Public Provisioning of Health and Decentralisation in Gujarat

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This paper presents primary data collected from two districts of Surat and Kutch in Gujarat and examines how and to what extent the decentralised system of governance has contributed to delivery of health services in rural areas of Gujarat. It finds several lacunae and shortcomings in the delivery by panchayati raj institutions of public health programmes.

A look at India’s history since Independence tells us that panchayati raj institutions (PRIs), in their current form, were born in the Nehruvian era as vehicles of development. They were set up in some states in the 1950s essentially to increase the efficiency and efficacy of the community development programmes. Agencies like the District Rural Development Agency (DRDA) were also later established for effective implementation of centrally-sponsored development programmes. However, it was soon realised that the community development programme could not be implemented without the engagement of people and local communities. Over the years, the failure of these models of top-down planning and implementation has been acknowledged and appraised (Shah and Agja 2007). In the 73rd and 74th Constitutional Amendment Acts (CAA) of 1992, that conferred constitutional status to the three-tier structure of the federation, many of the shortcomings have been addressed.

Interestingly, a nation that took no time to realise the need for a third-tier of government took more than 40 years to make a strong legal provision for its effective implementation and is still struggling to operationalise it.

The ever-changing scope of functions of these institutions has resulted in confusion regarding distribution of powers as well as the relationship between governments at various levels. The 73rd Constitutional Amendment Act, 1992 envisages people’s participation in decision-making, implementation and delivery of services to better address issues of people at the grass roots. In order to achieve this objective, it provides for devolution of power to the panchayats. Devolution necessitates the creation of independent units of government with the necessary authority and resources (Harsha 2005). Operationalisation of devolution is the responsibility of the state governments. This means that resources from the centre and the state, meant for programmes falling within the jurisdiction of PRIs, must be directly allocated to these institutions along with powers to take decisions in matters designated to them. The responsibility for devolving functions, functionaries and finance related to 29 subjects of rural development to the panchayats lies with the state governments. Thus, the authority to assess needs, make decisions, allocate funds, monitor the functioning of institutions and individuals would lie with the panchayats at the village, block or district levels, gram sabhas or meetings of all adults who live in the area covered by a panchayat, function as social accountability mechanisms.

The rationale for establishing a three-tier structure is very strong but has met with tough resistance, both in terms of ideas and practice. The rationale is that the elected representatives...
being from the community have a realistic understanding of the people's needs and preferences and if empowered with the necessary tools have the potential to become vehicles of social change. Democratisation of the PRI ensures that all sections of society are represented and the issue of equity is addressed. Compulsory participation of women and marginalised communities ensures that the system slowly but steadily becomes more sensitive to their existence as well as needs. Giving greater authority to the field staff solves problems of formulation and implementation of realistic and effective plans, reduces red-tapism, bureaucratic delays and bad targeting (Sylendra 2010). The capacity of the field staff develops while the top administration can engage itself in better policy formulation and more careful monitoring of programmes. With people's participation and their increased stake in development, not only do transparency and accountability go up but there is better channelisation of people's needs through politics. It is also argued that proximity encourages better monitoring and enforcement (Hammer et al 2006).

This paper examines how and to what extent the decentralised system of governance has contributed to delivery of health services in rural areas of Gujarat. Literature (Bandi 2011; IRMA 2007-08; Unnati nd) on the state of devolution in Gujarat is available but little is known about how the health concerns of people are dealt with by the PRIs. Health is one of the 29 development subjects listed in the CAA to be devolved by the state government to the panchayats. Health includes matters of drinking water, sanitation, family welfare and epidemics. The Gujarat Panchayat Act, 1993 makes provisions in line with the central act devolving functions like oversight of primary health centres (PHCs), sub-centres and anganwadis to zilla, taluka and village panchayats, respectively. Functionaries of various line departments are expected to function out of the zilla or taluka panchayats and also be accountable to them. Village health and sanitation committees (VHSCs) have been recommended to be established in each village to function as advisory/regulatory bodies to the village panchayats in matters of planning, finances and monitoring.

