THE ROLE OF NON GOVERNMENTAL ORGANISATIONS AND PANCHAYATS IN RURAL HEALTH: A COMPARATIVE STUDY OF THE DISTRICTS OF MANDYA AND MYSORE

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CONTENTS

ACKNOWLEDGEMENT

LIST OF ABBREVIATIONS

LIST OF MAPS AND TABLES

INTRODUCTION

1

CHAPTER I

DECENTRALISATION, CIVIL SOCIETY AND RURAL HEALTH 10

CHAPTER II

GENESIS & DEVELOPMENT OF PANCHAYATI RAJ
IN INDIA AND KARNATAKA 50

CHAPTER III

NATIONAL RURAL HEALTH MISSION 83

CHAPTER IV

A COMPARATIVE STUDY OF THE DISTRICTS OF
MANDYA AND MYSORE 98

CONCLUSION

140

BIBLIOGRAPHY

147

LIST OF ABBREVIATIONS

NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
PHC	Primary Health Centre
CMO	Chief Medical Officer
Dist.	District
PDO	Panchayat Development Officer
CEO	Chief Executive Officer
GP	Gram Panchayat
CSO	Civil Society Organisations
PRI	Panchayati Raj Institutions
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
SHG	Self-help groups
CBO	Community based organizations
TB	Tuberculosis
RCH	Reproductive and child care
Etc.	Etcetera
Eg.	Example
Viz.	Videlicet
ASHA	Accredited Social Health Activist
IPHS	Indian Public Health Standard
IMR	Infant Mortality Rate

MMR	Maternal Mortality Rate
MPW	Multi-purpose worker
ANM	Auxillary Nurse Midwife
EAG	Empowered Action Group
TSC	Total Sanitation Campaign
PPP	Public Private Partnership
CBHI	Community Based Health Insurance Schemes
HFW	Health and Family Welfare
PRC	Population Research Centre
RRC	Regional Resource Centre
SIHFW	State Institute of Health & Family Welfare
GOI	Government of India
PMU	Programme Management Unit
MOU	Memorandum of Understanding
TDB	Taluk Development Board
MP	Member of Parliament
MLA	Member of Legislative Council
SC	Scheduled Caste
ST	Scheduled Tribe
OBC	Other Backward Classes
PO	People's Organisation
WHO	World Health Organisation
VO	Voluntary Organisation

PSC	Public Service Contractors
GO-NGO	Governmental non-governmental organisations
VHSC	Village Health and Sanitation Committee
VHND	Village Health and Nutrition Day

LIST OF TABLES AND MAPS

Table or map

Map of Karnataka

Map of Mandya district

Map of Mysore district

Table 1: Funding source of Health Infrastructure in Karnataka

Table 2: Human Resource availability under NRHM in Karnataka

Table 3: Number of Institutional Deliveries under NRHM in Karnataka

Table 4: Expenditure on JSY Incentives

Table 5: National Disease Control Programme

Table 6: Percentage of distribution of beneficiaries who are accessing NRHM

Table 7: Percentage of distribution of beneficiaries according to their knowledge of health personnel

Table 8: Percentage of distribution of beneficiaries according to their knowledge of regular visits

Table 9: Percentage of distribution of beneficiaries aware about various NRHM activities

Table 10: Percentage of distribution of beneficiaries aware about VHSC and VHND

Table 11: Percentage of Gram Panchayats having VHSC and preparing a health plan

Table 12: Percentage of various actors acknowledging various sources for improvement in health standards

INTRODUCTION

All over the world the right of people to govern themselves has accrued to them through long years of struggle. It has always been an arduous exercise to traverse from governance by autocratic decree to one by democratic dialogue leading to development of the country and its people. Development is now regarded as a process that requires democracy.[1] Our country has also followed this long path of struggle in order to win not only independence but democracy. Through the principle of democracy India has tried to provide the best of the environment to its citizens in order for them to grow to their maximum potentials. The acceptance of a democratic system of government, while a major achievement, is not the end of the road. The very essence of democracy lies in the fact that people should decide their own fate and in order to do so, decentralisation is the first step.

According to a study done by the World Bank in 1999

> More than 80% of all developing countries and countries with economies in transition are experimenting with some form of decentralization so that they can balance the need for economic growth with the goal of sustainable development and achieve the objectives of efficiency, equity and democracy by bringing government closer to people, increasing local participation and accountability of government.[2]

According to the Census 2011,[3] the total population of India as recorded on 1st March, 2011 is 1,210,193,422 of which 83,30,87,622 is urban and 37,71,05,760 is rural. A large portion of this population resides in villages (68.84%)[4] of which a huge portion is poor too and hence an enabling environment is required to make this vulnerable section involved in the process of development and democracy. The State-Centre government partnership led development has been widely criticized by the local population throughout the country because it was not able to become responsive, lacked cost effectiveness and did not develop local capability and self-reliance. Attempts have therefore been made to improve people's participation in the

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[1] Amal Mandal, *Women in Panchayati Raj Institutions*, New Delhi, 2003

[2] Rukmani, *Decentralized Governance of Forest Resources: A Case Study Of Uttarakhand,* Jawaharlal Nehru University Master of Philosophy Dissertation, 2011, p. 2

[3] www.censusindia.gov.in

[4] Ibid.

decision-making and control of resources at the local level. As a result of these attempts, the local governance is now strengthening its base in the country with people-centered approach adopted by both the state and the centre government through decentralisation.

Decentralisation as a process implies not only the sharing of the decision-making authority with lower levels in the organisation but also division of power in the context of institutional framework. It being combined with democratisation in its electoral representative form provides greater transparency, accountability, responsiveness, probity, frugality, efficiency, equity and opportunities for mass participation[5] as can be observed to a certain extent in countries like India. Decentralisation brings along empowerment in the context of social groups not covered by the process of democracy and development because of social and economic constraints. This empowerment of the local masses through decentralisation creates popular knowledge, questions the monopoly of the dominant paradigm and keeps alive the population's resentment against the most visible aspects of political and social discrimination.[6]

India is a prime example for advocating decentralisation as it is advocated for countries which are diverse in size, socio-economic complexity and have religion, language, economic development and cultural complexities. It is also feasible for nations whose customary law, traditional practices, community ethos, modes of living, organization make it impossible to govern from a single central government.[7] It is "a process whereby the government divests

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[5] Richard C. Crook and James Manor, *Democracy and Decentralization in South Asia and West Africa*, Cambridge: Cambridge University Press, 1998, p. 2

[6] Rahnema Majid, *"Participation*", in Wolfgang Sachs, (ed.), *The Development Dictionary: A Guide to Knowledge as Power*, New York: Orient Longman, 1997, p. 163

[7] Bhuria Committee Report, Report of the Committee of Members of Parliament and Experts Constituted to make recommendations on law concerning extensions of provisions of the Constitution (Seventy-third Amendment) Act, 1992 to Scheduled Areas, New Delhi, Ministry of Rural Development, Government of India, 1995, p. 3

itself completely of certain duties and responsibilities and devolves them on to some other authority".[8]

Decentralisation is not just devolution of powers but also responsibilities and duties by the central authority to the institutions at the lower levels, thereby, providing to the latter adequate incentives for autonomous functioning. Lord Bryce described the local governments as, "tiny fountainheads of democracy"[9] or "free popular management of local affairs".[10] In decentralisation "local units are established with certain powers of their own and certain fields of action in which they may exercise their own judgment, initiative and administration".[11]

This concept of decentralisation creates a sense of responsibility in the government at all levels. "It is training in self-government. It confines the administration of powers to those who feel most directly the consequence of those powers".[12]

> The concept of democratic decentralisation implies devolution of sizeable powers and responsibilities by the central government through properly enacted legislative measures to democratically created territorial units. These units enjoy more or less complete autonomy within the territorial and functional jurisdiction delimited to them. The clamour for further decentralization happens when the polity fails to address the needs of diversities, regions and groups. Decentralization relates to organizational tasks, finance and human resources, policy making, strategy formulation, planning, priority–setting and implementation of programmes. Financial and human resources autonomy relates to generation and procurement of resources, controlling and owning them and their effective utilization.[13]

Though it is the duty of the state to look after the overall welfare of its citizens through effective utilisation of finances and human resources in all the sectors like education, health, etc., it has been observed that over the years this is not what has been happening either due to the fact that it is impossible to reach

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[8] Government of India, Report of the Team for the Study of Community Development and National Extension Service, New Delhi, Committee on Plan projects, 1957, Vol. 1, p. 7

[9] S. Bhatnagar, *Panchayati Raj in Kangra District*, New Delhi: Orient Longman, 1974, pp. 3-4

[10] P.R. Dubashi, *Rural Development Administration in India*, Bombay: Popular Prakashan, 1970, p. 11

[11] Harold F. Alderfer, *Local Government in Developing Countries*, New York: McGraw Hill, 1964, p.176

[12] Harold J. Laski, *A Grammar of Politics*, London: George Allen and Unwin, 1960, p. 61

[13] Udai Pareek, *Decentralization for Effective Governance*, Jaipur: Centre for Administrative Change, 1989, p. 2

every citizen cause of physical and economical constraints or due to the lack of the will of the political bosses who run the state. It was because of these problems that the idea of local governance was highly appreciated by the citizens at large as they were finally getting their due share in power and could now look after their interests on their own though state have a role to play.

With the entry of local self-governance in the welfare sphere there also started arising problems regarding the unequal pattern of development in the local self-governed areas or panchayats. To counter this inequality which arose due to political, social and other factors, the civil society finally made an entry at the ground level with the aim to bring about transparency in the process and to bring to the helm the underdeveloped areas and strata of the panchayats. The civil society represented by the non-governmental organisations (NGOs) have been an instrument in keeping tab on the various developmental works introduced by both the state and the central government at the grass root level around the country.

