

Community Based Monitoring under National Rural Health Mission (NRHM) at Village Level in the State of Maharashtra, India

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ABSTRACT

Background: Government of India, under National Rural Health Mission has established Village Health Sanitation Nutrition Committees (VHSNCs) and selected-appointed Accredited Social Health Activists (ASHAs) in all the villages. Government of India also started Community Based Monitoring (CBM) project through Non-Governmental Organizations (NGOs). State of Maharashtra was one of the nine states selected for implementation of in the pilot project.

Objectives: To assess the effect of training and implementation of CBM on Knowledge, Attitude and Practices of VHSNC members including ASHAs.

Design: It is a descriptive study using comparison group.

Settings: The study was carried out in 90 villages, 45 each from study group and comparison group, in the State of Maharashtra, India.

Interventions: The study was conducted with the help of the Community Medicine Departments from nearby Medical Colleges. From each village one ASHA and three members of VHSNC were interviewed. An assessment instrument was developed having some parameters. Based upon responses to each parameter, a scoring system was also developed. Then comprehensive score was calculated for each respondent.

Main variable: Comprehensive score obtained by the interviewed individual was studied.

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Results: Only 41% ASHAs and 28% VHSNC members were trained in CBM by the concerned

NGOs. The Mean score of ASHAs' was 7.52. The mean score was 6.55 for trained members

of VHSNC trained members was 6.55 and the score was 5.00 for un-trained members.

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Discussion: The interviewed members were lacking in core areas. The members are not ready to take ownership and to monitor services.

Conclusions: The training and implementation of CBM did not have any difference in awareness and active participation of ASHAs. This may be due to improper coverage of training. The training helped VHSNC members in improving score but actual implementation of project did not improve the score.

Key words: Accredited Social Health Activist, Community Based Monitoring, Village Health Committee, Un-Tied Fund

1. INTRODUCTION

In pursuit of enhanced pace towards achievement of Millennium Development Goals and taking into consideration the state of public health, some concrete mechanisms of enhancing the community partnership and accountability of public sector towards the community have been initiated in the National Rural Health Mission (NRHM) across the India since 12 April 2005 [1]. These mechanisms included decentralization of health planning and monitoring responsibility by constituting committees at village, block and district levels. At institutional level, Rogi Kalyan Samitis (Patient Welfare Committees) have been established for various functions purposes have been established. At the community level in rural areas dedicated women have been selected and appointed as Accredited Social Health Activists (ASHAs). They specially function for improving health of the women and children. In addition to these mechanisms Community Based Monitoring project with help of Non-Governmental Organizations (NGOs) had been launched in 9 states in first phase, including the State of Maharashtra. Community Based Monitoring (CBM) in the State of Maharashtra started in the year 2007-2008. A total of 5 districts were selected. Then 3 blocks from each district, from each block 3 Primary Health Centers (PHCs) and 5 villages from each PHC were selected by the state level nodal NGO. The nodal NGO selected district and block level NGOs for actual implementation of the project. Village Health, Sanitation and Nutrition Committee (VHSNC) are constituted in all the villages after

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57 implementation of NRHM. In the committee one representative each from women's' help group and
58 weaker section like Scheduled Cast/ Schedule Tribe is mandatory [2]. Government of India also
59 recommended inclusion of one member nominated by the block level NGO in the VHSNC in CBM
60 project area. All villages are allotted Rs.10,000 per year for carrying out health related activities. The
61 guidelines about expenditure are very flexible and hence the provision is termed as Un-Tied Fund
62 (UTF). VHSNC is expected to monitor expenditure of UTF. Maharashtra State was the first state to
63 include and provide allocation to CBM in Project Implementation Plan of NRHM. Apart Excepting from
64 the reports from implementing Non-Governmental Organizations-NGO's, evaluation studies of the
65 project have not been carried out. After 3 years of implementation, expansion of the project was
66 planned in most of the states by state level nodal NGOs and the governments. In Maharashtra, the
67 State government and NRHM desired to carry out appraisal of the first phase of implementation
68 before expansion. NRHM, Maharashtra sought technical help from State Health System Resource
69 Center (SHSRC) where the investigators were then working. Accordingly the investigators decided to
70 conduct an observational study with comparison group to assess effect of CBM on village level
71 functionaries. Investigators selected village level functionaries not only because they represent the first
72 level contact with the people but also that they are present existing in very large number to which
73 can influence the performance of the project. The two objectives of the study were; to study the effect
74 of training pertaining to CBM on awareness and active participation of members of VHSNC and to
75 study the effect of implementation of CBM process on awareness and active participation of members
76 of VHSNC. Community Based Monitoring CBM revolves around ownership and monitoring of health
77 services. Training and working are the key methods of learning and affecting Knowledge, Attitude and
78 Practices (KAP). Studying KAP status, variations and suggestions for modifications accordingly if
79 needed in the scheme is ought to help better implementation of the process. Given these rationale,
80 we conducted this study with following two objectives : 1) to study the effect of training pertaining to
81 CBM on awareness and active participation of members of VHSNC and 2) to study the effect of
82 implementation of CBM process on awareness and active participation of members of VHSNC.