Objective and Research Questions
In the context of health, the role of the PRI is to (a) bridge the gap between the existing healthcare providers and the people needing the services; (b) make health services responsive to the needs of the people; (c) be accountable to the people by making the process participatory; and (d) focus on local problems (bottom up approach) and prioritise them. In the process the PRI should be able to generate public demand for services, ensure their quality and use the available resources (financial and other) efficiently. Also, coordination between the existing health facilities and their functionaries (such as the auxiliary nurse midwife (ANM) at sub-centre and medical officers and other staff at PHCs) is envisaged. Further, since the launch of the National Rural Health Mission (NRHM) in 2005, services such as of ambulance by calling the telephone number 108, encouraging and ensuring that women deliver their babies in health institutions to control maternal mortality, and ensuring that all children receive basic child

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<td>Presenting a range of approaches, views and conclusions, this collection comprises papers published in the Economic and Political Weekly between the late 1990s and 2008 that are marked by an empirical awareness necessary for an understanding of a growth history. The articles reflect a certain groundedness in their approach in that they privilege content/context over methodology.</td>
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**Readings on the Economy, Polity and Society**

This is the first book in a new series jointly published by EPW and Orient Blackswan. The series is being published as part of a University Grants Commission project to promote teaching and research in the social sciences in India. The project (2010-12) is being jointly executed by the Tata Institute of Social Sciences, Mumbai, and the Economic and Political Weekly. The series is meant to introduce university students and research scholars to important research that has been published in EPW in specific areas. The readers draw on the EPW’s archive of published articles.

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immunisation have been made widely available in rural areas and are placed under PRI. The underlying rationale is that health services should be responsive to the needs of the people and be accountable to them by making the process participatory.

The questions to which we sought answers to were: have health services in rural areas improved? Is there coordination between health department and panchayat? Are all people, especially the marginalised groups and women, able to articulate their health needs and participate in decision-making as well as in programme implementation? Instead of the top-down approach, has the focus shifted to local problems? Are the immediate concerns of people, such as village sanitation and access to safe drinking water prioritised and attended to while ensuring the quality of services? How were the untied funds at the disposal of the VHSC spent? While interacting with the health functionaries, we also probed into the demands made by the community and the hindrances faced by them in meeting the demands.

Methodology

The paper presents primary data collected from two districts of Surat located in south Gujarat and of Kutch in Saurashtra region. The reason for selecting these two districts was that while Surat, in spite of having close to 30% of an adivasi population, is perceived as a progressive district and its health indicators are supposed to be quite good, Kutch is a backward district with poor socio-economic indicators, including those of health.

In order to understand whether the devolution of functions, functionaries and finance has led to better healthcare services for the rural citizens in Gujarat, we conducted in-depth interviews of health and panchayat members, focus group discussions (FGDs) with health workers, panchayat members and community members. Additionally, we also attended training of the VHSC in a Kutch village. The research methodology was thus qualitative in nature.

The field visits to villages, purposively selected, in Kutch and Surat, were made during June 2010. In Surat district, the long-standing association with a research institution was tapped to identify the two villages that were selected for fieldwork. In Kutch the selection was done in consultation with a non-governmental organisation (NGO) working for more than five years with women panchayat members in the district.

In Surat, we held discussion with VHSC members in a sub-centre. Eight of the 11 members were present (two teachers and deputy sarpanch were not present). We also conducted one FGD with women in the same village. In all, about 15 women participated in the discussion throughout. However, an equal number came at the beginning, stayed for a shorter period and left halfway through the FGD. It was not possible to control this behaviour. No health functionary or the other members of the VHSC was allowed to remain present during the FGD. Towards the end, they were allowed to join the discussion.

In Kutch, the NGO organised for us to conduct a FGD with the panchayat, VHSC and other health functionaries in the block headquarters. These functionaries came from 16-18 villages of the block. Nearly 25 of them were present during the FGD. Given this rather large number, the discussions continued for more than two and half hours. In addition, we interviewed the panchayat and health officials in Bhuj in Kutch district and in Surat city, and those in the block headquarters in both the districts.

The study is based on limited qualitative data and the inferences or findings are at best tentative or more in the nature of hypotheses requiring further in-depth larger studies. Since the selection was purposive and recommended by our contacts in both the districts, it is possible that we have selected “good” villages in terms of the presence of health personnel who are actively involved in the communities. The real situation could be quite different.