Through their questioning the local administration for creating awareness among the local population regarding the various developmental works and their progress these organisations have tried to bring about some kind of transparency and equality among various areas where decentralisation has been introduced. This approach has also been adopted by the NGOs in the health sector. During this study it was found that the NGOs involved in the health sector not only publish their progress reports regularly but also conduct surveys to access the impact of programmes like the National Rural Health Mission (NRHM) at the grass root level.

This entry of the NGOs at the grass root levels has helped all the parties involved in developmental works. It keeps the government and the Panchayati Raj institutions (PRIs) aware about the work undertaken by the NGOs in the health sector, the needs of the local population, the progress of their schemes and programmes and the work done by the PRIs and local administration at the grass root level. On the other hand the local population gets an insight of the work being done by the central and state governments, PRIs, NGOs and

local administration in their area. They are also able to raise their voice regarding their demands for the development of their areas.

One of the most neglected sectors of development in the country has been the health sector, especially the rural health sector. In order to bring about easy access to the health services and raise the standard of rural health in the country the National Rural Health Mission was introduced in 2005. The aim of any such mission cannot be accomplished unless the people are involved in the planning process. It is impossible to evolve meaningful, rational and cost effective health care system that can provide adequate amount of appropriate health care to the people without the active participation of the people.

According to scholars around the world like Mills, Matheson, Azfar, Ndiaye, etc.(their studies have been discussed in the next chapter) who have conducted studies on decentralisation, civil society and rural health, the ‘top-down’ approach prevalent in the past in delivering health care in India as well in countries around the world has been known for its lack of sensitivity to cultural and social factors of the local people and for its lack of accountability to the people whom it is intended to serve. Hence, they argue that to face these challenges the role of the civil society becomes very essential as non-governmental organisations can connect to the common man at the level which the state can never ever dream about. Therefore, the partnership between the panchayats and Non-governmental institutions becomes all the more important.

Panchayats in India are an age old institution for governance at village level. In 1992, through the enactment of the 73rd Constitutional Amendment, Panchayati Raj Institutions were strengthened as local government organisations were given clear areas of jurisdiction, adequate power, authority and funds to commensurate with the responsibilities. Panchayats have been assigned 29 rural development activities though the number of activities assigned differs from state to state for eg. in Karnataka all 29 activities have been assigned to the panchayats. These activities include several ones which are related to health and population stabilisation. The XI schedule includes Family Welfare, Health and Sanitation, (including hospitals, primary health centres, and dispensaries,) and the XII schedule includes Public Health.

The 73rd Constitutional Amendment Act makes it mandatory that functions related to the provision of primary health care - maternal health and family welfare are the responsibility of the PRIs. Besides the various development sector departments come under the functional jurisdiction of the district panchayat. Creating a health system with the panchayats being and being made responsible for supervising and monitoring health services seems to be an ideal model as they are in direct contact and control of the local population

Effective health care is not within the realm of the health department alone. At the village level convergence is required with agencies providing nutrition, sanitation, education, livelihood/poverty alleviation and empowerment schemes at the very least. Beyond the functionaries of each of the line departments, the only institutions at the village level which can coordinate all these functions are the PRIs. In reality however there is little convergence at the village level in many states, much less an active role for the PRI in facilitating convergence. At the District level a District Health Mission coordinates NRHM functions. Sanitation has also been aligned with the NRHM. The National Health Policy, 2001, also emphasizes implementation of public health programmes through local self-government institutions especially relating to the national disease control programmes.

Conclusion

The extent to which health care is enhanced by the panchayats depends on the funds and functions devolved to them for carrying out these responsibilities. Clarity in the separation of powers between the elected representatives and the bureaucracy at the local government are important in this context. While the development targets include reducing the incidence of maternal mortality and morbidity, the question still remains whether the institutional interventions and resources allocated are adequate to address these problems. Gram Panchayats have a supervisory role in ensuring proper delivery of services. Many of them were not even aware of what comprised the role and responsibility of panchayats in healthcare service delivery before the commencement of NRHM.

In this study an attempt is being made to analyse the impact of the role of the Non-Governmental Organisations and the Panchayatsin increasing the

participation of the people in management of rural health through NRHM. The study will compare and analyse the role of these two institutions in the districts of Mandya and Mysore in the state of Karnataka. Further, the study seeks to examine how these institutions function differently together as compared to the working of the state alone through Panchayats. It further emphasises on this collaboration which produces different outcomes in specific conditions, differences and commonalities in their performance and also the factors affecting and facilitating the effective functioning of both the NGOs and the Panchayats. The participation of the people and the institutions will be examined in the backdrop of rural health.

Hypothesis

The collaboration of Non-Governmental Organisations and Panchayats in the management of rural health in the districts of Mandya and Mysore has improved the participation of people in the National Rural Health Mission, thereby leading to improved outcomes.

Research Questions

- Why do we need the civil society specially the Non-Governmental organisations to collaborate with the panchayats?
- What is the role of Non- Governmental organisations in relation to panchayats?
- Whether this role is positive or negative?
- What are the social and political factors that influence the working of Non- Governmental organisations in these two districts of Mandya and Mysore?
- Do these factors have an influence on the participation of people in the panchayats?
- What work is being done by the panchayats related to health?
- Is the inclusion of Non-Governmental organisations making any difference regarding the management of rural health in these two districts?
- Which district is better off and why?

- Should the scope of activity of Non-Governmental organisations be increased or not?

Outline of the Research

This study assesses the process of decentralisation by linking it up with the functioning of local level gram panchayats and NGOs. The central objective of the study is to explore the collaboration of NGOs and Panchayats in the management of rural health in improving the participation of people in the National Rural Health Mission, thereby leading to improved outcomes. Keeping the objective of the study in mind, this work is structured to comprise of four chapters, an introduction and conclusion.

Chapter I provides a concise introduction to the topic and focuses on the rationale of the study and the main questions being addressed.

Chapter II of the study deals with the concept of Panchayati Raj both in India and the state of Karnataka. The first section explains the emergence of the Panchayati Raj Institutions (PRI) in India as a whole. It covers the history of the Panchayati Raj as the original form of political structure to its current status in India. The second section of the chapter covers the history of Panchayati Raj in Karnataka.

Chapter III of the study deals with the National Rural Health Mission both at the national and the state level. It discusses in detail the working and the organisational structure of the mission at both the levels. The goals, vision, important components, technical support, role of state, PRIs and NGOs, current achievement and future plans are mentioned extensively, both in India and Karnataka.

Chapter IV of the study deals with the case study of the role of Non-Governmental Organisations and Panchayats in rural health in the districts of Mandya and Mysore of the state of Karnataka. It discusses the institutional design of the gram panchayats and the composition of the NRHM in association with the other state run health programs in rural health. The chapter also discusses the role and functioning of the NGOs and gram panchayats through the selected case studies of six gram panchayats, three in each of the districts of Mandya and Mysore. It also deals with the analysis

of the role of NGOs and Panchayats in rural health in each of the six gram panchayats which eventually leads to a comparative study of both the districts of Mandya and Mysore. The study further elaborates on the observations made during the field study on both the positive and negative aspects of the collaboration between the NGOs and Panchayats in the management of rural health in detail.

This study concludes by reiterating that though the role of NGOs and Panchayats has improved the participation of people in the NRHM, therefore leading to improved outcomes, a lot is still desired to be done. Both the districts do not fare too ahead of each other and there is still need of a lot of work to be done by all the actors involved. However, it also makes suggestions for improvement in strengthening local participation in NRHM further in the light of the observations made during the study.

CHAPTER I

DECENTRALISATION, CIVIL SOCIETY AND RURAL HEALTH

Introduction

The government run rural health services in developing countries like India previously were highly centralised in their approach towards providing resources or running programmes in the rural sector. This resulted in a number of problems like the services being unresponsive to local demands and needs, lack of resources in the shape of infrastructure, shortage of supplies and staff, under-trained staff, ill-equipped health centres and hospitals. In many instances medical staff was found to commonly indulge in private practice and rarely attend to their duties and there was no emphasis on patient satisfaction i.e. the patients and poor working of referral systems was also a huge problem.[14]

On the other hand the privately-run medial facilities or NGO-run medical services were almost totally decentralised. This above mentioned concept of decentralisation in the private and NGO sector in health as well as better functioning as compared to government health functioning are considered the reasons why most of the local population of a region prefer to use these services regardless of the high fees and/or average quality of services provided. Hence, in recent years reforms have taken place in the sector of rural health services which has introduced the concept of decentralisation in the government run public health sector.[15]

The World Bank has also pointed out that "a policy that can improve both efficiency and responsiveness to local needs is decentralisation of the planning and management of government health service".[16] On the other hand, some scholars like Ugalde, Jackson and Collins have criticised this viewpoint of the World Bank. According to them "decentralisation is a complex

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[14]Devender B. Gupta and Anil Gumbler, 'Decentralisation: Some Initiatives in Health Sector' in *Economic and Political Weekly*, Vol. 34, No. 6 (Feb. 6-12, 1999), pp. 356-362

[15]Ibid.