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2. MATERIAL AND METHODS

2.1 Study Location

85 As per the census 2011 the population of the state is 112.37 million and it is second most populous
86 state after Uttar Pradesh in India [3]. The rural population in the state is 54.67% and which resides in

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43,663 villages. There are six administrative divisions and 35 districts in the State of Maharashtra. CBM **project** was implemented in following five districts; Amravati, Nandurbar, Osmanabad, Pune and Thane. One district was selected from each division excepting one division as Government of India insisted maximum five districts for implementation of the project.

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2.2 Selection of Villages

CBM- Group: **List of villages was obtained under each PHC in which the project was implemented, was obtained**. The villages were arranged alphabetically and one village was selected from each PHC by random number generated using Open-Epi software. Thus ~~in~~ total 45 villages were included in ~~the~~ sample.

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Non-CBM Group: **In each district, the blocks which were not implementing the CBM project were arranged in alphabetical order**. From that list three blocks in the district were ~~then~~ selected using the computer generated random number. From each block, three PHCs and from each selected PHC one village was ~~then~~ selected adopting the identical method. Thus in control group also 45 villages were included in the sample.

2.3 Survey and assessment instruments

Separate questionnaires were prepared by SHSRC and finalized after discussion among the participant coordinators. One questionnaire was prepared to interview the ASHA. Other questionnaire was prepared for interviewing the VHSNC member. The questionnaire assessed awareness and active participation pertaining to key aspects like village health plan, village health calendar, functioning of VHSNC and Un-Tied Fund (UTF) ~~etc.~~ [34]. **From Based on the information obtained after from the interviews, distinct assessment instruments having 12 and 10 parameters for ASHAs and VHSNC members respectively were developed. Scoring system for the possible responses to each parameter was decided. The assessment instrument and the system of scoring based on the information obtained from the personal the interviews of ASHAs is given in table annex 1. Similarly The assessment instrument and scoring system based on the information obtained from the interviews of the VHSNC members, other scheme of scoring was developed and it is given in annex table 2. The total was considered as comprehensive score and was calculated for each respondent.**

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2.4 Process and analysis

Department of Community Medicine of ~~the~~ nearest medical college was involved as coordinating agency for carrying out the study. Professor and Head of the Department was **nominated as**

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117 District Chief Coordinator for that district. The State Health System Resource Center (SHSRC) is
118 located in Pune; hence study of that district has been undertaken by the team from SHSRC. The
119 design of the study was developed seeking active help from the state level nodal NGO which is also
120 located in Pune. The authors conducted the study with cooperation from the NGOs implementing the
121 project at block, district and state levels. The study was planned and conducted in 2010-2011.

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122 From each selected village following four members from VHSNC were selected for interview: (1)
123 ASHA, (2) Sarpanch (elected peoples' representative heading local self-government), (3) and two other
124 members of Village Health, Sanitation and Nutrition Committee (one female member representing self-
125 help groups of women and (4) one member from Scheduled Cast/ Schedule Tribe category which are
126 identified communities. These communities, that are socially segregated and are usually from lower
127 socio-economic class) were interviewed. The district chief coordinators identified suitable team
128 members, based on availability and willingness, if there were more than one eligible member. VHSNC
129 members were interviewed by post graduate students from Community Medicine Department. They
130 were trained prior to data collection. In the field visits they were supervised by their teachers. Each
131 village was visited twice. Prior intimation was given to the persons to be interviewed were given prior
132 intimation through concerned Block Health Officer/Medical Officer of Primary Health Center.
133 The information collected by the teams was filled entered in the computer by the trained data entry
134 operators and was checked by SHSRC. Analysis was done using SPSS and Excel statistical
135 package. Investigators used 't' and χ^2 test and considered $P=0.05$ or less as significant level. The
136 proposal received clearance from Ethical Committee of State Health System Resource Center,
137 NRHM, Government of Maharashtra.

