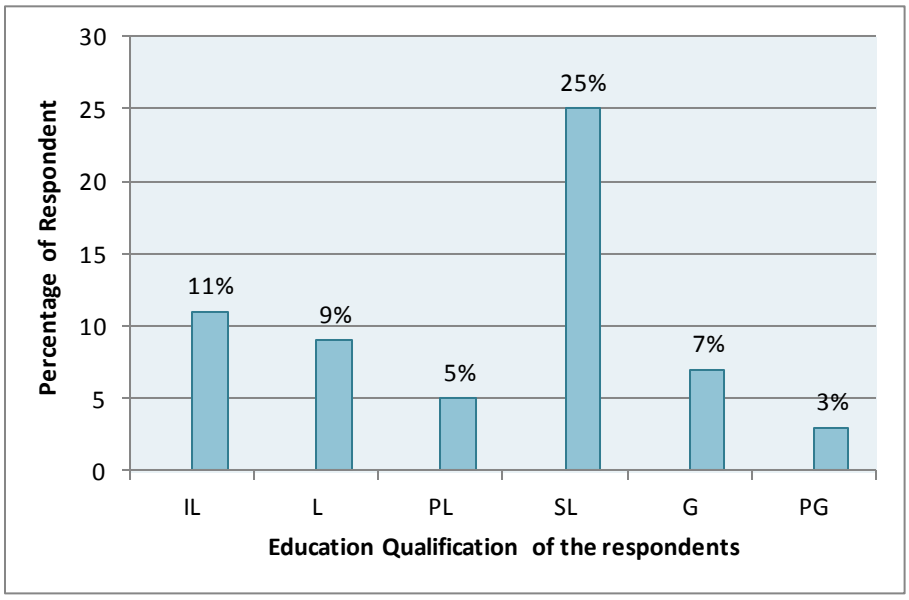


Table 4: Level of Education of the Respondents

Category of the Respondent: The respondents included 16 % PRI members, 17% ASHA, 23 AWW, 5% ANMs and teachers and 35 % other members**.**

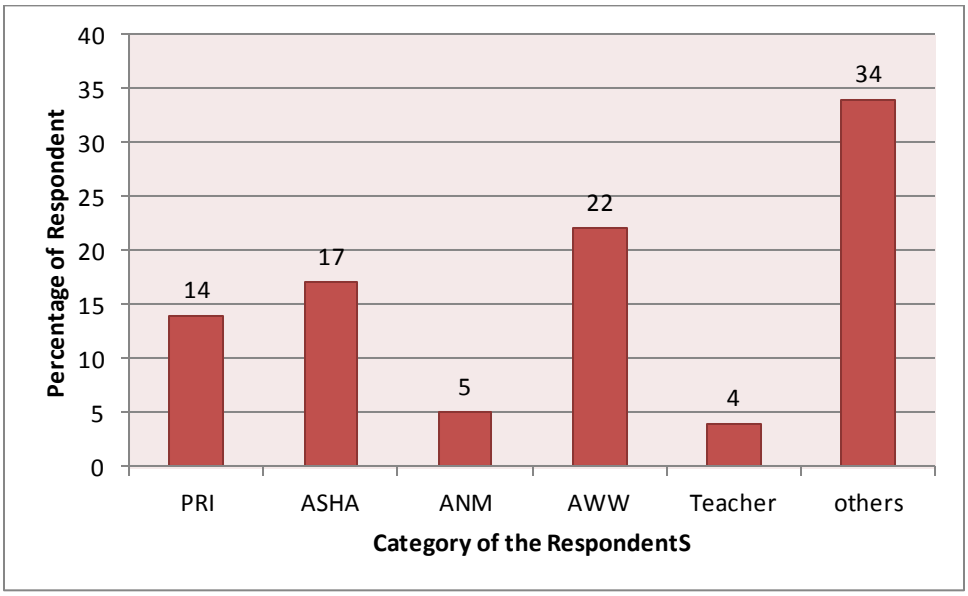


Table 5:Category-wise Distribution of the members

Knowledge about VHSC and VHSC membership: Out of 150 VHSC members interviewed, 12% of the respondents not even knew about VHSC and rest of them (88%) knew about it.

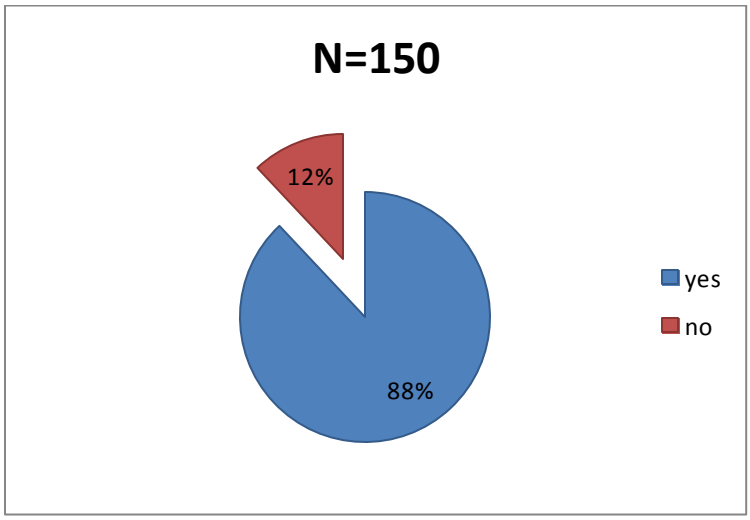


Table 6: Graph showing the knowledge of members about VHSC and their membership

Duration of Membership: Most of the respondents (62%) are the member of the VHSC in the range of 1 yr-2 yrs. 13% members did not remember the duration of their

membership where as 15% respondents are the members of the VHSC in the range of more than 2 yrs.

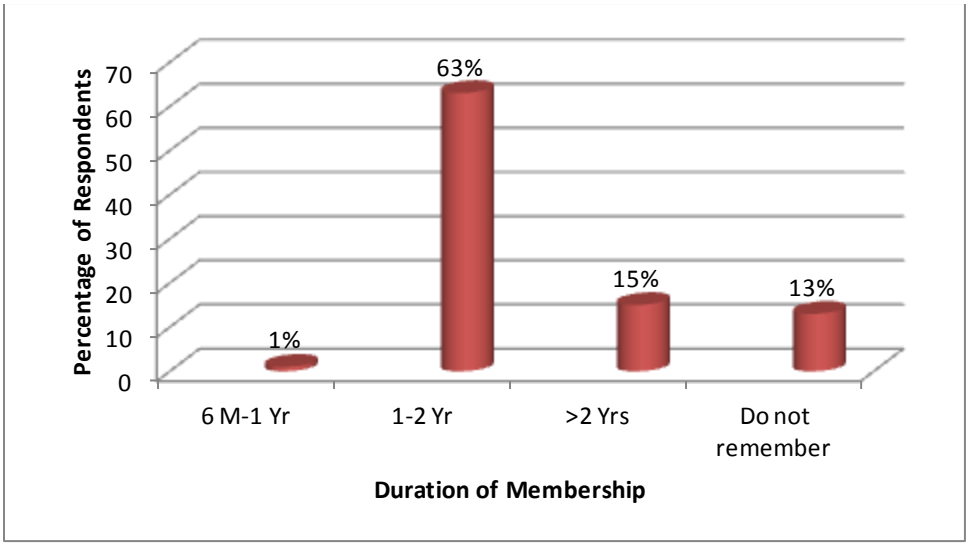


Table 7: Graph showing the Duration of membership of Respondents

B. Questions Related to the VHSC Training : It included the questions related to the recall of the VHSC training, duration of the training, whether the members had been provided with any study material or not during the training and if the members found training useful for them or not.

VHSC Training: 90% of the respondents attended the VHSC training and 10% did not attend the meeting.

