A STUDY OF ROLES & CAPACITIES OF PRI'S TO MANAGE THE GRASS ROOT HEALTH SYSTEM

(Multi-centre Task Force Study)

Report submitted to

Indian Council of Medical Research (ICMR), New Delhi

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ACKNOWLEDGEMENT

73rd constitutional amendment reinforced the importance of local institutions in development of the rural community. The National Rural Health Mission has further strengthened the position of the Panchayati Raj Institution in management of Health and health services. Indian Council of Medical Research, Delhi is conducting a multi task center study to asses the performance of Panchayats particularly in the area of health, its potential and limiting factors. The multi task center study is being conducted in Haryana, Assam, Madhya Pradesh, West Bengal and Kerala. Samarthan-Centre for Development Support has been entrusted to collect the data and compile the report for Madhya Pradesh.

Samarthan has over the last 11 years worked towards strengthening the Panchayati Raj Institutions and participatory processes in Governance and Development. We are thankful to Dr. Azad Kundu, ICMR for reposing his trust in Samarthan to conduct the study in the state of Madhya Pradesh. We are also thankful to him for his timely and valuable guidance provided in designing the interview schedule and research methodologies. I am particularly thankful to Dr. Reetesh Babu for his support in providing tables and tools for data entry and analysis along with other necessary guidance to the team. We are also thankful to our Director and Samarthan and colleagues for providing unconditional support and guidance.

We hope the learnings and findings emerging from the study will be relevant and useful for the ICMR to prepare the national report as well as provide meaningful guidance to policy makers in designing relevant execution methodologies in strengthening the health through Panchayati Raj Institutions.

We look forward to the continued co-operation and support.

Shrdha Kumar
Principal Investigator

Chapter – 1

ROLES AND RESPONSIBILITIES OF PANCHAYATS UNDER THE CONSTITUTIONAL MANDATE

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ROLES AND RESPONSIBILITIES OF PANCHAYATS UNDER THE CONSTITUTIONAL MANDATE

1. Background

The 73rd and 74th Constitutional Amendments paved the way for democratizing governance at the grass-roots. They mandated the setting up of institutions of self governance at the Panchayat and Municipality levels, providing these bodies the required authority and responsibility to undertake planning and implementation of developmental programmes to suit local needs.

In spite of inherent political and philosophical differences, the Indian people and the body politic unequivocally accepted local self governance as a relevant concept for the country, identifying Panchayats as socially rooted local institutions to carry this concept forward.

Historically speaking, the first efforts to strengthen Panchayati Raj institutions (PRIs) can be traced to the 1950s, with several committees being set up to look into the issue. The Balwant Rai Mehta Committee recommended the establishment of a three-tier Panchayati Raj system in 1957. Later in 1985, the G.V.K. Rao committee recommended the district as the basic unit for policy planning and programme implementation and emphasized the need to hold regular elections to the Panchayats.

The Seventh Five Year Plan took the process further, suggesting devolution of resources and authority to the Panchayats in order to blend macro interventions with micro realities. The 73rd Amendment of 1993 reinforced this position, with Article 243G endowing the Panchayats with powers and authority to function as institutions of self governance. Panchayats at the appropriate levels were also entrusted with the responsibility of preparing and implementing plans for economic development and social justice.

The 11th Schedule of the Constitution listed the functions the Panchayats had to perform to develop local infrastructure and achieve social justice and economic growth. Health and family welfare, sanitation and other health-related matters were among the priority functions, with public health being added to the list in the 12th Schedule. Many of the 29 subjects devolved to the Panchayats had direct or indirect repercussions on community health, so the Panchayats were seen as bodies to enhance accountability in welfare service delivery and to mobilize community participation.

The 11th Finance Commission classified the mandated duties of Panchayats into core functions, welfare functions, agriculture and allied functions and economic functions, the breakdown under each broad category being summarized in the following table. Health and sanitation (including hospitals, primary health facilities and dispensaries) are classified as core functions, but they have obvious inter-sectoral linkages with other core functions like

provision of safe drinking water and welfare functions like women and child development and family welfare.

Box-1

Functions of the 11th schedule of constitution –division by 11th finance commission

Core functions	Welfare functions	Economic functions	Agriculture and allied functions
• Drinking water • Health and sanitation, including hospitals, primary health facilities and dispensaries. • Roads, culverts, bridges, waterways and other means of communication • Maintenance of community assets	• Rural housing • Non-conventional energy • Poverty alleviation programmes • School education • Adult and non formal education • Family welfare • Women and child development • Welfare of the weaker sections like scheduled castes and scheduled tribes • Public distribution system	• Tax collection on property and housing • Optional taxes like bus stand fees, user charges for drainage etc	• Agriculture and agricultural extension • Land development, land reforms, soil conservation etc • Minor irrigation, watershed development, water management etc • Fisheries • Social and farm forestry, including minor forest produce • Khadi, village and cottage industries • Fuel and fodder • Markets and fairs

1.1 Decentralization and community processes in health: the Madhya Pradesh experience

The 73rd Amendment left it to the state governments to come out with state Acts in parity with the constitutional mandate. Madhya Pradesh, which had a vibrant tradition of caste and village Panchayats, took the lead in this respect, coming out with progressive legislations and a policy frame-work to facilitate decentralization in governance, planning and infrastructure development to the village level.

1.1.1 Madhya Pradesh Panchayati Raj Act 1993

In 1993, the state government drafted the Madhya Pradesh Panchayati Raj Act 1993 to amend existing laws for establishing Panchayati Raj institutions. The Act, which is the backbone of Panchayati Raj in the state, received the Governor's assent the following year. It provides for setting up a three-tiered Panchayati Raj system as well as a State Election

Commission, State Finance Commission and independent audit organization (under the control of the state government) to facilitate functioning of the system.

Spirit of the Act

The primary objective of the Act is to strengthen and empower all three tiers of the Panchayat, in particular the village-level tier, in order to ensure their effective involvement in local administration and development through the active participation of the local people.

The Act ensures the participation of disadvantaged groups by reserving seats in elections to all tiers for women, scheduled castes and scheduled tribes. The elections are organized and conducted by the State Election Commission.

The State Finance Commission looks into financial matters and allocation of financial resources to the Panchayat bodies. Since the Act seeks to empower these bodies by building up their resource base, Panchayats are entitled to levy certain mandatory and optional taxes and to also levy user charges for providing services like safe drinking water, sanitation, electricity etc.

Some important highlights of the three-tier structure under the Act are as follows:

Structure of the Gram Sabha

A Gram Panchayat may have more than one village under its purview. Each village has a Gram Sabha or Village Assembly, with every voter in the village entitled its membership - which means that adults from all households, economic categories and castes participate in the decision-making process.

Being the grassroots unit in the Panchayati Raj structure, the Gram Sabha plays an important role in decentralized self governance, formulating its own annual plans and monitoring their implementation. It conducts one meeting every three months to discuss the development needs and welfare of the village and takes action where needed. At least 10% of the adult population of the village must participate in the meeting to complete the required quorum. The Gram Sabha is also empowered to monitor the functioning of village-level functionaries like teachers, ANMs (Auxiliary Nurse and Midwife), etc.

Structure of the Janpad Panchayat

The Janpad Panchayat is the second tier of the Panchayati Raj system at the block level and consists of members elected from different sections of the community, members co-opted from marketing societies or cooperatives, and all members of the State Legislative Assembly representing constituencies of the block. (A single member constituency has a population of not more than 5,000.) To ensure representation of SCs/STs, OBCs and women at this level, seat are reserved for them.

Structure of the Zilla Panchayat

The district-level Zilla Panchayat is the third tier and consists of members elected from the constituencies, chairpersons of district cooperative and development banks, all members of the Lok Sabha representing the district partially or wholly, all members of the State Legislative Assembly returned from district, and members of the Rajya Sabha returned from the state who are voters of the district. There are reservations at this level as well to ensure representation of SCs /STs, OBCs and women.

Decentralization of subjects/ functions to the Panchayats

Various line departments in Madhya Pradesh have devolved 29 subjects to the Panchayats. These functions mainly relate to formulating developmental plans or selecting beneficiaries of departmental welfare schemes. However, the devolution is notional in most cases since financial control still largely rests with the departments, with less than 5% of the funding of centrally sponsored schemes being devolved to the Panchayats.

The following table lists the departments that have devolved their functions to the Panchayats:

Box-2 : Devolution to Panchayats –list of Departments

Departments influencing health	Departments of little relevance, to health
Public Health and Engineering Public Health and Family Welfare Women and Child Development Social Welfare Education Food and Civil Supplies	Rural Development Khadi Gramudyog and Village Industries Non Conventional Energy Public Works Fisheries Veterinary and Poultry Development Sports and Youth Welfare Revenue Forest Agriculture and Agricultural Engineering Irrigation and Water-works

The initial response to decentralization was tepid, with the bureaucracy and departmental administration showing reluctance to devolve power and authority. The system kept finding a plethora of bureaucratic mechanisms to stall the Panchayati Raj agenda at the operational level.

But there is cause for hope. Several amendments to the 1993 Act have been made to remove roadblocks and further empower the Panchayati Raj bodies. More importantly, the concept of decentralized governance has gained a firm foothold in the state and raised people's expectations following several rounds of Panchayat elections. The stage has now

been reached to translate hope and expectations into real empowerment and concrete action at the grassroots.

1.1.2 Madhya Pradesh Panchayati Raj and Gram Swaraj Act 2001

The first attempt to revise and broad-base the 1993 legislation was made in 2001, with the drafting of the Madhya Pradesh Panchayati Raj and Gram Swaraj Act 2001. The revised Act seeks to maximize community involvement in the Panchayat's functioning and strengthens the Gram Sabha by permitting it to nominate a village treasurer to manage its own account.

The amended Act provides a legislative framework to commoditize and democratize the development delivery mechanism in the state, setting up eight sectoral committees for different development and welfare needs, including health, education, agriculture, infrastructure development, social justice and village development.

Other salient features of the revised Act are as follows:

- It recognizes and includes non-monetized contributions to the village fund. Many contributions in the subsistence-level village economy are in the form of manual labour, grain, forest produce and so on. Recognition of the financial value of these contributions as community participation in the development of the village is a big step forward.
- It empowers Gram Sabhas to conduct social audits of their Gram Panchayats. The social audits cover development work implemented by the Panchayats as well as their accounts.

Village Health Committees

The 2001 Gram Swaraj Adhiniyam mandates the setting up of Village Health Committees headed by the Sarpanch in every Gram Sabha. The Gram Sabha is tasked with nominating or selecting committee members, the operative principle being to ensure representation of women as well as all caste groups in the village. The committee has a functional interface with several departments including the:

- Public Health and Engineering Department
- Department of Health and Family Welfare
- Department of Women and Child Development

Unfortunately, the health committees, like other committees of the Gram Sabha, have not been able take the required initiatives to perform their role. Most were set up in a hurry and their members were selected by influential parties like the Sarpanch, not by the Gram Sabha; hence several members are not even aware of their membership. They also do not have any untied funds and, departmental ownership being poor, they do not get any institutional support for capacity building. So they remain inactive in most parts of the state.
The only instance where the health committees have been given some tangible role is in the implementation of the PHED Sector Reform Projects for piped water supply in villages.

Box-3

Functioning of the village health committee in Gram Swaraj Adhiniyam

Functioning of Village Health Committees

The Village Health Committee formed under the Gram Swaraj Adhiniyam has the following functions and powers:

- Preparing the health plan of the village.
- Selecting the site for the Anganwadi centre and health centre in the village.
- Facilitating the selection of a women candidate by the Gram Sabha as the Anganwadi worker to manage the Anganwadi centre.
- Facilitating the selection of a traditional birth attendant by the Gram Sabha who can be trained by the department.
- Facilitating the management of maternal and child healthcare in the village.
- Facilitating the implementation of all national health programmes.
- Ensuring immunization of all children in the Panchayat.
- Monitoring the functioning of health service providers in the village (for instance, they can verify the attendance of the health worker).
- Selecting beneficiaries for various health schemes of the line department.

The Madhya Pradesh experience

The Village Health Committees, like other committees, were formed in a hurry and in most Panchayats the members are not even aware of their membership, role or powers.

These committees do not have any untied funds to initiate independent health programmes, but in districts where the Sector Reform Programme for implementing piped water supply schemes is in operation, they have been empowered to access the scheme in collaboration with the Panchayats, the Sarpanch and committee president being joint signatories of the accounts. In these districts, the health committees have become active – for example, in Sehore district alone, 238 piped water supply schemes were implemented by them in a short span of time.

Jan Swasthya Rakshak experiment in decentralizing health delivery in Panchayats

The state government sought to prepare a cadre of 'barefoot doctors' in an attempt to reach basic health services to the grassroots. The Gram Sabha identified and selected village youth to be trained as Jan Swasthya Rakshaks, the training in managing common mild diseases being conducted by the Health Department. The Jan Swasthya Rakshaks were supposed to receive a small honorarium from the department and undergo regular refresher courses. However, the programme met with limited success because many Jan Swasthya Rakshaks either did not receive training or underwent only one or two training courses. Nor did they get the promised honorarium. Quite expectedly, the initial enthusiasm for this community based health delivery method soon faded. Many of these partially trained Jan Swasthya Rakshaks are still providing primary healthcare at a cost to the community, although they no longer have institutional linkages with the Panchayats.

1.2 National Rural Health Mission

The 73rd Amendment saw the central and state governments taking up several measures of varying intensity and scope to align their health programmes with the concept of community ownership and accountability to the people. The National Rural Health Mission (NRHM) is a step in this direction, its focal commitment being to institutionalize community participation in healthcare within the framework of Panchayati Raj institutions.

The mission seeks to involve Panchayats and the community in the management of healthcare by decentralizing planning of healthcare to the district level, with the district plans emerging from the annual plans of the Gram Panchayats. Consequently, the village health plans prepared by the health committees form a significant component of the NRHM, even though its mission objectives are mostly centered around child and reproductive health.

1.2.1 Links between the community and Health Department

Village Health and Sanitation Committee: NRHM provides for a Village Health and Sanitation Committee for every Panchayat, which is supposed to establish a link between the community, Panchayat and Health Department. The committee is mandated to prepare the village health plan, promote healthcare and undertake preventive health programmes in the Panchayat. It has also been given some resources to meet basic health and sanitation requirements and emergency medical needs of the Panchayat.

> The Village Health and Sanitation Committee has 12 to 15 members, including representatives from the ward, SHGs in the panchayat and even NGO representatives, if NGOs are working in the Panchayat. ASHA from the Panchayat is also part of the committee. Wherever possible, attempts are made to ensure that a woman member heads the committee.

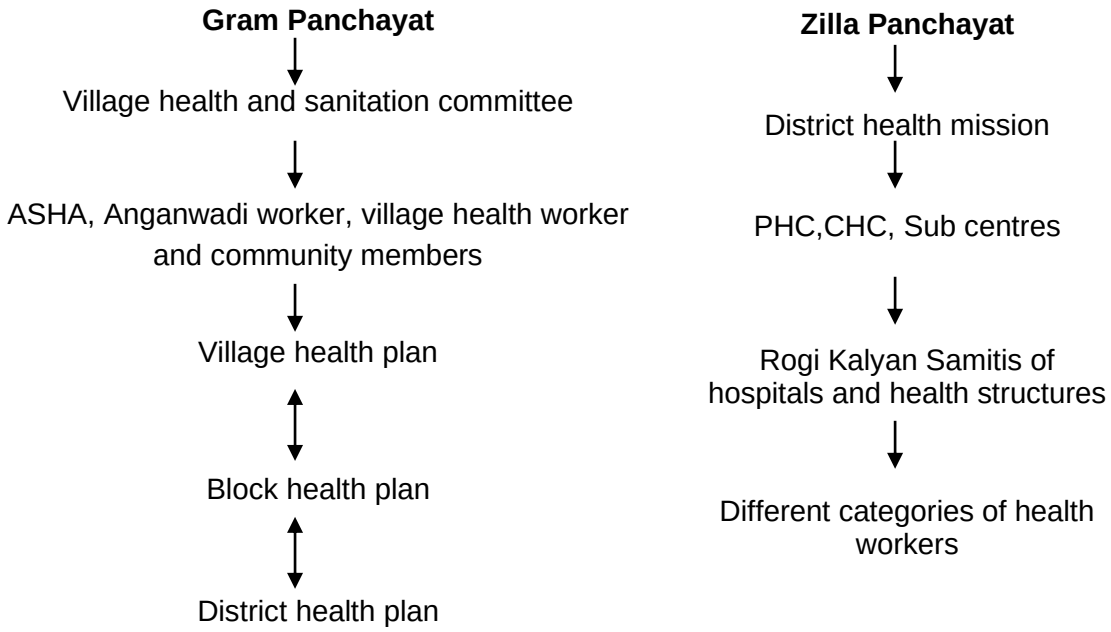
Among the important functions of the committee are education and awareness on health issues, promoting safe births through institutional deliveries or with trained birth attendants, promoting immunization, anti natal check-ups, sanitation and, most importantly, preparing the health plan of the Panchayat. These plans subsequently get consolidated at the block level and further at the district level, the compiled plans of all the Gram Panchayats forming the district plan.

ASHA: Another step to strengthen decentralization is the introduction of the ASHA (ACCREDITED SOCIAL HEALTH ACTIVISY), a multipurpose health volunteer in every Panchayat, who assists and links the Panchayat to the Health Department.

Rogi Kalyan Samiti: These samitis grew out of an experiment carried out by a Collector of Indore to involve the community in the functioning of the district hospitals. He encouraged the setting up of Rogi Kalyan Samitis (Patient Welfare Cooperatives) to ensure community participation and Panchayat representation in the management of these hospitals. The experiment was acknowledged and encouraged by the then Chief Minister and Rogi Kalyan

Samitis were subsequently formed across the state. The NRHM has also adopted this approach, providing support for the rural health centres through these Rogi Kalyan Samitis.

The NRHM envisages the following structure to coordinate healthcare with the Health Department at the Panchayat level:



1.2.2 Current attempts at decentralization within the NRHM framework

Madhya Pradesh is making fresh attempts to involve Panchayats and decentralize healthcare in the state in accordance with the NRHM directives. These attempts include the following:

- The Gram Sabhas are selecting ASHA or link volunteers of the department to undertake health education functions. The process has begun in most districts but been completed in only some blocks.
- The training of these volunteers who serve as a link between the community, Panchayat and Health Department will soon be taken up in many districts.
- Village Health and Sanitation Committees are being set up by the Panchayats in many districts, following the directives of the Health Department.
- Panchayat-level health planning was initiated on a trial basis in 2006. Sehore district was among the sample districts, with five Panchayats each from the district's five blocks being selected for the purpose. The health plans of these Gram Panchayat were consolidated at the block level with the help of the Block Medical Officer, Janpad Panchayat CEO and concerned health machinery. The block plans were subsequently compiled at the district level. The Health

Department is contemplating scaling up health planning this year by involving all the Gram Panchayats of the district through the health committees.

- Funds to the tune Rs20,000 have been devolved to Gram Panchayats in which Sub-Health Centres are located. This account is meant for maintenance; miscellaneous and contingency expenditure related to the functioning of the Sub-Health Centre and is jointly operated by the Panchayat and health worker, with the Sarpanch and ANM being the signatories. Unfortunately, the flexible grant was not utilized well during the past year due to conflicting interests of the signatories. Informal complaints were received from both parties regarding mismanagement of the fund. Consequently, a more convenient arrangement has been worked out wherein a smaller amount of up to Rs3,000 can be withdrawn with the joint signatures of the ANM and Block Medical Officer.
- The Rogi Kalyan Samitis already existing in the state are being strengthened, institutionalized and legitimized under the NRHM. These samitis are operated with the registration fees paid by patients visiting government health facilities. They have the Zilla Panchayat as a member and contribute financially to the functioning of Primary Health Centres and Community Health Centres.

Box-4

Initiation of district Health Plan under NRHM

District level Health plans are made at each district under NRHM.A predesigned format is taken to selected villages in each district. For instance, data is collected on general health information, seasonal illness, and expectation from 50 Panchayats(10 villages each from each block) and the collected information is used to formulate a plan at the district level. At district level, funds of the RCH Program and NRHM are merged to meet the district health plan.

The planning is undertaken at the initiative of the health department only. Since the initiatives were coming from the health department, the response was conditioned on the services provided by the health service providers. Most of the village plan demanded regularity of the health service providers, and availability of the necessary drugs at the Panchayat level .Even though the planning was facilitated by the health functionaries issues important for promotion and prevention did not figure in the Health plans .Many issues like water, sanitation, nutrition were left out on consideration that it is outside the preview of the Health department. Therefore health plans facilitated by the department were nothing like a plan but response to the problem that community is facing with respect to health delivery. Ironically the community process has not been very strong in making health plan.

Chapter – 2

THE STUDY DESIGN

Chapter – 2

THE STUDY DESIGN

2.1 Objectives of the study

Despite policy articulation that decentralization is the cornerstone of planning, implementing and monitoring programmes for all social sectors, including health and family welfare, progress has been uneven and poorly optimistic. The lack of fiscal devolution, a significant factor in strengthening local institutions, has taken its toll on their performance. So has the lack of a policy framework, institutional modalities and clear guidelines on PRI participation.