[16]World Bank, *World Development Report: Investing in Health,* World Bank, New York,1993

process and cannot be recommended across the board as the World Bank has done without taking into account historical, political, social and geographical realities".[17]

None the less, since the 1980s decentralisation in the health sector policies have been implemented throughout the developing world on a large scale. Decentralisation has been touted as a key means of improving health sector performance and promoting social and economic development, often in collaboration with health finance reform.[18] Beyond decentralisation reform itself, civil society participation especially the role of NGOs is considered crucial in improving not only the health service delivery but enhancing the level of community participation in the health sector in the developing countries around the world. It has been argued that there is no doubt that NGOs, people's organisations (POs) and socio-civic groups have the "capacity to mobilize communities for health-related activities and social action, generate resources, and organise communities around health and development issues".[19]

In the health service delivery system, civil society groups and volunteers in the area of health are in the process of performing some of the democratising roles such as,

> Effecting transition from clientelism to citizenship at the local level; recruiting and training new political leaders; disseminating information and therefore empowering people in the collective pursuit and defence of their interests and values; and strengthening the social foundations of democracy even when their activities focus on community development.[20]

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[17] Antonio Ugalde and Jeffrey T. Jackson, 'The World Bank and International Health Policy Policy: A Critical Review'in *Journal of International Development*, Vol. 7, No. 3, 1995, pp. 525-554; and C. Collins, 'Decentralisation and the Need for Political and Critical Analysis'in *Health Policy and Planning*, Vol. 4, 1989, pp. 168-171

[18]Ibid.

[19]Dennis B. Batangan, 'Policy Paper to Strengthen Civil Society Participation in Health Development' in *Public Policy*, January-June 2006, 10(1), pp. 103-121

[20] Larry Diamond, *Developing Democracy: Towards Consolidation,* Baltimore and London, 1999, pp. 218-260

These roles being played by the civil society in the management of rural health form the basis of the successful initiation of the concept of decentralisation in the everyday life of the common people.

It has been observed that all over the world, the modern governments now-a-days are changing both their scope and mode of operations by trying to build on the comparative advantages of the state and the market, both spheres highly important to its citizens.[21] There is a new emphasis on market-oriented economic reforms and reduced government intervention with a view of optimising public service provision.[22] This reconstructive effort is marked by a growing recognition that citizens who are the users of public services also need to be given a voice in the process of decision-making through participatory partnerships.[23] It is the concept of decentralisation which provides the community with this opportunity of being a part of the decision-making process.

These reforms, therefore, seek to make governments more responsive, cost-effective and accountable to the citizens.[24] Their thrust is on institutional restructuring, both by shaping rules and regulations that determine how people act and the organisations that set the patterns of their productive relationships within the given institutional framework.[25] Therefore, the emergence of decentralisation as government reform process in many developing countries since the mid-1980s has been widely viewed as the

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[21] Rogerio F. Pinto, 'Innovation in the Provision of Public Goods and Services'in *Public Administration and Development*, 1998, 18(4), pp. 387-97

[22] Dani Rodrik, 'Understanding Economic Policy Reform'in *Journal of Economic Literature*, 1996, XXXIV, pp. 9-41

[23] Chamneirn Paul Vorratuchaiphan and Elizabeth C. Hollister, *'Managing the Change in a Complex World: A Case Study of Urban Environmental Management, Governance Innovation and UNDP LIFE Programme in Thailand,* Regional Dialogue, 1998, 19(1), pp. 44-55

[24] P.A. Volcker and W.F. Winter, *'Democracy and Public Service in Deregulating the Public Sector: Can Government Improve?* Edited by J.J. Dilulio Jr., Washington D.C., Brookings Institute, 1994

[25] Douglas C. North, 'Institutions'in *Journal of Economic Perspectives*, 1991, 5(1), pp. 97-112; and Derick W. Brinkerhoff and Arthur A. Goldsmith, *'Promoting the Sustainability of Development Institutions: A Framework for Strategy'*, World Development Report, 1992, 20(13), pp. 369-83

institutional panacea for effective service delivery and overcoming the bottlenecks to local development.[26] Since a long time the rural populations have had a grievance that policies were being formulated for them by the government without knowing the ground realities but decentralisation has tried to combat this problem especially in the health sector.

Hence, one aims to study the relationship between decentralisation, civil society through NGOs and rural health and their impact on the participation of people especially in relation to NRHM. This chapter therefore deals with the concepts of decentralisation, civil society and rural health individually and their relationship with each other.

Decentralisation

> *Decentralization has, not only an administrative value, but also a civic dimension, since it increases the opportunities for citizens to take interest in public affairs; it makes them get accustomed to using freedom. And from the accumulation of these local, active, persnickety freedoms, is born the most efficient counterweight against the claims of the central government, even if it were supported by an impersonal, collective will.*
>
> Alexis De Tocqueville[27]

Meaning

Decentralisation as a concept is very wide and difficult to be pinned down. Scholars all over the world have viewed the concept of decentralisation through different lenses which are often inconsistent and contradictory to each other. A huge difference which occurs in the study of decentralisation among scholars around the world is due to the application of decentralisation in a number of administrative sectors such as education, etc. as in comparison to it being specifically applied to the health sector only.

The term decentralisation has been explained in a number of ways such as:

> Democracy is considered as one of the best forms of government because it ensures liberty of thought, expression, belief, faith and worship, equality of status and opportunity, fraternity as well as the right to participate in political

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[26] J.S. Wunsch, 'Sustaining Third World Infrastructure Investments: Decentralization and Alternative Strategies'in *Public Administration and Development*, 1991, Vol.11, No.1, pp. 5-24; and P. Bardhan, 'Decentralization of Governance and Development'in *Journal of Economic Perspectives,* 16(4), 2002

[27] Alexis De Tocqueville, *Democracy in America : Historical- Critical Edition,* 1835

> decision-making. Participation and control of governance by the people of the country is the essence of democracy. Such participation is possible only when the powers of the state are decentralised to the district, block and village levels where all the sections of the people can sit together, discuss their problems and suggest solutions and plan execute as well as monitor the implementation of the programmes. It is called the crux of democratic decentralization.[28]

> Decentralisation implies transfer of authority and responsibility from the central government to the district and subordinate levels to make development more locally sensitive and participatory. It is a two-dimensional process--one that increases the sensitivity of the bureaucracy to local conditions and needs; and, second, wherein communities can participate in making decisions on their local requirements and priorities in a more direct and immediate manner based on a system of leadership accountability and transparent information. Decentralisation is expected to usher in more efficient institutions capable of greater responsiveness and more effective provision of local services.[29]

However, at the same time, studies also acknowledge that decentralisation is a complex process that cannot be recommended across the board without taking into account historical, political, social and geographic realities related to the people it is to be applied for.[30] Hence, decentralisation has witnessed varied amount of success in countries around the world.

Types of Decentralisation

According to Rondinelli and Cheema "the transfer of planning decision-making or administrative authority from the Central Government to its field organisations, local administrative units, semi-autonomous and parastatal organisations, local governments, or non-governmental organisations"[31] is known as decentralisation.

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[28] T.V. Sekher, '*Health Care for the Rural Poor: Decentralization of Health Services in Karnataka, India'*, Institute for Social and Economic Change, Bangalore, India

[29] Ibid.

[30] C. Collins and A. Green, 'Decentralization and Primary Health Care: Some Negative Implications in Developing Countries' in *International Journal of Health Services*, 1994, 24(2); and J.P. Vaughan, *'Lessons from Experience',* in A. Mills (eds.) *Health System Decentralization: Concepts, Issues and Country Experience,* World Health Organisation, Geneva, 1990

[31] Dennis Rondinelli and G.S. Cheema, *Implementing Decentralization: Programmes in Asia,* Princeton University Press, 1986

This definition captures the four main forms/types of decentralisation which have been identified in the literature: deconcentration, delegation and devolution.

Since the World Health Organisation (WHO) proposed decentralisation as a way to empower communities to take ownership and control of their own health in 1978, the strategy has been variously pursued in both developed and developing countries as a key management approach on the belief that it enhances efficiency in public sector performance.

Decentralisation involves the transfer of political, administrative and fiscal authority from the central government to subnational governments and authorities. The transfer takes place down a hierarchy of levels of authorities. The most typical being authority being devolved from the centre to the state and then to the local government in a three tier arrangement of governance. In his early work Dennis Rondinelli offered a typology of approaches to the location of authority under decentralisation which is the standard adopted by many authors in the health sector such as Mills, Saltman and Figneras, Bossert and Beauvais. They are the same as the types of decentralisation. These typologies are:

Decentralisation by Deconcentration: This type of decentralisation is said to have taken place when there is a transfer of authority from one level of the central government to another level of the government. Though there is a transfer of authority to the local units from the central government or ministry but the same level of hierarchical level of accountability is maintained.

Decentralisation by delegation: It is the redistribution of authority and responsibility to the local units of governance. These local units may or may not be branches of the delegating authority.

Decentralisation by devolution: It is the transfer of powers to a local unit or institution. It awards the local institution broad autonomy, legal status. These local units are representative in nature like the PRIs. To devolve fully the local population has to be provided with mechanisms to participate in the decision making process.

Devolution involves mass participation and this mass participation leads to the search for new forms of associations or partnerships between various local actors. Partnership is the most recent trend in decentralisation and involves various actors like professional or representative organizations, private sector or other NGOs, so that they can be included in the decision-making processes and accountability.

The concept of decentralisation can be attributed to have begun in the 1980s due to the disillusionment of the common masses with stagnant economies and inefficient central bureaucracies all over the world. This disillusionment led to a variety of changes in countries all over the world including India. The world has passed through cycles of centralisation and decentralisation and has always been in dilemma.[32] During the independence and revolutionary movements in the countries like France, USA and India, the writings and sayings of the national leaders of these countries were in favour of decentralisation so that the disgruntled common masses could be given a say in the decision making process and their feeling of alienation from the government could be put to rest.

It is a vigorous initiative to support rural development. In its most simplest of definition, decentralisation is the transfer of a part of the powers of the central government to regional or local authorities such as happened in the case of the PRIs. On one hand, centralisation is in response to the need for national unity whereas on the other hand, decentralisation is in response to demands for diversity as different regions have different needs which when not fulfilled properly lead to disharmony at both the national level as has happened in various parts of India.