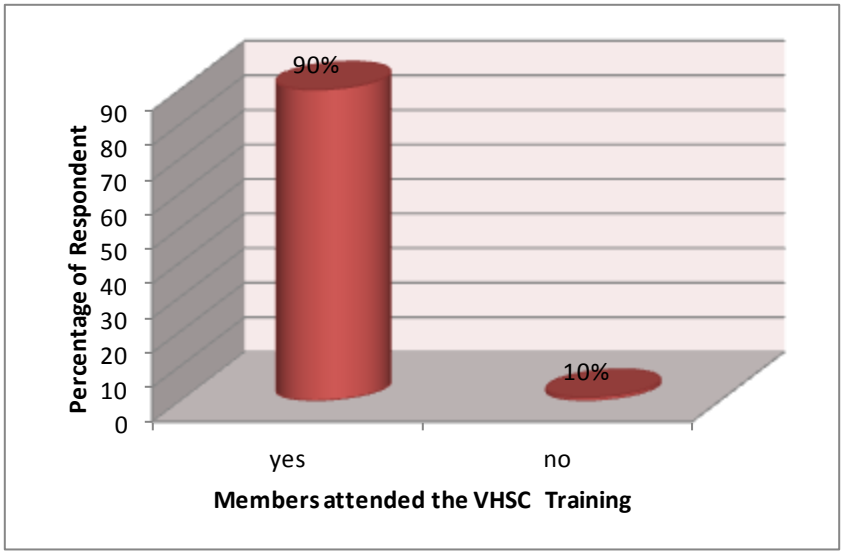


Table 8: Attendance of members in VHSC training

Duration of VHSC Training: 63% respondents replied that training was of 2 days, 20% did not remember the duration of the training, 3% replied 3 days where as 1% replied that training was of 1 day.

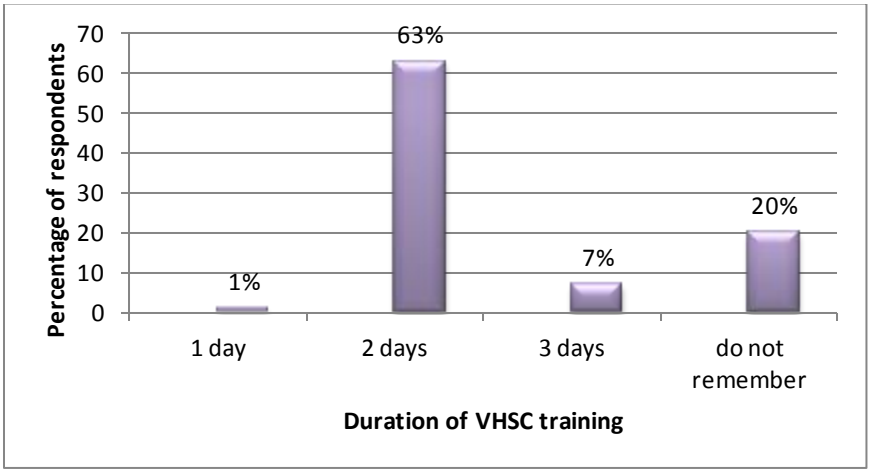


Table 9: Responses of members about Duration of training

Attending the full session: 89% respondents attended the full session of the training, 5% respondents replied they did not remember and 6% replied no.

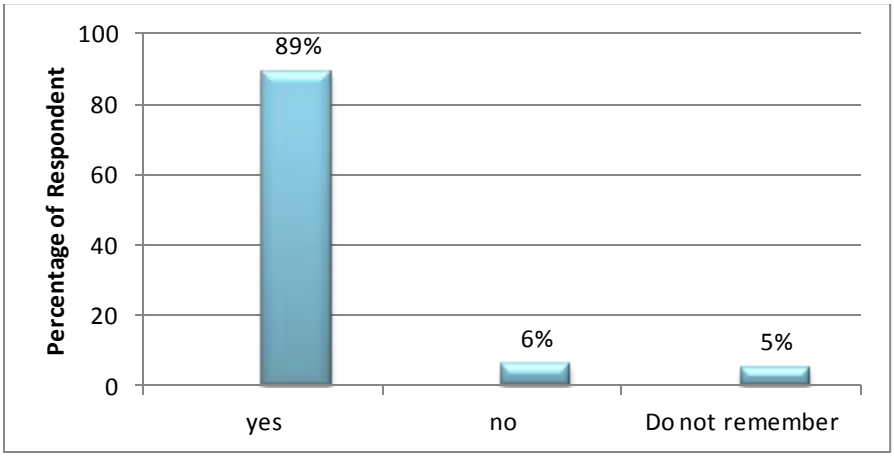


Table 10: Responses of members: Attending the full session of training or not

Study Material: 58% respondent replied that study material had been provided during the training, 37% replied no and 5% did not remember.

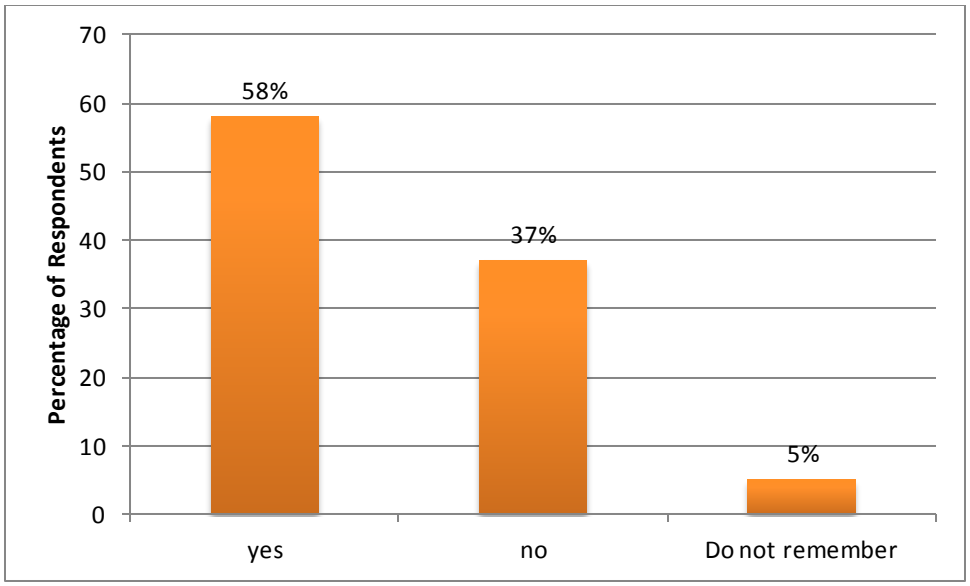


Table 11: Responses of members: Study material provided during the training or not

Study Material is useful or not: 52% Respondents replied that study material was **very useful** where as 46% respondents found it **useful**. 2% Respondent replied that study material provided to them was **not of any use**.

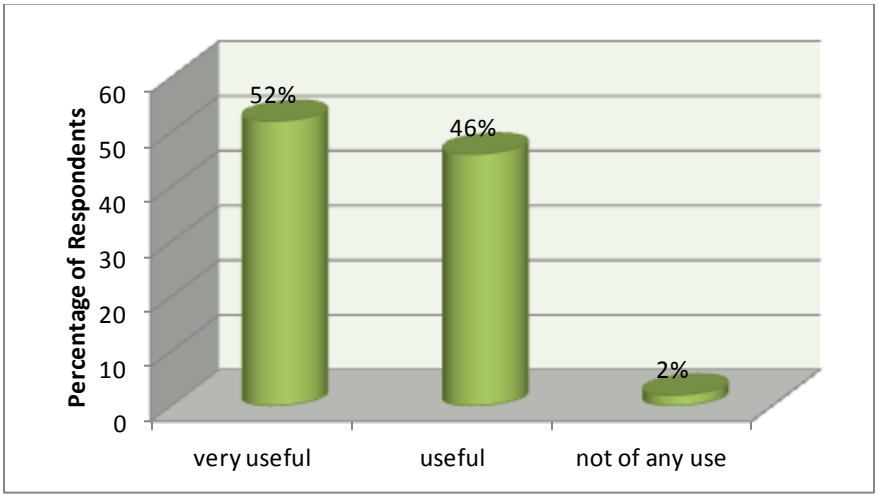


Table 12: Responses showing that whether study material was useful or not

C. **Questions related to the recall level:** In this section various questions had been asked to check the recall level of the respondents. The questions included the topics covered in

the trainings i.e. knowledge about VHSC, untied funds, various diseases, dangerous sign and symptoms of pregnant lady and new born.

Issues Covered in the Training: Most of the respondents (97%) replied that health related issues had been discussed,72% respondents replied that VHSC Related issues had discussed,51% replied that untied fund had been discussed, 39% replied MCHN day where as only 9% respondent said that NRHM had been discussed during the VHSC training.