The study seeks to assess the capacity and potential of PRIs to deliver healthcare at the village level. At the same time, it tries to capture the elements of the policy framework and practices at the grassroots that could enable Panchayats to perform their role. Its objectives can be summarized as follows:

- To document the role and responsibilities of PRIs in relation to health matters under the constitutional framework.
- To assess the level and process of devolution of power to the PRIs by the state.
- To gauge the capacity of PRIs and the constraints they face in managing the health system.
- To understand their actual level of involvement in providing support and corrective measures to the health system.
- To find out the attitudes and opinions of health service providers on the role of PRIs in the health system.

2.2 Methodology

Primary data for this multi-task centre study, commissioned by the Indian Council of Medical Research (ICMR), was collected from five states, namely Kerala, West Bengal, Madhya Pradesh, Assam and Haryana. These states were identified on the basis of the diversity of experience and status of functioning of their PRIs. While Kerala is perceived as being progressive in this respect, Haryana is regarded as a poorly performing state. West Bengal and Madhya Pradesh are progressive with respect to decentralization, while Assam is relatively unexplored and has a neutral image on this score.

A consensus building workshop of all the participating centres was held to arrive at a common understanding of the study and its objectives. The design of the interview schedule was finalized after fine tuning the sample size, method of data collection and objectives of the study.

The questionnaires went through several rounds of discussion to incorporate feedback and suggestions, following which each centre carried out a pilot test in its field area. A second workshop was convened to finalize the questionnaire on the basis of feedback from the pilot testing.

A standardized data entry package was used for data entry. Each centre prepared its own state report on the specified objectives, on the basis of which a national report was subsequently compiled.

Primary data was collected through an interview schedule administered to three constituencies - Panchayats, beneficiary community, health service providers - with different schedules for each constituency. All three tiers of the Panchayat as well as all levels of health service providers (village-level ANMs and Multipurpose Health Workers (MPWs), block level and district level health officials) were included. The questions in the schedule were both qualitative and quantitative in nature, the qualitative responses being further quantified after codification into specific categories. The rich qualitative responses had relevance to a range of issues, given the intensive fieldwork conducted and the large number of respondents in each category, so they proved useful in contextualizing the objectives of the study.

Primary data was also generated through a process of consultation with senior departmental functionaries and district administration officials like the Collector and CEO Zilla Panchayat.

Secondary data was collected from government agencies like the Panchayat and Health Departments and earlier research studies. Also included was data from Samarthan's resource base, generated during its work with Panchayats. The pertinent issues for secondary data collection, structured and contextualized to cover the objectives of the study, were identified on the basis of readings of the secondary sources and field experience.

Being a multi-task centre study, it was necessary to codify and quantify all the qualitative responses into given categories. This proved to be a limitation of the research, since many responses did not exactly fit into a specific category and were 'put under' the closest fit. It was also difficult to identify a suitable category for responses that could easily fit into more than one category. For instance, the question about the Panchayat's efforts to improve health services at the health centre drew responses like 'making requests for additional manpower for the health centre' or 'making complaints about poor supply of medicines', which did not exactly answer the question but were nevertheless included in this category. As a result, some of the percentages may not be exactly representative of the qualitative responses, although this limitation was adequately dealt with while writing the report.

2.3 Sampling technique

In order to get a diversity of data and experience, three districts from each state were selected for data collection on the basis of their development status. They included one district each in the high, medium and low development ranges, these categories being standardized and simplified on the basis of the Human Development Index (HDI) of the district. This index, widely used in the preparation of the Human Development Report of the states, is a measure of how far a district has traveled from a minimum level of achievement and the path it still has to travel.

2.3.1. Calculating the HDI of selected districts in Madhya Pradesh

The following formula was used to calculate the index:

$$HD1_{ij}\,(\text{Index}) = \text{Value}_{ij} - \text{Min}_{j}$$

$$\text{Target}_j - \text{Min}_j$$

$HD1_{ij}$ = Index of deprivation for the i^{th} district for the j^{th} criterion

Target j = Maximum achievable target for the j^{th} criterion (for example, it is 100% for literacy)

Value ij = Value of the i^{th} district for the j^{th} criterion

Min j = Minimum value for the j^{th} criterion (for example, it is 0% for literacy)

The index is calculated on the basis of the average of three important indicators of the district - health, education and income generation.

Box-5

Districts selected on the basis of their Human Development Index

Indicator	Gwalior	Sehore	Panna
HDI	.624	.560	.470
Rank in Madhya Pradesh	8	22	41
Gender-related development index	.527	.590	.462
Rank in Madhya Pradesh	30	9	42
Life expectancy	653	54.4	53

Three districts at different stages of development – Gwalior, Sehore and Panna - were chosen on the basis of their Human Development Index. Care was taken not to choose highly urbanized districts like Bhopal or highly urbanized blocks within a district. Of the state's 48 districts Gwalior is high ranking (8^{th} position, HDI=.624), Sehore medium ranking (22^{nd} position, HDI=.560) and Panna low ranking (41^{st} position, HDI=.470).

Once the districts were selected, the blocks and Panchayats sample was randomized to avoid any discretion in order to present as correct and comprehensive a picture as possible.

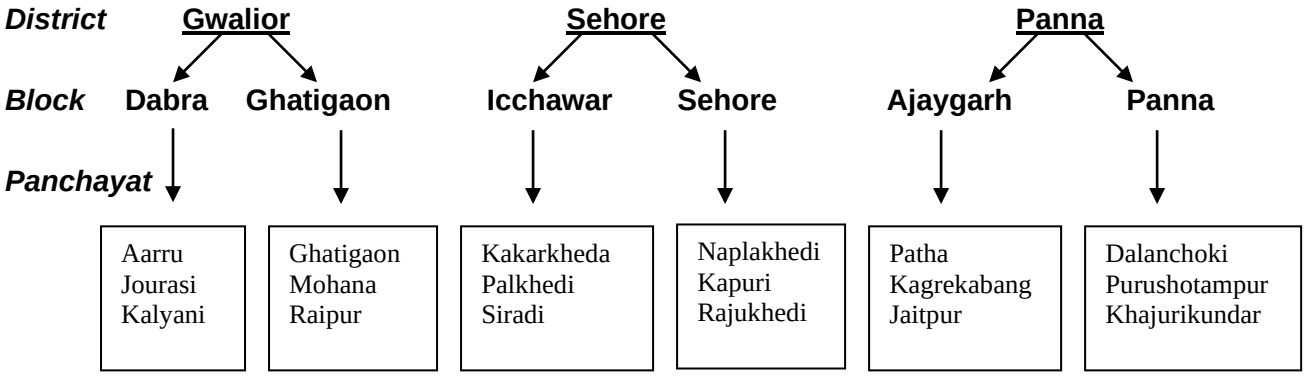
2.3.2 Sample size

Two blocks each from Gwalior, Sehore and Panna were selected for the study, with three Panchayats from each block being chosen for data collection. The details are given below:

Table - 1

District-wise distribution of respondents

	PRI members			General population			Health provider			Total		
District	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**
Gwalior	60	30	90	148	151	299	13	10	23	221	191	412
Panna	54	36	90	150	152	302	10	12	22	214	200	414
Sehore	69	36	105	151	149	300	13	13	26	233	198	431
Total	183	102	285	449	452	901	36	35	71	668	589	1257



Total No of respondents from the beneficiary community: 901
Elected Panchayat representatives : 285
Health service providers : 71

Table - 2

No of members in different panchayat tiers

Tier of Panchayat/no.	Position in Panchayat / No	District / No
Gram – 193	Elected member – 245	Gwalior - 60
Janpad – 64	Head – 21	Panna – 54
Zilla - 28	Vice head – 19	Sehore - 69

The sample size of health providers was 76 and included officials at the district level, like Deputy CHMO and Deputy Block Medical Officer. However, since such staff positions did not exist in all the chosen districts and since many doctors in the district hospitals were not available, only 71 interview schedules were administered. The number of respondents among Panchayat representatives (285) and the beneficiary community (901) exceeded the sample size of 270 and 900 respectively.

2.3.3 Profile of the respondent

The socio-economic profile of the three categories of respondents is given in the tables below:

Table - 3

Socio-economic profile of PRI member

Age (years)	Occupation	Caste	Education	Income (Rs)
Up to 30 21%	Wage labour 11%	General 9.8%	No formal education 34%	<15000 40.3%
31-40 38.5%	Skilled labour 4.2%	OBC 57.8%	Up to primary 67%	15-20000 45%
41-50 28%	Agriculture 53%	SC 17.5%	Up to Middle 43%	20-25000 27%
51-60 8.42%	Business trader 4.2%	ST 14%	Up to Secondary 48%	Above 25000 10%
60 and above	House wife 14.3%		Graduates & above 30%	

Table - 4

Socio-economic profile of health service provider

Age (years)	Education	Designation	Place of work
Up to 30 84%	Up to primary 0%	ANM & MPW 56%	Sub-centre 90%
31-40 22.5%	Middle 4%	BMO 8.4%	PHC 6%
41-50 45.07%	Secondary 2.8%	BEE 11.26%	CHC 28.35%
51-60 23.9%	Sr. Secondary 30.9%	LHV/Superviser 11.2%	District 7%
	Graduates >above 62%	CMHO/ Dist. Health Officer 24%	
		Sr. Health Officer/ Doctor 5%	

Table - 5

Socio-economic profile of beneficiary community

Age (years)	Education	Occupation
Up to 30 – 355	Non formal – 508	Labour - 392
31-40 – 319	Primary – 144	Agriculture - 357
41-50 – 151	Secondary - 142	Service - 37
51-60 – 62	Senior secondary - 82	Business - 32
Above 61 – 32	Graduates-18	Housewife - 133

Chapter – 3

PERFORMANCE OF PANCHAYATS

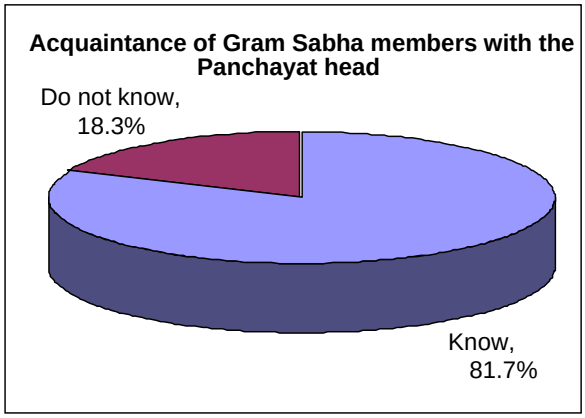
Chapter – 3

PERFORMANCE OF PANCHAYATS

3.1 Performance of Gram Sabhas

The 73rd Amendment entrusts the Gram Sabha with the responsibility of micro planning, conducting social audits of the functioning of Panchayats, reviewing their accounts, identifying and approving beneficiaries for welfare schemes and undertaking supervisory and regulatory functions.

Figure – 1 (Detail in Annexure-1)

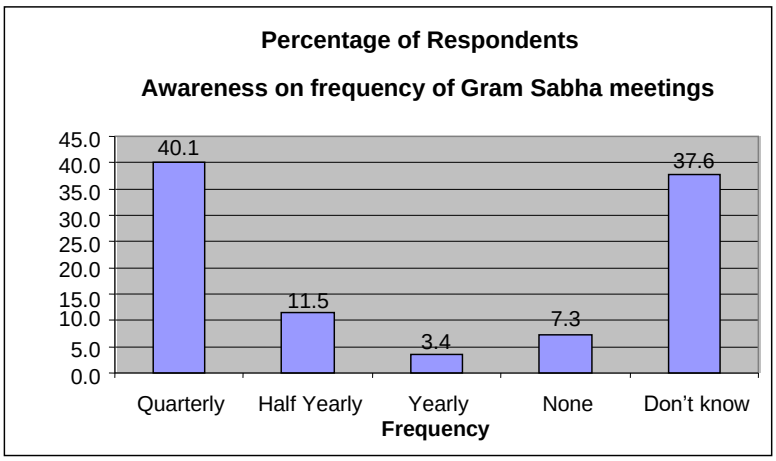


Ground realities suggest that these units of self governance have considerable territory to cover before they are in a position to take up their mandated functions. Almost a fifth of respondents surveyed do not even know who their elected Gram Sabha representatives are (see Figure 1). Gram Sabhas also have little scope to function as planning and supervisory bodies because the Panchayats rarely share their records with them. Hence their role is mostly limited to identifying and approving beneficiaries of welfare schemes.

3.1.1 Gram Sabha meetings

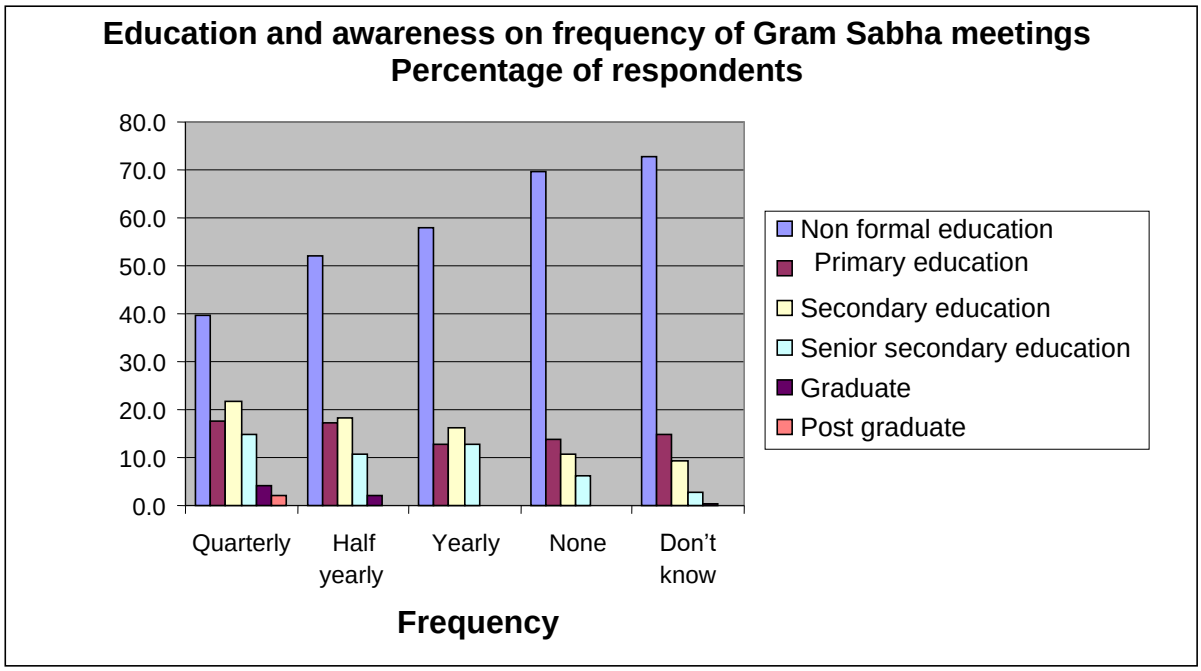
Gram Sabhas are mandated to meet once every three months, although they can meet more frequently if they feel the need to do so. The survey reveals that most Gram Sabha members are not aware of this minimum meeting frequency, with the level of awareness being lower among women – against 50% of men who know about the meeting frequency, the figure for women is only 30%. In fact, almost 50% of women are not even aware that the Gram Sabha is supposed to meet.

Figure – 2 (Detail in Annexure-2)



The data also shows that less educated respondents are less aware of the Gram Sabha meeting provisions, as seen in the bar diagram below.

Figure – 3 (Detail in Annexure-3)



The survey reveals that the prescribed quorum for meetings, which is 10% of the Gram Sabha membership, is seldom observed in practice. Instead, the meeting register is taken from house to house to get signatures to fulfill the quorum. In 2001, an amendment was made stipulating that at least a third of the quorum should be women. However, the amendment was revoked in 2005 because experience showed that very few women attended the meetings.

Overall, participation in the meetings remains low. This low level can be attributed to the strong caste, class and gender divides in villages. Moreover, the meetings are conducted in a manner that most people are unable to understand the outcomes, recommendations and decisions taken. There is also no mechanism to ensure that the views of unrepresented sections of society are taken into account by the Panchayats.

Figure – 4 (Detail in Annexure-4)

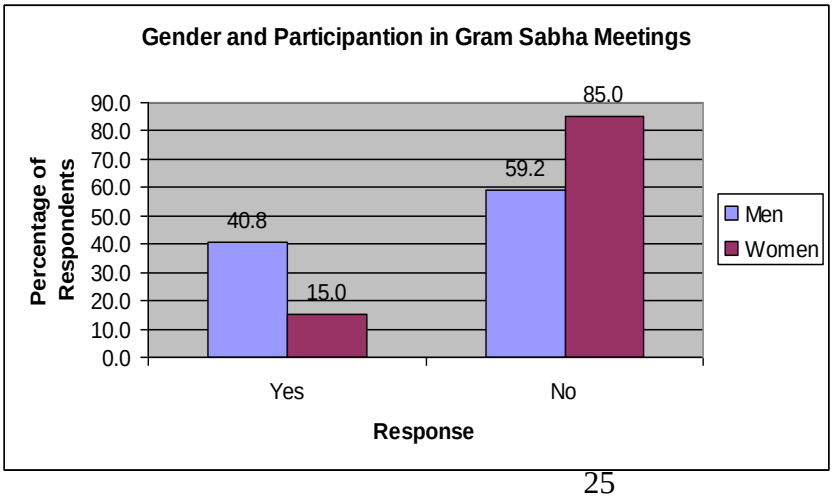
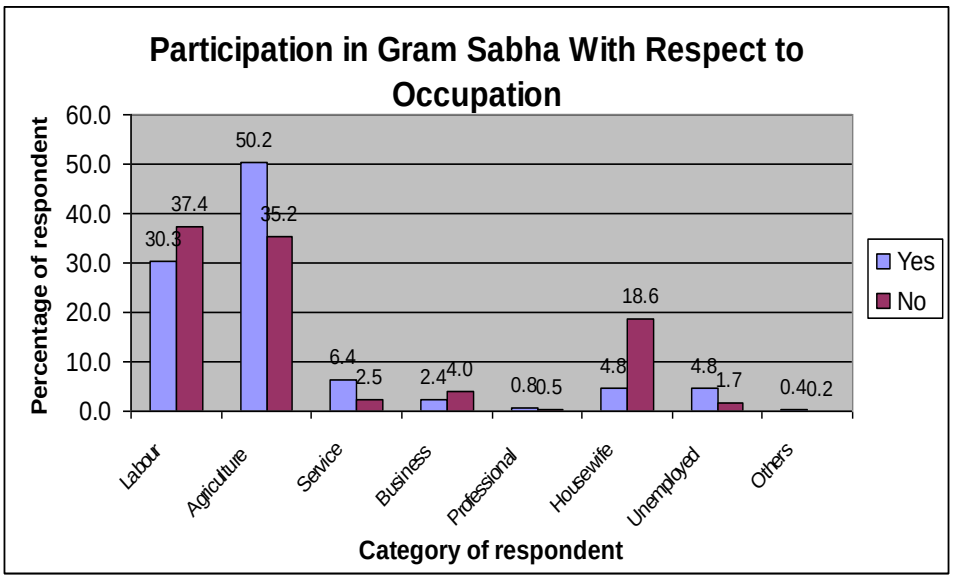


Figure 4 shows the attendance figures for men as well as women. While 41% of male respondents say they attend the meetings the figure for women is a dismal 15%. The largest section among those

who attend comprises small and medium farmers. Next come wage labourers (including farm labour), who are among the poorest sections of village society. They participate to avail the benefits of welfare schemes.

Among those who do not attend regularly are women wage labourers, whose households cannot afford to lose even a day's wages. However, even women from better-off households, who are normally housewives, do not attend.

Figure – 5 (Detail in Annexure-5



The Gram Sabhas seldom decide the agenda for their meetings, the job being performed by the block officials. They mostly discuss central and state schemes and their implementation and the discussions are usually so lengthy that they leave little room for taking up other health issues.

3.1.2 Transparency and accountability

Ensuring transparency and accountability of the Panchayat to the Gram Sabha is one of the most challenging aspects of Panchayati Raj in Madhya Pradesh. Transparency is almost non-existent, given the communication gap between the Gram Sabha and Gram Panchayat which ensures that the former

Box-6

Role and authority of Gram Sabha

Madhya Pradesh is seen as a success story in decentralization of governance. The state has constantly striven to strengthen and empower the Gram Sabhas through progressive amendments to the Panchayati Raj Act and supportive executive orders. However, the Gram Sabhas remain underutilized and dormant even after a decade, despite their potential to radically alter governance.

While local power relations are largely responsible for this state of affairs, government insensitivity also plays its part. Take, for example, the dates fixed by the government for Gram Sabha meetings - January 26, April 14, August 20 and Oct 2. These are dates of national importance but they do not take into account local needs, in particular agricultural needs.
Another area of insensitivity is departmental apathy. Gram Sabha decisions are seldom taken seriously by the administrative machinery.

