**Scope of Work**

Mentor-Mentee Program

**Roles, Responsibilities of Village Health and Sanitation and Nutrition Committees (VHSNC) and its future scope of opportunities in improving access to care – A Qualitative Evidence Synthesis and Participatory Rural Appraisal**

Right since the Alma Ata Declaration in 1978, community participation is considered as one of core principles of primary healthcare. The government of India under the National Health Mission (NHM) has emphasized on the involvement of local communities in improving access to various national health programs. To facilitate the same in 2005, Village Health Sanitation and Nutrition Committees (VHSNCs) were constituted as a key mechanism to augment health governance in India. VHNSCs are local bodies formed at an revenue village level and act under the Gram Panchayat. They are envisaged as being central to the “local level community health action” under NHM, facilitating decentralized health planning.VHNSCs hold meetings every month at the anaganwadi centre, discussing opportunities for community level action pertaining to health, nutrition, early child development and sanitation. VHSND brings together representatives from different departments including Health and Family Welfare (DHFW), Women and Child Development (DWCD), Social Welfare (DSW), Panchayati Raj Department, Rural Development (RDD), Drinking Water and Sanitation Missions and community level stakeholders including VHSNC members, self-help groups (SHGs), and other Community Based Organizations (CBOs).

However, there are wide disparities in performance of VHSNC across the country. The recent twelfth common review mission,revealed that only fewer VHSNCs are functional, and there is lacunae in clarity of roles and responsibilities of VHSNC members. In addition, the VHSNC meetings are irregular, infrequently organised, and there is poor utilisation of untied funds. Considering the limited evidence and the need to study the roles, responsibilities and future opportunities of VHSNCs, thereby aiding its implementation, our paper intends to fill research gap. In the present review, we aim to systematically review articles that has explored on the roles, responsibilities, functions, good practices of VHSNCs from India, and do qualitative interviews among various stakeholders to venture newer opportunities for its better implementation towards access to health care.

**APPROACH AND METHOD/METHODOLOGY**

**PHASE I:**

***Qualitative Evidence Synthesis:***

**Data source and variables:**

The protocol will be registered in the PROSPERO database. An extensive search in PROSPERO and the Cochrane, will be done to ensure that no similar review protocol has been reported. A preliminary search wasundertaken and found that there are no previous reviews of our similar topic targeting the VHND’s or VHSNCs from India, will also be undertaken.

**Study design**

A Qualitative Evidence Synthesis including all the available evidence exploring the i) roles, ii) responsibilities, and iii) functions of functioning VHSNCs from India. This review will help us synthesize concrete evidence of peer-reviewed articles on functioning and implementation of such community led organisations.

**Eligibility criteria**

**Study type**

Both qualitative/quantitative peer-reviewed studies from India will be included for the review. Furthermore, supportingevidence from other mixed methods studies will also be screened for its eligibility and will be included. In addition, studies using qualitative techniques for data collection such as focussed group discussion (FGD), in-depth interviews (IDI), and Key Informant Interviews (KII), and other Participatory rural appraisal techniques will also be included.

**Outcome**

The phenomenon of interest in our review is to understand the various roles, responsibilities and functioning ofVHSNC’s functioning in India

**Exclusion criteria**

Studies from books/ conference abstracts/ grey literature, correspondence or editorial comments will be excluded

**Search strategy**

A comprehensive and systematic search in databases and search engines such as Medline, Cochrane library, ScienceDirect, EMBASE and Google Scholar will be done. A combination of medical subject heading (MeSH) and free-full text terms will be used for carrying out a literature search. In addition to which, efforts will be made to check the reference list of primary studies to include more articles relevant to our review. The search will be conducted in all the databases from inception of VHSNCs (2005) to August 2021.

**Data Extraction and Management**

After the study selection, two investigators will independently scrutinize the extracted data and retrieve study characteristics into a predetermined data extraction format. Data entry will double-checked for accuracy. As a result, the following study characteristics: general information such as the name of the first author, the state in which the study was done, and year of publication, in the methods section: data collection period, study design, number of VHSNC’s included, study participants, sample size, sampling technique, and data collection procedure. In addition, the roles, responsibilities and functions of variousVHSNC’sfunctioning inIndia will be identified systematically.

**Quality assessment**

Two authors will perform the quality check using the Critical Appraisal Skills Programme (CASP) criteria.This checklist has been widely used for assessing the quality of studies. This will help to determine if the studies to be included are coherent with the quality appraisal standard for qualitative studies or quantitative studies. This checklist consists of 10 questions concerning the study's clarity, methodology, and results to rank the included studies. Subsequently, these studies were stratified into high quality (three stars for studies scoring 8 to 10 points), medium quality (two stars for studies scoring 4 to 7 points), and low rate (one star for studies scoring 0 to 3 points).