Findings

Based on the discussions in the FGDs with the community members and with the PRI functionaries and in-depth interviews, the findings, questions and challenges are grouped under the three important arms of the PRI – functions, functionaries and finances. Questions addressed relate to the extent functions and finances meant for health are devolved to the panchayats, the extent to which the health functionaries are entrusted with responsibilities, trained and made accountable to the gram sabha or the community to carry out the functions and whether relevant bodies or committees are constituted to carry out the functions.

Health-related Structure and Functions

Health and population stabilisation are included among the various development activities assigned to the PRIs since 1993 but they were operationalised only around the middle of the first decade of this century. Until then, PRIs were neither equipped to take health planning and monitoring functions nor did the health system see a role for PRI in healthcare delivery. Both the National Population Policy 2000 and the National Health Policy 2001, recognised and reiterated the need for decentralisation and convergence of health service delivery at the village level and for the PRI to be the key and appropriate agency for the purpose. It was in August 2003, that the central council of ministers of health and family welfare resolved “that the States would involve PRI in the implementation of health and family welfare programmes by progressive transfer of funds, functions and functionaries, by training, equipping and empowering them suitably to manage and supervise the functioning of healthcare infrastructure and manpower”.

The NRHM acknowledged that local governance institutions alone can ensure provision of preventive and promotive health interventions to the vulnerable and marginalised population. The role of the PRI has been engineered into the basic structure of the NRHM, which has refrained from creating parallel mechanisms, and instead, provide scope for the existing social infrastructure to be used and strengthened. PRIs are, therefore, seen as critical to the planning, implementation and monitoring of health delivery and meeting the NRHM goals. The gram sabha is expected to act as a community level accountability mechanism to ensure that people’s health needs are met. The structure created in every village as a representative body to coordinate the health delivery is the VHSC. It is constituted to function as a link between the gram panchayat and the community.
The VHSC along with the PRI functionaries identifies a local woman resident – Accredited Social Health Activist (ASHA) – to facilitate healthcare seeking and also serve as a depot holder for basic medicines. She is a member of VHSC along with the ANM, the anganwadi worker (AWW), schoolteacher, members of local community-based organisations, such as self-help groups (SHGs), etc. The ASHA’s job is to identify and provide services, to the extent she can, to people in need of reproductive and child healthcare, which range from provision of family planning services and immunisation for both children and pregnant women. Additionally, she is also expected to assist the ANMs in programmes for vector-borne diseases, blindness, TB control programmes, etc., and is reimbursed on a performance-based remuneration plan.

In both the districts, under the PRI VHSCs have been constituted. The VHSCs in most villages had nine to 11 members that included the sarpanch, ANM, schoolteacher, the ASHA, etc. However, the officials admitted that most of them were very new and therefore not fully operationalised. Although the circular to form VHSCs as per the NRHM guidelines was issued in Gujarat in 2007 and therefore the ASHAs were identified only since then, the VHSCs had not become fully functional. The untied fund of Rs 10,000 that was sanctioned for each VHSC had been released only once so far towards the end of the financial year 2009-10.

The ground reality in both the districts was very different as evident from the interactions with the functionaries and community members.

In Surat, the perceptions and responses of the community members and of the functionaries about the functions performed by the VHSCs were very different. The majority of the women we talked to during FGDs, were not even aware that VHSCs have been formed in their village. Therefore, they had no idea about their specific functions. When asked what their immediate health needs were, the group indicated that their priority was the provision of potable drinking water; the need for it was articulated again and again. However, they also felt that water was not the priority of the panchayat or the village leaders. The women’s claims were backed by the fact that they were completely unaware of who their panchayat members were, let alone women members. They knew of a gram sabha but some women members knew of it when panchayat functionaries visited them at home to get their thumb impressions. In spite of our probing about their health needs or concerns other than availability of drinking water, the discussion kept coming back to the water issue. The upper caste/class community of the village had a reverse osmosis plant while the tribal women failed to make their demands for chlorine tablets heard. They did not perceive any change or improvement in the healthcare services available to them even after the VHSCs were set up.