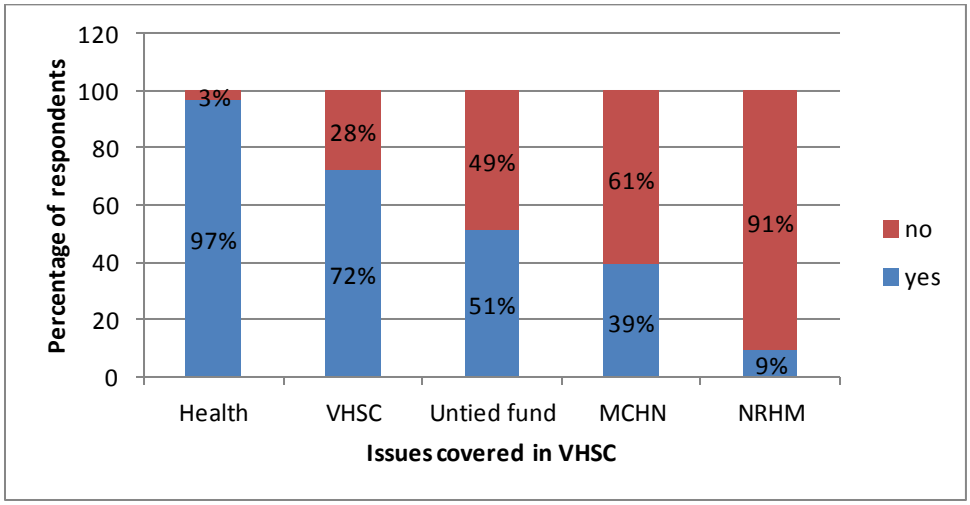


Table 13: Responses of members: Issues discussed during the training

Number of members in the VHSC: 50% of the respondents replied that there should be more than 7 members incorporated in the VHSC according to the guidelines, 27% replied 7 members, 16% replied 6 members, 4% replied 4 and 3% replied 5 members.

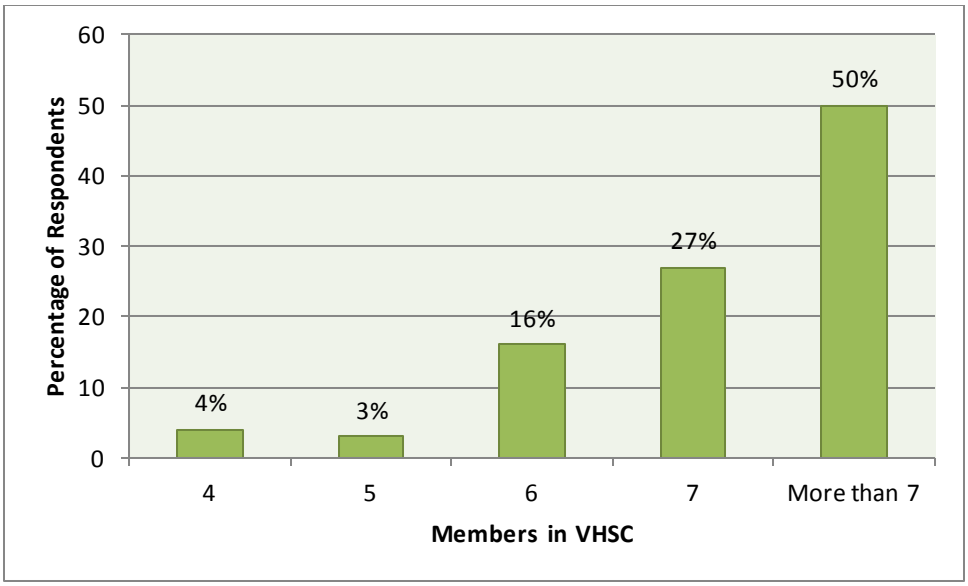


Table 14: Responses of members: No. of members incorporated in VHSC

Knowledge about membership of VHSC: 70% members got to know that they are the member of the VHSC at the time of the training and 30% members knew it before the training.

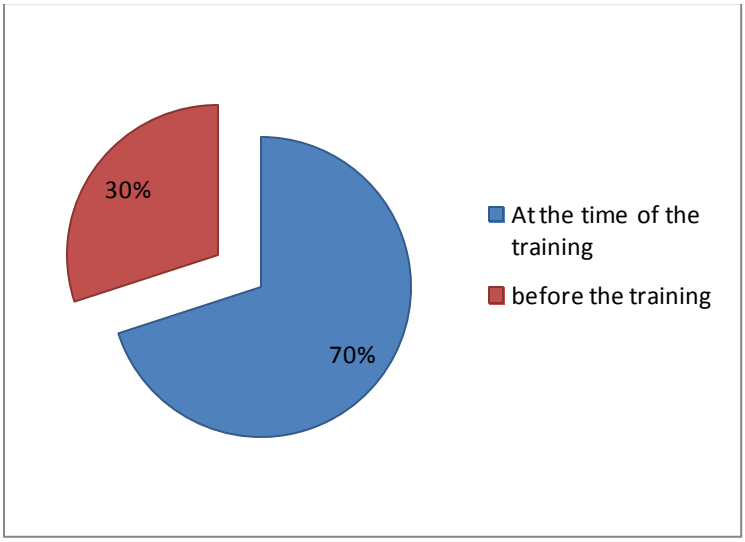


Table 15: Chart showing when the members got to know about their membership

Frequency of VHSC meeting: 75% of the members replied that VHSC meeting occur once in month, 14% members did not know about the frequency of the meeting, 6%

replied once in a year, 4% replied after every 15 days and 1 % replied that meeting occur after every 6 months.

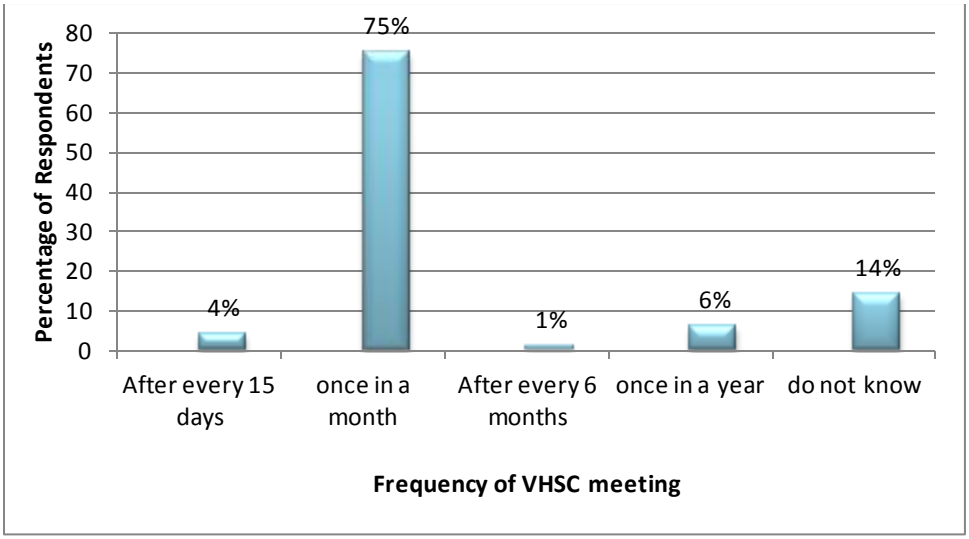


Table 16: Responses of members: Frequency of meetings

VHSC Meeting Place: 62% of the respondents replied that the VHSC meetings occur at the Aaganwadi center, 17% replied at the house of the PRI representative, 14% did not know about the meeting place and 8% replied at the sub-center.