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138 3. RESULTS

139 In all the 45 villages in both the groups VHSNCs were established and one member nominated by
140 CBM implementing NGO was included in the respective VHSNC. Monthly meetings of the VHSNCs
141 were expected but were never conducted as per schedule. Quarterly reports were almost not
142 never sent to PHCs. Interviews were planned for 90 ASHAs, however in four villages (1 in CBM
143 category and three in non-CBM category) ASHAs could not be contacted due to various reasons like
144 vacancy, illness etc. Only 18 out of 44 (i.e. 40.9%) ASHAs from CBM category of villages
145 acknowledged that they had received some training in CBM. The duration of training varied

from 1-3 days. The summary of marks scored by the ASHAs as per the **developed scoring** system is shown in **table 13**. The average marks obtained by an ASHA were 62.67%. The difference between the average marks scored by the ASHAs in CBM and non-CBM category of villages **was** marginal and **was** ~~is~~ statistically not ~~statistically~~ significant. ($t = 1.377$, $P = 0.17$). Similarly, the difference in the average marks scored by trained and untrained ASHAs ~~is~~ ~~was~~ also marginal and ~~statistically~~ not ~~statistically~~ significant. ($t = 0.0849$, $P = 0.40$). A total of 54 members of VHSNC were expected to be interviewed from each district. However this target could not be achieved in three districts namely Osmanabad, Pune and Thane. Overall 95.18% VHSNC members were interviewed. There ~~is~~ ~~was~~ no significant difference ($\chi^2 = 9.326$, $P = 0.053$) in ~~the~~ district wise training status of the VHSNC members.

No member from Scheduled Caste and Scheduled Tribe category was available for interview in Nadurbar and Osmanabad district respectively. Coverage of "Sarpanch" (excepting Pune) and "female members of self-help group" was 100% in all districts. In Pune district "Sarpanch" and SC/ST category members could not be contacted and interviewed leading to lowest coverage of 81.48% in that district. Out of the 128 VHSNC members interviewed from selected CBM villages, only 28.1 % had received any training of CBM. The district wise details are given in **table 24**. The duration of training varied from 1-7 days. The marks scored by the member of VHSNCs are given in **table 3-5**. The average marks of obtained by VHSNC member were 52.10%. The difference between the average marks scored by the VHSNC members from CBM implementing and CBM-non implementing villages is statistically not significant ($t = 0.433$, $P = 0.67$). However, the difference between the average marks scored by the trained and untrained VHSNC members is statistically significant ($t = 3.408$, $P < 0.001$). For identifying the areas which need more attention analysis of scoring in various aspects was carried out. The points emerged after analyses of the forms were as follows:

1. Village health plan and role of VHSNC members in it.
2. Village health calendar and its importance.
3. Un-Tied Fund and its utilization.
4. Common agenda points that need be discussed in the VHSNC meetings.

4. DISCUSSION

The project of community based monitoring identified broadly two approaches of monitoring. The first approach is monitoring at administrative **geographical** units like village, block, district and state and the

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175 second is monitoring at institution particularly Primary Health Center. In both the approaches separate
176 committees have been advocated. The project functions on triangulation process between
177 community, Non-Government Organizations/Community Based Organizations and Panchayati Raj
178 Institutions (local self-governments). Enormous importance is placed on involvement of village level
179 functionaries to ensure assured health services under NRHM. The reasons are obvious. The health
180 indicators are poor in rural area and the rural population still is substantially higher (68.84%) than the
181 urban population as per 2011 census. While describing the status of public health in NRHM initial
182 document, it has been pointed that lack of community ownership of public health programs influences
183 levels of efficiency, accountability and effectiveness [1]. Adequate emphasis is given to monitoring
184 and evaluation. Apart from routine monitoring from the health department, the additional component in
185 the form of CBMs as a project has been introduced. It was expected that it would serve at least two
186 purposes: firstly it would enhance community ownership and secondly would establish a
187 good monitoring system with accountability. Investigators developed simple and comprehensive tools
188 to assess effect of CBM. The assessment instrument incorporated the core aspects mentioned in the
189 managers' manual developed for CBM [34]. The implementing NGOs carried out the all expected
190 steps including training [4, 45]. The trainees included ASHAs and VHSNC members. The poor training
191 response from VHSNC members was also observed by the implementing nodal agency [56]. There
192 were many interactive sessions between implementing NGOs and VHSNC members. The response
193 for inclusion in VHSNC improved only when they felt that the process may offer them some political
194 benefit. There was no uniformity in the duration of the training in both the categories. After inquiry with
195 the NGOs about the poor performance in the training process of the ASHAs, investigators learnt that it
196 was largely because of the recent elections held for Gram-Panchayat (local self-government) and
197 subsequent election of new members to the VHSNCs. Most of the ASHAs were involved directly or
198 indirectly in the election process. It appears that absence of statistically significant difference in the
199 average marks in the CBM and non-CBM categories of villages is due to the presence of large
200 number of untrained personnel in the CBM category. It may however be noted that even in CBM
201 category, the trained VHSNC members the mean score was 6.55 (maximum score = 10) which is
202 lesser than mean score obtained by ASHAs. This difference is obviously possibly due to formal
203 training in health, a person has to undergo before appointment as ASHA. The rise in score due to