The health department has continued to provide certain health services such as antenatal care, immunisation, etc, to the people through the ANMs posted at sub-centres. There was no change or improvement in the routine health services that the villagers received. In fact, it was surprising that the women we talked to in FGD did not even know that a village woman was identified as an ASHA worker who was supposed to be a link between the community and the health system and who must ensure that all in need of various health services should be able to access them. In fact, we learnt that the ANM of the sub-centre in the Surat village along with other functionaries from the PHC, had identified a local woman as the ASHA. Neither the PRI functionaries nor the gram sabha had any role in identifying the ASHA. The caste politics or dynamics appeared to be the determining factor in identifying the ASHA, who was a quiet woman and had very little idea about the scope of her work or that of the VHSC and had to be prompted by the multipurpose health workers (male and female) even while responding to some of our queries.

However, in Kutch, the situation appeared to be quite different although admittedly, our interaction with the community was very limited. The local NGO appears to have been quite active in identifying potential candidates as ASHAs from several villages (which includes some literate traditional birth attendants (TBA)s) as well and recommending them to the sarpanch and other functionaries of the PRIs. Several ASHAs described how they were identified by the NGO and the community, could tell us the specific tasks they performed, how many women in their villages had accessed their services and even shared with us specific details of some of their encounters and experiences.

The ASHAs in Kutch knew the activities with which payments were linked and therefore ensured that pregnant women in their villages were registered, received the antenatal check-ups, including tetanus toxoid injections, and children received the routine vaccinations. They saw their work as a successful business model, where every activity they performed brought in remuneration. They further ensured that women (especially those belonging to below poverty line) delivered their babies in institutions to take advantage of the various schemes designed for the purpose such as Janani Suraksha Yojana (JAY) and Chiranjeevi Yojana. Thus, they had become quite adept at discharging those health functions to which incentive monetary payment was linked. To the question, if any woman complained to them about reproductive tract infections such as white discharge, how the ASHA worker would deal with it, evoked no response, except indicating that for such problems women would generally consult private practitioners and thus they had no role. It was evident that an ASHA worker can easily earn around Rs 2,000 a month as remuneration.

Functionaries and Training
The NRHM administers three-day training for VHSC members at the taluka level. In Gujarat, the training for them was initiated only in 2010 on a pilot basis. Kutch was selected as one of the two districts where the training was conducted through local NGOs. Kutch Mahila Vikas Sangathan (KMVS), which is a women’s organisation, was chosen to impart training in 212 villages out of
nearly 900 villages of Kutch. Two other NGOs were identified who between them were responsible for training the VHSC members in the remaining villages.

The purpose of the training was to orient the VHSC members about the functions of a VHSC, their role as members, sharing experiences and providing information on routine tasks. Emphasis was laid on community monitoring of health services, and informing them about the various health delivery institutions in their area. The training given to the VHSC members by KMVS also focused on informing them about mundane issues such as how to select members of VHSC, how frequently to hold meetings and need for quorum, formation of subcommittees, their role and functions. The training seemed to have made a difference in the outlook of the various members of VHSC with whom we interacted. In the words of one ASHA worker:

After our training with KMVS, we realised that no women from our village were part of the VHSC, but men and women from the neighbouring village were. This error had occurred since VHSCs were formed for revenue Panchayats and our village is a joint Panchayat. Women from the Sahiyar Federation ( floated by KMVS) got together and appealed to the Panchayat, nominated members and a new 11 member VHSC was formed.

Given the relatively low literacy level among women in this region, the NGO had helped a few active TBAs with schooling less than the stipulated under the norm, to become ASHAS and taught them to maintain accounts. A few TBAs present in the focus group indicated that they no longer conduct deliveries at home but instead help women to go to government facilities by calling the 108 ambulance service and help poor women to get money under the schemes launched for institutional delivery. During the FGD, most of the issues raised related to women’s reproductive health and child health. Both the panchayat members and the ASHAS narrated their experiences about the measures that they had taken to provide health services to poor migrant labourers from other states, or to women who needed emergency care. Health concerns of the whole community such as sanitation and water were not brought up during the discussions.

Majority of the panchayat members, TBAs and ASHAS were very critical of the functionaries working in the public health system. According to them, nurses or ANMs were not regularly available, quality of service was low, records were not maintained properly, skills as well as motivation were low and some even charged for the services. One TBA narrated an incident where the ANM did not record against the names of the children all the vaccines she was administering.

I had taken an infant for immunisation when the ANM mistakenly tried to administer the same vaccine dose twice to the child. The illiterate mother did not understand enough to point it out to the nurse but I insisted that the child was given the vaccine just five minutes ago. Why are you giving the same injection again to the child?