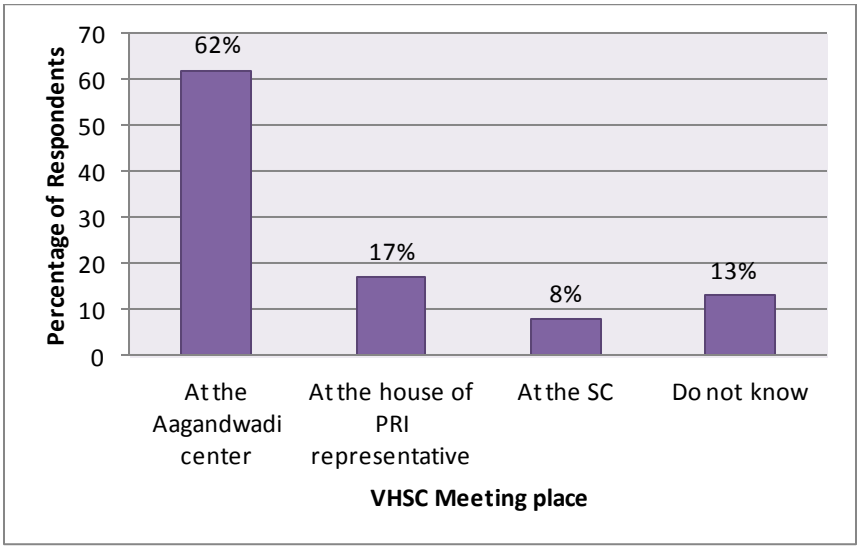


Table 16: Responses of members: VHSC meeting place

Activities done in the VHSC Meeting: 82% replied that in the meeting of VHSC they decide the functions of the different members, 74% replied that monitoring the activities of the previous month, 61% members replied that they also discussed about the utilization of untied fund and 23% replied that activities related to the MCHN day.

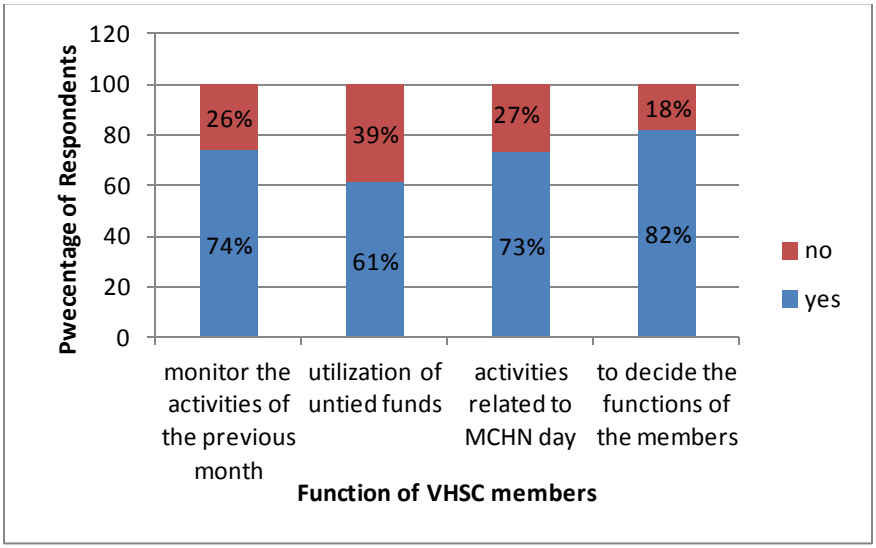


Table 17: Responses of members: Functions of the members

Untied funds: About 66% of the respondent replied that VHSC received 10.000 Rs as an untied fund, 23% replied more than 12500, 7 % did not know about the amount received by VHSC as an untied fund, 2% replied 5000 and 1% replied 7500.

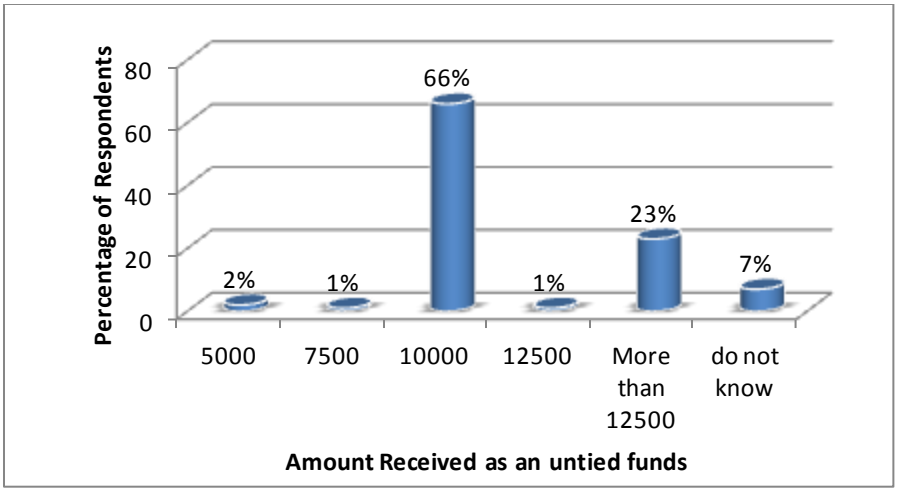


Table 18: Responses of members: Amount granted as untied fund

Utilization of Untied Funds: 84% of the members replied the untied funds has been used for cleanliness and sanitation drive in the village, 76% replied for dealing with health related problems, 22% replied for organizing the MCHN day and 4% replied it has been used for advertisement of MCHN day.

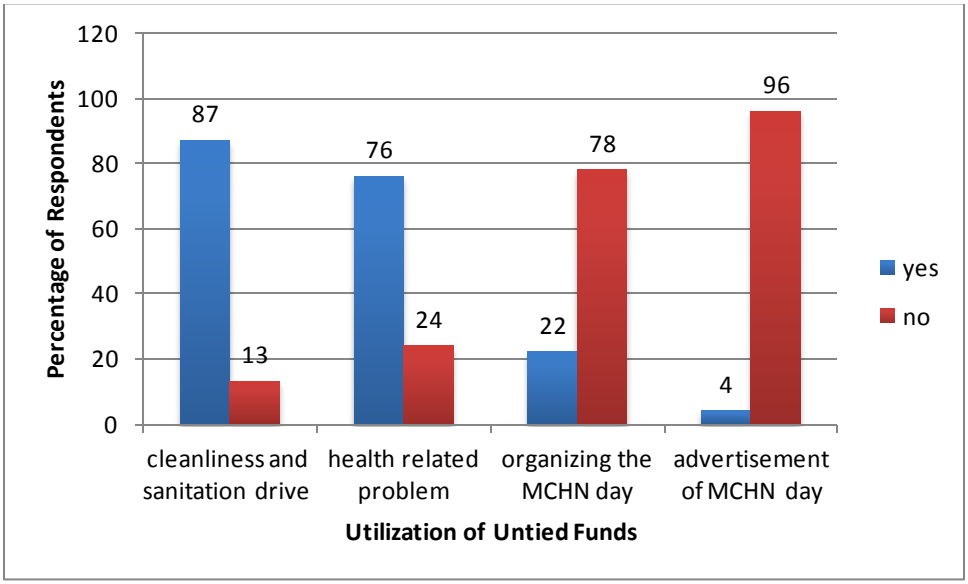


Table 19: Responses of members: Utilization of untied funds

Malaria: About 86% of the members were aware about the sign and symptoms of Malaria where as 99% had the knowledge that Malaria is transmitted by mosquito and 35% members did not know that blood test has been done for confirmation of Malaria.

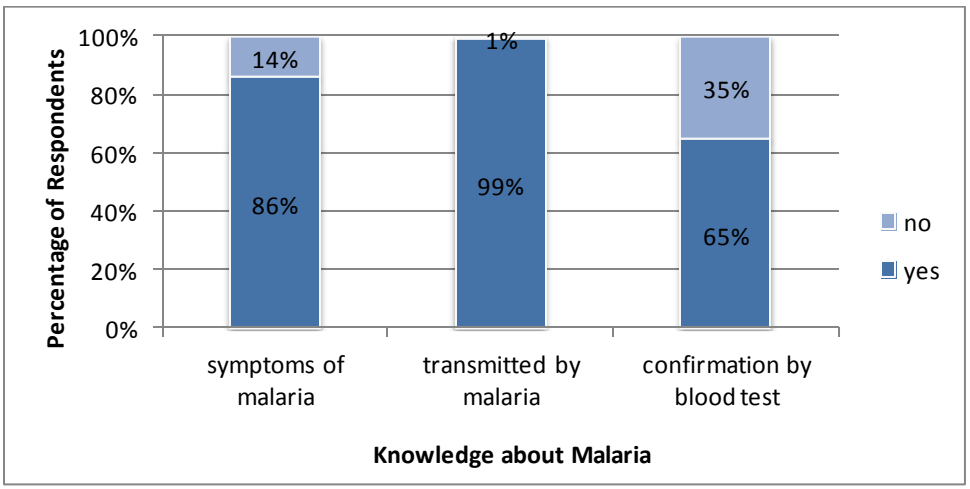


Table 20: Graph showing the knowledge of members about Malaria

T.B.: 70% of the members did not know about the different types of T.B. whereas 74% members knew that T.B. has been confirmed by the sputum test. 66% members knew about the DOTS treatment.