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204 training among ASHAs (0.61) and among VHSNC members (0.55) was almost similar, but the
205 difference was significant among later because of their large number.

206 For the first time ~~some amount of money in the form of UTF for carrying out health related~~
207 ~~activities~~ ~~shas been~~ kept at the disposal of the committee. ~~b~~But even the members ~~weare~~ not aware
208 and do not utilize as desired. It ~~hasbeen was~~ perceived by many VHSNC members that the UTF ~~is~~
209 ~~was~~ primarily meant for management of malnutrition in children in Anganwadi since the UTF accounts
210 at village are maintained by the Anganwadi worker. ~~Similar~~ ~~P~~problems pertaining to ~~utilizationof~~ UTF
211 were ~~similarly~~ observed in exactly 45 villages from three districts in Jharkhand [67]. The state nodal
212 agencies in their published reports [65,87] have shown some positive changes. Investigators believe
213 they are basically because of before- after design. All these members of the committee are non-
214 technical persons are not exposed earlier to health related trainings. All the points identified as lacking
215 areas are core components of CBM process and all the village level functionaries were deficient in the
216 core aspects. The members are not sure about their role. The opportunity of monitoring as well
217 planning health of the village is not utilized to full extent. ~~We suggest that before expansion of the~~
218 ~~scheme, modifications in content of training material, standardization of duration of training and more~~
219 ~~emphasis on the identified aspects~~ may be carried out. There can be interaction meetings between
220 excellently functioning VHSNCs and poorly functioning VHSNCs.

221 4.1. Limitations

222 Investigators did not include ~~any~~ outcome variables including the availability and status of
223 village report card in the study.

224 CONCLUSIONS

225 There was no difference in comprehensive score about knowledge, attitude and practices
226 among all the groups ~~excepting~~ ~~except~~ difference between trained and untrained VHSNC members. It
227 indicates that synergistic effect is absent between institutions established under NRHM and additional
228 institution of CBM. The comprehensive score was low in VHSNC members. The village level
229 functionaries are not playing expected role which may have direct effects on the ~~health~~ outcome
230 variables. Probably the reason is the large number of untrained persons in both the categories.
231 Absence of uniformity of duration of training and adequate emphasis on core aspects ~~isare~~ also
232 contributory factors. Many NGOs are involved in the CBM project and hence may not deliver the
233 expected result at every place.

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COMPETING INTERESTS

Authors declare Nil/no competing interests.

AUTHORS CONTRIBUTION

This work was carried out in collaboration between both the authors. Both the authors contributed to the study conceptualization and design. PPD finalized the design and contributed to writing of the article, analysis and interpretation of the data. APK conducted field visits.

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<u>Item</u>	<u>Marks</u>
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<u>1</u>	<u>Is she is aware about the health plan of the village</u>	<u>Y=1, Else 0</u>
<u>2</u>	<u>Mentions at least one element in the health plan</u>	<u>1, Else 0</u>
<u>3</u>	<u>Is she aware of village health calendar</u>	<u>Y=1, Else 0</u>
<u>4</u>	<u>Mentions correctly where the calendar is displayed</u>	<u>1 if correct, Else 0</u>
<u>5</u>	<u>Mentions correct frequency of meetings of VHSNC</u>	<u>1 if correct, Else 0</u>
<u>6</u>	<u>Attended at least one meeting of VHSNC</u>	<u>1 if YES, Else 0</u>
<u>7</u>	<u>Says has raised at least one issue in VHSNC meeting</u>	<u>1 if YES, Else 0</u>
<u>8</u>	<u>Aware of UTF for village</u>	<u>1 if YES, Else 0</u>
<u>9</u>	<u>Mentions correct amount of UTF for the village</u>	<u>1 if correct, Else 0</u>
<u>10</u>	<u>Mentions at least one purpose for which UTF can be used</u>	<u>1 if mentioned, Else 0</u>
<u>11</u>	<u>Mentions financial assistance to needy patient as one of the purposes of UTF</u>	<u>1 if mentioned, Else 0</u>
<u>12</u>	<u>Has recommended at least one item for expenditure from UTF</u>	<u>1 if recommended, Else 0</u>
	<u>Maximum</u>	<u>12</u>