Since the 1980s it has been realized that concentration of power at a particular level is harmful and hence it is essential to put in place a better system of collaboration between the national, regional and local centres of decision-making. The renewed interest in decentralisation is also due to the recognition that less centralised decision-making would make national public

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[32] Gert W. Kueck, D.D. Khanna and Lakhna Mahrotra, *Democracy, Diversity, Stability: 50 Years of Independence,* Macmillan India Ltd., 1998

institutions more effective and transparent in their working and that it would make local governments and civil society more competent in the management of their own affairs.

Objectives of decentralisation

To handle promptly the local-specific development needs: There are functions which have only or predominantly local significance along with functions which depend substantially for their performance upon information and resources available locally. Hence, such functions can be better managed by the local bodies. Village panchayats in India look after the developmental needs of their area according to the demands and needs of the resources in the particular local area of the local population. For example, community roads, local water supply, schools and markets are better handled by the local administration.

To improve the efficiency of programme implementation: Considering the issues from the point of view of administrative efficiency, there was felt an urgent need to divide up and disperse the workload from the top to the bottom of the administrative setup. The programmes when drawn and implemented for a local population can benefit from local knowledge for their efficient implementation. Decentralisation of functions does not only that but it also increases speed and efficiency of service and performance. It helps in achieving better coordination of related functions assigned to a variety of local officers and it takes lesser time in taking decisions at the local level than the time taken in centralised planning system.

To reach the distant locations effectively: Through decentralisation it becomes easier to make the benefits of development to be extended to people in distant localities more equitably and to meet the different needs of a diverse population specially in a politically, socially and economically diverse country like India.

To increase the responsiveness of local administration to people's needs: The actions of local level development functionaries can be best monitored by the local population and through their regular feedback an effective control is possible which will help in making the local administration more responsive

and also fight corruption prevalent at different levels of administration in countries like India.

Hence, decentralisation is able to provide the local population with remedies to the problems which they had been facing for a long time such as programmes not being made according to the local needs, apathy of the local administration in developmental works and towards local needs, lack of efficiency and resources not reaching the remote parts of the country. Therefore, decentralisation can be seen as a welfare measure for the masses.

Arguments for Decentralisation

The arguments supporting decentralisation are of the belief that the

> quality of political participation and therefore of public life itself, will be substantively transformed only when people foregather to collectively debate and deliberate on issues of common concern, and are provided with decision making powers to give effect to their shared concerns. The most distinguished ancestor of this view was, of course, none other than John Stuart Mill who provided two important arguments for local democracy: First, that local political institutions are 'a school of political capacity', making citizens capable of genuine and informed participation; and second, that such institutions would be more efficient if informed by local interests and local knowledge. Local democracy, thus, became a way of enabling both participation and deliberation of effecting a form of direct democracy, and so imparting a richer and more immediate meaning to the democratic ideal than the rather minimal conception of it implied in the idea of elections.[33]

Another argument that has been supporting decentralisation, though not as strong as the first one states that the centralized patterns of decision making end up being insensitive to the local problems and aspirations of the local population specially due to the fact that the ones making the plans at the central level are not aware of the conditions requiring urgent attention in a locality which are only known by the people living there. Hence, "the people on this account are the best judges of their needs and aspirations, and decentralisation ensures that those who are likely to be affected by decisions participate in the making of them".[34]

Decentralisation is often thought to bring government closer to the people especially in the given right circumstances like where government actions are

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[33] Niraja Gopal Jayal, Amit Prakash, and Pradeep K. Sharma, *Local Governance In India; Decentralisation and Beyond,* Oxford University Press, 2006

[34] Ibid.

transparent and civil society is permitted to operate freely. Hence, decentralisation should increase the accountability of government officials and root out most forms of corruption prevalent. The advocates of decentralisation argue on that the decentralisation of local public good finance and delivery provided they are devoid of any inter-jurisdictional spill over, improve governance in public service provision in at least three ways and depend on local governments being at least quasi-democratic[35]:

By improving the efficiency of resource allocation: The most common theoretical argument for decentralisation is that it improves the efficiency of resource allocation. One pillar of this argument proposes that because local institutions are closer to the people as compared to the central government, they are considered to have better information about the preferences of the local population as compared to the central government. Hence, it is argued that they are better informed to respond to the variations in demands for goods and services in that particular region.[36] It also gives the local population to put forward their demands and needs and have developmental plans chalked out for them according to these demands and needs. The public delivery system is able to cater more efficiently to the local population due to this proximity between the local institutions and the people.

By promoting accountability and reducing corruption within government: Decentralisation is argued to promote accountability and reduce corruption in government.[37] One of the biggest factors for introducing decentralisation especially in the developing countries has been the reporting of rampant corruption at the higher levels of government which ultimately led to no resources not ending up with the local populations. Hence, decentralisation has brought about transparency in the working of the government and has

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[35]Omar Azfar and Others, *'Decentralisation, Governance and Public Services The Impact of Institutional Arrangements'*, IRIS Centre, University of Maryland

[36]Wallace Oats, 'The Theory of Public Finance in a Federal System' in *Canadian Journal of Economics*, No. 1, 1968; and Friedrick Hayek, *'The Use of Knowledge in Society'* in American Economics Review, No. 35, 1945, pp. 519-30; and R.A. Musgrave, *The Theory of Public Finance,* New York: McGraw Hill, 1959

[37] Elinor Ostrom, Larry Schroeder and Susan Wayne, *Institutional Incentives and Sustainable Development: Infrastructure Policies in Perspective,* Westview Press, 1993

made it more accountable to the citizens and laying course for fighting against corruption too. On the other hand Treisman[38] is of the view that corruption is greater in decentralised countries than in centralised countries.

By improving cost recovery: It is further argued that making services more demand responsive through decentralisation is argued to have the added benefit that it increases a household's willingness to pay for services.[39] Effective local monitoring of the public service delivery system can take place if there is transparency in the working of the government at all levels, a close match of the supply and demand according to the needs of the local population and handing over of at least some financial powers to the local institutions. But overall, there are a number of case studies of governance improvements arising from local efforts in decentralised systems.[40]

Experiences of decentralisation around the world

Drawing on different country experiments of decentralisation, studies recognise that the effects of decentralisation depend on location-specific institutional design which vary from country to country and suggest the need for a stronger focus on institutions in designing decentralised policies.[41] Even if there is a strong political will and administrative mechanism to see to it that decentralisation of the service delivery is done there are a number of concerns that arise such as the extent to which the devolution of power should take place or what are the methods by which the community participation can be increased or which other actors can play a positive role in

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[38] Daniel Treisman, 'Decentralization and Inflation in Developed and Developing Countries', June 1998

[39] John Briscoe and Harvey Garn, *'Financing Water Supply and Sanitation under Agenda 21'* in Natural Resources Forum, 19(1), 1995, pp. 59-70; and Jennie Litvack and Jessica Seddon, 'Decentralisation Briefing Notes' in *World Bank Working Papers*, The World Bank, 1999

[40] Jennie Litvack, Junaid Ahmad and Richard Bird, *Rethinking Decentralisation in DevelopingCountries,* Washington DC, The World Bank, 1998; and Robert Klitgaard, *Controlling Corruption,* Berkley and Los Angeles, CA: University of California Press, 1988

[41] J. Litvack, J. Ahmad and R. Bird, *Rethinking Decentralization in Developing Countries,* World Bank, Washington D.C., 1998

taking decentralisation to the grass root levels. All these concerns need to be taken care of in order for decentralisation to work properly.

In many countries, decentralisation is often undertaken as part of a sectoral reform process. In this context, the World Development Report of 1993 states that a policy that can improve both efficiency and responsiveness to local needs is decentralisation of the planning and management of government health service.[42] In reality, health system decentralisation takes many different forms depending not only on overall governmental political and administrative structures and objectives, but also on the pattern of health system organization prevailing in the particular country.[43]

It is generally believed that the decentralisation of health sector would result in greater community participation in local health activities which in turn will lead to improved service quality and coverage. The following advantages are generally cited as justification for decentralisation of health care services[44]:

- A more rational and unified health service that caters to local preferences
- Improved implementation of health programmes
- Reduction in duplication of services as the target population are defined more specifically
- Reduction of inequalities between rural and urban areas
- Greater community financing and involvement of local groups
- Greater integration of activities of different public and private agencies
- Improved inter-sectoral co-ordination

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[42]World Bank, op. Cit.

[43] A. Mills et. al. (eds), *Health System Decentralization: Concepts, Issues and Country Experince,* World Health Organisation, Geneva, 1990

[44] A. Mills, 'Decentralization and accountability in the health sector from an international perspective: what are the choices?' in *Public administration and Development*, 1994; and Collins Y. Wang, S. Tang and T. Martineau, 'Health systems and decentralisation and human resources management in low and middle income countries' in *Public Administration and Development,* Vol. 22, 2002, pp. 439-453

Most of the developing nations around the world have introduced the concept of decentralisation in their countries and to fully understand the concept one needs to go through the observations of the scholars who have conducted extensive research in countries around the world. These studies argue both for and against decentralisation. Bird, Ebel and Wallich[45] examined decentralisation in Eastern and Central Europe. Their results suggest that public services can suffer as a result of decentralisation at least in the short run. On the other hand Matheson and Azfar[46] studied the impact of decentralisation on health and education outcomes in the Philippines. In the Filipino provinces where national minorities formed local majorities after decentralisation, it improved health outcomes.

West and Wong[47] have shown that in China decentralisation increased regional disparities in the provision of health and education services whereas Winkler and Rounds[48] demonstrate that decentralisation created inequities in education services in Chile. Isham and Kahkonen[49] analysed the performance of community-based water services in central Java and found that only if user themselves are directly involved in service design and selection were services likely to match user preferences. Finally, the performance of decentralised service delivery depends on the design of decentralisation and institutional arrangements that govern its implementation.