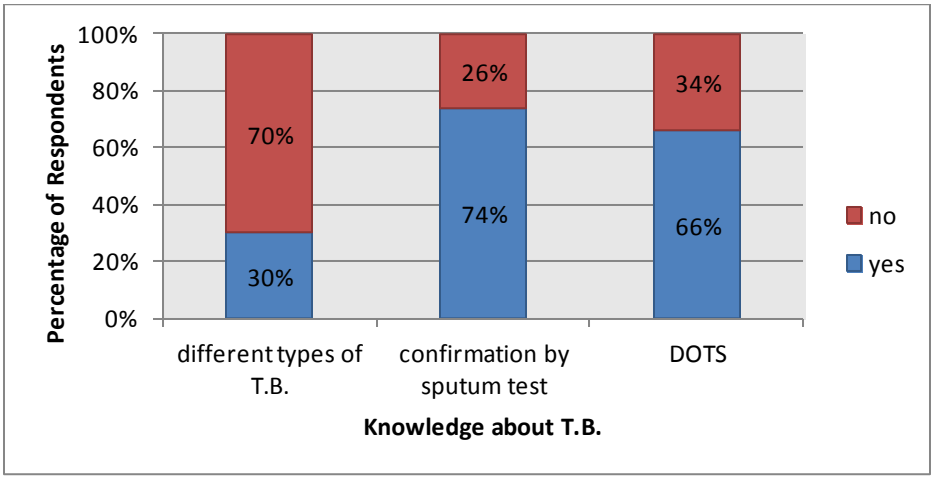


Table 21:Responses of members about T.B.

Care and Services provided at the time of the pregnancy: 68% of the members were aware about 3 anti-natal visits where as 92% know that folic acid has to given at the time of the pregnancy. Only 29% replied that 500 Rs has to be given to the BPL card holder pregnant woman in the 7th month of the pregnancy and 71% were aware of JSY scheme.

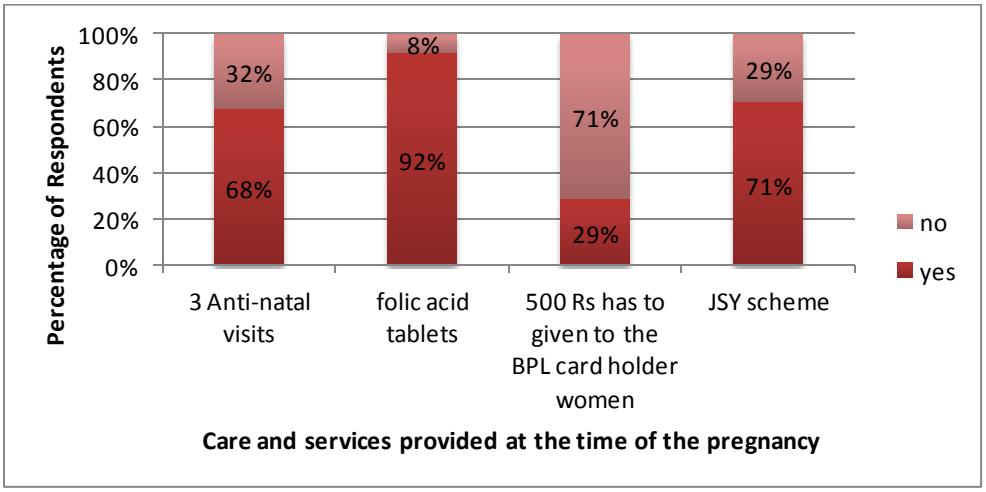


Table 22: Responses of members: Services provided to the pregnant lady

D. Benefits of the VHSC Training: It included the questions that whether VHSC training is beneficial or not, what are the different benefits of training etc

95% respondents replied that VHSC Training was beneficial and 5% replied no.

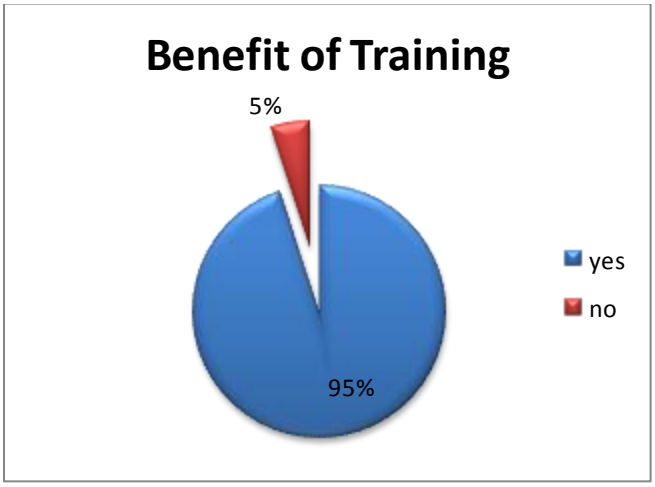


Table 23: Responses of members that whether VHSC Training is beneficial or not

Benefits of VHSC training: 93% members replied that the training increases the knowledge of the members, 77% replied that it helps in improving the health status of the village,63% replied that it enhances the skills of the members, 50% members replied that VHSC training enhances the efficiency of the members.

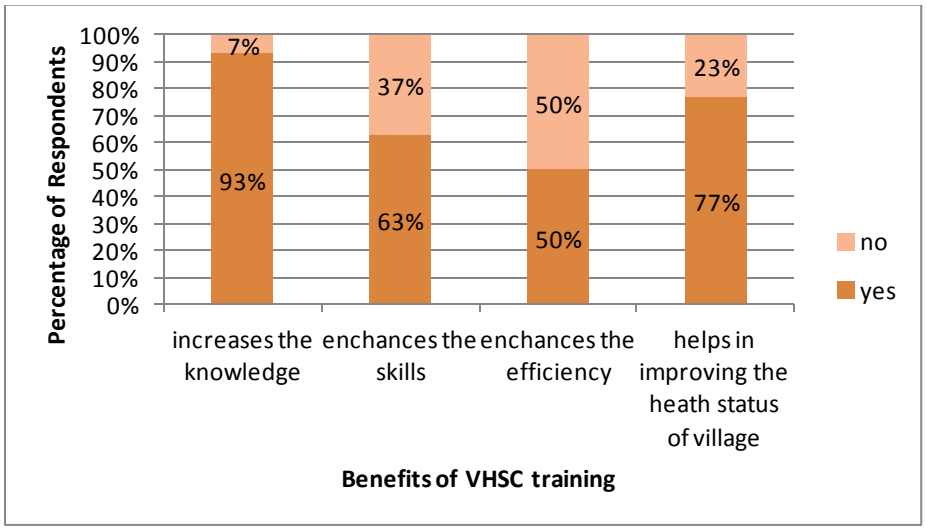


Table 24: Different benefits of VHSC training

Duration of training is sufficient or not: 62% respondents replied that duration of training was not sufficient for learning. 33% replied that duration of training was sufficient and 5% replied that they cannot say anything.

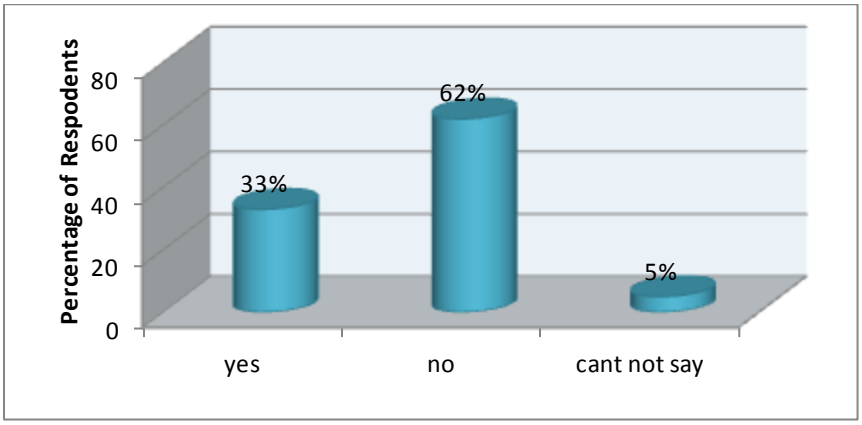


Table 25: Responses of members: Duration of training was sufficient or not

E. Comparing the Recall level of Different VHSC Members:

No. of Members should be incorporated in VHSC according to the guidelines: 64% ASHA 57% ANM and 42% replied that 7 members should be incorporated in VHSC according to the guidelines. Only 19% PRI, 12% AWW and 15% other members replied that there are 7 members in the VHSC.