We thus have a situation where a bureaucracy conditioned to centralized authority conducts the Gram Sabha as a mere formality. So these local bodies remain weak, emasculated by a centralized agenda and the lack of space for independent action and initiative.

remains unaware of the latter's functioning. The target groups of the government's welfare programmes also do not have access to information from the Gram Panchayat.

The Madhya Pradesh Panchayati Raj Act stipulates that the recommendations of the Gram Sabha are binding on the Gram Panchayat. The reality is somewhat different. It is the Gram Panchayats (mostly the Sarpanch/Up-sarpanch and Secretary) that decide the kind of development work that needs to be undertaken. These decisions are usually read out at the Gram Sabha meetings to complete formalities and make it appear as if it is the Gram Sabha that has finalized the Panchayat's development plan.

Another area where accountability is a casualty is account keeping. The state government had made provisions for financial management of the Gram Sabha by introducing the concept of the Gram Kosh. This Village Fund includes funds for grain (Ann Kosh), labour (Shram Kosh), cash (Nakad Kosh) and materials (Vastu Kosh). Separate accounts for each are maintained by the Gram Sabha. In addition, funds for development activities are supposed to be transferred by the Panchayat to the Gram Sabha account. However, in practice it is seen that these accounts are practically operated by the Sarpanch and Secretary, with the Gram Sabha having little autonomy to utilize resources at its disposal.

> The Panchayat meeting is called by the Sarpanch or CEO of the particular Panchayat tier and is held once every month, failing which the Secretary or CEO issues a notice for a meeting. The quorum is 50% of the elected membership (ward Panch, Janpad Panchayat member, Zilla Panchayat member). Thus, Panchayat meetings differ from Gram Sabha meetings, which are the general assembly of the village.

Social audits conducted by Gram Sabhas in Sehore have shown the Sarpanch accepting money or distributing more than 20 to 30% of government grants to administrative officials. Block level officials and block presidents have been equally aggressive in blocking efforts of local youth to conduct a social audit in their Panchayat.

In spite of these constraints, the Gram Sabhas have been able to bring about minor social changes in some pockets of the Panchayats. These include improved supply of safe drinking water, better sanitation, improved birth and childcare practices, education of the girl child, etc.

4.5 Performance of Panchayats

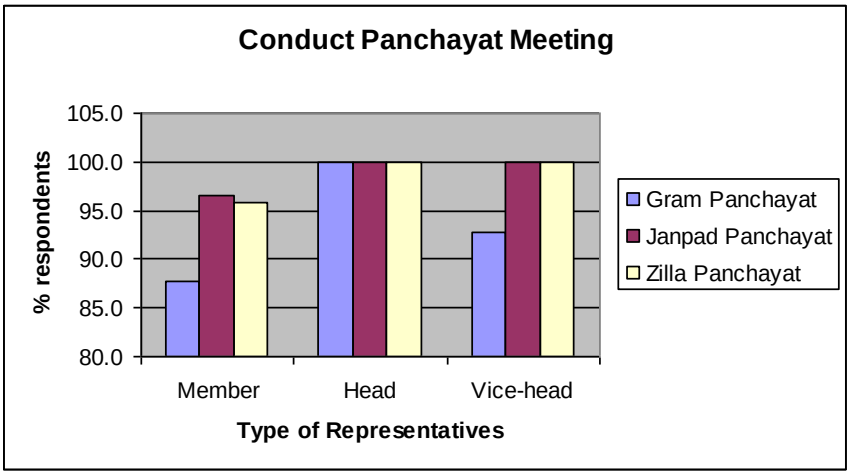
The non-performance of Panchayats, despite the powers and responsibilities given to them, is a matter of concern. The study reveals several factors that hinder Panchayats from functioning as institutions of self governance. The primary reason is apathy of their members, reflected in their irregularity in attending meetings.

3.2.1 Panchayat meetings

The Act mandates that Panchayats meet once a month to discuss development issues. However, this frequency is rarely observed in practice. 91% PRI members say they do

conduct meetings, a claim strongly supported by Panchayat heads (Sarpanch, Janpad Panchayat Adhyaksh, Zilla Panchayat Adhyaksh) and Zilla and Janpad Panchayat vice heads and less strongly by Gram Panchayat members and vice heads (see Figure 7).

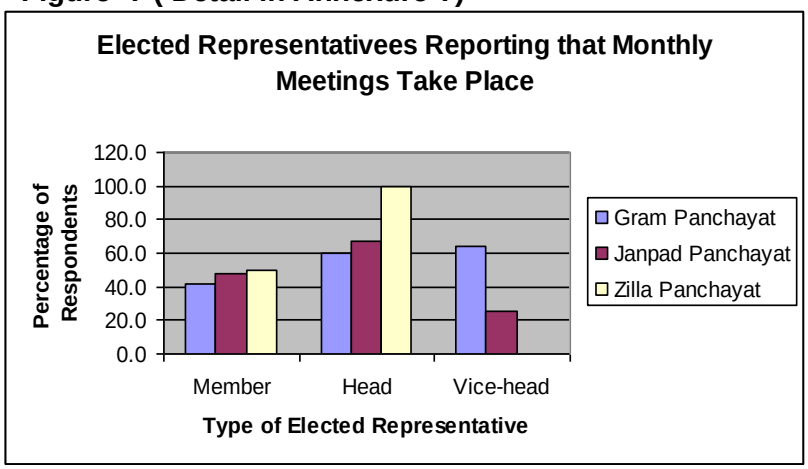
Figure – 6 (Detail in Annexure-6)



However, only 46% of all respondents agree that meetings take place once every month, the average for PRI members being around 50% (see Figure 8). Here again, the strongest support for the claim comes from Panchayat heads and vice heads, although, even among them, several Gram Panchayat and Zilla Panchayat heads and vice heads tend to disagree. The lowest support comes from the Janpad Panchayat vice heads (25%) and ordinary members of all three tiers (43%).

In most cases, respondents say they meet as and when required, with members not always attending.

Figure- 7 (Detail in Annexure-7)



The survey reveals that Panchs (members) are not as actively involved in decision making as the Panchayat heads. Many Panchs say they are not given any responsibility and are only asked to sign the attendance register. This is a more commonplace occurrence in Panchayats where the Sarpanch or Up-Sarpanch is influential.

3.2.2 Perception on functions

Perceptions of the functions assigned to Panchayats are also varied. Around 48% PRI representatives see their role as implementing development programmes (sponsored by the state or central government), most of them being heads and vice heads of different Panchayat tiers. Among these respondents the majority feel this entails planning and executing infrastructural development activities in the village. Only 13 of 285 respondents

(4.5%) feel they also need to pay attention to health issues, supply of drinking water, employment generation, poverty alleviation, etc. Some others see their responsibility as solving people's problems, conducting Panchayat meetings, distributing financial aid from the government to the people, helping the poor and vulnerable, etc.

Around 39% respondents, most of them members of different Panchayat tiers, say they don't know their responsibilities. Of these, 80% point out that they don't know the functions of the Panchayats because they are not given any responsibility or work. Among them is Heera Lal Ahirwar, Janpad Panchayat member of Kuwarpur Panchayat in Ajaygarh block. Alvel Singh Jaar (member of Arru Panchayat, Dabra Block, Gwalior district) accuses the Sarpanch and Secretary of being reluctant to share responsibility for the Panchayat's work with the Panchs.

The lack of clarity about the Panchayat's functions is further compounded by the partial devolution achieved by the government. Although Madhya Pradesh is among the front-runners in devolving functions and many departments have passed on responsibilities to the Panchayats, the devolution of functions has not been matched by the devolution of functionaries and funds. Had such all round devolution taken place, the Panchayats would have been better placed to fulfill their role as institutions of self governance.

Since Panchayats can only perform those functions that are devolved to them, there is need for a synergetic interface between them and line departments. Most departments do have some level of coordination with the Panchayats, the strongest links being at the Zilla Panchayat level. This is ironical because it is at the Gram Panchayat level that coordination is most needed because it is at this level that the delivery of health services actually takes place. Weak coordination between line departments and Gram Panchayats and lack of accountability of line department functionaries are a major cause of concern.

At the district level, the nodal official for the departmental interface is the CEO Zilla Panchayat. The study shows that while the CEO is kept in the loop from time to time regarding the functioning of the department, the Zilla Panchayat Chairperson is not so fortunate. It also points out large overlaps in the devolved functions. Take school education as an example. The Education Department, Gram Panchayat, Janpad Panchayat, Zilla Panchayat, all has responsibility for monitoring the quality of education in schools. So no one agency can be pin-pointed and held responsible for the poor quality of delivery.

3.2.3 Access to financial resources

Panchayats need resources if they are to take up developmental activities and function as effective institutions of local governance. The state government has taken some initiatives to devolve funds from various departments to the Panchayats so that they are empowered to take their own decisions. However, a lot more needs to be done to make Panchayats resource sufficient.

The Gram Swaraj Act 2001 does give Janpad Panchayats, Gram Panchayats and Gram Sabhas the power to impose certain compulsory and optional taxes and fees to build up their own resource base. Proceeds of land revenue, cess on land revenue, cess on education, grazing fees etc are passed on to them, as are royalties received for minor minerals and income from leasing fisheries. However, poor tax buoyancy coupled with lack of systems and infrastructure lead to poor tax collection. The untied grant given to Panchayats (approximately Rs1 lakh for a population of one thousand) is also minuscule compared to their infrastructure requirements. So their dependence on departmental funds is high.

Theoretically, the Gram Panchayat is the end user of a large amount of funds spent in the district by various departments. Yet, the Gram Sabha, which is supposed to be the beneficiary of these schemes, has to forward proposals to the departments to access these tied funds. Since there are no fixed indicators to determine sanctions and since there is no system for getting a time-bound reply in case of non-sanction, fund sanctioning is totally at the discretion of the departments and Zilla Panchayat. In a situation where the departments often refuse to acknowledge their responsibility to the Gram Sabhas, it is these grassroots institutions that end up being victimized.

Departments are even known to work at cross purposes with the PRIs, promoting their own user associations like the Palak Shikshak Sangh, Van Samiti, watershed user groups etc to which they divert crucial funds. This weakens the position of the Panchayats since they have fewer resources than these parallel institutions, which perform similar functions.

3.3 Key Findings

The issues highlighted in this chapter help us understand the constraints Panchayats and Gram Sabhas face in performing their functions, which limits their scope to become powerful institutions of decentralized self governance. There are many more such issues that have emerged from the qualitative responses and analysis of the study data. It would be useful to sum up and categorize these findings under the broad heads of procedural issues and gender issues.

3.3.1 Procedural issues

- Field experience and the data from the study suggest that most Gram Panchayats hold only mandatory Gram Sabha meetings. The date, time and agenda of these meetings are decided by the district administration. The agenda, which mostly focuses on implementing development schemes of the government, is so lengthy and time consuming it leaves little room for discussing local issues of concern. Moreover, government officials attending the meetings are not serious about the discussions. As a result, a large number of people abstain from Gram Sabha meetings.

- The centralized top-down agenda limits the scope of Panchayats to take up local issues. This is clear from the response of most PRI representatives that implementing development schemes is their main function.
- The Panchayats allot higher priority to implementing government schemes and achieving targets to the detriment of important local issues. Elected heads, in particular, are perceived to favour construction activities and other tangible functions with financial implications. Beneficiary selection and distribution of monetary benefits are also given more importance at Panchayat and Gram Sabha meetings than development issues and participatory governance.
- Despite these limitations and constraints, the study responses show that health continues to figure prominently in Panchayat and Gram Sabha discussions.

3.3.2 Gender issues

- Many women-headed Panchayats are dominated by male family members. The women are often mocked by the Panchs and Gram Sabha members, given the traditional male-dominated culture in the three study districts (Gwalior, Panna and Sehore). In such a situation, they find it difficult to perform their duties.
- Male domination also makes women wary of attending Gram Sabha meetings. Many are unclear of the role expected of them in the Gram Sabha, while many others are unable to assert their viewpoint. As a result only 15% of those who attend Gram Sabha meetings are women.

Chapter- 4

HEALTH PROBLEMS IN GRAM PANCHAYATS

Chapter- 4

HEALTH PROBLEMS IN GRAM PANCHAYATS

The analysis of quantitative data and qualitative responses brings to the fore the health problems prevailing in villages. Before moving forward with the analysis, it is important to clarify that at times the data was sufficiently indicative of a particular response but examination of the qualitative responses pointed to a different reality. The three sets of stakeholders perceive health issues from their own perspective and they often differ considerably in interpreting the magnitude and cause of health problems. So it is futile to assess problems, their causes and possible solutions by focusing only on one constituency.

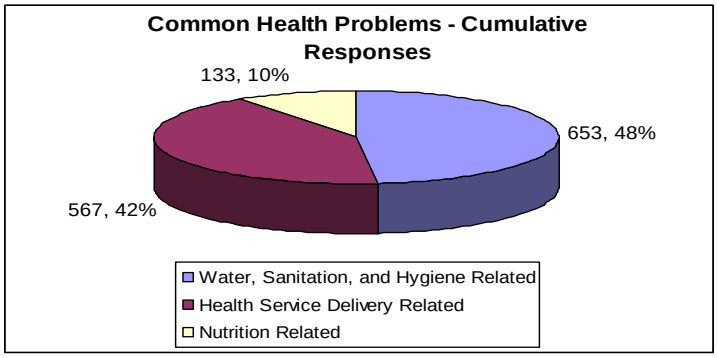
4.1 Community perception of healthcare

The study shows that the beneficiary community in general views health-related problems as a major hindrance and would like to see improvements being made in the healthcare delivery system. Although the questionnaires had no direct questions on health-related expenditure of the beneficiaries, it is apparent that health-related problems are an integral – and often expensive - part of their lives in terms of the anguish caused and the time and money spent. People do understand the reasons for these problems, as seen in the many suggestions and solutions given by the respondents. Overall, the general perception of healthcare in the community is determined by attitudes, monetary costs and collective decision-making abilities.

4.2 Health-related problems

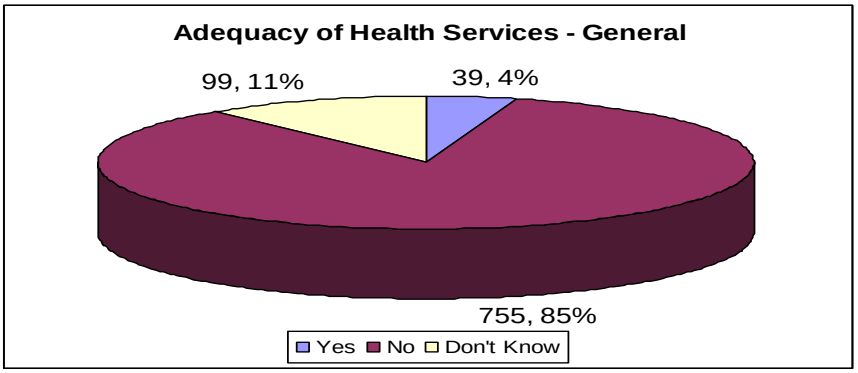
The data suggests there are three broad categories of health-related problems – water, sanitation and hygiene related; health facilities related; and nutrition related. The first two categories are discussed at length in this section. The reason for leaving out the nutrition-related problem is because it is more the outcome of personal food habits, dietary awareness levels and purchasing power.

Figure- 8 (Detail in Annexure-8)



The interactions with respondents bring out a clear linkage in their minds between their living environment and available health services – both disease prevention and control. In most cases, the linkage is so strong that issues tend to overlap. For instance, issues

Figure – 9 (Detail in Annexure-9)



relating to health facilities and health service delivery often crisscross, as do issues related to the prevalence of common diseases and the living environment of the people.

4.3 Existing health facilities and treatment

Most respondents feel the existing health facilities and treatment received are inadequate. Despite the existence of a large number of schemes and the operation of many programmes, people feel they are receiving limited benefits.

Most PRI functionaries corroborate these views when asked to comment on the appropriateness of treatment available in their Panchayats. They also specify reasons for such sub-optimal health services.

Figure 10 (Detail in Annexure-10)

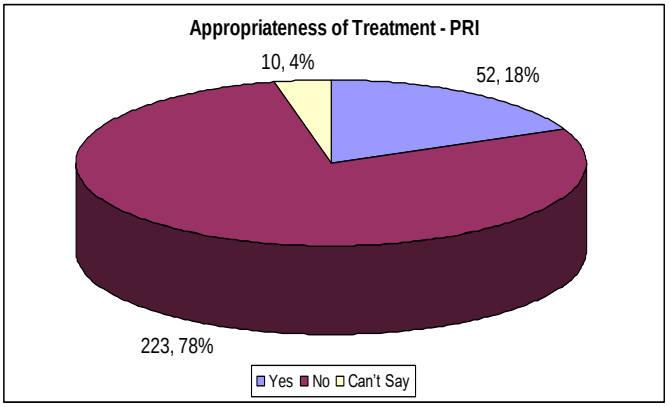
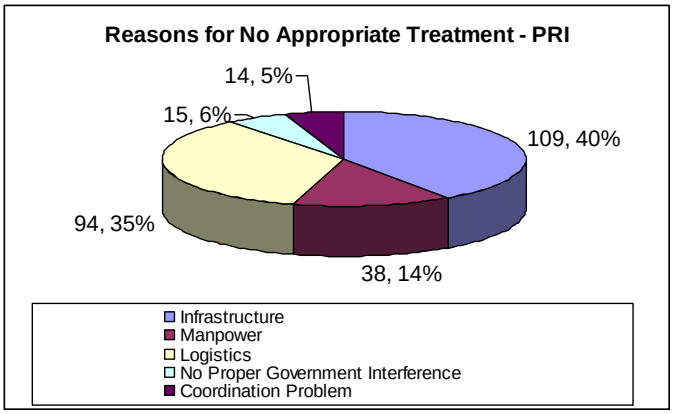


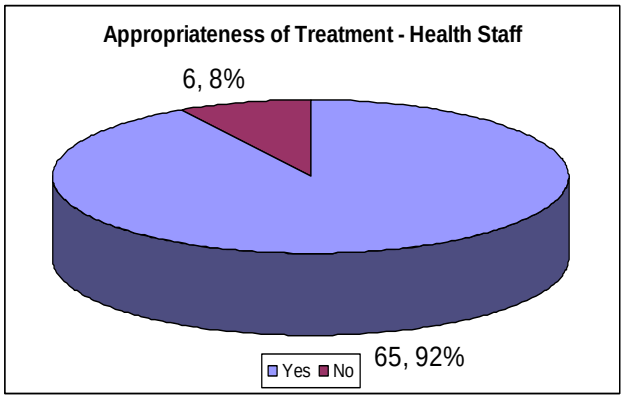
Figure – 11 (Detail in Annexure-11)



PRI functionaries – No appropriate treatment	Gram Panchayat	Block Panchayat	District Panchayat	Total
Elected member	139	49	17	205
Panchayat head	11	1	1	13
Panchayat vice head	14	1	0	15
Total	164	51	18	233

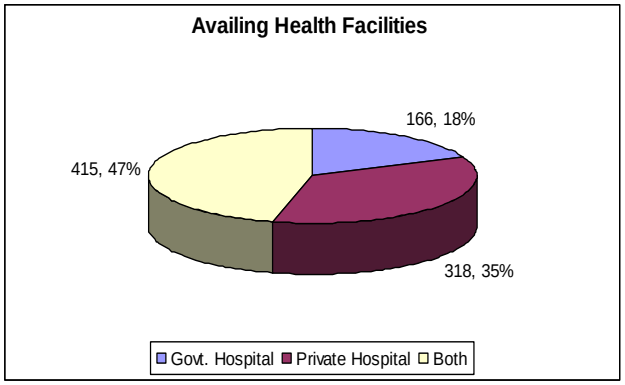
The major reasons appear to be under-developed infrastructure and inadequate logistics. Manpower-related constraints do not seem to play an important role, maybe because the questions were restricted to government hospital facilities and did not include Multipurpose Health Workers (MPWs). Less crucial reasons include government interventions to effect better service delivery and the extent of coordination between health staff and Panchayats.

Figure – 12 (Detail in Annexure-12)



It is apparent that if PRI functionaries develop better rapport with the health staff and vice versa, improvements in infrastructure and logistics could be worked out. But how to achieve such coordination is the challenge.

Figure – 13 (Detail in Annexure-13)



When the issue was discussed with the health staff at different levels, their response was diametrically opposite. It is not as if they do not accept the inadequacies of the system, but their responses need to be seen in the light of their willingness to take responsibility for these inadequacies. A number of implied cues came out during the discussion. They are mentioned in the subsequent sections dealing with health service delivery.

Health staff	Sub - centre	PHC	Block PHC	District hospital
Yes	34	6	18	7
No	6	0	0	0
Total	**40**	**6**	**18**	**7**

4.3.1 Government vs private

The response of the beneficiary community to existing healthcare facilities is mixed. When asked whether they prefer government or private facilities for treatment, most people say they avail the services of both. Some say they first approach the government facility, but go to private establishments when they don't receive proper treatment. Some others say they prefer to go to government facilities only if the injury or disease is minor and prefer the private sector for other health needs.