In another case, the pregnancy registration card was not filled up to show what treatment was given to a woman. When she went to her maternal village for delivery, the health staff there had no clue about her status and what treatment to give her. The overwhelming response of the participants was that even those who can barely afford private healthcare prefer it over the indifferent government services. With services like 108 ambulance, better roads and schemes like Chiranjeevi Yojana, people’s access to private services has definitely improved.

Many of the PHCs which have been notified as 24×7 PHCs (based on the demand for services according to the district health officer) are ill-equipped particularly in terms of human resource. The women also acknowledged that in many cases where the health worker is a woman, it becomes difficult for her to stay at PHC if the infrastructure is not up to some standard or if there is no local support. The women thought this was where the VHSC (as also the panchayat) could play a facilitative role in making the everyday running of a health facility smoother, thereby also bringing in accountability and ownership.

The Caste Card

Compared to Kutch, Surat district is considered a better developed district and we were informed by the NRHM officials that VHSCs have been constituted in all the panchayat villages in the district. However, no training to the VHSC members had been imparted, although each committee had been allocated untied funds of Rs 10,000. During our visit to a sub-centre in one village, we met eight of the 11 members of the VHSC at a short notice. The VHSC included members as per the requirement of having a sarpanch, deputy sarpanch, schoolteacher, female health worker (FHW), multipurpose male worker, ASHA, anganwadi worker, etc. The sarpanch who was from the Halpati community was part of the meeting but was completely unaware about what or why the group had collected there. He was able to explain his own role in terms of mobilising the community. It was evident that he was not taken seriously by the FHW and MPW, who responded to most of the questions put to the group.

The health system functionaries talked about the kind of work that they carried out in the village. More than 70% of the population belonged to the Halpati group, who according to the FHW were not receptive to the health services provided, particularly the maternal and child health services. However, according to them the VHSC plays a unique role in convincing families to take medicines, vaccinate their children and use other healthcare provided free by the public healthcare system. Most of the members of VHSC were leaders of their community groups or of societies such as milk cooperative and were aware of various government-sponsored schemes and benefits such as the Indira Awas Yojana, public distribution scheme, BPL card, meant for the BPL families and reported that they helped families to access them. During the FGD with the community members in the same village where we held a meeting with the VHSC members, women did not even know that a VHSC was constituted and/or functioned in their village or that some woman from their village was selected as an ASHA.

The majority of women delivered their babies in institutions such as the community health centre (CHC) and also used the 108 ambulance service for the purpose. However, according to them, the FHW was contacted directly who arranged for the vehicle, etc. During informal conversations we also learnt that the tense relations between the various social groups required taking the caste politics into account while choosing members of the VHSC and that the workers of the health centre played the caste cards carefully. The tension was evident when one of the VHSC members...
who was reportedly present during the FGD, did not admit that she was its member. The felt needs of the village women and the needs perceived by the health official were totally out of sync.

Financial Allocations and Use

Both in Kutch and in Surat, the VHSC members reported that they had thus far received Rs 10,000 as untied funds just once. The money was meant to be spent on improving sanitation and environment of the villages, including quality of water, and for the whole community and not for meeting needs of any particular individual. The VHSC could also decide to plan a health diagnostic camp. We were also informed by a district health officer that if the VHSC has a concrete plan meant for the community and fell short of the allotted funds; it can appeal to the district authorities for more funds by giving specific proposals. Since VHSCs in Gujarat have been set up recently and have not been fully functional to plan well in advance, most of them have reportedly spent the money allotted to them on improving the infrastructure of the health centres by buying weighing machines, blood pressure or haemoglobin testing machines, ensuring water supply in the health facility or repairing rooms. Both the districts received the money only in January 2010 and since it had to be spent within two months, the VHSCs had little time to plan spending.

In Kutch the training imparted to the VHSC members by the local NGO included ways that the untied funds available to the VHSC can be spent for the welfare of the people. While a large part of the money received by the VHSCs was spent on buying tables, chairs, small equipment like weighing machine, and devices for measuring haemoglobin and blood pressure, some was spent also on getting the village surroundings cleaned by filling the ditches that bred mosquitoes. Small repairs in the anganwadi centres and sub-centres were also undertaken with the money. In one village, the VHSC decided to use some funds to take a poor woman to the nearby hospital under emergency. Some participants from a few villages in Nakhatra block also reported that they directed the local schools to stock up on sanitary napkins to ensure participation of girls in schools.