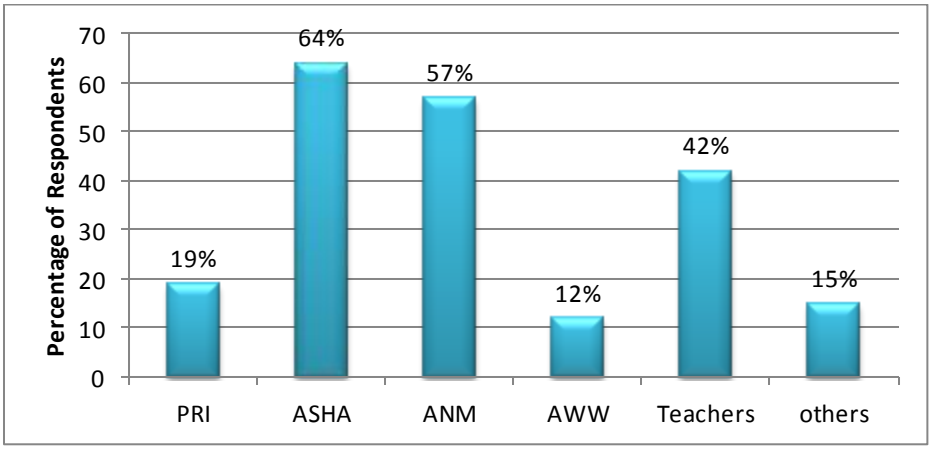


Table 26: Responses of different members of VHSC

Amount Received as an untied fund: 100 % ANM and teachers replied that VHSC receive 10,000 as an untied funds where as 84% ASHA and 75% PRI representative said the same. The percentage is low in the case of AWW (59%) and other members (45%).

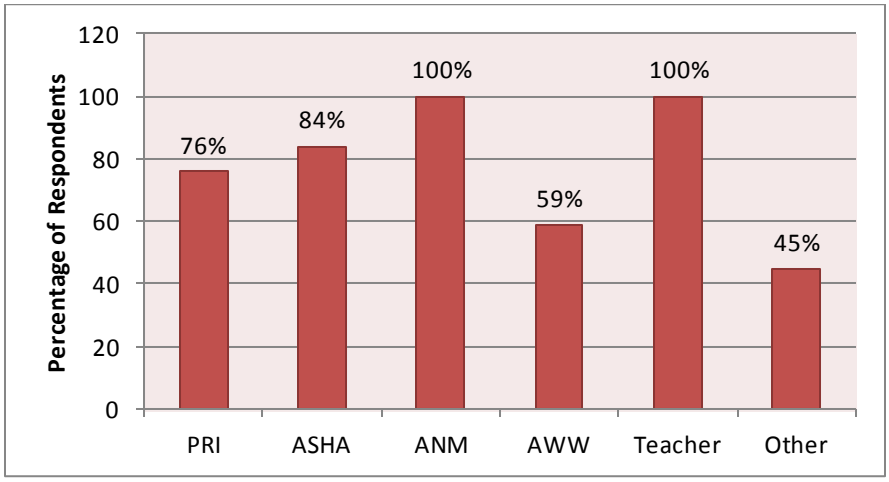


Table 27: Responses of different members of VHSC: Amount Received as an untied fund

Knowledge about membership: 15% ANM replied that they got to know about their VHSC membership at the time of training where as 57% PRI representative and 44% ASHA replied the same. The percentage was quite high in the case of teacher (71%) and AWW (81%) and it is highest in the case of other members i.e. 90%.

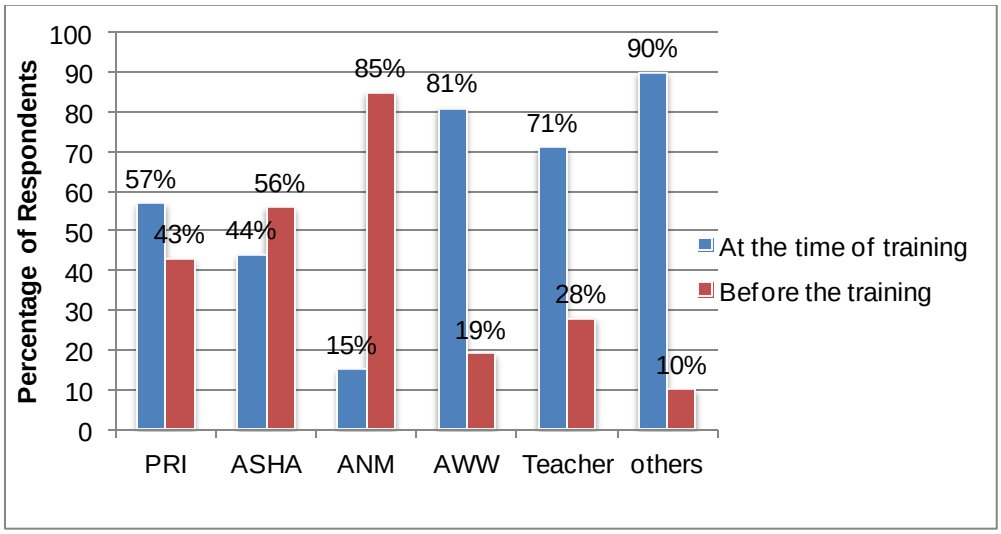


Table 28: Responses of different members of VHSC:

Comparing the Recall level of different members about Frequency of VHSC meeting: The Recall level about the frequency of VHSC meeting was almost same in the case of ANM, ASHA and AWW i.e. 85%, 82% and 84% respectively. The recall level was highest in the case of teachers. The Recall level was lowest in the case of other members (53%)