Figure – 14(Detail in Annexure-14

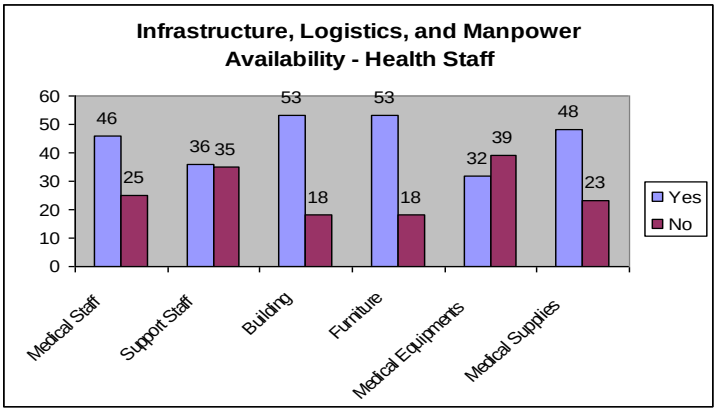
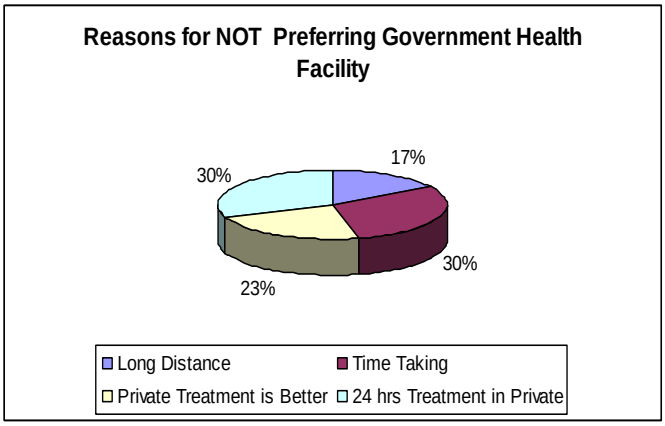


Figure – 15 (Detail in Annexure-15)



The number of people who favour private healthcare is almost double the number preferring government services. A correlation between financial status and preference for health facility may have helped in presenting a better picture. But the questions were not directed to such an enquiry, so any projection can only be speculatory.

A substantial number of respondents were unable to provide any concrete reasons for preferring private healthcare. The stated reasons in their order of relevance are: 1) private services are available all the time; 2) treatment takes more time in government hospitals; 3) private hospitals provide better treatment; 4) government hospitals are more distant.

Box-7

Private treatment-reasons for prefrence

Although the cost of government hospital services may appear low, the experience of people is quite different. Various factors like proximity, treatment duration, attendance of health staff, promptness of diagnosis, extent of waiting hours, and other such heads get included in the total cost and affect patient decisions.

A respondent named Bhagwati Bai Bairagi of Kapuri Panchayat in Sehore district points out that after repeated visits to government and private health facilities, she found that 'except for the government hospital bed, everything else involved more or less the same expenditure."

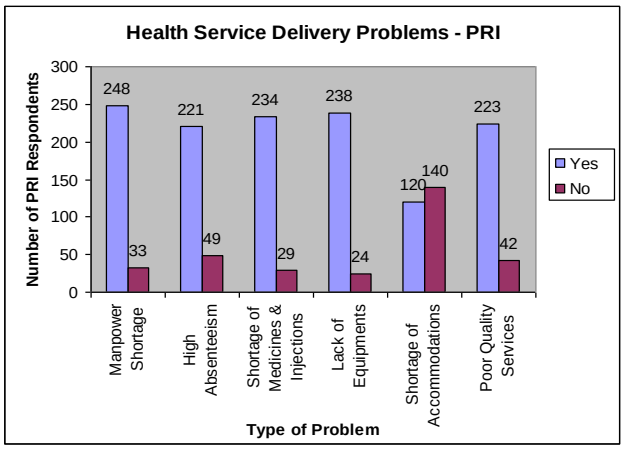
Another respondent from the same Panchayat says the "one way fare to reach the nearest government facility is Rs30, and medicines also cost significantly. Adding to this is the huge crowd in hospital which means one wastes a whole day in getting treatment."

4.4 Problems in health service delivery

Problems in health service delivery can be classified in three categories – infrastructure related, manpower related and logistics related. The responses to these

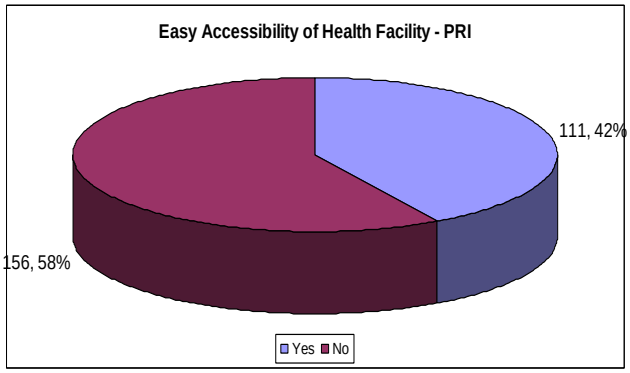
three categories are contrasting. While the beneficiaries and PRI functionaries complain that all three are lacking, most health staff are relatively satisfied with infrastructure and logistics, although they do acknowledge manpower constraints - specifically relating to the shortfall of 'support staff'.

Figure – 16 (Detail in Annexure-16)



It is also difficult to assess how well the health staff is performing its duties at the health centre or in the field. A common finding is that a large geographical work area is a barrier for health workers, since they find it difficult to visit all villages at defined intervals. But to what extent these workers are observing their residential obligations (living at the Panchayat HQ or in the field) is also an issue that needs to be looked into.

Figure - 17 (Detail in Annexure-17)



Apart from these, the respondents also highlighted some logistics issues, like shortages of drugs and non-availability or non-functioning of equipment.

4.4.1 Infrastructure related problems

Infrastructure related issues are diverse, ranging from availability of a health facility to accessibility of the facility and the village. Accessibility of the facility matters to people who wish to use it while accessibility of the village is a problem faced by the health worker. In both cases, the absence of good roads and lack of cheap and regular transportation creates a problem.

The responses of the three categories of stakeholders cannot be compared because no direct questions were asked about infrastructure-related problems. However, the beneficiaries emphasize such problems the most, followed by PRI

Box-7

Panchayat's grievance with health workers

Despite the large-scale appointment of health workers in villages, most community and PRI respondents complain about their prolonged absence or inappropriate way of functioning.

For instance, Manjit Kaur of Mohna Panchayat in Gwalior points out that the health worker does not live in the village and comes only once or twice a week and her work is restricted to vaccinating children for the polio campaign.

Other respondents say they do receive maternity and family planning-related information and, at times, advice for undergoing other tests. But such sharing is restricted only to some chosen residents who have a 'good' relationship with the health worker.

Many respondents say the frequency of village visits of health workers ranges from twice a month to twice a year.

functionaries, with health staff not attaching much significance to them.

Box-8

Difficulty faced by Health workers

Ramswarup Dwivedi, an MPW from Banaharikala, Ajaygarh describes at length the practical problems he faces in delivering health services to villagers. He complains of lack of cooperation from the Panchayat as a result of which he finds it difficult to fulfill his responsibilities in health schemes like the polio campaign.

Without a vehicle and without relevant information about potential beneficiaries, it becomes difficult for him to cater to such a large work area and reach the neediest village inhabitants. He expects much better proactive support from the Panchayat and feels such support will provide multifarious linkages.
But such cooperation is linked to the health worker being regular in attending to his work.

4.4.2 Manpower-related problems

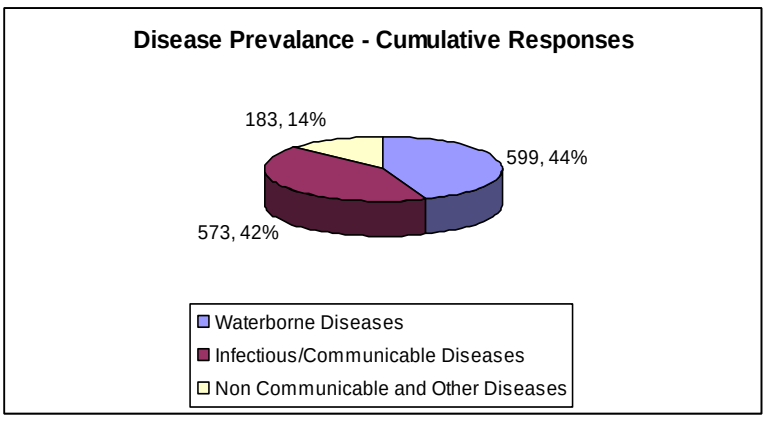
The study data shows the large-scale availability of health workers in villages but questions have been raised about their actual contribution to decentralized delivery of health services. When asked about the help extended by local health staff, people complain about their long absences from the village.

When queried about the nature of interactions they have with these personnel, their responses are unclear. But an analysis of the responses shows that the interactions do not serve any useful health promotion purpose, being restricted to communications about vaccination camps and family planning advice.
When health workers were asked the reasons for their sub-optimal performance, they cited the large geographical work area, limited support from their department and the PRI functionaries and low living standards in villages.

General	**N**	**%**
Yes	**761**	**84.4**
No	**111**	**12.3**
Don't know	**29**	**3.2**
Total	**901**	**100**

A prime concern of the beneficiary community as well as PRI functionaries is whether the health worker lives at the Panchayat headquarters or not, the implied demand being to control and facilitate such residence. The demand suggests that the preference for private healthcare is not the outcome of choice but of need. The underlying assumption is that there is much scope for improvements in the government health services if the present levels of accountability and responsibility are strengthened by PRI coordinated social monitoring.

Figure – 18 (Detail in Annexure-18)



4.4.3 Logistics-related problems

The supply and distribution of medicines and the availability of equipment/instruments are major logistics-related issues. A significantly

large proportion of the beneficiaries and PRI functionaries say they almost always face a medicine crunch in government hospitals or with the health worker.

There are two aspects to the medicine supply problem. First is inadequate/low transparency about inflow-outflow of medicines/vaccines. Second, the health staff have no specific instructions to share the details of medicine supplies with the people. This lack of information gives rise to speculation about malpractices of the health staff working at the health centre and in the field.

The problem of equipment/instrument availability cannot obviously be dealt with at the Panchayat level unless additional financial resources are provided. People complain about the difficulties they face on account of poor/inadequate equipment, but they understand that any solution to the problem lies in the hands of the higher authorities of the Health Department. So they don't consider lack of equipment to be an indicator of malfunctioning of the Panchayat.

4. 5 Disease patterns and living environment

The most prevalent diseases in rural areas can be broadly classified into three categories: 1) waterborne diseases; 2) infectious or communicable diseases; 3) non-communicable and other diseases. Local variations can be observed in Panchayats, depending on their level of development. The data suggests the respondents understand the inter-linkage between disease and hygiene. But the fact that they do not change their living habits and health behaviour even after knowing is a matter of grave concern. They appear reluctant to alter the status quo.

One issue that constantly came up in discussions on health problems and diseases was the living environment in villages. People are concerned about poor sanitation and cleanliness-related issues of their villages. Most respondents blame these unhygienic conditions for the prevalence of disease. PRI functionaries highlight water, sanitation and hygiene as among the most challenging issues connected with health-related problems while health staff point to low levels of public sensitization about cleanliness and hygiene.

Many departments are involved in improving living conditions in villages, including those dealing with supply of clean and safe water, sanitation, drainage and waste disposal, hygiene promotion and so on. It is difficult to affect improvements if synergy is not developed between these functional entities. Unfortunately, the preventive aspects of health promotion generally take a backseat, even though it is evident to most respondents that waterborne diseases as well as communicable diseases can be controlled to a large extent if PRI functionaries work with the community to promote a healthy living environment.

4.6 Key Findings

Curative and preventive health depends crucially on state-provided health services and infrastructure. But while the supply side of health services tends to limit the state response to provision of physical facilities, the demand side asks for much more. It focuses on qualitative changes in the nature of service delivery, demanding a more sensitive attitude on the part of the state machinery.

The qualitative responses of the stakeholders reflect their perceptions and projections of the healthcare problem. Two key issues are accountability and ignorance about health issues. The responses suggest that people see themselves as victims of inadequate and loose delivery by the health service providers. There seems to be some truth in this assertion because wherever PRI functionaries and health staff have worked in coordination, they have been able to significantly change the situation.

The gaps between expectations and delivery can be traced to the confusion about the role and responsibilities of the health personnel, with the low levels of education and sensitization among the people exacerbating the situation further.

The following table sums up the perceptions of stakeholders of the Panchayats' health problems:

Box-9

Factors influencing health-response of different stakeholders

Respondents	Casual factors	Complementary inadequacies
Beneficiary community	Unclean surroundings, poor sanitation, open waste and garbage disposal, underdeveloped drainage and sewerage systems	Absence of or distance of health facility, inadequate/non-functional equipment and instruments in the health facility, lack of commitment, irregularity and rude behaviour of health staff, low activity of Panchayat, low transparency in dealings
PRI functionaries	Under-developed village infrastructure leading to unclean environment, neglected preventive aspects resulting in spread of infections and prevalence of diseases	Poverty and malnutrition, inadequate resources with Panchayat, limited government support, sub-optimal performance of health staff, coordination problems, accountability of health staff and other government functionaries to the respective departments rather than to the Panchayats
Health staff	General ignorance of people, low levels of education and health sensitivity, poor hygiene, low treatment adherence, poverty and malnutrition	Large work area, commuting problems, limited number of support staff, scant proactive support from Panchayats, some shortage of medicines and supplies, uncalled for door-to-door visits, popular superstitions and scepticisms

4.6.1 Differential perception of the magnitude of the problem by the different Stakeholders

Wide gaps exist between the perceptions of health service providers and other stakeholders on the delivery of health services. Most health service providers seem content with the functioning of the system while the beneficiaries and the Panchayat representatives think otherwise. They complain about frequent absenteeism, non-availability of drugs and poor quality of service delivery. Even when the infrastructure is in place and the required staff is posted, the service delivery remains poor, with the beneficiaries complaining about irregularity and frequent absenteeism of the staff and the lack of interest in their health problems. So even if the data shows a high percentage of Panchayats being serviced by health service providers, the quality and regularity of service is so poor that around 90% of the beneficiaries remain dissatisfied. As a result only 18% of the people go to government health centres with their health problems.

The field experience and qualitative responses seem to indicate that the contentment of health service providers is a mere cover up for the poor quality of services they provide. Village-level health service providers feel they are doing their job even if they visit the Panchayat only once in two months. The beneficiaries perceive the frequency as inadequate. Similarly, health service providers mostly perceive their function as implementing immunization programmes, while the beneficiary community expects better quality treatment from them. The data reflects the following flip side of the departmental delivery.

- There is a willful negligence of duty by the departmental functionaries.
- Poor coordination between Panchayat and Health functionaries, at the grass root level.
- Wide gap between community aspiration and the delivery of the Health department and

.

This is a disturbing finding. It calls for improved coordination in the field between Panchayats and departmental staff and the creation of a climate in which villagers feel emboldened to avail of government facilities and services. This is possible only if responsibilities are clearly defined and accountability strictly ensured. Also, health staff and PRI functionaries require to enhance their competence through capacity building if they are to win the confidence of the people.

Chapter – 5

PANCHAYATS' PERFORMANCE IN HEALTH CARE

Chapter - 5

PANCHAYAT'S PERFORMANCE IN HEALTH CARE

The Madhya Pradesh Gram Swaraj Adhiniyam 2001 and National Rural Health Mission (NRHM) assigned several healthcare functions and responsibilities to Panchayats, including preparation of the village/Panchayat health plan, taking care of local health problems and building health awareness within the community. Their performance in some functions has been efficient and effective while it has been found wanting in many others. The factors affecting performance include the indifferent attitude of the Panchayats towards health, weak financial and resource base, inadequate capacity to handle health issues, lack of authority to undertake their assigned role and insufficient cooperation from departmental functionaries.

Panchayats are not direct implementers of health programmes, nor is their engagement in healthcare delivery very intense. But the study reveals across-the-board unanimity among the different stakeholders (PRI representatives, health service providers and the beneficiary community) that they are important institutions for improving the health status of their operational areas. The wide array of responses on their track record in healthcare, however, suggests varying perceptions of their role and responsibilities.

Panchayat representatives cite a support role (health education, planning and budgeting, coordinating and monitoring healthcare delivery, record keeping) while the beneficiary community points to the 'obvious and successfully' performed role of a facilitator (their engagement in various national health programme like malaria control, TB control, blindness control or women and child programmes). Many respondents also cite a number of 'do-able' functions that Panchayats can perform. This could be the reason why many of the functions identified by the respondents are 'desired' functions and not necessarily 'performed' functions.

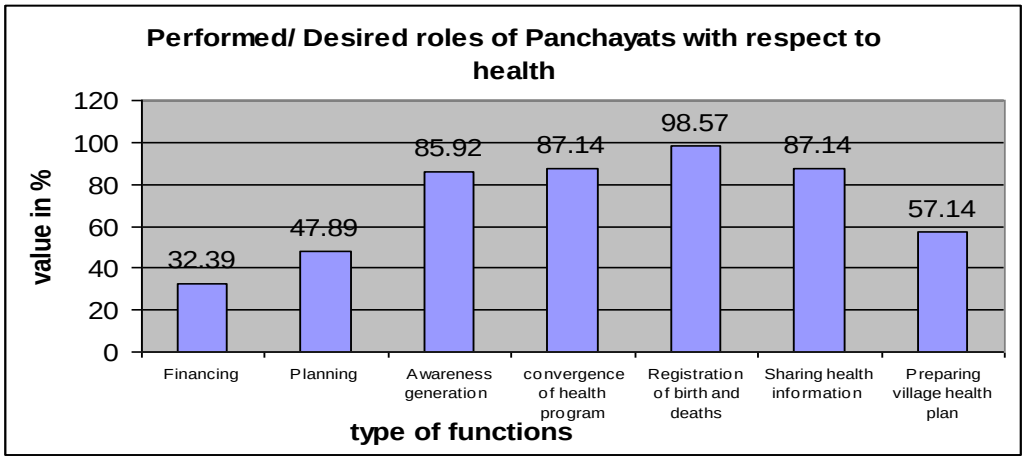
This section assesses the performance of Panchayats on parameters relating to their support role. The assessment is in three parts - the first deals with the desired vs performed role of Panchayats in healthcare, the second focuses on the kind of healthcare functions undertaken by Panchayats and the third captures the impact of Panchayats in improving the health status of the community.

5.1 Desired vs performed role of Panchayats

The interview responses reveal gaps between the perceived role and actual performance of Panchayats. Over three-fourths of health service providers agree that Panchayats have the competence to improve the health status of the community but only 30% feel they are actually doing so. The number of respondents from the beneficiary community who believe Panchayats have the necessary competence is much lower.

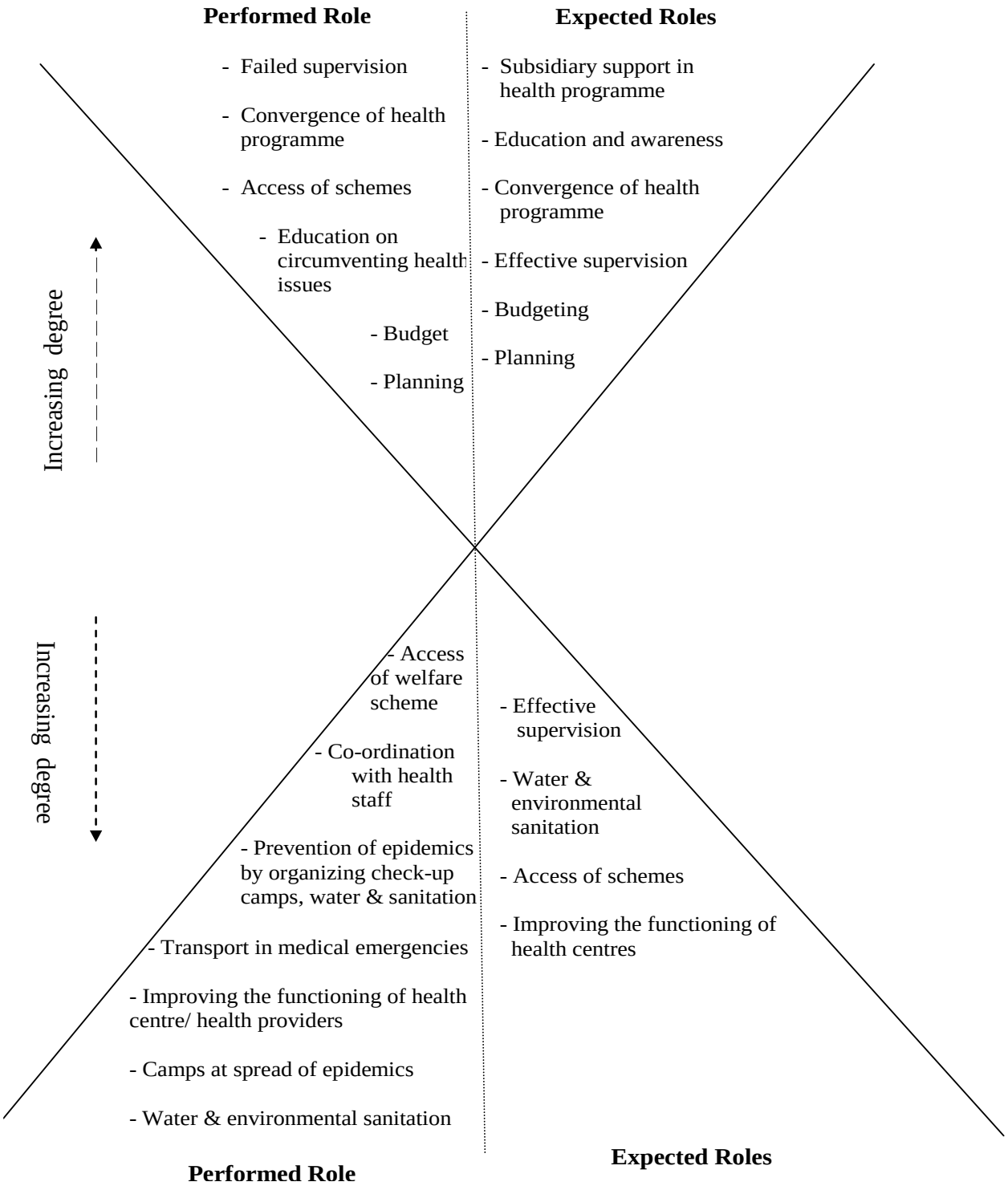
The following bar chart captures the opinions of health service providers. Not many of them think Panchayats are expected to play the role of a financier or planner. Rather, the perception is that they can play an important role in health education, linking/converging health programmes at the grassroots and registering deaths, births, pregnancies and marriages.