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Table 1. Scheme of scoring of ASHAs based on the information obtained in personal interview

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S. No.	Item	Marks
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300 Table 1. Scheme of scoring of ASHAs based on the information obtained in personal interview

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1	Is she is aware about the health plan of the village	✓=1, Else 0
2	Mentions at least one element in the health plan	1, Else 0
3	Is she aware of village health calendar	✓=1, Else 0
4	Mentions correctly where the calendar is displayed	1 if correct, Else 0
5	Mentions correct frequency of meetings of VHSNC	1 if correct, Else 0
6	Attended at least one meeting of VHSNC	1 if YES, Else 0
7	Says has raised at least one issue in VHSNC meeting	1 if YES, Else 0
8	Aware of UTF for village	1 if YES, Else 0
9	Mentions correct amount of UTF for the village	1 if correct, Else 0
10	Mentions at least one purpose for which UTF can be used	1 if mentioned, Else 0
11	Mentions financial assistance to needy patient as one of the purposes of UTF	1 if mentioned, Else 0
12	Has recommended at least one item for expenditure from UTF	1 if recommended, Else 0
Maximum		12

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Table 2: Scheme of marking for VHSNC members

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S. No.	Item	Marks
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1	Is the member aware about the Village Health Plan? (VHP)	
2	Is the member able to tell at least one element in latest VHP of the village?	
3	Is the member aware about Village Health Calendar? (VHC)	
4	Is the member able to tell where the VHC is displayed?	
5	Is the member able to tell correct frequency of the meeting of VHSNC?	
6	Has the member attended at least one meeting?	
7	Is the member able to tell at least one issue discussed in meeting of VHSNC?	
8	Is the member aware of UTF for village?	
9	Is the member able to tell correct amount of UTF for village?	
10	Has the member recommended at least one item for expenditure from UTF?	
	Maximum	10

For all questions; 1 if yes, Else 0

Table-3. Summary of scores of ASHAs as per the scheme

Category	N	Mean	SD	t	DF	P
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GBM	44	7.90	2.60				
Non-GBM	42	7.11	2.71	1.377	84	0.172	
Total	86	7.52	2.67				
Training	N	Mean	SD	t	DF	P	
Trained	18	8.00	2.47				
Un-trained	68	7.39	2.72	0.849	84	0.398	
Total	86	7.52	2.67				

Table 4. District wise proportion of trained VHSNC members

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District	Total	Received training (%)
Amravati	27	3 (11.1)
Nandurbar	27	7 (25.9)
Osmanabad	26	11 (42.3)
Pune	24	10 (41.7)
Thane	24	5 (20.8)
Total	128	36 (28.1)

Table 5. Summary of marks scored by VHSNC members

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Category	N	Mean	SD	t and DF	P
GBM	128	5.28	2.56	0.433, 255	0.665
Non-GBM	129	5.14	2.62		
Total	257	5.21	2.59		
Training	N	Mean	SD	t and DF	P
Trained	36	6.55	2.17	3.408, 255	<0.001
Untrained	221	5.00	2.59		
Total	257	5.21	2.59		

Annex 1. Scheme of scoring of ASHAs based on the information obtained in personal interview