One of the main reasons for young girls dropping out of school was the embarrassing situation they faced due to menstruation while at school. The girls face an added disadvantage since most of the teachers tend to be men particularly in high schools. The women members of our VHSC wrote up an appeal, asking the panchayat to store and provide sanitary pads to girls in schools whenever required. The fund for this would be provided from the VHSC. The resolution was passed without any discussion at all and our job was done.

The health functionaries of the sub-centre in Surat reported on behalf of the VHSC, having received Rs 10,000 once thus far (Surat District NRHM M&E Report, 2009-10). The money was essentially spent on sprucing up the sub-centre. The anganwadi members of the VHSC felt the need to provide durries for the children in the anganwadi centres so that the young children would not have to sit on the cold floor but were told that the money for the purpose would be earmarked for the year 2010-11. There was no mention of discussing the felt needs of the community in the village sabha. The members of the VHSC took the decisions on allocation of the untied funds at their disposal. In fact, the need of the women, articulated in the FGD, of clean drinking water was not even mentioned as a felt need of the people. Money was not provided for even chlorinating village wells. Ironically, in the same village, one better-off community group had installed reverse osmosis water filtration plant for its members.

Overall, the untied VHSC funds were used for buying furniture (fans, tables, chairs, weighing machines, blood pressure measurement or haemoglobin testing instruments) in both the districts. The decision on spending in Kutch was taken in the meetings of the VHSC members and thus some community needs were met but in Surat apparently the decision was taken by the sub-centre staff along with the ASHA, who was identified by them. Also, a VHSC’s role was by and large perceived as spending Rs 10,000 allocated to it by the health department. In fact, the FHW in Surat already had in mind how the coming year’s allocation would be spent.

While speaking to the officials at the block and district levels (including the supervisor, medical officer, district health officers and the staff in the NRHM office), it was evident that they did not have faith in the abilities of people and their representatives either in the decentralised mode of functioning or in ensuring health services. At all levels, there were unwritten but very clear instructions on what and how the money was to be spent. A growing trend, that may be true beyond the government and the health sector, is that most money allocated is preferred to be spent on visible infrastructure (such as haemoglobin measuring device) rather than on smaller, simpler but more immediate needs (like chlorine tablets) or towards empowering democratic processes.

Summary and Conclusions

There were some positive and noticeable changes evident due to functioning of PRIs. In the context of health and family welfare, perhaps the most significant impact of the amendments is the ability of women to get elected to local bodies. In Kutch we noted that some PRI women members in their role as members of the VHSC have taken an active part in ensuring immunisation, organising reproductive health camps and generally mobilising women to take advantage of schemes designed for institutional deliveries.

The emergency ambulance service by calling the telephone number 108 has become the most widely used service in rural areas of Gujarat. All women, in both districts, including the panchayat members and the health workers endorsed the usefulness of 108 ambulance services for transporting pregnant women for institutional delivery or use them in the event of medical emergency. The Chiranjeevi scheme, a Government of Gujarat initiative, targeted at poor women, was also widely praised by the people. It, however, appeared to us during discussions with women that the panchayat members played little role in publicising, implementing and monitoring the service. The ASHA workers and the sub-centre FHWs have been instrumental in encouraging women to use the services. The media also seems to have played some role by giving wide publicity to these schemes.

We found the ASHAs to be far more active in Kutch compared to the one we interviewed in Surat. Participatory training provided by an NGO in Kutch seems to have made a difference by encouraging
them to take a range of initiatives. For example, three ASHAS reported during the FGD that their VHSCs passed a resolution that was initiated by the women mandating the village middle schools to stock sanitary napkins in schools for use by girls and agreed to provide funds for the purpose.