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[45] Richard Bird, Robert Ebel and Christine Ebbel, *Decentralisation of the Socialist State: Intergovernmental Finance in Transition Economies,* Washington D.C., The World Bank, 1995

[46] Thorton Matheson and Omar Azfar, *'Decentralisation and Social Welfare in the Minority Provinces of the Philippines,* Mimeo, University of Maryland, 1999

[47] Loraine West and Christine Wong, 'Fiscal Decentralisation and Growing Regional Disparities in Rural China: Some Evidence in the Provision of Social Services'in *Oxford Review of Economic Policy*, Vol. II, No. 4, 1995, pp. 70-84

[48] Donald Winkler and Taryn Rounds, 'Municipal and Private Sector Response to Decentralisation and School Choice'in *Economics of Education Review*, Vol. 15, No. 4, 1996, pp. 365-376

[49] Jonathan Isham and Satu Kahkonen, *'Improving the Delivery of Water and Sanitation: A Model of Coproduction of Infrastructure Services'* in IRIS working Paper Series, No. 210, University of Maryland, 1998

There are varying experiences reported from different countries on whether decentralization results in improving the provisioning of health services. The experience of Botswana shows that a strong administrative structure is needed at district level for the effective decentralization of health services.[50] On the other hand, the transfer of primary care clinics to municipalities in Chile has not resulted in extending coverage or in improving the quality of the services, mainly due to lack of professional supervision and poor planning by the area health services.[51] The initial experience of 'trial and error method' of introducing decentralised decision-making in Netherlands has indicated that the process is too slow and too complicated because of the large number of structural changes to be implemented.[52]

In Papua New Guinea, it has been observed that decentralisation has enabled the Department of Health to become revitalized and more technically competent.[53] In Senegal, the strong political will at the highest level for decentralisation and community involvement in health system and man management was coupled with a close integration of public and private health activities for operational purpose.[54] Drawing lessons from Spain, Artigas[55] suggests that the decentralisation process should take place slowly after creating legal framework and autonomous administrations so that the authorities become aware of what services can be transferred. In Sri Lanka, the decentralisation process paved the way for the active participation of non-

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[50] E.T. Maganu, 'Decentralisation of health services in Botswana', in A. Mills et. al., *Health System Decentralisation: Concepts, Issues and Country Experience*, WHO, Geneva,1990

[51] C. Montoya - Aguilar and P. Vaughan, 'Decentralization and Local Management of the Health System in Chile', in Mills et. al., pp. 55-63, 1990

[52] G. Schrijvers, 'The decentralization of the Netherlands health services' in Mills et. al. op. cit. p. 29, 1990

[53] Q. Reilly, 'Experience of decentralization in Papua New Guinea' in Mills et. al. op. cit. p.29, 1990

[54] J. M. Ndiaye, 'Decentralization of Health Services in Senegal' in A. Mills et. al. op. cit. p. 29 1990

[55] J. Artigas, 'Health Services Decentralization in Spain' in A. Mills et. al op. cit. p. 29, 1990

governmental and governmental organisations in the activities of health teams at the village level.[56]

The above brief review of country-wise experiences indicate that many countries (developed and developing) at different times have felt the need to institute large-scale organisational reforms that favour a greater degree of decentralisation in the health sector for supporting the implementation of 'primary health care' and 'health-for-all' strategies. However, the contemporary interest in health sector decentralisation in developing countries has not been sufficiently extended to the development of decentralised systems of human resource management, especially in the onset and process of decentralisation.[57]

The underlying problematic aspects of decentralisation and human resources have previously arisen due to the lack of constructive policy dialogue between those responsible for the formulation and implementation of health sector reforms and other stakeholders in the health sector. Even in India before the renewed introduction of the concept of decentralisation by the 73rd Constitutional Amendment Act in 1993 and health sector reforms especially through programmes like the National Rural Health Mission (NRHM) there used to be a huge difference between the demands of the people and the services provided due to lack of proper exchange of information between the reformers and the local population.

Kolehmainen-Aitken[58] underline the pre-requisites for decentralisation of health services such as active involvement of health managers in the decentralised design, clear national resources allocation standards and health services norms and regular system for monitoring. The one lesson that does seem clear from the existing experiences of the countries around the world is that without proper planning and acknowledgement of the lessons from other

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[56] N. T. Cooray, 'Decentralization of Health Services in Sri Lanka' in A. Mills et. al op. cit. P. 29, 1990

[57] Supra

[58] R.L. Kolehmainen–Aitken, *Decentralization of the health sector in Decentralization Briefing Notes,* Litvak J. Seddon (eds), Washington DC: World Bank Institute,1999

countries, decentralisation of health care can be disappointing at best and detrimental at worst if not properly planned.

While a few developing countries have long-term experience with health sector decentralisation like United States of America and Canada, its impact on the management and the services delivered has rarely been evaluated. Many country-study evidences confirm that poorly designed and hastily implemented decentralisation has serious consequences for health service delivery and so far we do not have an analytical framework to isolate or generalise the factors behind successful and unsuccessful decentralisation.[59] The case studies from various developing countries provide mixed results. Some reveal that decentralisation schemes are performed in a positive manner and pro-poor. In some other cases the responsiveness to the poor and development orientation is lacking.

Advantages of decentralisation

Decentralisation has brought about changes in the way the government plans it's policies for its citizens and the level of participation in the decision making process to a completely different level as compared to the times before it's introduction. Hence, a number of advantages of decentralisation can be enumerated as given below[60]:

Tailor-made plans as per the needs of heterogeneous regions and groups are being framed: One of the biggest advantages of decentralisation is that it is able to provide an option to the common masses who previously use to complain of having policies being made for them by governments and its officers who had no idea about the particular regions and it's needs. These policies were seen as being forced upon the common people at the lowest levels around the country. Many times the resources provided by the

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[59] L. Gilson, P. Kilima and M. Tanner , 'Local Government Decentralization and the Health Sector in Tanzania' in *Public Administration and Development*, Vol. 15,1994; and Kolehmainen - Aitken and W. Newbrander, Decentralizing the Management of Health and Family Planning Programs: Lessons from FPMD Monograph Series, Management Sciences for Health, Boston, 1997

[60]G. Shabbir Cheema and Dennis A. Rondinelli, *Decentralisation and Development: Policy Implementation in Developing Countries,* Sage, 1983

government were totally different as to what was needed by the masses. Decentralisation has provided communities all over the countries a voice to demand and participate in the decision making process. It has given them opportunity to plan for themselves and even check the execution of their plans and then also reap the benefits.

It cuts red-tape: It has and is cutting a lot of red-tape. Many of the plans meant for the development of the rural classes never were able to make it to the grass root levels due to the non-sympathetic attitude of the administration or never ending paper work. Many times the aid was too late to be of any use but decentralisation has done away with red-tape to quite an extent as both financial resources and human resources are being provided to the panchayats for their disposal as they deem fit for the development of their areas as can be widely observed in the case of the NRHM.

Closer contact between government officials and local population is possible: Before the introduction of the concept of decentralisation the contact between the officials and the local population use to be bare minimum. The officials were held responsible for framing developmental plans without ever consulting the population involved. It brought about a lot of resentment in the public towards the bureaucracy. But now, both the parties are able to work together for the development of their areas and share a much more cordial relationship where ideas are exchanged with each other and a tab is kept on the development work through mutual sharing of information.

It allows better penetration of national policies to areas remote from the national capital: Previously only the areas that were near to the national capital or were geographically well suited for travel in the states all over the country were the ones who benefitted the most from the government policies. But introduction of local level governments has brought governance and development even to the remotest of the villages.

It ensures greater representation of political, religious, ethnic and tribal groups in development decision-making that leads to greater equity in allocation of resources: Since time immemorial some sections of the society like the tribals, schedule castes, women, etc. had no say in the decision-making process.

These sections were exploited by the high placed sections as well as no resources were allocated to them as to fulfil their needs and demands. But decentralisation has brought about a huge upliftment of these neglected sections. All of them have now a say in not only the decision making process but they are being provided with reservations in panchayats and special policies are being framed for their upliftment. For eg.the*Janani Suraksha Yojna* under NRHM for the expecting mothers and their new born babies.

Capacity of local institutions and their managerial and technical skills have developed: Due to devolution of powers and functions, local institutions at the grass root level have seen a huge upsurge in both human resources and other resources. These institutions have become more up-to-date not only technologically but are being managed more efficiently now especially with e-governance tools.

Top management has been relieved of routine jobs and now devote time to more important jobs: Before decentralisation took place at the grass root level the top management used to be busy in doing routine mundane jobs due to either lack of resources or non interest in their duties. But due to the increased participation of the local masses they are devoting more time to planning developmental works and looking after their completion.

It ensures better coordination: Decentralisation ensures better coordination between the government and the common people. Both the sides are able to coordinate with each other more effectively. The community through its participation is able to put its demands and needs to the officials of the local institutions and coordinate with them for their proper fulfilment. The officials on the other hand are able to raise awareness among the masses regarding the developmental work being done for them in different sectors by the government, report the status of the different works to the people and listen to the problems to the local population.

It institutionalises the participation of the citizens and exchange of information: The participation of people is not a vague concept anymore. Decentralisation has provided them with a definite institute where they all are collectively able to air their opinions. Both the government and the common population are

able to exchange information with each other which ultimately is beneficial for both the parties as it is beneficial for the government in order to give good governance to the people.