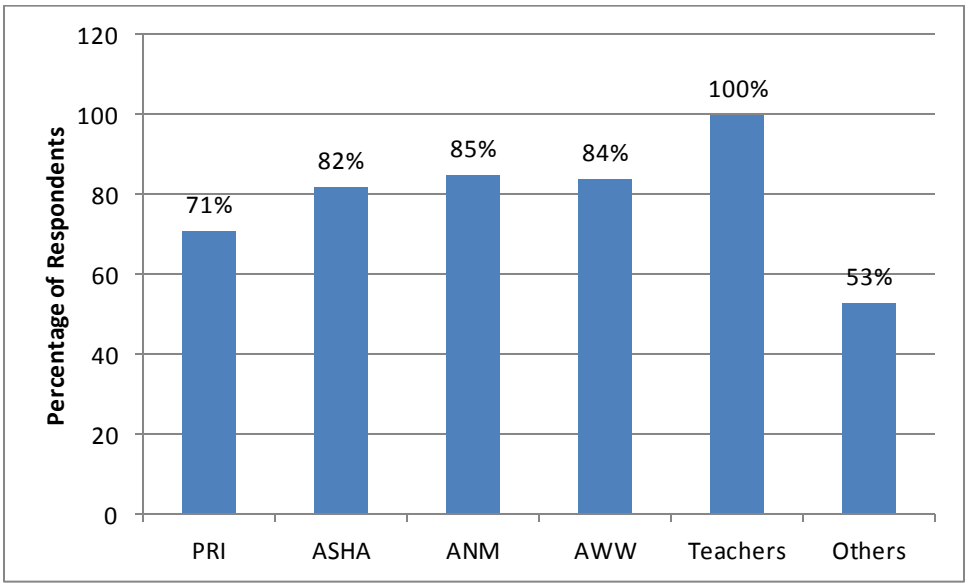


Table 29: Responses of different members of VHSC: Frequency of Meeting

KEY FINDINGS

- About three fourth respondents were women; it shows the dominance of the women in the committee. Majority of the respondent belonged to the age group 25-45. General group and OBC members formed the chunk of the respondents. Most of the respondents were literate, majority of them educated up to the primary level. Other members had the ascendant presence among the respondents
- Surprisingly even after the training, 12% of the respondent did not know about VHSC and that they are the member of such committee.
- In response to the question about their membership, most of them (63%) replied that they are the member of the committee from 1-2 yrs and this is that time period during which VHSC training had been conducted in the study area. So it shows that before the training most of the members did not know about their membership.
- Attendance rate was quite high i.e. 90% during the training and the members found study material providing during the VHSC training quite useful for them.
- Surprisingly very few respondents (9%) replied that NRHM had been discussed during the training whereas most of them remembered that health issue had discussed during the training.
- Responses of the members varied when asked about the no. of members incorporated in the VHSC. This is because no. of members in the VHSC varies from village to village.
- One of the advantage of the training is that majority of the members (70%) got to know about their membership status due to the training.
- Knowledge about frequency of VHSC meeting was quite high i.e. 75% and 66% members were also aware that VHSC received grant of Rs 10,000 as an untied funds.
- Knowledge about Malaria was quite good. Most of them know that malaria is transmitted by mosquito and they also knew about the sign and symptoms of Malaria.
- The knowledge of members about T.B. was average.
- Most of the respondents found VHSC training beneficial for them. Acco. to the members VHSC training increases the knowledge of the members and it also helps in improving the health of the village.

- Large no. of Respondents (62%) was not satisfied by the duration of the training. They want that duration of training would be increased for better learning if such type of training would organize in the future.
- On comparing the recall level of different members of the VHSC about untied funds, the recall level was found 100% in case of ANM and teachers where as recall level was quite high in the case of ASHA (84%) and 76% in the case of PRI representative. Recall level was low in the case of AWW and other members.
- Most of the ANM (85%) knew that they are the members of the VHSC before the training where as this percentage was quite low in the case of AWW, Teachers and other members.

CHAPTER 5: CONCLUSION

The VHSC training has been started with the overall aim of empowering the members of the VHSC. The VHSC training has a positive impact on the members of the committee. The common perception of the members was that VHSC training was beneficial for them. They got to learn something useful from the training and such type of training would also be conducted in the near future. The most important benefit of VHSC training is that the members of VHSC got to know that there exists a committee which is known as VHSC and they are the member of the VHSC. Only ANMs, few ASHAs and few PRIs representative are aware of the fact that they are the member of VHSC before the training. This also means that before the VHSC training activities related to the VHSC did not conducted properly as most of the members were not aware of their roles and responsibilities. Most of the members remembered that issues related with health, VHSC and untied funds had been discussed during the training whereas most of them did not remember that issue related with NRHM discussed during the training. The awareness level about untied fund was good. The committee utilized the untied fund generally for health and hygiene related issues. The knowledge of VHSC members about different diseases was also satisfied, although members knew more about Malaria as compared to T.B. Members were also aware of different services provided at the time of pregnancy though the awareness level was low about the service of providing Rs.500 to the pregnant lady of the BPL family in the 7^{th} month of the pregnancy (this might be due to low percentage of BPL Family in the study area).

Recall level varied among the different category of the members. Recall level was highest in the cast of ANM followed by Teacher, ASHA and PRI representative where as the recall level was lowest in the case of other members and AWW. One of the reasons for the difference in the recall level of the different members is that ANM and ASHA are more active on the field and separate training programmes has also been conducted for ANMs and ASHAs from time to time.

CHAPTER 6: RECOMMENDATIONS

From the findings of the study, it has been clear that VHSC training has a positive impact on the members of the VHSC. The impact level of training varies from member to member. There are some recommendations for further increasing the impact of VHSC training.

- Impact of such training can be enhanced if timely refresher or reorientation training is given to those who have been already trained.
- Duration of training should be increased. Almost all the members felt that duration of training i.e. 2 days is not sufficient for effective learning and there is need of increasing the duration of the training if such type of trainings would be conducted in the future.
- The Recall level was different among the different category of the members. The recall level was highest in the case of ANM and ASHA and it was lowest in the case of other members. So. There should be separate training programmes for the different members of the VHSC as some category of members (other members) need more training as compared to the others.
- Active learner should be identified from the different batches. These active learners can act as a trainer for reorienting the other members of the VHSC.
- Monitoring should be done at the regular intervals to make ensure that the members are practically implementing the knowledge of the training. It further enhances the recall level of members and at the same time it also increases the efficiency of such kind of trainings.
- Training should be done in a more planned way. Many of the respondents complained that they got the information about the training at the last hour. Respondents were also a lit bit dissatisfied with the arrangements at the training place. So, these things should be taken into consideration while organizing such trainings in the future.

LIMITATION OF THE STUDY

- Sample Size is small.
- There might be chances of biasness in the responses of the VHSC members.

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Books:-

1. *VHSC Monitoring Report*
2. *Report on Capacity-Building Needs: Village Level committee -cum-Village Health and Sanitation Committee. (July 2010).*
3. *Pankaj Prasad, R. S. (Jan-March 2012). A COMPARATIVE STUDY TO ASSESS THE IMPACT OF 6 DAYS CORE COMPETENCY TRAINING OF THE ANMs OF DAMOH DISTRICT OF MADHYA PRADESH. National Journal of Community Medicine Vol 3 Issue 1, Page 121.*

Journals:-

4. *National Rural Health Mission (2005-2012), Mission Document*
5. *¨http://wcd.nic.in*
6. *¨http://mda.nic.in¨http://*
7. *www.haryanahealth.nic.in*
8. *¨http://india.gov.in (Pankaj Prasad, Jan-March 2012)*

ANNEXURES

Questionnaire for the VHSC members

छ प्रश्नावली – ग्राम स्वास्थ्य एवं स्वच्छता समिति के सदस्यों के लिये

ब्लॉक का नाम .....

पंचायत का नाम.....

गॉव का नाम .....

1. उत्तरदाता का नाम .....
2. लिंग पुरुष ☐ महिला ☐
3. उम्र (वर्षो में)
   अ. 25 से कम ब. 25 – 45 स. 45 से अधिक
4. जाति
   अ. एससी ब. एसटी स. ओबीसी द. सामान्य
5. शिक्षा का स्तर
   अ. निरक्षर ब. साक्षर स. प्राथमिक द. माध्यमिक
   य. स्नातक र. स्नातकोत्तर
6. क्या आपको ग्राम स्वास्थ्य एवं स्वच्छता समिति के बारें में पता हैं?
   अ. हां ☐ ब. नही ☐
7. क्या आप ग्राम स्वास्थ्य एवं स्वच्छता समिति के सदस्य हैं?
   अ. हां ☐ ब. नही ☐
8. यदि हां,तो कब से हैं?
   अ. 6 महीने – 1 साल ब. 1 साल – 2 साल
   स. 2 साल से अधिक द. याद नहीं
9. आप ग्राम स्वास्थ्य एवं स्वच्छता समिति ग्राम सें किस रुप में जुड़े हुये हैं?
   अ. पंचायत प्रतिनिधि
   ब. आशा
   स. ए.एन.एम
   द. आंगनबाड़ी कार्यकर्त्ता
   य. शिक्षक
   व. स्वास्थ्य कार्यकर्त्ता
   र. अन्य (बताएं) .....

प्रशिक्षण से सबंधित प्रश्न

10. क्या आप ने राष्ट्रीय स्वास्थ्य मिशन द्वारा आयोजित ग्राम स्वास्थ्य एवं स्वच्छता समिति प्रशिक्षण में भाग लिया था ?
    अ. हां ☐ ब. नही ☐
11. यदि हां, तो प्रशिक्षण कितने दिनों का था ?
    अ. 1 ब. 2 स. अन्य (बताएं) द. याद नही
12. क्या आप ने प्रशिक्षण की पूरी अवधि में भाग लिया था ?
    अ. हां ☐ ब. नही ☐
13. यदि नहीं तो आपने प्रशिक्षण की कितनी अवधि में भाग लिया था?
    अ. 0-8 hrs ब. 4-8 hrs

ब. 8-12 hrs द. अन्य (बताएं) .....