However, several lacunae and shortcomings came to our notice. VHSCs have been constituted at the initiative of the health department under the central scheme of NRHM and in reality the village panchayat had practically no role in their functioning. While talking to the health officials in the district headquarters of both Kutch and Surat, it was learnt that even at that level there was no staff in the health departments that was accountable to the panchayat department for anything at all. Under the NRHM, there is on paper a directive that suggests that integration can be achieved through sharing the functions and funds of the two departments. But as one official stated wryly, “Integration comes from sharing the same premise”. While PRIs are mandated to carry out health activities, they are not backed by the necessary policy/legal framework, authority or fiscal commitments. Many centrally-sponsored schemes are implemented outside the purview of the panchayats, thus keeping them out of the loop and undermining their authority and credibility.

Along the same lines, it was evident that the ASHA who was supposed to be reimbursed by the panchayat on a performance-based remuneration plan, continued to be supported by the health department and was thus accountable to those who provided her remuneration. Even though theoretically ASHA and the other health functionaries working at the grass-roots level are accountable to the village panchayat, they continue to report to and be monitored by the line or parent departments who remain their supervisory authority. The reality is that the panchayat or gram sabhas have no stake in their appointment or functions.

The fear of a nexus between a few PHCs, sarpanches and ASHA workers is quite real. This partly stems from the caste dynamics and politics evident in multi-caste villages. The vested interest of powerful people in the village comes into play when money is involved and ASHA workers are selected without the sanction of the gram sabha. Also, in the process, women members and those belonging to social groups other than the dominant group are bypassed from receiving any benefits rightfully due to them. As one elected PRI member, not belonging to the ruling clique, reported that she is not even informed about the meetings and her signature on decisions taken in the gram sabha is taken by visiting her at home.

The untied funds of Rs 10,000 for each VHSC were released only once in 2010, although VHSCs were constituted in Gujarat in 2007 and 2008. Also, the funds were released towards the end of the financial year and the VHSCs were instructed to spend the entire amount within two months on infrastructure or on awareness campaigns. This prevented the VHSCs from planning, let alone allowing the matter to be discussed in the panchayat and money was spent in an ad hoc manner. As we noted in Surat, the needs of the FHWs received precedence over that of the community in spite of the fact that each PHC, sub-centre and anganwadi routinely gets maintenance funds from health department. While fiscal devolution is a significant step forward, lack of institutional modalities and clear guidelines on PRI participation and variable capacity among PRI members are responsible for the ad hoc manner in which funds are utilised.

Village level panchayat bodies do not appear to be taking action against the FHWs who either charge money for services, or abscond from work, or are even careless in discharging their duties. Apparently, there are no mechanisms established for addressing or dealing with such instances, even though the FHWs are accountable to the panchayat.

Based on the Kutch experience where a local NGO was proactively involved in strengthening the capacities of elected women members of the PRIs, it became evident that the linkages between PRIs and grass-roots non-governmental groups need to be established and nurtured. The presence of a strong NGO willing to train elected representatives makes a noticeable difference in their articulation of needs, demands and also in getting work done. Capacity-building of PRIs is required in thematic areas and leadership skills, negotiating, monitoring, ability to withstand patronage and political interference. NGOs could be involved in PRI strengthening in a variety of ways, including in awareness generation, provision of technical advice, support in participatory planning, capacity-building and facilitating monitoring processes, such as community and social audits to improve accountability. In the area of health, the NGO can organise joint orientation and sensitisation meetings between PRI members and health and medical professionals to facilitate access to reproductive and other health services.

**Protecting Fundamental Rights**

If the PRIs and VHSCs are sufficiently empowered and backed by creditable NGOs, they can take up issues that violate individual rights and discriminate against women's participation in panchayats. Gujarat, for example, has a policy that bars people who have more than two children from holding office in the local bodies. Such a policy is inherently anti-women, and threatens to undo the good of a decade's work in enabling women to participate in political processes and violates women's freedom and individual rights. There have been studies to show that it encourages abandonment of women who become pregnant after giving birth to two children, disowning the third child or giving it away and thereby denying the child of its rights as well. PRIs members can use the gram sabhas for discussion of such issues. Initially, the PRIs would need backing of other informed groups to spearhead debates on controversial issues that undermine the fundamental rights of people (Buch 2005; Visaria et al 2006).