**Data Analysis**

The data will be reported as findings as VHSNC’s committee composition,details on the number of meetings held, funding held, ongoing monitoring activities, logistics, scale of activities performed in the last one year towards health nutrition and sanitation, andbest practices followed in VHSNCs. We will adopta thematic framework analysis to analyse and synthesize the data.

**PHASE 2:**

***Qualitativeand Participatory Rural Appraisal:***

Phase II follows Qualitative Evidence Synthesiswhich analyses the roles, responsibilities, and functions. This phase will enable us to identify potential opportunities and best practices followed under the VHSNCs of Tamil Nadu. We will be interviewing various stakeholders of the VHSNCs, exploring the best practices, facilitators, and barriers in implementing the VHSNC framework in Tamil Nadu, the same setting will also be utilized to extract ideas for future opportunities, thereby scaling up VHSNC to improvise access to health care. A series of qualitative interviews with stakeholders from selected districts (preferably Chennai, Kanchipuram and Villupuram – for convenience and time constraints)will be done for the above-mentioned objective. We will also ask the stakeholders regarding the feasibility of implementing the policy measures identified through the review and interviews. And finally,through a participatory rural appraisal technique (Pairwise ranking) will be utilized to extract the priority list of problems identified, and possible solutions for them.

***Identifying key stakeholders:***

Stakeholders from all four levels of functionaries will be invited for thein-depth interviews (IDI). IDIs will be conducted for understanding the implementation of VHSNCs and exploring ideas for future opportunities

State level: Departments of Health & Family welfare, Women and Child development, Sanitation and Rural development

District level: Chief Medical officer, Zila parishad members and District officials

Block level: Block level nodal officers, Child development project officer, Gram panchayat members

Sector level: Community health officers, Lady health visitors, Anganwadi workers, ASHAs

**Interview procedure:**

At least 2-3 in-depth interviews will be conducted from each level among purposively selected group of participants in each district or till the point of data saturation is achieved. An interview guide will be developed after the Qualitative Evidence Synthesisto collect information regarding the best practices, facilitators, and barriers in implementing the program, and to explore future opportunities to expand the services improving access to health care. Efforts will also be madecapture their perception on possible policy measures or recommendations, to overcome the challenges in program implementation. Interviews will be conducted by the trained set of data collectors (research assistants), formally trained in qualitative research.

Interview will commence after explaining the need of the study and formal informed consent. Each interview will last for around 20-30 minutes and will take place through any mode (telephonic, online call, or personal) and place convenient to the study participants. Confidentiality of the information will be ensured. All the interviews will be audio-recorded which will be utilized to make transcripts. Field notes will also be taken during the interview. At the end of the interview, summary will be presented to the participants for validation of the data collected.

**Analysis plan:**

Transcription of the interview will be performed in verbatim format within the same day of interview (to prevent the loss of information). Transcripts will be reviewed by another person to decrease the bias and increase the interpretive credibility. Manual descriptive content analysis will be performed to derive the themes and sub-themes. Codes will be derived using hybrid approach (inductive and deductive). The findings will be reported by using consolidated criteria for reporting qualitative research (COREQ).

**EXPECTED TIMELINE**

The proposed timeline of the study is 2 months and 17 days (September 10 to November 25). The activities and the timeline of doing these activities from day 1 to day 77 (2 months and 17 days) is shown below in the Gantt Chart.

Application, table

Description automatically generated

***Mentor:***

**I kindly request the members of IHSC to assign me a suitable mentor for my research proposal**

**Compensation**

The Consultancy fee for this engagement is USD 5,000(Inclusive of all indirect taxes). The payment will be disbursed in three instalments, in the proportions given below and the consultant should provide the invoice against each deliverable.

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| --- | --- | --- | --- |
| **Instalment** | **Percentage** | **Amount (USD)** | **Deliverable/ Milestone** |
| 1 | 25 | 1250 | On Signing Contract |
| 2 | 25 | 1250 | On submission of literature review and methodology (including stakeholders for a qualitative interview and analysis plan) approved by the Mentor, and |
| 3 | 50 | 2500 | On submission of the final deliverable approved and accepted by the Mentor & AHI Team. |

**Term**

This engagement shall commence upon execution of this Agreement. The Agreement shall continue in full force and is effect from **September 15, 2021** to **December 15, 2021** and is extendable based on the review of Consultant’s performance by the Foundation and mutual concurrence on revised terms of engagement.