Figure - 19



But Panchayats require capacity building support if they are to play a meaningful role in these areas. Around one-fourth of PRI representatives have received some capacity building training, the percentage being highest for Zilla Panchayat representatives (50%) and lowest for Gram Panchayat representatives (20%). Considering that the Gram Panchayat is where healthcare delivery actually takes place, the situation is worrisome, particularly since the training also focuses on subjects like the role and responsibilities of Panchayats, the 73rd Amendment, developmental issues and schemes, general administration, accounting, etc.

Health providers and Panchayat

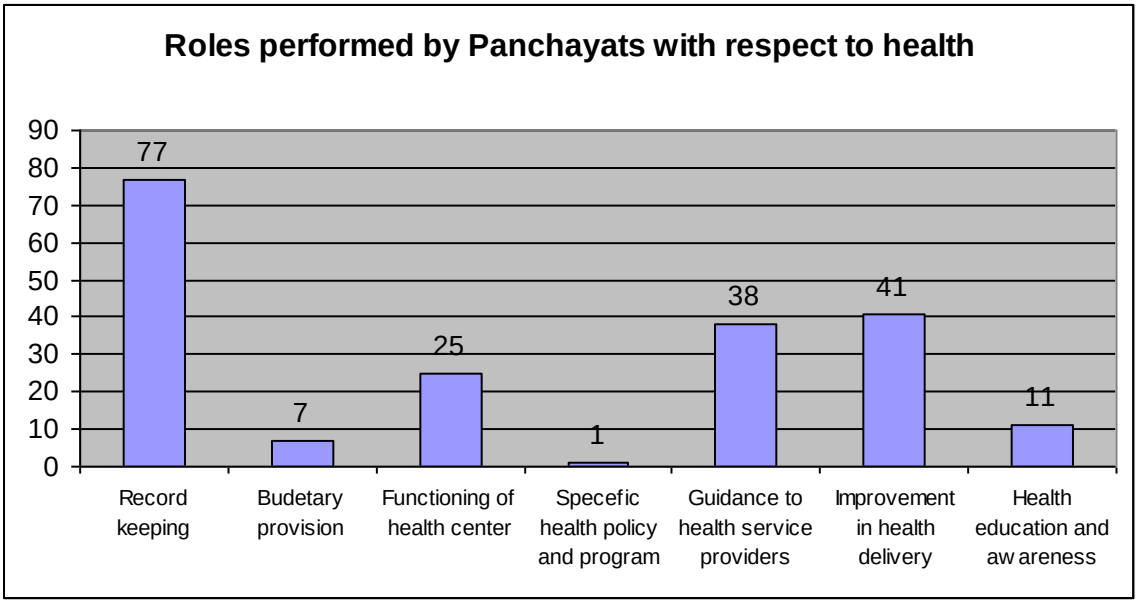


Community and Panchayat

5.1. 2 Performed roles of Panchayats

The following bar diagram (Figure 20) presents the views of PRI representatives on the different functions performed by Panchayats, including record keeping, guiding health service providers, streamlining the health centres, solving common health problems, health education and awareness building, formulating policy and planning and budgeting.

Figure 20



Record keeping and data maintenance: Record keeping seems to be a regular and well-performed function of Panchayats, with over 76% of PRI representatives (including heads and members from all three tiers) seeing it as their main function. The percentage of health service providers is even higher at 94%, suggesting they have a generic perception of Panchayat records. Important record-keeping functions include registration of births, deaths, pregnancies and marriages and collection of data on common health problems, diseases and epidemics. However, 22% of health service providers are sceptical whether such records are actually maintained by Panchayats.

Preparing health plans: There seems to be a disjoint when it comes to the planning function of Panchayats, reflecting poor understanding and coordination between health service providers and Panchayats. The general perception among departmental officials is that planning is an 'expected' rather than 'performed' function of Panchayats, with 25% expressing the view that planning is a departmental domain into which Panchayats are not

Almost all the Sarpanchs say they maintain records of births, though some of the Panchs are not very sure these records are kept. The data suggests that Panchayats maintain records as a duty. Neither the Panchayats nor the departments refer to these records when formulating their annual plans.

supposed to infiltrate. 35% of them say Panchayats actually use the records they maintain for planning purposes, a claim that seems to be contradicted by the Panchayats themselves, with only one percent saying they actually do any planning at all.

Figure 21
Response of the Panchayat

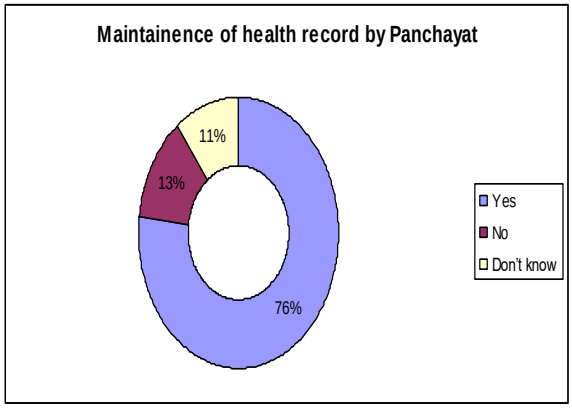
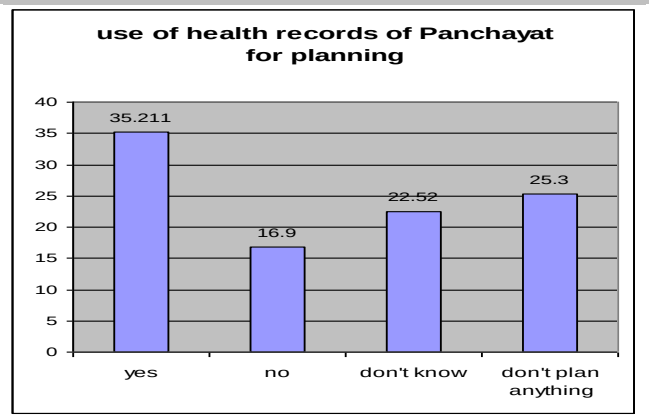


Figure 22
Response of the health provider



5.3 Addressing local health problems

The survey data shows that 90% of respondents identify delivery of health services and combating commonly occurring diseases as the chief healthcare concerns of Panchayats. Commonly occurring diseases are mostly linked to water-sanitation issues and Panchayats have sought to address all these interlinked issues. But the response of PRI representatives to improving health services is slightly higher compared to their response to water and sanitation issues.

However, less than 8% of Panchayats make budgetary provisions for health. They do not have untied funds to allocate for healthcare and very few (1.4%) receive grants for undertaking health activities. They largely depend on state-run programmes for their health-related needs - whether it is buying medicines, improving health facilities or providing support to women and children.

Dharma Bai Adivasi, a first time elected president of the Gwalior Zilla Panchayat, points out that Panchayats are almost totally dependent on the department for financial support and staff. She says the department has yet to allocate any grant to her Panchayat for improving health services.

5.2.1 Health as an important agenda item

Although healthcare is not a prominent perceived function of Panchayats, the subject forms an important agenda item at Panchayat and Gram Sabha meetings, with 41.5% of the beneficiary community and 38.5% of PRI representatives saying they discuss health issues in their meetings. However, health education, planning and budgeting don't figure prominently in the discussions, possibly because Panchayats aren't too sure about their role in these areas and also because these technical aspects of health are poorly understood by them.

The most frequently discussed issues, as seen in the responses, are listed below:

- Availability of safe drinking water and sanitation tops the chart, according to 20% of PRI representatives, the frequency of response being 145.
- Functioning of health service providers and implementation of health welfare schemes are other important concerns, their frequency being 119 and 117 respectively.
- Functioning of health centres follows with 86 responses from PRI representatives.

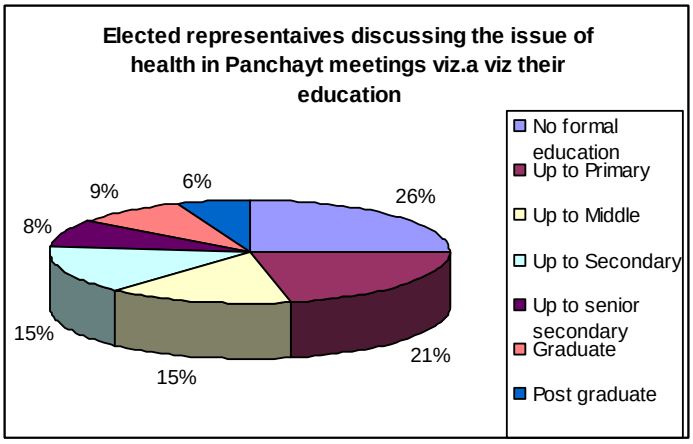
Table - 6

Discussions on health issues in Panchayat meetings
(% of respondents confirming positively)

Gram Panchayat	Janpad Panchayat	Zilla Panchayat	Gram Sabha (Beneficiaries)
45.1%	65.6%	92.9%	41.5%
Type of issues discussed			
• Water and sanitation • Functioning of health service providers • Education on welfare schemes, prevention of epidemics and other health-related issues. • Beneficiary selection	• Health camps • Special campaigns during epidemics • Implementation of health schemes	• Health plan and health budget • Functioning of health centres and district hospitals	• Availability of safe drinking water and proper sanitation. • Specific health problems occurring from time to time • Access to health schemes • Functioning of the health department • Immunization etc.

There is no significant relationship between education levels of PRI representatives and their responses on health-related discussions, although the percentage of members discussing health issues is higher among the more educated. But with representation of members in the higher education bracket showing a declining trend, around 25% of those who say they discuss health issues are not formally educated and an equal percentage has attended only primary school.

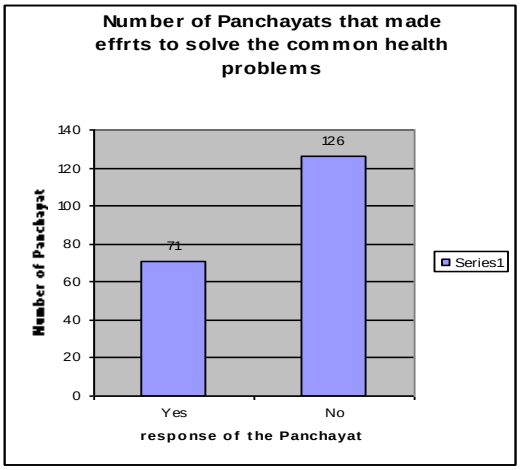
Figure- 24



5.2.2 Improving facilities at health centres

Elected representatives discussing the 12% of the beneficiary community say the absence of a health centre is an important health problem. Where health centres exist, 25% of PRI representatives say they try to combat shortages and remove bottlenecks in their functioning, the percentage being higher in the higher tiers. The number of Gram Panchayats seeking to do so is also high. Similarly, elected heads (44%) appear to make more efforts compared to elected members (12%), although elected members at the Zilla Panchayat level do seem to be taking keener interest in local problems.

Figure - 25



Dharmabai Adivasi, a first-time elected female head of the Gwalior Zilla Panchayat, says the Panchayat does not have adequate funds - untied fund in particular. So it can't allocate funds for combating health problems. Neither does it have specific health programmes of its own. However, there are funds with the Health Department which the Panchayat can certainly facilitate better usage of. She pointed out that the Panchayat can and does support the implementation of departmental health programmes.

5.2.3 Bringing health issues to the notice of the relevant authority

Most issues brought to the notice of the department relate to improving the functioning of the health services. They include frequent absenteeism of health functionaries like the

ANM and MPW, lack of medicines and equipment in the health centre, poor functioning of the health programmes in the Panchayats, problems in immunization programmes, need for additional staff, etc. The second type of issues relates to measures to be taken to combat epidemics like malaria and chikungunia, providing information on the spread of diseases like cholera, seeking help from the national health programme for TB control, etc. Other issues, which are fewer in number, relate to seeking advice from health providers or enquiring about a specific disease.

According to the CHMO Gwalior district, the Panchayat undertakes a regular review of the health situation in the district and provides feedback to the Health Department. Similarly, a BEE in the district said Panchayats request funds and health workers from the department and regularly apprise the department of problems in their area. When the Janpad Panchayat president of Panna block in Panna district required a female doctor in the block he made a request to the district collector who ensured that a lady doctor was posted in the block.

However, apart from bringing issues to the notice of the relevant authorities and coordinating with them to find solutions, Panchayats are unable to respond in any other way to the health problems in their area.

Box-10

Some efforts of Panchayat representatives in improving health

Panchayat representative	Initiatives
Narsingh Jatav, Arrs Panchayat, Dabra, Gwalior	Sent a request for opening a health centre to the Janpad Panchayat.
Chali Gond, deputy head of Khajoori Kudar Panchayat, Panna	Sent several requests to district administration and Health Department for opening a health centre in the Panchayat.
Vijay Shankar Kushwaha, Purshottam Pur Panchayat, Panna	Sent a proposal for opening a sub-health centre in the Panchayat to the Janpad Panchayat and Health Department.
Phool Singh Jatav, Dalhan Choki Panchayat, Panna	Sent several requests for construction of a building for the sub-health centre
Gram Panchayat, Panna	Sent a request for a lady doctor in the district.
Gram Panchayat in Sehore	Mobilized the Gram Sabha to register a complaint regarding the poor functioning of the PHC with the relevant authority.
Janpad Panchayat President, Sehore	Collected complaints from the Gram Panchayats and forwarded them to the Zilla Panchayat and Health Department.

Rameshwar Tiwari, Janpad Panchayat, Dabra, Gwalior	Took up problems with the Zilla Panchayat, BMO, MP and MLA of the area. Requested appointment of additional staff as well as opening of new health centres.
Pyarelal Aadivasi, Ghati Gaon, Gwalior	Sent feedback to Zilla Panchayat and Health Department. Made efforts to increase resources with the help of the Health Department.

5.2.4 Opinions of health functionaries

Many health service providers agree that Panchayats play a facilitative role in healthcare. This role is perceived more strongly by the district health machinery than the village health providers, with 85.7% of district-level health staff saying the Panchayats provide support and guidance to strengthen the health services, against 42% of village level functionaries.

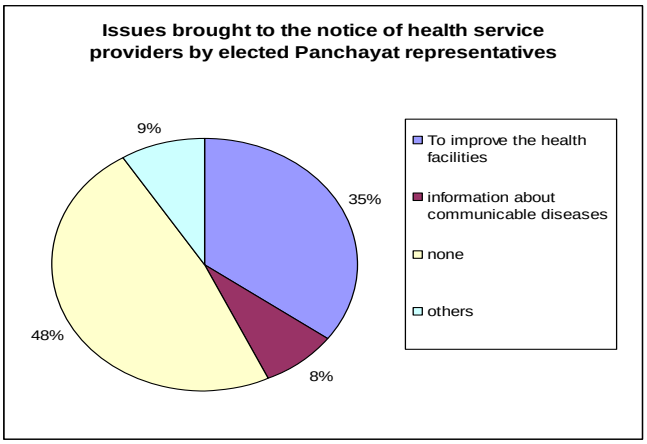
> Not all health service providers consider bringing a problem to the notice of the relevant authority and offering guidance as support of the health services by elected representatives.

A reasonably high percentage of health providers (35%) say PRI representatives regularly bring issues to their notice. Some of these efforts are listed below:

- An ANM of Gwalior district points out that Panchayats made repeated requests for the appointment of ANMs in their area.
- The CHMO of the same district says all three levels of the Panchayat play different roles in the management of health services. They provide feedback to the relevant authorities for necessary action. They facilitate the implementation of the national health programme. They also ensure registration of children and expectant mothers in their area.
- An MPW of Sehore district says Panchayats continuously monitor the functioning of health centres and make this an agenda item for their meetings. They also facilitated the appointment of the ASHA and Aanganwadi worker.
- Another MPW of the same district says the Panchayats conduct monthly and quarterly meetings to review the health status and provide written feedback to the CMO and BMO.
- An LHV of the same district points out that Panchayats try to access resources for improving water and sanitation facilities in their area.

- A BEE of the same district states that Panchayats try to establish links between the department and people and communicate issues to the department during monthly visits of departmental staff.

Figure -26



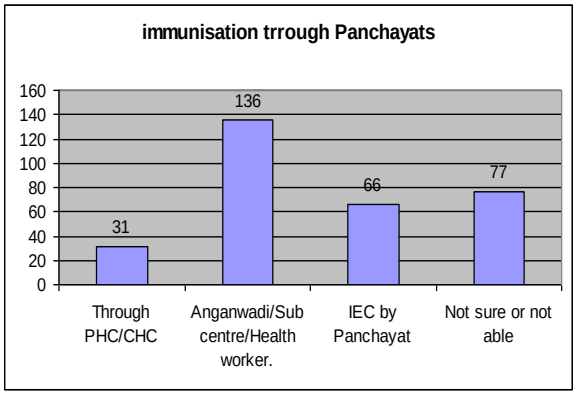
38% of PRI representatives say they provide regular feedback to health service providers to improve their functioning. In contrast only 25% health providers confirm that Panchayats make efforts to improve the health situation in their villages.

So not all health service providers consider bringing a problem to the notice of the relevant authority and offering guidance as support of the health services by PRI representatives. They say Panchayats hardly do anything besides bringing the problems to their notice.

5.2.5 Implementing government health programmes

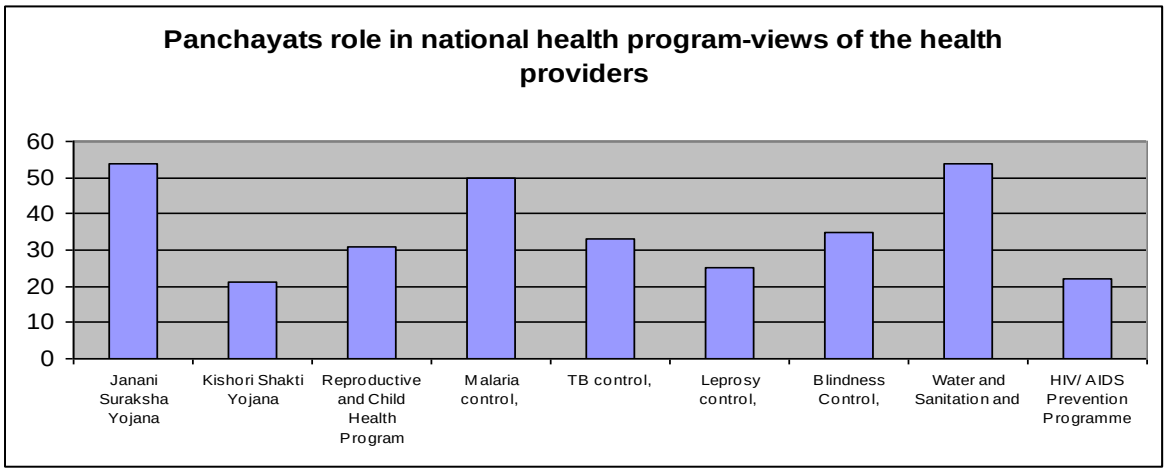
Panchayats help in implementing national health programmes like the national immunization programme, malaria control programme, TB control programme, etc. Around 25% of PRI representatives are not clear if they have a specific responsibility to implement the immunization programme and 10% categorically deny they can ensure immunization.