In view of the lack of coordination that we observed at the village level between the PRI members and the functionaries of the health department, it is felt that provision of a physical space for all functionaries would help. Perhaps in the panchayat building every government salaried or remunerated person be provided a desk, where she/he reports every day for some time, where a roaster is maintained indicating his or her availability, travel schedule, etc. This would, on the one hand, ensure their accountability to the community and on the other hand, interaction between the functionaries in charge of a wide range of activities would bring out core issues and concerns of the village population needing actions. In the periodic meetings of the various functionaries some of the fundamental or core questions related to the decentralisation
process can be discussed. The questions such as (a) does the devolution of power necessarily improve the performance and accountability of the local government, (b) does it simply empower local elites to capture a larger share of public resources, and (c) how does the informal process and functioning that has existed for decades in India’s rural areas and where power is rooted in class, caste and gender accept and bring about change in rural societies so that the democratisation and decentralisation take root, need to be discussed at the local level as well. Equally important is the question whether decentralisation on its own is sufficient to produce a system of governance that is more effective or accountable to local needs and interests or that ensures accountability.

Finally, there is an urgent need for training in fiscal management, systems training and appropriate checks and balances. The functionaries or members of VHSC need clarity about their roles such that duplication of work of the ASHA worker and of FHWS, for example, can be minimised. Both are supposed to be functioning within the framework of PRIs and need to ensure that women seeking health or other services are neither constantly pestered nor are they left out from information or access to services.

Annex: A List of Health Programmes That Are As Per the Guidelines Monitored by the PRIs

Key health-related functions for each of the three tiers of the PRI are: reproductive and child health (RCH), programmes for vector-borne diseases, blindness, TB control programmes and sexually transmitted infections (STIs/AIDS). Many of the activities proposed are related to identification of people in need of services, in collaboration with the health system and monitoring of village level health workers, and primary and secondary healthcare facilities. Currently the PRI are not equipped to take on such planning and monitoring functions, nor is there a cognisance in the health system of the role of PRI.

Accelerated Rural Water Supply Programme

Under the Accelerated Rural Water Supply Programme (ARWSP), the central government is expected to supplement the efforts of the state governments in providing access to safe drinking water to all rural habitations of the country. The roles of PRIs in implementation of this scheme are:

• PRIs should be involved in selecting the location of standpost, spot sources, operation and maintenance, fixing of cess/water tariff, etc.
• In the pilot districts, where the sector reform projects under the District Water and Sanitation Missions (DWSM) are located, the district panchayats should be responsible for their implementation, provided they are willing to take up the responsibility and are strong to do so, instead of DWSM.
• At the village level, the individual rural water supply schemes are to be implemented through village water and sanitation committees which should be committees of gram panchayats.
• Drinking water supply assets are transferred to the appropriate level of panchayats and such panchayats are to be empowered to undertake operation and maintenance of drinking water systems.

Central Rural Sanitation Programme

This programme aims at improving the general quality of life in rural areas; accelerating coverage in rural areas; generating demand through awareness creation and health education; and controlling incidence of water sanitation-related diseases. The roles of PRIs in implementation if this scheme is:

• Total sanitation campaign (TSC) is a community-based programme where PRIs are in the forefront.
• As per TSC guidelines, the implementation at the district level is to be done by the district panchayats. Panchayats at block and village level are to be fully involved for implementation of the programme.
• Where district panchayat is not in a position to implement the programme, it needs to be implemented by District Water and Sanitation Mission which is chaired by the chairperson of district panchayat and the village committees are chaired by the chairpersons of gram panchayats.

Swarajdhar

This programme aims at providing community-based rural drinking water supply. The key roles of panchayat in this programme are:

• Panchayats/communities should plan, implement, operate, maintain and manage all drinking water schemes; thus, full ownership of drinking water assets are with gram panchayats.
• Gram panchayat shall convene a gram sabha meeting, where the drinking water supply scheme of people’s choice, including its design and cost, etc, are finalised. Gram panchayats would need to undertake procurement of materials/services for execution of schemes and supervise the execution of the scheme.
• A resolution must be passed in the gram panchayat meeting calling for users/beneficiaries to contribute 10% of the capital expenditure. However, GP can remit towards community contribution from its tax revenue (but not from government grants) with the approval of gram sabha.
• Gram panchayat will decide whether the panchayat wants to execute the scheme on its own or wants the state government agency to undertake the execution. After completion of such schemes, the gram panchayat will take over the schemes for operation and maintenance.
• Panchayat must decide on the user charges from the community so that adequate funds available with panchayat for operation and maintenance.