14. यदि नहीं, तो प्रशिक्षण छोड़ने के क्या कारण थे ?
    अ. व्यक्तिगत आपात स्थिति
    ब. सरकारी आदेश
    स. असुविधा
    द. आपके क्षेत्र/विषय के लिए अप्रासंगिक
    य. अन्य (बताएं) .....
15. क्या प्रशिक्षण की अवधि बेहतर सीखने के लिए पर्याप्त थी ?
    अ. पर्याप्त ब. अपर्याप्त स. आवश्यकता से अधिक
16. क्या प्रशिक्षण के दौरान आपको पढ़ने/संदर्भ सामग्री प्रदान की गई थी ?
    अ. हां ☐ ब. नही ☐
17. यदि हां, तो क्या सामग्री आपके लिए उपयोगी थी ?
    अ. बहुत उपयोगी ब. उपयोगी स. किसी काम की नहीं
18. प्रशिक्षण के दौरान किन–किन मुद्दों के बारें में जानकारी दी गईं?

	मुद्दें	हां	नही
1	स्वास्थ्य से जुड़े मुद्दें		
2	ग्राम स्वास्थ्य एवं समिति के बारें में		
3	अनटाइड़ फंड़ के बारें में		
4	मातृ शिशु स्वास्थ्य एवं पोषण दिवस के बारें में		
5	राष्ट्रीय स्वास्थ्य मिशन के बारें में		
6	नही पता		

19. क्या आप को लगता हैं कि ग्राम स्वास्थ्य समिति के प्रशिक्षण का कोई फायदा हैं?
    अ. हां ☐ ब. नही ☐
20. यदि हां, तो प्रशिक्षण के विभिन्न फायदें क्या–क्या हैं?

	प्रशिक्षण के विभिन्न फायदें	हां	नही
1	यह समिति के सदस्यों की जानकारी को बढ़ाता हैं		
2	यह समिति के सदस्यों को बेहतर ढंग से काम करने के लिए प्रेरित करता हैं		
3	यह सदस्यों की क्षमता को बढ़ाता हैं कि ताकि वो स्वास्थ्य समस्याओं को बेहतर तरीकें से समझ सकें		
4	यह गांव की स्वास्थ्य स्थिति को बेहतर करने में मदद करता हैं		

प्रशिक्षण में दी जानकारी से सबंधित प्रश्न

21. नियमानुसार ग्राम स्वास्थ्य एवं स्वच्छता समिति में कितने सदस्य होते हैं?
    अ. 4 ब. 5 स. 6 द. 7 य. अन्य (बताएं).....
    ..
22. आप को कब पता चला की आप ग्राम स्वास्थ्य एवं स्वच्छता समिति के सदस्य हैं?
    अ. ग्राम स्वास्थ्य एवं स्वच्छता समिति के सदस्य के प्रशिक्षण के समय
    ब. ग्राम स्वास्थ्य एवं स्वच्छता समिति के प्रशिक्षण से पहले
23. ग्राम स्वास्थ्य एवं स्वच्छता समिति की बैठक कब आयोजित की जाती हैं?
    अ. प्रत्येक 15 दिन के बाद
    ब. महीने में एक बार
    स. वर्ष में एक बार
    द. अन्य (बताएं)
    य. नही पता
24. ग्राम स्वास्थ्य एवं स्वच्छता समिति की बैठक कहां आयोजित की जाती हैं?
    अ. आंगनबाड़ी केन्द्र पर

ब. पंचायत प्रतिनिधि के घर पर
स. समिति के किसी भी सदस्य के घर पर
द. अन्य (बताएं)
य. नही पता

25. ग्राम स्वास्थ्य एवं स्वच्छता समिति की बैठक में कौन–कौन सी गतिविधियां होती हैं?

	गतिविधियों के नाम	हां	नही
1	गत माह की बैठक की समीक्षा करना		
2	अनटाइड़ फंड के खर्चे की योजना बनाना		
3	मातृ शिशु स्वास्थ्य व पोषण दिवस की समीक्षा करना		
4	सुनिश्चित करना की समिति ने अपने लक्ष्य को प्राप्त किया की नही		
5	समिति के विभिन्न सदस्यों के कार्य को तय करना		
6	पता नही		

26. समिति की बैठक में आप कौन से मुद्दों को प्राथमिकता देते हैं?
अ. समिति के सदस्यों से जुड़े मुद्दों को
ब. किसी व्यक्ति विशेष से जुडें मुद्दों को
स. समुदाय से जुड़े मुद्दों को

27. समिति के सदस्यों को कितने रुपयें सालाना अनटाइड़ फंड के रुप में प्राप्त होते हैं?
अ. 5000 ब. 7500 स. 10,000
द. 12,500 य. अन्य (बताएं)..... र. पता नही

28. अनटाइड़ फंड का उपयोग किन–किन गतिविधियों के लिए किया जाता हैं?

	गतिविधियां	हां	नही
1	ग्राम स्तर पर स्वच्छता संबंधित अभियान के लिए		
2	ग्राम स्तर पर स्वास्थ्य संबंधित समस्याओं के लिए		
3	मातृ शिशु एवं स्वच्छता समिति के आयोजन के लिए		
4	मातृ शिशु एवं स्वच्छता समिति के प्रचार–प्रसार के लिए		
5	पता नही		

29. आप को मलेरिया के बारें में क्या पता हैं?

	मलेरिया के बारें में	हां	नही
1	ठंड लगकर बुखार आना, उल्टियां, मलेरिया के लक्षण हैं		
2	मलेरिया मच्छर के काटने से होता हैं		
3	खून की जांच करवाकर बीमारी का पता किया जा सकता हैं		
4	कुछ भी नही		

30. आप को टी.बी. के बारे में क्या पता हैं?

	टी.बी. के बारें में पता	हां	नही
1	टी.बी. की बीमारी के अनेक प्रकार पाए जाते हैं, परन्तु ज्यादातर लोगों में फेफेड़ो की टी.बी. पाई जाती हैं		
2	बलगम की जांच से टी.बी. का निदान किया जाता है		
4	क्या आप को DOTs के बारें में पता हैं		
5	कुछ भी नही		

31. गर्भावस्था के दौरान गर्भवत्ती महिला को कौन–कौन सी सुविधाएं दी जाती हैं?

	सुविधाएं	हां	नही
1	गर्भावस्था के दौरान तीन बार ए.एन.एम द्वारा जांच		
2	आयरन फॉलिक एसिड की गोलियां उपलब्ध करवाना		
3	बी.पी.एल. कार्ड धारक महिला को 500 रु. गर्भावस्था के सातवें महिने में देना		

4	जननी सुरक्षा योजना के तहत विभिन्न सुविधाओं का लाभ उपलब्ध करवाना		
5	पता नही		

32. गर्भावस्था के दौरान गर्भवत्ती महिला के लिए जानलेवा स्थितियां कौन–कौन सी हैं?

	मां के लिए जानलेवा स्थितियां	हां	नही
1	गर्भावस्था में/प्रसव के दौरान/ प्रसव के बाद अधिक रक्तस्त्राव होना (खून बहना)		
2	गर्भावस्था में हाथ–पैर में सूजन होना, नाखून होठ, जीभ व चमड़ी पर पीलापन होना, चक्कर आना		
3	रक्तचाप अधिक होना या दौरे पडना		
4	प्रसव के बाद बुखार होना, योनि से बदबूदार पानी निकलना		
5	पता नही		

33. नवजात शिशु के लिए जानलेवा स्थितियां कौन–कौन सी हैं?

	शिशु के लिए जानलेवा स्थितियां	हां	नही
1	जन्म के समय पर नही रोना		
2	2.5 किलोग्राम से कम वनज होना		
3	स्तनपान में कठिनाई होना		
4	सांस तेजी से चलना		
5	पेशाब/मल का त्याग न होना		
6	शिशु का रंग नीला/पीला पडना तथा दौरे पडना		
5	पता नही		

34. बेटी बचाओं अभियान में स्वास्थ्य समिति की क्या भूमिका हैं?

	बेटी बचाओं अभियान में स्वास्थ्य समिति की भूमिका	हां	नही
1	लोगों में बेटी बचाओं अभियान के बारें में जागरुकता फैलाना		
2	गर्भस्थ शिशु का लिंग जांच के दुरुपयोग को कानून की मदद से रोकना		
3	ज्यादा से ज्यादा लोगों को बेटी बचाओं अभियान से जोड़ना		
4	पता नही		