Figure- 27



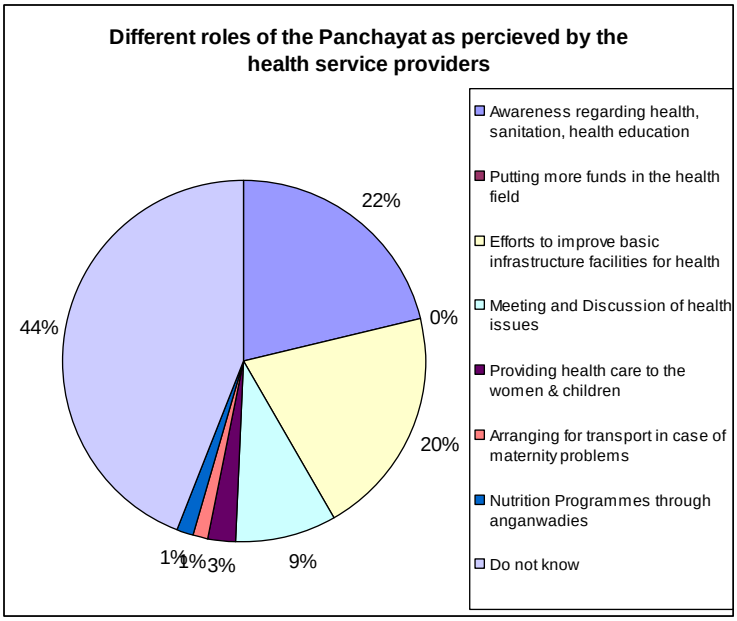
Panchayats mostly take the help of Anganwadi workers ANMs and MPWs of the Anganwadi and sub-health centres to facilitate immunization. They coordinate with these functionaries and the community to ensure better implementation by motivating the community for immunization, announcing the start of immunization campaigns, facilitating the gathering of people at a fixed point, and so on.

Figure - 28



Panchayats play a role in improving drug and medical supplies to health centres and medicine depots under the national health programmes. 41% of health providers say the Panchayats' interventionist role has improved over the last decade. About the same number of health officers believe the delivery of national health programmes has improved because of improved functioning of the health system at all levels due to the interventions of Panchayats.

Figure – 29



Panchayats play a facilitative role in national water and sanitation programmes and in health programmes to control vector-borne diseases like malaria, filaria, dengue, chikungunia, etc as well TB and blindness.

They are actively involved in the maternity benefit scheme and health programmes of the NRHM and Reproductive Child Health (RCH) programme.

5.3 Impact of Panchayats on healthcare delivery

The acid test of the Panchayat's ability to deliver better healthcare is the perceptions of the beneficiaries. Unfortunately, the beneficiary community is often not aware of the Panchayat's efforts to liaison with the Health Department to ensure better services so it isn't surprising that improvements engineered by the Panchayat are often credited to the department.

That could well be the reason why a large percentage of the beneficiary community feels that Panchayats are not directly responsible for improving the health status of the community - only around 9% of the rural population feels that Panchayats are doing anything useful in the field of healthcare, the percentage being even lower for female respondents at 6.6%. However, 35% of health service providers do feel that Panchayats make serious efforts to improve the healthcare delivery system, with an even higher percentage (48%) agreeing that these interventions have improved the availability of medicines and equipments as well as the overall functioning of health centres.

80% of elected heads of Panchayats say they provide regular feedback on health problems and issues to health service providers, with 50% of health providers confirming this claim. However, such actions don't seem to enthuse the rural community which tends to discount liaisoning, coordination and forwarding of complaints, seeing only direct help and support as performance indicators. This is ironical because health service providers and PRI representatives view the support function as the most important function of Panchayats.

The community also does not take cognizance of failed attempts of the Panchayat to improve health services.

Other perceptions of the community about the contribution of Panchayats to improving healthcare are listed below:

In Ghatigoan Panchayat of Gwalior district, a villager pointed out an instance of encroachment on the sub health centre. The Panchayat had the encroachment removed after repeated efforts. It then put pressure on the department to regularize the visits of the ANM to the health centre. As a result, the Panchayat now has a regularly functioning sub centre.

- Efforts to improve water supply and sanitation systems. The people clearly see the linkage between safe drinking water, sanitation and better health.
- Efforts to facilitate access to health and welfare schemes and better treatment facilities.

Table - 7

Panchayats role as stated by the beneficiary community (900 respondents)

Role of Panchayat	No of responses	% confirming Panchayat's role	Kind of functions undertaken in a particular category
Organize awareness/health education programmes	49	62.8	• Regulation of immunization programme • Educating and facilitating access to schemes, especially Deen Dayal Upchar Yojana (free treatment for the poor) and Janini Surakha Yojana (maternity benefit) • Issuing certificates and making requests for free treatment of extremely needy persons • Awareness meetings in the Panchayats • Meetings for educating the masses in case of epidemics etc
Panchayats initiation of health facilities	16	20.5	• Improving functioning of the PHC • Getting new staff appointed • Getting a new health centre opened in the Panchayat
Cleaning Surroundings	16	20.5	• Improving drainage • Spraying mosquito repellent in the rainy season • Spraying bleaching powder in the rainy season in wells and other water sources • Construction of a soakpit • Construction of toilets and community latrines • Other issues of environmental sanitation
Transportation of patients in case of emergencies	2	2.6	• Transportation of women during childbirth

5.4 Key Findings

The findings about the Panchayats' role in healthcare delivery are summarized here under four broad headings. The first deals with policy issues where adequate efforts have not been made to build a shared understanding on the Panchayats' role. The second deals with attitudinal problems with respect to the educational status of PRI functionaries. The third deals with the Panchayats' potential in healthcare delivery and the fourth with the difficulties Panchayats face in taking up with healthcare issues.

5.4.1 Poor shared understanding on devolution and decentralization

Policy makers had a vision when devolving health functions to Panchayats. They wanted these units to undertake health-centric planning, mobilize the community around health issues, impart health education, provide leadership to health functionaries and develop the long-term vision of Panchayats with respect to health. The responses of different stakeholders amply illustrate that each category of stakeholders has its own understanding of the Panchayats' role in healthcare delivery. Yet no serious efforts have been made to build up a common shared understanding on what is expected of Panchayats.

Though mandated to undertake health planning, neither the initiatives of the department nor the mindset of the Panchayats permits them to perform this function. Limited by their lack of capacity and technical understanding, Panchayats are overly dependant on the department for health planning. Departmental functionaries, on their part, tend to discount the Panchayats' role in health planning, with even grassroots functionaries like the ANM and MPW seeing planning as a departmental function. So it is senior officials like the BMO (Block Medical Officer) and CHMO (Chief Medical Officer of the District) who take up the planning function.

The understanding among the different stakeholders regarding other related functions is also blurred. For example, health service providers see coordination in converging health programmes as subsidiary support and leg work, while Panchayats perceive this function as giving guidance and direction. Similarly, the monitoring to be done by Panchayats is again seen as coordination expected from them. As a result, neither the Panchayats nor the departmental functionaries are clear about the role and functions of the PRIs.

Differences in perception exist even within the three tiers of the Panchayat. Zilla Panchayats seem to have a relatively clearer understanding of their role, perceiving themselves as a higher authority, while the Gram Panchayats perceive their functions differently.

Perceptions also differ among the different levels of health service providers. Senior staff at the district level expects Panchayats to coordinate and monitor the convergence of health programmes in the field, while village level functionaries like the ANM and MPW don't have a clear understanding of the Panchayats' role, seeing them only as agencies to mobilize the community for immunization programmes. These field functionaries are also reluctant to take directions from the Gram Panchayats.

5.4.2 Education levels of PRI representatives

Health is a technical subject although not all its aspects are of a technical nature. Unfortunately, many stakeholders attach undue importance to the educational qualifications of PRI representatives, attributing the non-performance of Panchayats to their illiteracy and ignorance. The reasons for inaction may range from poor role clarity to blurred lines of control, insensitive attitude of health service providers, budgetary constraints and factional dynamics in the Panchayats but they all tend to be linked to the poor education of the PRI representatives.

Health service providers question the ability of illiterate PRI representatives to take up healthcare-related responsibilities, with even the village-level health functionaries showing their distrust. The better educated community members and PRI members also mock them, openly declaring that nothing much should be expected from them.

The study, however, presents a different picture. It shows that even though the PRI representatives of the beneficiary community may not have completed formal schooling they are sensitive to health issues. 50% of the people who participate in the discussions on health issues are poorly educated, half of them having never attended school and the other half just completing primary schooling. Yet the qualitative responses captured by the study give evidence of their deep understanding of the relationship between good health and water, sanitation and environmental conditions.

The situation is acute when it comes to women, dalit or tribal Panchayat heads. These individuals from marginalized communities are not only uneducated and more ambiguous about their roles but are mocked at and face greater discrimination and factionalism from the community. In the absence of affirmative support, their performance is badly affected. Many women-headed Panchayats are managed by their husbands, with the community not accepting the leadership of these 'figure heads' or their husbands.

5.4.3 Panchayats' potential in healthcare delivery

Several Panchayats in Gwalior and Sehore districts have demonstrated substantial contributions to healthcare delivery. They have imparted health education to the community, coordinated the convergence of various health programmes in the field and

effectively monitored the functioning of health centres and health service providers. However, most others have not come up with the same level of performance. Nevertheless, the study reveals the inherent potential of Panchayats to take up such functions if they are given adequate capacity building support and provided a conducive environment for action.

5.4.4 Capacity constraints of Panchayats

Panchayats are plagued by capacity constraints. Capacity relates not just to technical understanding but also to attitudes and mindset.

Health functions are not as obvious a delivery function of Panchayats as, for example, infrastructure development or road construction. Many stakeholders point out that Panchayats are not even interested in the issue, particularly since there are no budgetary provisions involved. Others say the Panchayats undertake only those functions that are explicitly instructed by the administration and departments. So health, preventive health measures, healthcare delivery and related subjects are completely overlooked by Panchayats.

Most Panchayats have a limited understanding of health. Although field experiences show that they appreciate the linkages between health and issues like water, sanitation, immunization and nutrition, they often fail to see the bigger picture. For instance, they usually fail to see the linkage between nutrition and maternal or child mortality or immunization and epidemics. In fact, they fail to understand the value of total immunization. Many are victims of superstitious beliefs and the community is also not always supportive.

If such an institution is expected to deliver healthcare, a capacity building intervention on specific health issues is necessary. Given the low literacy rate in rural Madhya Pradesh and the growing number of poorly educated representatives from disadvantaged groups, it is also important to build functional literacy on health.

Limited by their capacity constraints, lack of technical understanding and attitudes to health, Panchayats tend to be over-dependant on the department for many health issues. One significant finding of the study is that they expend substantial energy in coordinating and collaborating with the Health Department. Whatever be the health issue involved or the nature of health delivery - immunization programme, functioning of the health centre, availability of drugs for malaria control, improving health facilities in the Panchayat - the response of the Panchayats has largely been to discuss the issue in their meetings and forward requests/complaints/proposals/memoranda to the relevant authority for action. Even the IEC functions dispensed by Panchayats are mostly restricted to information dissemination on health welfare schemes, safe water and hygienic sanitation and camps organized with the help of the Health Department.

The only direct engagement of Panchayats in healthcare delivery is thus limited to water and sanitation and facilitating implementation of health schemes. Significantly, Panchayats are also important agencies for collecting health data and health records at the local level. Panchayats, with the help of the Anganwadi centre, village chowkidar and Panchayat Secretary, collect and maintain important death and birth registration records. In some Panchayats morbidity records are also maintained, especially during the break out of epidemics.

Chapter - 6

HEALTH COMMITTEE OF THE PANCHAYAT

Chapter - 6

HEALTH COMMITTEE OF THE PANCHAYAT

Table - 11 Awareness on Health committee

	Health staff	PRI	General public
Yes	61	161	94
No	2	124	199
Don't know	8	0	608

Around 85% of the health staff says Village Health Committees do exist in the Panchayats, even specifying the frequency of their meetings. The committees appear to meet fairly regularly, some at fixed intervals and others according to health exigencies. The agenda of these meetings is not known so one cannot assess whether they serve any useful purpose. The health staff gives mixed responses when asked if the committees contribute usefully to health promotion in the villages. Nearly half, mostly from the lower level, say they do while the rest are uncertain or give negative responses, especially the higher level staff.

Around 55% of PRI representatives say the committees exist, the higher tier functionaries giving more affirmative responses compared to the lower level ones. The affirmative replies indicate that the health committees have definitely been constituted, at least on paper.

Table - 12

Frequency of committee meetings	Health staff	%
Monthly	**33**	**54.0984**
Quarterly	**14**	**22.9508**
Half yearly	**1**	**1.63934**
Yearly	**1**	**1.63934**
As and when required	**12**	**19.6721**
Total responses	**61**	**100**

The responses of the beneficiary community present an altogether different picture. Over 67% are not sure the committees have been set up while 22% say they don't exist. It should be noted

Table - 13

Health committee – source of formation	PRI responses
By government order	**116**
Statutory requirement	**32**
Panchayat's initiatives	**11**

Department's initiative	**2**
Total	**161**

here that the community is not always aware of what happens at the policy level and in practice. For example, if some activity takes place through the initiative of the committee, most respondents fail to link the activity to the committee. More often, they see the Panchayat as working towards health promotion, not some health committee.

The major reason for the formation of the committees is government orders and statutory requirements. Only a few committees were set up through PRI initiatives. In such cases, their performance is good and their activities are visible. Where committees do not exist, most PRI functionaries do not know the reasons for their not being set up.

Health committees came into existence to comply with government orders and statutory requirements, not as a felt need of important constituencies like the Panchayat, health functionaries or community. Consequently, most were redundant, especially at the Gram Panchayat level.

The training provided to Panchayats covers health only occasionally. Issues concerning the health committee are never covered in any training programmes.

This wide variation in responses to the committee's existence is an outcome of the 'order from above' syndrome, raising the crucial point about the utility of merely complying with formalities. It is clear the activities and outreach of the committees are low, so low in fact that people question their very existence and functioning. They appear to have been constituted on paper in the records of the Health Department and Panchayats but their functioning leaves a lot to be desired, putting a question mark on their utility as change agents. Any reform to improve the situation would be infructuous if it does not take note of the reasons for the inactivity of the committees.

In Londia village of Sehore district the health committee involves youngsters in its work. These youth, mobilized for other ventures, understand the significance of health promotion in their villages. They have persuaded the village elders to come forward and work together through the committee. As a result, awareness programmes and service delivery monitoring have begun to take effect. Wherever 'bottom-up or horizontal' initiatives are facilitated, the results are heartening.

An analysis of the responses shows that wherever the committees do exist they perform a wide range of functions. Some are engaged in registration of births, deaths, marriages and deliveries; others are working towards sensitizing people to health promotion and improving their living environment.

The beneficiary community sees the main responsibility of the committees as communication and information

dissemination, particularly regarding vaccination programmes and so on. To PRI functionaries, the committees are parallel monitoring bodies whose main task is to control the health staff and improve the health service delivery.

Over 80% of the health staff points out that Panchayats do not have health programmes of their own. If committee members promote a consolidated agenda and develop improvement indicators of their own, their work can become more visible and get measured. How the Panchayat and committee members work out such agenda that involves the Health Department and community is a major challenge.

Table - 8

Awareness among Panchayat tiers of functions of Village Health Committees

Gram Panchayat	Block Panchayat	Zilla Panchayat
• Low level of awareness among elected members, ward panchs. Casual attitude towards committee. • Committee hardly meets. Its meetings are usually merged with Panchayat meetings • Its role is limited to accessing health welfare schemes and disseminating them • Committee rarely monitors the functioning of health centres or health service providers, although it does so in some Panchayats	• Better awareness of committee's role and functions • Committee facilitates better delivery of health services and monitors implementation of health programmes • Runs campaigns and makes initiatives to disseminate information about important health schemes • Undertakes selection of ASHA • Issues/ facilitates Deendayal cards to the poorer sections • Collects records of births and other registration records from the Panchayat	• Committee undertakes assessment of the health needs of the district. • Reviews functioning of district hospital, health centres • Monitors implementation of health schemes • Tries to resolve problems and complaints brought to its notice

If the committees are to function effectively, 'bottom-up initiatives' of the community and the lower tier Panchayat functionaries should be simultaneously promoted.

Although the expected roles of Panchayats include streamlining health centres, providing guidance to health functionaries and solving common health problems, their performance is mostly restricted to making memorandums, forwarding complaints and requests to the department and administration. Their education and communication work mostly related to passing on information about schemes and how to access them. Panchayats have not engaged themselves in the deeper issues of health or health education .

Table – 9 Functioning of the health committee-stakeholder responses

Respondents	Functions of health committees (in decreasing order of relevance)	
Health staff	Facilitating health programmes, undertaking activities for disease prevention, supervising service delivery, planning, deliberating	
PRI functionaries	**District and Block level**	**Village level**
	Holding meetings and deliberations to make plans, passing resolutions and proposals, supervising the work of health centres, monitoring and evaluation, communication and coordination with the Health Department, extending schemes to beneficiaries, registrations	Conducting awareness-related programmes, raising health-related issues in the Gram Sabha, water and sanitation related issues, vaccination and RCH promotion, helping disease prevention
General public	Medical camps and health awareness programmes, village hygiene and sanitation, disease prevention, monitoring service delivery	

CHAPTER 7

CONSTRAINTS OF PANCHAYATS IN HEALTHCARE DELIVERY

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CONSTRAINTS OF PANCHAYATS IN HEALTH-CARE DELIVERY

The previous chapters built a case for Panchayats to address health issues and assessed their performance by analyzing the perceptions of different categories of stakeholders. This section analyzes the performance of Panchayats on the basis of their own perceptions of their role and responsibilities, their competence, capacity building efforts and their accountability to the community. Answers are sought not from the direct questions and responses of the stakeholders, but from the interpretation of their qualitative responses and our field experience. However, we have been cautious to not let the field experience bias or over-shadow the study data. Therefore, time and again, references are made to the quantitative and quantitative data.

The constraints Panchayats face in delivering/improving health have been clustered under four broad headings. The first relates to functional issues like inadequate resources and poor training support, while the second is the 'poor commitment to decentralization', which includes issues like accountability of the health service providers, centralization of the health agenda and control over the Panchayats. The third set of constraints deals with the grey areas within Panchayats, such as the non-inclusion of ward Panchs in the functioning of Panchayats, poor role clarity and perceptions of authority at different Panchayat levels. The fourth is the exclusion of PRI representatives from marginalized communities from the activities and functioning Panchayats.

7.1 Constraints in managing healthcare delivery: an overview

The rural community and administration have high expectations from the PRIs, especially the Gram Panchayats, which have been entrusted with a lot of responsibilities. Many PRI representatives are poor, illiterate and have come into positions of power for the first time in their lives. Nevertheless, 40% of them feel Panchayats have the required competence to manage health issues, although only 30% of health service providers agree with them. It is the beneficiary community that has little faith in them, with only 15% feeling they can deliver the goods.

Health is a technical subject that requires a higher level of competence than, say, general infrastructure development. But many Panchayats lack this technical ability. More worrisome, however, is their poor perception of their role and authority. Poor health infrastructure at the Gram Panchayat level, non-accountability of health staff to the Panchayats and lack of untied grants to spend on health issues seriously stifles their potential to deliver.

Table- 10 : Constraints in healthcare delivery: Stakeholder responses

Constraints	Responses
Beneficiary community	• Lack of interest and poor attitudes to health issues among PRI representatives. They do not perceive healthcare as their function • Lack of competence to improve primary healthcare • Lack of training to build competence and capacity • Lack of infrastructure and capacity. Panchayats are only interested in infrastructural development • Lack of funds for educational programmes. • Lack of authority to improve healthcare • Lack of accountability of health staff. Health service providers are not willing to listen to poorly educated PRI representatives
Health service providers	• Panchayats only complain and do little else • Poorly educated PRI representatives are unable to contribute • Lack of awareness in Panchayats and community of health issues. Building awareness is essential • Lack of infrastructure • Lack of funds • Lack of health staff • Poor coordination by the Health Department. Coordination is limited to the district level and neglected at the Gram Panchayat level
PRI representatives	• Poor education levels of PRI representatives • Lack of knowledge about health schemes • Lack of technical knowledge on health issues • Lack of training to build competence. Even competent functionaries are unable to perform • No accountability of health functionaries to Panchayats. Health functionaries do not listen to PRI representatives • Poor sensitivity of the community • Lack of resources with Panchayats

7.2 Functional issues affecting performance in healthcare delivery

Despite a decade of field experience, Panchayats have not been able to build up their competence levels to address health issues, primary healthcare in particular. All three categories of stakeholders identified this lack of capacity as a serious constraint. A second constraint is the poor resource base of the Panchayats.

7.2.1 Capacity building support for Panchayats

A large percentage of PRI representatives, especially at the Gram Panchayat level, are poorly educated and this constrains their ability to handle health issues which are technical in nature. This is confirmed by the responses of all three categories of stakeholders. The situation is serious because many of them cannot even read or write and require immediate and sustained capacity building support from the government to develop their understanding of the basics of PRIs and their healthcare functions. However, training support is limited, hence their performance is poor. Only 27% of PRI representatives have received some capacity building input, the situation being worse at the Gram Panchayat level where only 20% have attended training camps.