<u>S. No.</u>	<u>Item</u>	<u>Marks</u>
<u>1</u>	<u>Is she is aware about the health plan of the village</u>	<u>Y=1, Else 0</u>
<u>2</u>	<u>Mentions at least one element in the health plan</u>	<u>1, Else 0</u>
<u>3</u>	<u>Is she aware of village health calendar</u>	<u>Y=1, Else 0</u>
<u>4</u>	<u>Mentions correctly where the calendar is displayed</u>	<u>1 if correct, Else 0</u>
<u>5</u>	<u>Mentions correct frequency of meetings of VHSNC</u>	<u>1 if correct, Else 0</u>
<u>6</u>	<u>Attended at least one meeting of VHSNC</u>	<u>1 if YES, Else 0</u>
<u>7</u>	<u>Says has raised at least one issue in VHSNC meeting</u>	<u>1 if YES, Else 0</u>
<u>8</u>	<u>Aware of UTF for village</u>	<u>1 if YES, Else 0</u>
<u>9</u>	<u>Mentions correct amount of UTF for the village</u>	<u>1 if correct, Else 0</u>
<u>10</u>	<u>Mentions at least one purpose for which UTF can be used</u>	<u>1 if mentioned, Else 0</u>
<u>11</u>	<u>Mentions financial assistance to needy patient as one of the purposes of UTF</u>	<u>1 if mentioned, Else 0</u>
<u>12</u>	<u>Has recommended at least one item for expenditure from UTF</u>	<u>1 if recommended, Else 0</u>
	<u>Maximum</u>	<u>12</u>

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Annex 2. Scheme of marking for VHSNC members

<u>S. No.</u>	<u>Item</u>	<u>Marks</u>
<u>1</u>	<u>Is the member aware about the Village Health Plan? (VHP)</u>	
<u>2</u>	<u>Is the member able to tell at least one element in latest VHP of the village?</u>	
<u>3</u>	<u>Is the member aware about Village Health Calendar? (VHC)</u>	
<u>4</u>	<u>Is the member able to tell where the VHC is displayed?</u>	
<u>5</u>	<u>Is the member able to tell correct frequency of the meeting of VHSNC?</u>	
<u>6</u>	<u>Has the member attended at least one meeting?</u>	
<u>7</u>	<u>Is the member able to tell at least one issue discussed in meeting of VHSNC?</u>	
<u>8</u>	<u>Is the member aware of UTF for village?</u>	
<u>9</u>	<u>Is the member able to tell correct amount of UTF for village?</u>	
<u>10</u>	<u>Has the member recommended at least one item for expenditure from UTF?</u>	
	<u>Maximum</u>	<u>10</u>

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385 For all questions; 1 if yes, Else 0

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Table 1. Summary of scores of ASHAs as per the scheme

<u>Category</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>t</u>	<u>DF</u>	<u>P</u>
<u>CBM</u>	<u>44</u>	<u>7.90</u>	<u>2.60</u>			
<u>Non-CBM</u>	<u>42</u>	<u>7.11</u>	<u>2.71</u>	<u>1.377</u>	<u>84</u>	<u>0.172</u>
<u>Total</u>	<u>86</u>	<u>7.52</u>	<u>2.67</u>			
<u>Training</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>t</u>	<u>DF</u>	<u>P</u>
<u>Trained</u>	<u>18</u>	<u>8.00</u>	<u>2.47</u>			
<u>Un-trained</u>	<u>68</u>	<u>7.39</u>	<u>2.72</u>	<u>0.849</u>	<u>84</u>	<u>0.398</u>
<u>Total</u>	<u>86</u>	<u>7.52</u>	<u>2.67</u>			

430 Table 2. District wise proportion of trained VHSNC members

<u>District</u>	<u>Total</u>	<u>Received training</u> <u>(%)</u>
<u>Amravati</u>	<u>27</u>	<u>3 (11.1)</u>
<u>Nandurbar</u>	<u>27</u>	<u>7 (25.9)</u>
<u>Osmanabad</u>	<u>26</u>	<u>11 (42.3)</u>
<u>Pune</u>	<u>24</u>	<u>10 (41.7)</u>
<u>Thane</u>	<u>24</u>	<u>5 (20.8)</u>
<u>Total</u>	<u>128</u>	<u>36 (28.1)</u>

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Table 3. Summary of marks scored by VHSNC members

<u>Category</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>t and DF</u>	<u>P</u>
<u>CBM</u>	<u>128</u>	<u>5.28</u>	<u>2.56</u>	<u>0.433, 255</u>	<u>0.665</u>
<u>Non-CBM</u>	<u>129</u>	<u>5.14</u>	<u>2.62</u>		
<u>Total</u>	<u>257</u>	<u>5.21</u>	<u>2.59</u>		
<u>Training</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>t and DF</u>	<u>P</u>
<u>Trained</u>	<u>36</u>	<u>6.55</u>	<u>2.17</u>	<u>3.408, 255</u>	<u><0.001</u>
<u>Untrained</u>	<u>221</u>	<u>5.00</u>	<u>2.59</u>		
<u>Total</u>	<u>257</u>	<u>5.21</u>	<u>2.59</u>		

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