It will offset the influence of the elite people: From the commencement of decentralisation at the grass root level it has given a chance to people belonging to the neglected strata to get a voice in the decision-making process. Previously it was only the wealthy or the politically well connected who were able to enjoy any kind of political power. But today due to decentralisation even the marginalised sections are able to give voice to their needs and demands. It has been able to bring an end to some degree to the feeling of alienation of the marginalised sections from the mainstream society

It will lead to a more flexible, innovative and creative administration: Due to the constant community participation through decentralisation the administration ends up becoming more flexible, innovative and creative according to the needs of the masses. The administration in order to coordinate with the local institutions becomes more flexible in its attitude towards other authorities. In drafting policies for the developmental works it uses it creativity and innovation as a lot of suggestions are provided by the community through active participation in the decision making process.

Local people execute, monitor and evaluate better than the central agencies: One of the biggest advantages of decentralisation is that it hands over power to the local people. Local people have always had qualms against the policies framed by the central agencies as they happen to be ignorant of the current demands of a particular region but through decentralisation it is the local people who are executing the policies, keeping a tab on the developmental works and are even evaluating the results in order to take steps leading to better results in the developmental works. They are also presenting their views in front of the central agencies through their elected representatives in the local institutions so that better national and regional policies can be framed like NRHM, MGNREGA, etc.

Increased political stability ensured by increasing the participation of the local people in decision-making: Due to direct participation of the common

population in the working of the local institutions specially in electing their representatives, political stability is ensured as the masses happen to give a chance to their representatives to perform to their utmost ability and provide their full cooperation to them. If they are unhappy with their work it is pointed out in the village meetings held regularly and finally, if the representatives don't mend their ways they are shown the exit door in the next elections.

It also reduces the cost of planning and increase the number of public goods: Decentralisation due to the interest of the local population saves a lot of tax payers' money as due to the direct involvement of the local population not only a lot of planning is done by themselves in coordination with their elected representatives and the government officials but many times even labour and resources are being provided by the villagers themselves like in building roads, wells, etc. This increases not only the number of public goods but also caters to all the sections of the society. The work is done effectively and efficiently in a short span of time and according to the local needs and demands of the local population and area on a priority basis.

> Decentralization has kept its promise as far as the strengthening of democracy at the national level is concerned, as well as the central government's commitment in favour of rural development. It has thus contributed toward moving away from the bias toward urban areas in matter of development; to better management of the coordination of integrated rural development projects, and ensuring their sustainability. Decentralization has also reduced poverty which results from regional disparities, in paying more attention to the attendant socio-economic factors, in facilitating the gradual increase in development efforts, and the promotion of cooperation between the government and NGOs, while increasing transparency, accountability and the response capacity of institutions.[61]

These observations have led some states to turn to the decentralised approach to development especially so with the strong democratic processes in fashion and the demands of new organisations like NGOs of civil society that participate in the decision-making process. The local level has ceased to be the point of implementation of development policies decided by external actors but has become the place where local actors themselves determine the direction of their development and implementation of these developmental plans. Also, public policy decision-makers have finally realised and

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[61] Michael Edwards, *Civil Society,* Cambridge UK: Polity Press, 2009

acceptedthe necessity of citizen participation in order to make government action more effective and sustainable.

Overall, decentralisation based on devolution, participation and partnership, appears today to be the major challenge for governments seeking to accomplish of different tasks at different levels of governance. Governmental and spatial specialisation now ever present in the new decentralisation tasks, has made sure that the local levels of government are in proximity as well have solidarity jurisdictions. On the other hand, decentralisation has made intermediate levels such as regions turn toward the future through their activities in economic development, country planning and sustainable development of natural resources through active participation in the decision-making process.

Future trends of decentralisation

Based on both theory and experience, it has been stated that decentralised health system could perform certain functions that might result in the effective delivery of health care services.[62] The building of roles and responsibilities for civil society and local level governments should further the objective of popular participation and the desire to establish consultations at all stages, by ensuring that decentralisation is geared toward more citizen participation in public life. The foreseeable trends of these actions are:

The replacement of force by contract, in other words, the identification and implementation of local micro-projects, the establishing of contractual relations between the different actors in rural development, and the promotion of conditions that enable effective participation are the steps that have to be taken by the governments in order for decentralisation to dig its roots deep for providing governance at the local levels.[63]

Priority is being given to local jurisdictions governed by elected PRIs as an expression of the desire of the state to decentralise and to provide institutional framework for citizens to manage their own affairs in a partnership approach in what will keep decentralisation in the very basic and everyday lives of the

[62] Supra

[63] Ibid.

citizens. If only the citizens are able to relate to the concept of decentralisation and agree that it works for them effectively will they be ready to keep on participating in its activities enthusiastically.

It has to be remembered that community-based public health services inherently require involvement of a number of parties like community members, decision-makers, researchers and other specialists apart from the stakeholders. Decentralised governance is an ideal process that enables to bring all these these groups of people on a single platform. It also provided them with an opportunity for establishing equity measures among various socio-economic groups of the society. For example, prevention of diseases like cholera, typhoid, malaria and other communicable diseases require personal hygiene, increase in water quantity, and improvement in water quality, food hygiene, and provision of drainage and sanitation facilities.

Without involving people in preventing epidemics, the improvement of people's health may not be possible. This phenomenon has also been observed during the study at the Bydranahalli Gram Panchayat which suffers from the malaria epidemic but due to the combined efforts of the NGO workers, medical staff, panchayat and the local population it has finally come under control. Therefore, decentralised institutions become an important instrument in the provision and monitoring of public health delivery system.

It is, thus, an accepted fact that health care cannot be achieved only through the department of health services. Experiences all over the world suggest that one precondition for enhancing health status is community participation. This, to a great extent, can be ensured through the active involvement of the civil society including NGOs, locally elected leaders in health programmes as well as private service providers. Decentralised governance and local level participation can contribute improving the health care facilities through better monitoring and supervision of the functioning of the health system at the local level. The small jurisdiction of decentralised local bodies allows the communities to adjust to local social and cultural pecularities while the adoption of short and simple administrative process facilitates quick and focused responses to immediate needs.

Decentralisation in India

> My idea of village swaraj is, that it is a complete republic, independent of its neighbours for its vital wants, and yet interdependent for many others in which dependence is a necessity. Thus, the village's first concern will be to grow its own food crops and cotton for its cloth. It should have a reserve for its cattle, recreation and playground for adults and children. The village will maintain a village theatre, school and public hall. It will have its own waterworks ensuring a clean water supply. This can be done through controlled wells or tanks. Education will be compulsory up to the fiscal basic course. As far as possible every activity will be conducted on a co-operative basis. There will be no caste, such as we have today with their graded untouchability. Non-violence with its technique of satyagraha and non-cooperation will be the sanction of the village community….The Panchayat of five persons, annually elected by the adult villagers, male and female, possessing minimum prescribed qualifications, will conduct the government of the village. These will have all the authority and jurisdiction required. Since there will be no system of punishments in the accepted sense, this Panchayat will be the legislature, judiciary, and executive combined to operate for its year in office. Any village can become such a republic without much interference.

- Mahatma Gandhi in the issue of the *Harijan,* July 26th, 1942

Though numerous countries around the world have experimented with the concept of decentralisation in order to devolve powers and responsibilities to local institutions at the lower tiers of the political and administrative system, India's exercise of introducing panchayati raj is perhaps the most ambitious and largest in terms of number of elected representatives.

In India, a similar upsurge of interest on decentralised governance can be witnessed particularly since the late eighties as in other developing countries around the world. Major institutional reforms have been introduced with a view to creating elected local government bodies that underscore the relevance of decentralisation as an emerging development strategy in the country. In this regard, the institutional reforms for rural governance being introduced in the country following the 73rd Constitutional Amendment Act in 1992, has been described as an important step forward in dealing with its development problems.

The broad framework for rural local self-governments (Panchayati Raj Institutions- PRIs) has been laid down in India under this amendment act. This has ushered in a greater degree of uniformity in the structure (three-tier), reservation for vulnerable and deprived communities (for SC, ST and women), and devolution of powers and functions (financial and planning) in favour of these institutions with the objective of achieving faster social and economic

development at local grass root levels. The three-tier structures of the PRIs are Zilla Panchayat (ZP) at the district level, Taluk Panchayat (TP) at the intermediary/taluk level and Gram Panchayat (GP) at the village level. The Gram panchayat is the lower tier of the PRI system comprising a cluster of villages with a population of 5,000 to 7,000.

With the emergence of three-tier decentralised bodies, India has nearly three million elected representatives in about 2, 20,000 panchayati raj institutions. The average population covered by a Gram Panchayat is 3,194 with considerable variation among the states. Population per Taluk Panchayat (Block Council) is considerably larger, with an average of 1,20,000. Population per Zilla Panchayat, the highest rural level, is quite large, with an average of 1.43 million in 2001. In Karnataka, the population per GP is about 6,000. At the Gram Panchayat (GP) level approximately one member is elected for every 400 population and at the Taluk Panchayat level one member for every 10,000 population. Similarly, for every 40,000 population, one member is elected to the Zilla Panchayat, The representation ratio between citizens and their elected representatives is much larger in urban Karnataka as compared to rural areas.[64]

Factors leading to decentralisation in India

The multiple factors which have contributed to the emergence of decentralisation in south Asian countries though with varied degree of success especially in India[65] are as follows:

The emergence of decentralisation for the governance at the local level in Asian countries like India is based on several historical, social, political and economic factors. And one of the most important factors has been the traditional form of village councils (Panchayats) in the olden times. The belief in these councils has led to opinion building for setting up of local institutions as near to people as could be in some of these countries.