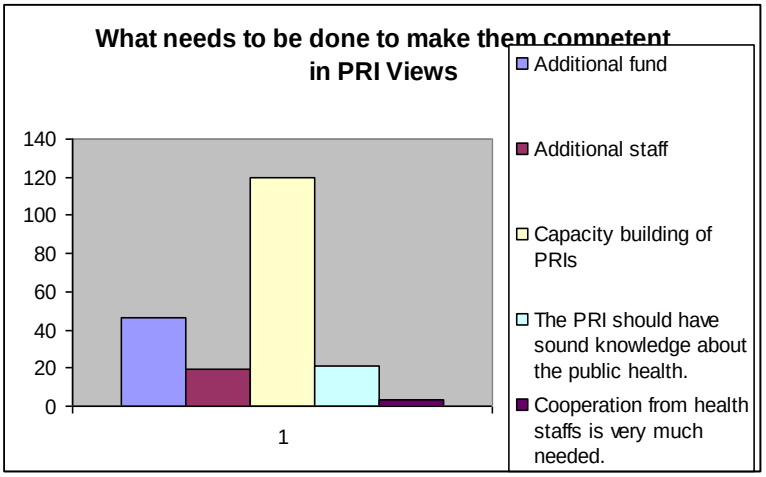
PRIs interviewed	Training received
21 Sarpanchs	16 Sarpanchs
17 Up-Sarpanchs	7 Up-Sarpanchs
245 Panchs	53 Panchs

Even in these cases, capacity building efforts seldom focus on health issues, the main thrust being limited to general administration and functioning of PRIs. That's the kind of training 60 of the 270 respondents say they have received. Only 13 respondents say they have received some training in health related issues and just 8 had a training input from the Health Department. Here, too, the emphasis was more on the administration and delivery of schemes rather than their technical aspects. Although these 8 respondents did find the training useful, very few were able to use their knowledge in planning or visioning healthcare development.

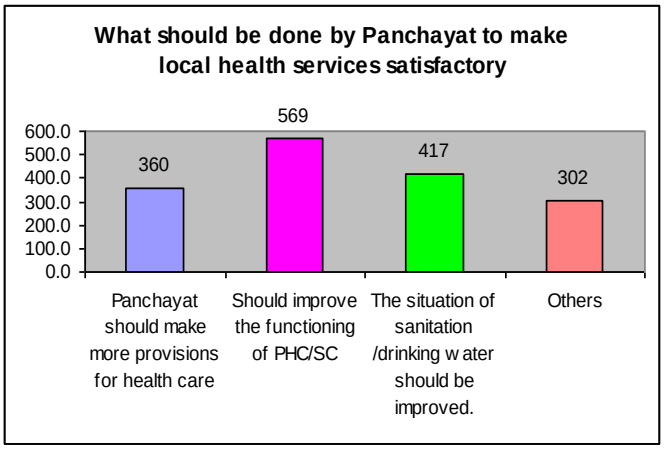
According to Dr V. Sharma, SMO, Gwalior district, accountability of the health staff to the Panchayats depends on the determination of the higher tiers of government to ensure accountability in practice. On the question of making available the necessary resources and personnel, he was of the view that the Gram Panchayat and Janpad Panchayat can take up the responsibility in a better manner. But any augmentation of staff should be accompanied by training and sensitization in a phased manner. He also felt that Panchayats could provide guidance and cooperation to the health staff through better coordinated efforts.

7.2.2 Financial constraints faced by Panchayats

The cornerstones of decentralization are empowerment and financial self-sufficiency. However, the financial condition of Panchayats is deplorable. As autonomous institutions, they are expected to make provisions for core services and infrastructure like water supply, roads and streetlights and take up developmental initiatives in education, health and employment generation. They are also expected to maintain these infrastructural assets and services.



The revenue allocations to Panchayats have increased in the last few years, but so have expectations from them. In any case, these allocations are still extremely inadequate to carry out the functions assigned to them in the 11th Schedule of the Constitution.



Panchayats depend largely on central and state grants and schemes. The total fund required for the 29 subjects devolved to Panchayats can roughly be calculated at Rs 80,000 crore nationally, but the devolution of funds is minimal. In such a situation Panchayats can meet health expenditures only from grants devolved by the Health Department or central/state health schemes. Grants under schemes like the NREGS are tied and specify the exact functions that Panchayats can undertake.

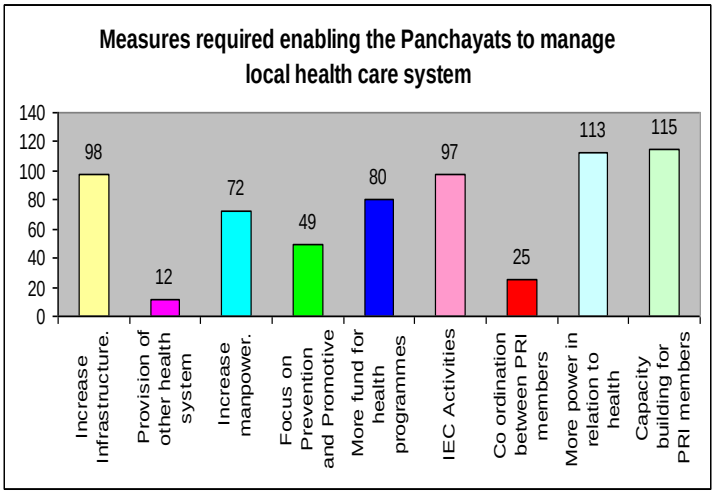
The responses of the beneficiary community show that it favours more allocations by the Panchayats for health. An even higher number of respondents expect Panchayats to improve the water and sanitation situation in villages. This only places more demand on funds.

In the case of Madhya Pradesh, there has been almost negligible devolution of grants to Panchayats from the Health Department. The un-tied grants are not only inadequate but get siphoned off or are directed to other bodies by the politico-administrative machinery.

Many Panchayats end up spending whatever untied grants they get in unproductive activities like entertaining senior political leaders.

Most stakeholders see this tight-fisted approach to fiscal decentralization as a major constraint in improving the performance of Panchayats in healthcare delivery.

Panchayats in Madhya Pradesh have very little capacity to generate local revenues to meet expenditures on healthcare and other welfare activities. Even the better financially managed Panchayats have not been able to raise more than 2 to 3 percent of their total revenue locally. In such a financial situation the Panchayat leadership is unable to perform even if it has the necessary commitment. Aggravating the issue is the rising demand of the community for the Panchayats to take up more developmental activities, but without raising the local tax burden.



PRIs expect increased funds to manage the health system. But even other activities cited by the elected representatives like IEC, improvement of infrastructure or provision of additional staff have financial implications either on Panchayats or the department.

About 10% of the funds for rural development in Madhya Pradesh now goes directly to Panchayats. Decisions regarding beneficiaries of various government schemes are taken at this level. As information about these funds is more widely available locally, it is hoped that this will lead to greater public awareness and transparency about these dealings.

7.3 Poor commitment to decentralization

It is now 14 years since Madhya Pradesh enacted its first Panchayati Raj legislation. Three rounds of Panchayat elections have been conducted since and there is a wealth of functional experience available to see how far the spirit of decentralization has percolated into the system at all levels – from policy makers to the administration to the Panchayats, and also within the three tiers of the Panchayat. This section analyzes the study data and collated experiences from this perspective. A few secondary documents have also been referred to.

7.3.1 Devolution of functions: no real control

A closer look at the devolution of functions by the state government shows that the departments have treated Panchayats merely as institutions to offload responsibility and carry out the leg work while retaining their authority, control and decision-making powers.

Take the example of maternal and child care. The Health Department assigned the task of 'managing' maternal and child health to the Village Health Committees of the Gram Sabha that were in existence three years back. It simultaneously assigned similar responsibilities to its ANM. The duties of the ANM were to provide vitamin and iron supplements and oversee immunization and birth-control measures, while the duties of the Panchayat were to supervise Anganwadi centres and Anganwadi workers. However, the ANM remained answerable only to the department.

Similarly, supplies to the Anganwadi centres were controlled by the ICDS department over which the Panchayat had no control. Panchayats could only recommend the names of candidates to be appointed as Angawadi workers. The department retained the prerogative to appoint them and to also punish, reward or remove them.

To take another example, in many health-related schemes like water and sanitation, Panchayats are supposed to access funds from the department and implement the schemes. But they have no control over the technical staff and functionaries from the Rural Engineering Services (RES) promoted by the Madhya Pradesh government.

> The duality in the line of control of health service providers is evident in department's structures. The Rogi Kalyan Samiti that is supposed to manage the functioning of health centres (including the PHC, CHC and District Hospital) has the District Coordination Minister as its head and District Collector as its secretary. The head of the local body is only a member of the committee, without the power to take action despite having the authority to manage the health centres.

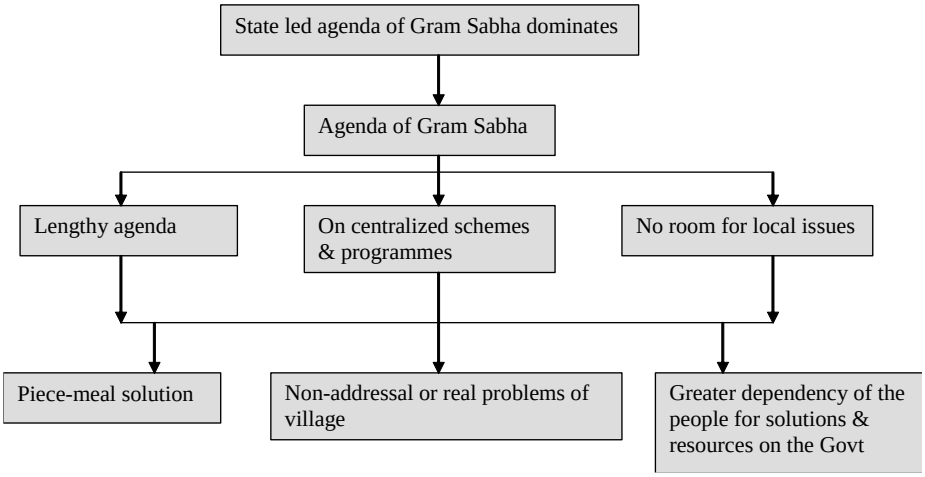
A third example is the on-going NRHM under which Panchayats are supposed to formulate village health plans. However, planning continues to be done at the district level with Panchayats only collecting data, making requisitions and providing unconditional support to the departmental plans.

It is not clear how Panchayats are expected to 'monitor, coordinate or ensure' health facilities if, in the name of supervision/monitoring/coordination, they only perform the leg work for departmental functionaries - like gathering the community for immunization. The outcome of such devolution is that the Panchayats end up as scapegoats for poor service delivery in healthcare.

7.3.2 Backseat driving by the department

Effective and forward looking decentralization exists only on paper in the form of progressive and enabling legislation. The situation on the ground is very different. It is mandatory for district-level functionaries to attend the four statutory Gram Sabha meetings, but the agenda for these meetings – relating mostly to central schemes and the targets set by the district administration - is decided by the state government and district administration. Hence, Gram Sabha decisions are predetermined by departmental functionaries. Even if members call a special Gram Sabha meeting after giving prior notice to the district administration, the decisions taken at the meeting are not binding on the department.

Another problem is that the government agenda is so exhaustive it leaves no room to discuss pressing local issues. It is highly optimistic to expect Panchayats to improve healthcare delivery at the village level if local issues are missing from their meeting agenda.



7.3.3 Accountability of health service providers to Panchayats

In Madhya Pradesh, the staff directly connected to Panchayats has been transferred to the Zilla Panchayats. The government has declared these categories of staff as a dying cadre. The Zilla Panchayat handle new recruitments. Madhya Pradesh is the first state to make such arrangements for handing over functionaries to the PRIs.

Panchayats and Gram Sabhas are supposed to exercise control over village-level functionaries like ANMs, teachers, etc and monitor their work. But in the event of dereliction of duty they cannot take any disciplinary action. At most, they can forward a complaint against the functionary to the department or make a remark in the attendance sheet of, say, a teacher. It is up to the department to take action. In most cases, the departments do not take action so the functionaries feel they are not answerable to the Panchayats and Gram Sabhas.

Accountability of department functionaries to Panchayats

Views of health service providers	Views of PRI representatives
72% agree that health functionaries should be made accountable to Panchayats.	98% want health functionaries to be accountable to them.
88.7% say Panchayats have been given powers with respect to healthcare delivery.	Only 28% say they have powers to control the functioning of health service providers. Of this small percentage, only 23.5% agree that health functionaries cooperate with them. Around 50% say the functionaries do not listen to them or resist feedback from them. The situation is worse in Gram Panchayats, compared to Zilla Panchayats.
They expect more cooperation from Panchayats. To them the Panchayats' 'authority' means greater cooperation in their work.	250 of 276 respondents say lack of cooperation of the health staff is a major problem that Panchayats face in carrying out their responsibilities in healthcare delivery.

An overwhelming 98% of PRI representatives feel the health service providers should be accountable to Panchayats, with only 3% feeling this is strictly a measure to reduce irregularity in attendance. Surprisingly, 72% of health service providers tend to agree because they see themselves as working within the Panchayat area, although they would like better coordination between the Panchayats and the Health Department. However, since they report to the departmental hierarchy, and since Panchayats cannot take disciplinary action against them, they feel they are accountable only to their departmental heads.

Panchayats rue the lack of clarity on this score. Rameshwar Tiwari, an elected member of Dabra Janpad Panchayat in Gwalior district, relates what actually happens in practice. He says the Janpad Panchayat meets regularly to review the health services. The BMO and CHMO are invited to these meetings. The problems discussed relate to lack of professional competence of doctors, absenteeism of health staff, non-availability of medicines and poor quality of equipment. The Panchayat apprises the administration, Health Department and the constituency's MLA (Member of the Legislative Assembly) of

these problems. Yet no action is taken to solve them. He feels unclear lines of control and accountability of the health service providers and the Panchayats' lack of skills constrains their performance in improving healthcare. Unless Panchayats are given authority to take punitive action, they can only go on passing memoranda to the authorities without much gain.

PRI representatives' views on health service providers

Jagdish Jatav Dabra, Gwalior	The ANM visits only once in two months or so and does not like our feedback or requests to come more regularly.
Purshottam Purshottampur, Panna	I don't provide guidance to the health staff because they don't even bother to listen to us. They don't pay attention to any suggestions of the Panchayat.
Jatal singh Kankan Kheda, Ichawar, Sehore	In my 17 years as a PRI representative, I have made requests to the health functionaries on several occasions. I have even passed on complaints and memoranda to the relevant officials but no action has been taken and no feedback is accommodated.
Anjali Vishnu Shivhare Mohna, Ghatigoan, Gwalior	Departmental functionaries and health service providers do not listen to the Panchayats. Despite providing feedback to senior officials, no action is ever taken on the complaints or requests.
Krishna Kumar Bihar, Purwa, Ajaygarh, Panna	Departmental functionaries only listen to their departmental authorities. They do not bother about the Panchayat.
Dharma Bai Adivasi Zilla Panchayat Head, Gwalior	The Panchayat can improve the health services by coordinating with the Health Department but this is possible only if the department pays attention to the PRIs.

37% of health service providers feel Panchayats play an important role in healthcare, although there were very few categorical responses supporting this view. 30% feel they should be accountable to Panchayats and they should keep the Panchayat informed of what they are doing because they work in its operational area. However, although they see Panchayats as local institutions, they don't consider them as the local health authority. Most interpret accountability as cooperation rather than answerability.

Senior health functionaries like the BMO and CHMO show greater inclination for accountability of health service providers to Panchayats. They feel this would improve the regularity of health staff and their service delivery.

For instance, an MPW in Panna district said since he works in a Panchayat it is justified that he works as per its requirement. This view was echoed by another MPW from Sehore district. An ANM in Panna district points out that Panchayats know the problems of the people and since health service providers

work in Panchayats, the feedback they get from the PRI representatives can be helpful in solving the health problems of the people.

The views of senior health officials differ marginally. They are clear that accountability should be improved because Panchayats are the legally mandated local authority so health service providers should be accountable to them. For instance a BEE of Sehore district says if accountability is enforced, health workers would start living in the Panchayats, leading to regularity in their work and better implementation of health programmes. Similarly, the CHMO of Gwalior district says such accountability would facilitate problem solving at the local level. Significantly, doctors posted at the district hospital did not respond to the question, possibly due their poor understanding of Panchayats and their indifference to them.

Table – 11 : Accountability of health services to Panchayats: Stakeholders perceptions

Village level health service providers
• We work in 5-6 Panchayats. Whom should we be accountable to? • We are appointed by the Health Department. • Accountability should be at the district and PHC level so that there is clear control. Panchayats may request help if primary treatment is required. • Panchayats don't understand health issues. • Most PRI representatives are uneducated and have poor knowledge of health issues. • They should cooperate with health functionaries. • They should support us in solving the health problems of the villages. • Their functions should be reviewed. • They should monitor health services and health service providers. • They should undertake awareness building and health education programmes. • They should improve environmental sanitation in villages.
District level health service providers • Panchayats should control village-level health functionaries. • Panchayats should review the implementation of health schemes to give feedback on regularity of functionaries to ensure the delivery of health services. • Panchayats must facilitate immunization. • They should facilitate the implementation of health programmes.

Panch of the Gram Panchayat

- Panchayats don't have the budget or the authority.
- They don't pay attention to health issues.
- They only focus on those healthcare issues which are directed to them by the administration and have budgetary provisions.
- They make requests and proposals to PSC but no action is taken.
- Their authority is only on paper; they have no authority in the real sense.
- May Panchayats do find local solutions to health problems.
- The ANM and MPW do not bother about the Panchayat.
- Only the Sarpanch and Secretary have information and authority.

Sarpanch

- Panchayats lack budgetary resources for healthcare programmes.
- They lack of technical knowledge of health issues.
- Health service providers do not cooperate.
- The community is not sensitive to the Panchayat's functioning.
- Panchayats can only send proposals. The department seldom passes them.

Beneficiary community

- Panchayats see health functions as the responsibility of the Health Department.
- Elected representative of Panchayat do not have knowledge or information.
- Panchayats don't take interest in health issues.
- The PRI representatives themselves need training and information.

7.4 Grey areas within Panchayats

While Panchayats talk of constraints in decentralizing healthcare delivery, one also needs to see whether they themselves have taken any initiatives to fulfill their commitments to meet the aspirations of the community. There is also the question of whether the three-tiered Panchayat structure is working smoothly and whether internal contradictions, unclear lines of control and lack of clarity about distribution of responsibilities among the tiers are constraints in their work. What are the links between elected heads and ordinary members of the PRIs? Is there a hierarchy of power at play between the tiers? Is there a subtle process of non-inclusion and supremacy?

7.4.1 Panchayats' perceived role in health

A study carried out by Samarthan for the Department of Panchayat and Rural Development in Madhya Pradesh reveals that the most important expectations of the community from Panchayats are providing safe drinking water, improving the delivery of primary healthcare and sanitation. The three issues directly affect the health status of villages. How do Panchayats perceive and perform their role in reaching healthcare to the people?

Authority of Panchayats in healthcare delivery:
Perception of Panchayats and health service providers

Panchayats have been given powers	Gram Panchayat (%)	Janpad Panchayat (%)	Zilla Panchayat (%)	All PRI representatives (%)	Health service providers (%)
Yes	32.1	45.3	67.9	38.6	88.3

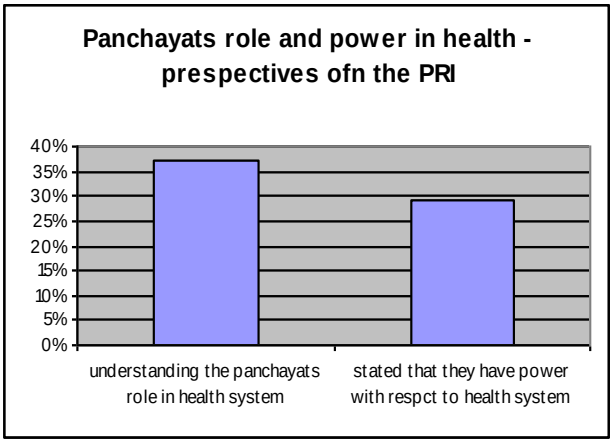
The percentage of PRI representatives who feel that Panchayats have the necessary authority to ensure healthcare delivery is not very high (38.6%), compared to 88.3% of health service providers who think so. The perception among the three tiers of Panchayats shows a rising curve from a low of 32.1% for the Gram Panchayat to 45.3% for the Janpad Panchayat to a high of 67.9% for the Zilla Panchayat.

This probably reflects the inability of the Gram Panchayat to exercise authority, with 39% of its representatives lacking clarity of their powers. The Zilla Panchayat, on the other hand, seems surer about its position, with only 7% of its representatives being confused about their powers. The percentage lacking clarity among Janpad Panchayat representatives is 28%.

Within each tier, the elected heads have a far clearer perception of the Panchayats' authority than the ordinary members like ward Panchs. This hierarchy of perception is seen even among the elected heads of the three tiers, with those at the district level being clearer than the other two levels.

The poor conception of their role and authority has limited Panchayats to a liaisoning role instead of being healthcare facilitators.