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[64] T.V. Sekher, *'Health Care for the Rural Poor: Decentralization of Health Services in Karnataka'*, India, Institute for Economic and Social Change, Bangalore

[65] A. Aziz and D.D. Arnold (eds), *Decentralized Governance in Asian Countries*, Thousand Oaks, CA: Sage Publications, SOAS, 1996

Another important factor of the political demands for democracy in countries previously governed by authoritarian regimes has played an important role. This has been the case in Nepal, Bangladesh, Malaysia and Philippines, where each of the country has undergone the transition from autocratic to democratic. The adoption of representative form of democracy at the national level is often seen as the first step towards giving role to people in national development. In these countries, decentralisation can be seen as the 'second wave' of democratic reform[66], depending and building on the democratisation process taking place at the national level. Also, oil shocks of 1970s gave signals to many Asian countries having over-centralised form of government to have a system that can withstand pressure at different levels.

The ethnic diversity in some of the countries and the different groups within Asian societies have also spurned the demand for greater political autonomy. This has been noticed in India, China, Sri Lanka, Indonesia and also in a number of south and south-east Asian countries. In India, for example, various regions such as North East, Kashmir and backward states are asking for more political devolution. There is gradual emergence of consensus in these countries for recognising the essential need for political decentralisation to manage the stresses and strains of ethnic and regional diversity.

Besides historical and political reasons, there are some very fundamental reasons as to why decentralisation has been accepted in a number of countries. It is sheer impossibility of the centralised form of development to reach intended beneficiaries and deliver tangible benefits to rural communities.

With the introduction of economic liberalisation policies in several Asian countries, the process of decentralisation has picked momentum. Conceptually, there is a logical connection between privatisation and decentralisation, if the primary objective is to reduce the control of central-state structures over economic decision-making. Besides, some international donor agencies have strongly encouraged decentralisation as part of an

[66] James Manor , *The Political Economy of Democratic Decentralization*, Washington DC: The World Bank,1999

overall structural adjustment package. Though economic liberalisation can't be a predominant factor in the decentralisation process but it has definitely contributed towards favourable policy climate for the promotion of local institution building.

Lastly, the concepts of nationally planned development adopted in developing world were followed vigorously in Asian countries. The economic failure of East European countries, which were evidenced by poverty and inequality, inefficiency, irresponsiveness of the centralised administration led to thinking in the Asian countries and generated a favourable climate for decentralisation.

Hence, these developing countries introduced the concept of decentralisation in order to bring development to the very grass root levels of governance in their countries and give the local population a chance to feel a part of the development and not feel neglected and side lined.

Civil Society and Non-Governmental Organisations

Every state attempts and aims to work as a welfare state because it is only then that it is able to win the full and active participation of the people and it is the civil society and specially the NGOs which play a very significant role in creating this welfare state. As the state keeps on planning and directing, it becomes more important for a large number of the people to both be aware of these plans and also actively participate in them in order to give a definite shape to the state's policies and running of its affairs. The more the voluntary activity is widespread, the more it is better for the society and its members as a whole for its development. It is because this wide voluntarism makes a large number of people participate which eventually makes the democracy work and helps in the development at the grass root level.

Decentralisation cannot work at the grass root level without the co-operation of NGOs. The kind of access these NGOs have to the local population is not only very deep but their area of influence is equally wide as has been observed in this study. Hence, it becomes essential to understand civil society and in case of this study the NGOs to realise its impact on the participation of people in the decision-making process and programmes like NRHM.

The civil society manifests itself through a bevy of households, communities, associations, voluntary groups of different hues and kinds, social service workers, non-government organisations, co-operatives, unions, women development groups and environmental NGOs. Over the years the civil society has been able to carve out a definite and important role and place in the modern state.

Meaning of civil society

Before moving on with the chapter further it becomes essential to define civil society and non-governmental organisation. Civil society is composed of the totality of civic and social organisations and institutions that form the very basis of a functioning society as distinct as possible from the sanctioned structures of a state. Generally, there is no universally accepted definition of civil society.

"Civil Society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, and market, though in practice, the boundaries between state, civil society and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organisations such as registered charities, development non-governmental organisations, community groups, women's organizations, faith based organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups".[67]

On the other hand "A voluntary organisation is the one, which is established and governed by a group of individuals. They are non-profit making bodies, mainly supported by voluntary individual contributions and grants from government and other agencies. They are largely independent of government and are characterised primarily by humanitarian or co-operative, rather than

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[67] Centre for Civil Society, London School of Economics

profit making objectives".[68]From the sociological point of view, NGOs are defined as a "Group of persons organised on the basis of voluntary membership without state control for the furtherance of some common interest of its members".[69]

The term NGO embraces a wide variety of organisations. They include[70]:

- Voluntary Organizations (VOs) that pursue a social mission driven by a commitment to shared values.
- Public service contractors (PSCs) that function as market oriented non-profit businesses serving public purposes.
- People's organizations (POs) that represent their members, interests, have member-accountable leadership, and are substantially self-reliant.
- Governmental non-government organizations (GO-NGOs) that are creations of government and serve as instruments of government policy.

History of civil society

The relationship between the civil society and the NGOs cannot be separated and so can't be its historical roots. The origin of the civil society and its very dynamic and volatile relationship with the state has been often traced back to the writings of philosophers such as Baron, Hobbes, Locke and Montesquieu during the 17th and 18th centuries. All of these great thinkers were of the view that there is co-existence between the civil society and the state. Hegel conceptualised the civil society by placing all importance on the economic aspect and placed the civil society somewhere between the family and the state. But he was of the viewpoint that the state was superior to the civil society. On the other hand, Marx was of the view that the state is a basic requirement and a product of the civil society. He further argued that "the very

[68] Snehlata Chandra, *Non-Governmantal Organizations – Structure, Relevance and Function,* Kanishka Publishers,2001

[69] M.A.Muttalib, 'Voluntarism and Development: Theoritical Perspectives' in *Indian Journal ofPublic Administration*,Vol. 33 (1987), pp. 399-419

[70] D.L. Seth, "Grassroot initiatives in India" in *Economic and Political Weekly,* Vol. 19 (1984), pp. 259-62

essence of the modern state is to be found in the characteristics of the civil society – in its economic relations."[71]

"The term civil society can be traced through the works of Cicero and other Romans to the ancient Greek philosophers, although in classical usage civilsociety emerged in the Scottish and Continental Enlightenment of the late 18th century. A host of political theorists from Thomas Paine to George Hegel developed the notion of civil society as a domain parallel to but separate from the state – a realm where citizens associate according to their own interests and wishes".[72] But with the passage of time the term fell into disuse in the middle of the 19thcentury. Though again suddenly in the 1990s, this term "civil society", became a global chant from the state governments to the political scientists to the common people.

But today the civil society and its wing of voluntarism is conceptualised and characterised as a set of diverse non-governmental institutions which counter balance the state much as had been noticed by the 20th century thinker Gramsci, "as a sector it is a melange of organizations rather than a homogenous structure, and contains within itself variations of size, purpose, philosophy and affiliation".[73] The NGOs have played a very important and significant role in the national life and have brought about vital progress in the social sphere. They are the ones who are able to secure the people's active participation more than the state alone can dream off and at a level which the state still has not been able to reach to the people.

NGOs have a relatively long history but their numbers and profile rose significantly during the past decade.[74] Over the decades the role of the state in social welfare and social services has declined to such an extent that the NGOs have over the time gained a lot of attention and prominence. In the

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[71] Supra

[72] Ibid.

[73] A. K. Kapur and Dharamvir Singh, *Rural Development through NGOs,* Rawat Publications, 1997

[74] M. Edwards and D. Hulme, *Non-Governmental Organizations: Performance and Accountability-Beyond the Magic Bullet*, Earthscan, 1995

present scenario they are being looked upon as alternative agencies which can and do promote awareness, change and development in society. If a civil societyis strong, vibrant and lively it is able to become the very foundation of a modern and an open democratic polity.Hence, NGOs are the very life-force for the civil society as they stand for the above mentioned principles of modernity and democracy. The NGOs also boast of distinctive features like informal structure, functioning and closeness to the people at the grass root level.

These organisations have always approached development which is one of their very important and basic aims on the basis of the important principle of people's participation. Unlike the state which bases its approach to development on the basis of the top-down approach, these organisations' approach is based on people's needs and analysis of priorities, issues and needs. "The approach adopted by the NGOs treats people not as objects but as subjects who possess cultural knowledge as well as abilities to take their own independent decisions, which can be collectively implemented in bringing about changes in the desired direction".[75]

Fiszbein[76] found that community participation increased demands for effective local governments and forced government accountability in Columbia. Putnam's[77] study of Italian regional governments also found that governments that were more open to constituent pressure, managed and delivered services more efficiently.

Civil Society in India and Karnataka

> In this age of shrinking governments and increasing privatisation, the social welfare delivery systems are incrementally being passed to the voluntary sector. The phenomenon of the NGOs is growing and at a remarkable pace. There has been an all-round acknowledgement of the abilities of the NGOs to deliver in a better manner in areas where the governments and the public sector has fared poorly. On the other hand, growing number of NGOs have

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[75] S.N.Pawar, J.B. Ambekar, D. Shrikant (Ed.), *NGOs andDevelopment The Indian Scenario,* Rawat Publications, 2004

[76] Ariel Fiszbein, 'The Emergence of Local Capacity: Lessons from Colombia'in *WorldDevelopment*, Vol. 25, No. 7, 1997, pp. 1029-1043

[77] Robert Putnam, 'The Prosperous Community- Social Capital and Public Life'in *The American Prospect,* 13, 1993, pp. 35-42

> also recognized that their own efforts were too meagre, and too often focussed on the consequences of system failure rather than the causes of this failure. Their financial resources were negligible and their modes of working were largely irrelevant to the real issues.[78]

Civil society and voluntarism have a very deep relationship with decentralisation and so they cannot be studied without going into this dynamic relationship. It is at the grass root level that the civil society comes closest to the state. It was in the decades of 1950s and 1960s that the general public and the civil society demanded the addressal of a variety of developmental needs which ranged from health to poverty alleviation to marketing of agricultural produce to basic civic amenities. And it was because of these demands that most of the countries around the world including India decided to set up local governments. There are various viewpoints regarding the relationship between decentralisation, civil society and voluntarism as discussed before.