Figure 31



7.4.2 Non inclusion/lack of interest of ward Panchs

Each Panchayat tier has an elected head and a general body comprising the elected members. The elected head of the Gram Panchayat, Janpad Panchayat and Zilla Panchayat are the Sarpanch, Janpad Panchayat Adhyaksh and Zilla Panchayat

Adhyaksh respectively. The ordinary members represent different constituencies at each level, the Panchs being the representatives of wards in a Gram Panchayat, the Janpad Panchayat members representing constituencies within a block and the Zilla Panchayat members representing constituencies in the district.

The understanding of ordinary members differs from that of elected heads, especially at the Gram Panchayat level. They have a poorer understanding, engagement and interest in health issues. Although they constitute the majority of PRI representatives, they do not contribute to their fullest potential. Compared to 80% and 46% of elected heads of the Zilla and Gram Panchayat respectively, only 26% of Panchs feel they are in a position to provide guidance to health service providers.

67% of elected heads see a role for themselves in healthcare delivery against only 23% of ordinary members. The situation is worst at the Gram Panchayat level with over 70% of Panchs seeing no role for themselves and over 40% saying they don't even know if they have a role. At the district level, 75% of elected members see a role for themselves, with only 8% expressing ambiguity and confusion on this score.

When it comes to actually doing something to improve the functioning of the health services, only 12% of Panchs say they have made efforts. Most Panchs say Panchayats either do not bother about healthcare or only the Panchayat head and secretary take decisions. They say they are seldom asked for their opinions. Their casual responses reflect their dissatisfaction and frustration. The problem could be either lack of interest, lack of opportunities provided by the elected heads or lack of enabling policies for their participation.

Hence the number of elected representative not contributing or seeing a role for themselves in improving health services is significantly high. The situation is worst at the Gram Panchayat level, where more than70% of Panchs saying they have no role in healthcare delivery and more than 40% saying they do not know if they have a role.

So while health functionaries feel the Panchayats have power the Panchayats either do not know about their authority or are not able to exercise it. This lack of clarity about their power and roles has several consequences. They have stopped giving feedback and guidance to the health service providers and senior officials of the Health Department. On their part, the health service providers tend to evade their responsibilities.

Table-12

Perceived role of Panchayat in management of healthcare system (% of total PRI respondents)

Panchayat tier	Elected member	Elected head	Overall %
Gram Panchayat			
Yes	23.8	66.7	27.5
No	29.9	33.3	32.1
Don't know	46.3	0	40.4
Janpad Panchayat			
Yes	49.1	66.7	51.6
No	26.3	0	23.4
Don't know	24.6	33.3	25
Zilla Panchayat			
Yes	75	66.7	75
No	16.7	33.3	17.9
Don't know	8.3	0	7.1

Responses of ordinary members on their role in delivery of healthcare

- Alwel Singh, Dabra block, Gwalior district: Panchayat's seldom conduct meetings and share information. I am neither asked nor informed about any such role.
- Mangupuri, Sirdi Panchayat, Sehore district: The Panchayat has not informed us about anything and the department provides training only to the Sarpanch.
- Parma, Dabra block, Gwalior district: I haven't been given any role. Only the Sarpanch has a role.
- Premlata Shukla, Purshottampur Panchayat, Panna district: A Panch has no role in healthcare or elsewhere.
- Ramjas Shivhare, Panna district: No Panch participates in the Panchayat meeting.
- Ram Swaroop Kewat, Aaru Panchayat, Dabra block, Gwalior district: Nobody informs us.

7.5 Exclusion of representatives from the marginalized community

While macro-policies have implications at the grassroots, local dynamics and caste structures play a crucial role. The dominant power structures at the village, block and district levels tend to consolidate their hold on the Panchayat structure. There is little affirmative support to the marginalized communities so their representatives elected

from reserved seats are either unable to participate in Panchayat activities or their performance is poor.

Dalit representatives interviewed	Dalit representative provided training support
4 Dalit Panchayat heads (1 Janpad Panchayat head)	Nobody received training
4 Dalit Up-Sarpanchs	Nobody received training
42 Dalit Panchs	10 Panchs received village-level orientation by NGOs

Tribal representatives interviewed	Tribal representatives provided training support
3 Tribal Panchayat heads (2 Zilla Panchayat head and 1 Gram Panchayat head)	All received training
2 Tribal Up-Sarpanchs	Nobody received training
36 Tribal Panchs	6 received village-level orientation

The tables show that PRI representatives from the Scheduled Castes (SC) and Scheduled Tribes (ST) have not been neglected in capacity building training programmes. No dalit Panchayat head has received training from any institution, not even the Janpad Panchayat head. This despite the fact that the training coverage at the Janpad Panchayat level is high, as evident in the previous section. 75% of Gram Panchayat heads have also received training from one institution or the other. The administration or NGOs conducting the trainings may not have deliberately excluded dalits, but the statistics show there has been a definite oversight. Affirmative support through training is definitely missing.

Though the training and support component to dalit Panchayat heads was zero, their perception of the role of the Panchayat in healthcare is fairly mature. All four dalit Panchayat heads would like to have a health committee in the Panchayat and they would also like health service providers to be accountable to the Panchayat.

Though the training and support component to dalit Panchayat heads was zero, their perception of the role of the Panchayat in healthcare is fairly mature. All four dalit Panchayat heads would like to have a health committee in the Panchayat and they would also like health service providers to be accountable to the Panchayat.

Many of these dalit Panchayat heads are daily labourers who cannot afford to miss a day's wage to attend the training. But we find that many Up-Sarpanchs seem to be attending not just the training but all types of official meetings. This is because many Panchayat seats reserved for the dalit community are captured by powerful landlords through proxy candidates who usually occupy this position. Thus while none of the dalit Panchayat heads of deputy heads received any training, 7 of the 17 Up-Sarpanchs interviewed had received training. All 7 belong to the general category or dominant OBC community.

The statistics are a sad commentary on caste dynamics at the local level, particularly since the dalits' perception of their role and competency in handling health issues is only marginally lower than that of the dominant castes.

Stakeholder groups have assessed the overall functioning of dalit-headed Panchayats differently than the elected heads, who have openly mocked and rebuked them while health service providers have negated their leadership.

7.6 Key findings

There is lack of clarity about the nature of power and roles devolved to Panchayats with respect to healthcare delivery. The confusion is not limited to PRI representatives. The local bureaucracy is also not clear about the division of roles. Responsibility thus tends to get diffused, often bringing work to a standstill. The lack of coherent and comprehensive government orders blurs lines of control, which are essential for smooth functioning at the grassroots level. The confusion provides undue advantages to some, laxity to some others and opportunities for disobedience to many. As a result, many practices like proxy candidates have emerged at the ground level.

The findings of this chapter can be clustered under two headings – policy/structural issues and socio-structural issues.

7.6.1 Policy structural issues

Many structural issues have yet to be sorted out 14 years after the introduction of Panchayati Raj in Madhya Pradesh. At best, PRIs may be considered to have evolved to the third stage of development administration. The ideology behind the enabling constitutional amendment was a 'bottom-up approach' but in practice structural un-clarity remains. The division of roles between the department and the Panchayats and between

the different tiers of the Panchayat is blurred while control over human and other resources is skewed.

Current practices require to be changed, with a comprehensive approach starting from the Gram Panchayat and moving up to Zilla Panchayat and department. Unless this happens, it will be difficult for PRIs to deliver. Strengthening the PRIs necessarily involves clarity of roles and clarity of the inter-linkages. These institutions must also become more pro-active and assert their control over local issues and local functionaries.

7.6.2 Socio structural issues

The constitutional mandate provided for one-third reservation of seats for women, dalit and tribal representatives in the Panchayats, the thinking being that this will promote the emergence of a new leadership at the grassroots. The hope was that the new leadership would bring a fresh perspective and sensitivity towards the most marginalized communities of the social fabric. However, interventions to strengthen PRIs have missed out on empowering this new leadership. Consequently, not only has this led to poor participation by a substantial number of PRI representatives from the marginalized communities, we are also missing out on promoting local leaders to take up the cause of these marginalized communities.

> The RCH-II programme was an initiative to provide an untied grant to meet the health-related contingencies of the Panchayat. Rs20,000 was disbursed at the sub-health centre level and the account was to be jointly operated by the Sarpanch and ANM. The power struggle to operate the account was so intense that an executive order was passed in Sehore district permitting the ANM and senior medical officer to withdraw Rs1000 at a time with their joint signatures and without the Sarpanch's signature.

The statistics on capacity building provides a fresh basis for the capacity building agenda of the state as well as voluntary organizations.

Chapter-8

CONCLUSION AND RECOMMNEDATIONS

CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

Madhya Pradesh has 23,051 Gram Panchayats, 313 block Panchayats and 48 district Panchayats. This vast body of localized institutions of self governance has created a new horizon for direct democracy in the state. However, when a system changes, a process of adjustment and re-alignment takes place among the key actors. This is not an easy process, often leading to conflict and tension between the different players. Conflict is constructive if it streamlines the system and enhances accountability to the community. Panchayats face such conflicts, which are being progressively resolved as they evolve. But the systemic limitations and contradictions need to be understood if their engagement in healthcare delivery and other issues of local governance is to be strengthened and institutionalized.

The quality of democratic processes depends on the integrity of the organs of the state as well as the capacity of local institutions to involve people in governance at the grassroots. While the debate on devolution of functions between the bureaucracy, district administration, line departments and Panchayats continues, the real challenge is to ensure that the process is not subverted by the economic, political or administrative elites who control the Panchayati Raj institutions.

This multi-task centre study has, to some extent, captured the performance of Panchayats in improving the health status of villages. It has also examined the capacity of Panchayats to handle healthcare delivery issues and the constraints they face in carrying out their designated functions. The present chapter enumerates a set of recommendations based on the findings and conclusions of the earlier chapters.

8.1 Key findings

8.1.1 Centralized agenda stifles grassroots healthcare initiatives

The study responses bring out the highly centralized and polarized nature of healthcare delivery. The focus seems to be on national healthcare programmes like family planning and vaccination and immunization campaigns, with primary community healthcare remaining un-serviced.

The study data and field experience suggest that most Gram Panchayats only discuss the departmental agenda at their meetings. The centralized top-down agenda, which focuses on implementing development schemes of the government, limits the scope to take up local health issues. In fact, most PRI representatives are of the view that implementing development schemes is their main function, so they tend to allot higher priority to these schemes and achieving targets to the detriment of important local issues. More attention is also paide to beneficiary selection and distribution of monetary benefits than to development issues and participatory governance.

8.1.2 Lack of health infrastructure

Madhya Pradesh is a sparsely populated state with widely dispersed hamlets within each Gram Panchayat. It is a challenge to reach and service these distant hamlets. Health service providers complain about the geographical area they have to cover to reach healthcare services to the community. But the mechanism adopted to deliver services is the same as that for states like Uttar Pradesh, West Bengal or Kerala which have a greater population density. So it is more likely to face breakdown in a state like Madhya Pradesh. A localized Panchayat-centric system that could probably counter the topographical disadvantages is missing to date.

8.1.3 Ambiguous devolution of functions

There is little common understanding among stakeholders on what is expected of Panchayats in healthcare delivery. Each category has its own understanding, with differences in perception existing even within the three Panchayati tiers and among different levels of health service providers. Field functionaries are reluctant to take directions from the Gram Panchayats, often openly defying their health initiatives. So Panchayats fail to perform as expected.

Nevertheless, the study reveals their inherent potential if they are given adequate capacity building support and provided a facilitative environment for action. Several Panchayats in Gwalior and Sehore districts have imparted health education to the community, coordinated the convergence of health programmes in the field and monitored the functioning of health centres and health service providers.

8.1.3 Undue emphasis on education

The study shows that PRI representatives may not have completed formal schooling but they are sensitive to health issues. The qualitative responses give evidence of their understanding of the relationship between good health and water, sanitation and environmental conditions. Unfortunately, many stakeholders attach undue importance to

educational qualifications, attributing the non-performance of PRI representatives to their illiteracy and ignorance.

The reasons for inaction are more wide ranging. They include poor role clarity, blurred lines of control, insensitive attitude of health service providers, budgetary constraints and factional dynamics in the Panchayats. But the tendency is to link everything to poor education. Health service providers question the ability of illiterate PRI representatives to take up healthcare-related responsibilities, with even village-level health functionaries showing their mistrust of elected Gram Panchayat heads. Despite these limitations, the study responses show that health continues to figure prominently in Panchayat and Gram Sabha discussions

8.1.5 Lack of accountability of health service providers

Panchayats may have a mandate to monitor the functioning of village-level personnel, but blurred lines of control ensure that health functionaries remain averse to being accountable to local bodies. They prefer reporting to the vertical hierarchy of their line department. Department officials also expect Panchayats to provide unconditional subsidiary support and not question their functionaries. Coordination is restricted to casual contact – chance meetings between department officials and the Sarpanch or other PRI representatives. So Panchayats can do little else except forward suggestions or complaints of the community to the Health Department, which more often than not does not take any punitive action. They have no way of ensuring that health service providers live in their operational area or visit villages on a regular basis.

8.1.6 Limited role of Panchayats in healthcare delivery

Most PRI representatives have a limited understanding of health. The data shows that they do appreciate the linkages between health and issues like water, sanitation, immunization and nutrition, but they often fail to see the bigger picture. For instance, they fail to see the linkage between nutrition and maternal or child mortality or immunization and epidemics. In fact, they fail to understand the value of total immunization. Many are victims of superstitious beliefs and, in the absence of public education on healthcare, the community is not always supportive.

Many stakeholders feel that Panchayats are not even interested in healthcare issues, particularly since there are no substantial budgetary allocations for local healthcare initiatives. They also see lack of knowledge and skills as a serious constraint.

Limited by their capacity constraints, lack of technical understanding and attitudes to health, Panchayats tend to be over-dependant on the Health Department. They expend substantial energy in coordinating and collaborating with the department, usually

forwarding requests/complaints/proposals/memoranda to the relevant authority for action. They also collect important health data and health records at the local level. Their only direct engagement in healthcare delivery is limited to water and sanitation and facilitating implementation of health schemes. They thus remain passive actors in healthcare delivery, their potential to educate people on healthcare issues and promote good health remaining untapped.

8.1.7 Inadequate capacity building support

All stakeholders, irrespective of gender, caste or category, unequivocally feel Panchayats need to understand primary healthcare management issues. But capacity building efforts remain inadequate. Their quality and the training strategy adopted by government agencies and NGOs need a second look. Most trainings focus on general administration and the functioning of Panchayats. The need is for subject specific trainings instead of generic orientations. Also, being the grassroots monitoring and delivery mechanism, Gram Panchayats require more capacity building support than the higher Panchayati tiers. However, the reverse is true in practice, with Zilla Panchayats receiving the most capacity building inputs.

8.1.5 Poor understanding of Panchayats among health service providers

Departmental functionaries have a vague understanding of the role and responsibilities of Panchayats and what devolution of functions means in practice. This is especially true of village-level functionaries. Although they believe that Panchayats have been given adequate authority in healthcare delivery, they interpret this authority as providing support to departmental work in the form of data collection, record keeping and doing the legwork for polio drives, family planning campaigns etc. They disregard local feedback from the PRI representatives and are only concerned with meeting the targets of centralized health programmes.

8.1.6 Side-tracking of PRI representatives elected from reserved seats

The constitutional mandate provides for reservations of seats in Panchayati Raj bodies for women, dalits and tribals, the thinking being that such affirmative action will promote the emergence of a new leadership at the grassroots. The hope is that this new leadership will bring a fresh perspective and sensitivity towards the marginalized communities. However, few proactive steps have been taken to empower the new leadership.

On the contrary, since most elected representatives from marginalized communities are uneducated and ambiguous about their role, they face discrimination and factionalism

within the community. They are even openly mocked, which affects their performance. The community is also reluctant to accept the leadership of women in Panchayats since many of them are 'figure heads', with actual control resting with their husbands. Consequently, their participation in the Panchayats' activities is poor.

8.2 Main recommendations

Based on the findings of the report, the following broad conclusions can be drawn:

8.2.1 Synergizing inter-sectoral linkages

Many health-related issues like water, sanitation, nutrition, hygiene etc fall outside the purview of health policy. They need to be addressed at the ground level to ensure inter-sectoral convergence. The need is for synergy between a wide range of service providers, including the Public Health Engineering Department, Rural Engineering Services and health functionaries. Local health workers like the Jan Swasth Rakshak, Anganwadi worker and ASHA also need to be included in the loop. But this would require clearer lines of authority if the Panchayat is to take the necessary proactive steps.

Experiments also need to be taken up to evolve structures to meet local healthcare needs. Given the topography and distances in a sparsely populated state like Madhya Pradesh, it is relevant to identify a decentralized mechnanism with health specific investments in Panchayats. Similarly, a decentralized understanding of national health programmes also needs to be built up among Panchayat and community members so that they work as partners in these programmes rather than as passive receivers.

8.2.2 Newer feedback mechanisms

Although PRI representatives routinely provide feedback on problems in delivering healthcare services to the health service providers and department, their voice is seldom heard and action is seldom forthcoming. Alternative systems for data and feedback collection by academic institutions or voluntary agencies also need to be explored. For example, the Gyarah Sutree initiative records the failure of Panchayats to provide 11 basic services. Similar data can be collected for other basic services like hand pump repair, ration shops etc. This would allow better coordination between policy makers and Panchayats on healthcare issues.

8.2.3 Providing space for local healthcare issues

Most stakeholders see the Panchayat as another administrative arm extended by the state. Its agenda is determined by the district administration, which also determines its functioning. This leaves little space for taking up local healthcare issues. If they have to

function effectively, Panchayats need to have a greater say in what issues and programmes need to be taken up in their local areas. Even national programmes need to have a specific local component and resource allocations should match local priorities. The community should be the central concern, not the administration and the Panchayats should act in accordance with the voice of the community.

Neither the Panchayats nor the administration shows any sense of accountability towards the Gram Sabha. They do not abide by its decisions so the Gram Sabha tends to be marginalized in the democratic process. Panchayats have also tended to become self-centred, establishing a relationship with the Health Department that benefits a close circle of influential families.

8.2.4 Clearer articulation of expected role

More than a fourth of PRI representatives cannot even articulate their functions. Office orders need to be specific so that roles are more clearly defined. Such role clarity is also needed for all three Panchayati tiers and the department. Overlaps in functions, authority and resources devolved should be minimized to remove ambiguities in functions and authority.

8.2.5 Strengthening the position of Gram Panchayats

Role clarity improves as we move up the Panchayati tiers. But there is little indication that such clarity improves the relationship between the Zilla Panchayat, which is the nodal agency coordinating functioning at the Gram Panchayat level, and the Gram Panchayats. The higher tiers tend to use their financial controls and authority to undermine the autonomy of the Gram Panchayat.

There is a need to reverse this trend by directing support and facilitating organic linkages at the Gram Panchayat level. Gram Panchayats should be vested with greater authority, with minimum dependence on the higher tiers to take decisions or provide finances.

8.2.5 Investing in capacity building

There is need to take another look at the training strategy adopted by the district administration, state nodal agencies as well as voluntary organizations. Subject-specific quality trainings need to replace generic orientations. At the same time, capacity building support needs to be focused on representatives from marginalized communities, especially dalits, who have been completely overlooked in capacity building efforts.

Box-12

Issues for capacity building support

Training issues for Panchayats	Training issues for health service providers
• Role and power of Panchayats in healthcare delivery • Relationship between hygiene, nutrition, water and sanitation and health • Schemes of Health Department • Primary healthcare • Preventive healthcare, like immunization, vaccination etc • Issues for inter-departmental convergence • Health planning at the Panchayat level	• Role and power of Panchayats in healthcare delivery • Health planning at the Panchayat level • Sensitization towards community health needs • Sensitization towards elected representatives from marginalized communities • Sensitization towards the needs of women and children • Inter-departmental linkages in healthcare delivery

- Need for regular capacity building support, so trainings should be seen as a long-term process rather than a one-time effort.
- Special and customized support to representatives elected from reserved seats like women, dalits and tribals.
- Inclusion of Panchs in training programmes so that they can contribute meaningfully to healthcare delivery.
- Since many grassroots' elected representatives are illiterate and not technically competent, it is important to design simple short-duration modules for them.
- It is equally important to reach trainings to the doorstep of the Panchayats - for single Panchayats or clusters of Panchayats - rather than in a centralized manner.

8.2.7 Public health education

Health is an articulated community need but there is a degree of ignorance about the cause-effect relationships in healthcare. The community is also poorly informed on the role and responsibilities of health service providers as well as the Panchayats. Ignorance constrains the community's capacity to exert pressure on health service providers. It also constrains any constructive response to the health initiatives of the Panchayats. A vibrant health education programme, using the mass media, would facilitate better understanding among all actors in healthcare delivery.

8.2.8 Accountability to the Gram Sabha

Neither the Panchayat nor the administration shows responsibility and accountability towards the Gram Sabha. The decisions of Gram Sabha are not abiding on any of the two nor it is sought for taking developmental. In such a situation, Gram Sabha has considerably withdrawn from the democratic processes. Accountable and people-centred governance can provide an operational framework for making democracy works.