The genealogy of NGOs and the civil society in the Indian scenario dates back to the social welfare and religious traditions imparted by the Indian thinkers and intellectuals during the 19th and 20th centuries brought ahead by Ambedkar, Gandhi, Gokhale, Phule, Raja Ram Mohan Roy, Shahu, Vivekanand and Tilak. “NGOs working in different regions/ strata of the country have an important role in development. By ‘development’ we mean planned socio-economic change as well as ‘attitudinal’ changes leading to distributive social justice and sustainable development”.[79]

In past the NGO and panchayat partnership in Karnataka also did not flower because of mutual suspicion about motives of the NGOs by the panchayats. But today a different perspective does exist. Though the NGOs in Karnataka were dubious towards the new decentralised political structure in the beginning, they however were forced to redefine their rules because PRIs have become part of the structure within which NGOs have to work and structural changes in PRIs are aimed at people-centred rural development which is also the objective of many of the NGOs. As part of this change, NGOs in Karnataka are reported to have supported PRIs both during and

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[78] Dharmendra Mishra, *Participatory Governance Through NGOs,* Aalekh Publishers, 2005

[79] Supra

after elections. During the post-election period, they have promoted capacity building among marginalised people by giving them formal training.

As observed in the study now there is a close collaboration between the NGOs and the panchayats especially in the health sector. All the NGOs and the gram panchayat observed under the study were collaborating regularly with each other in conducting health and awareness camps and the NGO workers are also members of the Village Health and Sanitation Committee (VHSC). Almost all the panchayat members of the six gram panchayats and the NGO workers share cordial relations with each other.

Decentralisation and Civil Society

As can be fathomed from the above discussion on decentralisation and civil society that regardless of being two totally different concepts in nature they are inter-linked and this link is hugely important for the development of the country. In the present times development is no longer the sole responsibility of the state. It is both the state and the society who have to work together to bring about development as a whole. In the context of this new context of development it has been observed that the developed western nations of the world along with the international organisations like the United Nations and its sister organisations, World Bank, etc. have started asking the developing nations to involve both decentralisation and civil society in their developmental plans.

In 1998, the World Bank had estimated that of all the 75 developing countries of the world with populations greater than 5 million had embarked on a process of political devolution except 12 countries.[80] The role of the civil society in decentralisation is to mobilise the local population to act as watchdogs of the government policies and programmes. The existence of a diverse and vibrant civil society is highly essential for decentralisation. It works as a buffer between the state and the government.

Civil society in the current times has repositioned themselves to play the role of a catalyst in order to shape the decentralisation process in countries

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[80] Richard Crook and James Manor, *Democracy and Decentralization in South Asia and West Africa: Participation*, Accountability and Performance, Cambridge University Press, 1998, p. 1

around the world. Among the major stakeholders in the process of decentralisation it is the civil society that has gradually emerged as the most effective pressure group. It is not only capable of serving a dual role, one is the role of collaborating with and facilitating the government in the development of the society and the state and the second is of acting as a watchdog over the government.

Civil society plays a very important role in the decentralisation process as can be corroborated by this study also. As it is specific in its purposes of dealing with the local masses they are able to instigate a large portion of the local population in becoming a part of the decision-making process under the concept of decentralisation. Due to this advantage of the civil society the governments all over the world have adopted participatory arrangements for it in their developmental goals. For eg. in India the state is including NGOs in institutional arrangements at the national, state and district levels to make people participate in more numbers in health programmes like NRHM.

Where governments are supportive of the role played by civil society and share a well organised relationship, the civil society is able to occupy a prominent role in the decentralised structures. As active, diverse actor NGOs often play a valuable role in advancing decentralisation as it disciplines the state, ensures that citizens' interests are taken seriously and foster greater civic and political participation. But their presence does not mean the decline of the state. These actors can only be more effective in shaping state policy if the state has coherent powers for setting and enforcing policy and as the NGOs cannot take strict action against the individuals it becomes all the more important for them to have the backing of the state. NGOs play an important role in both developed and developing nations. They exert pressure on governments by furnishing technical expertise to policy makers and hence shape policies. They also foster citizen participation and civic education and hence ultimately are able to not only create awareness regarding different developmental programs among the strata of society but are also able to influence the people in increasing their participation.

Rural Public Health

One of the biggest expectations of humans living in a civilised society is that the living conditions will be basically healthy and not pose any threat to their health. Hence, we expect to live healthy in this world. In the present times it is the duty of the state to look after public health. It frames laws and policies to cater to the health demands of its citizens and provide adequate health facilities.

There are a number of reasons why people's lives are basically healthier today than they were 150 years ago both in the developed and to a certain level in the developing countries as well. Today, we have cleaner water, air and food; safe disposal of sewage; better nutrition; more knowledge concerning healthy and unhealthy behaviours; and many other health reforms have taken place over these years. In the recent times especially in India the general population of the country specially belonging to the remote parts of the country was not able to access even the basic health facilities. It is due to the widespread network of NRHM since 2005 and the collaboration between the state governments, NGOs and the panchayats at the local level that people in the remotest of the villages of the country are able to access some kind of government health facility at last.

While conducting interviews during the field study it was found that many villages of the six gram panchayats of Mandya and Mysore have been provided with health facility such as a health sub-centre or a PHC for the first time under NRHM. The villagers used to go to private hospitals regardless of them being expensive. Many tribal area inhabitants used to not at all visit any kind of hospital and trust their traditional knowledge of medicines or go to a quack.

Meaning of public health

Public health has been defined as such by different scholars: According to Winslow "Public health is the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of principle

hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health".[81]

According to the Institute of Medicine "What we, as a society, do collectively to assure the conditions in which people can be healthy".[82]It is "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society" as per Acheson.[83] Rothstein goes ahead that describes the functions that are performed by the government and its officials in order to keep the general public health. "Government intervention as public health involves public officials taking appropriate measures pursuant to specific legal authority….to protect the health of the public…The key element in public health is the role of the government-its power and obligation to invoke mandatory or coercive measures to eliminate a threat to the public's health".[84]

Features of public health

According to Gostein it is the "Society's obligation to assure the conditions for people's health".[85] Chidress[86] prefers to list the features or aspects of public health by stating that Public health is primarily concerned with the health of the entire population rather the health of individuals. Its features:

- include an emphasis on the promotion of health and the prevention of disease and disability;

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[81] C.E.A. Winslow, 'The untilled fields of public health' in *Science* Vol. 51, p. 23-33, 1920

[82] Institute of Medicine, Committee on the Future of Public Health, Washington DC, National Academy Press, 1988

[83] Donald Acheson, *Independent Inquiry into Inequalities in health*, the Stationery Office, London,1988

[84] Mark A. Rothstein, 'Rethinking the Meaning of Public Health' in *Journal of Law , Medicine & Ethics,* Vol. 30, No. 2, 2002

[85] Bernard D. Goldstein, 'The Precautionary Principle Also Applies to Public Health Actions' in *American Journal of Public Health*, Vol. 91, No. 9, September 2001, pp. 1358-1361

[86] J.F. Childress, et. al. , 'Public Health Ethics: Mapping the Terrain' in *Journal of Law, Medicine and Ethics*, Vol. 30, No.2, pp. 170-178

- the collection and use of epidemiological data, population surveillance and other forms of empirical quantitative assessment;
- a recognition of the multidimensional nature of the determinants of health; a
- a focus on the complex interactions of many factors-biological, behavioural, social and environmental-in developing effective interventions.

Decentralisation and Rural Health

Decentralisation is the process of redistributing not only administrative authority but financial resources too to local communities for planning, program management and evaluation. As can be observed since the early 1960s in countries like the United States and in the mid-1970s in Canada and from the 1990s in countries like India, there have been notable efforts to shift decision making authority away from central governments to the local level in the area of community health.

Decentralisation of public health and health planning is basically intended to firstly, facilitate public participation of the local population. Secondly, it provides greater local and personal control over the factors influencing health and lastly, it spurs cooperation and inter-sectoral action among different stakeholders at the local level. There have been demands made by the public for less involvement of the central and the state government in local issues and a desire for self-determination. This has further ignited the initiation of the concept of decentralisation in most of the countries across the globe. By bringing decision making closer to home and involving local people, decentralisation has been able to result in more appropriate decisions about public health and health planning within local communities.

Decentralisation has also enhanced the democratic principles and community empowerment. It has given a boost to the local people's autonomy and capacity to take control over the determinants of their own health as it was one of the most neglected aspects of an individual’s life in most of the countries around the world like India where even today a very small percentage of the union budget is spent on the health sector as compared to

other sectors like defence. The field study also corroborates the fact that decentralisation in the health sector has made the people participate more in the decision making process related to important sectors like health. The inhabitants of all the six gram panchayats were found to have attended atleast one health or awareness camp run by the panchayat in collaboration with the NGOs or the health centres. Some of the gram panchayat members were also found to actively participate in the VHSC meetings

By increasing the decision-making power of local communities decentralised public health and health-planning systems place greater fiscal responsibility for health on local governments and agencies as more power is getting divided at the grass roots level to provide more autonomy in the decision making process. In the state like Karnataka the state government has given some financial responsibility to the local gram panchayat in case of health. This phenomenon was also observed in developed countries like the United States and Canada.

In India federal or central control over financial functions has declined. The amount of money available to transfer from central to state or provincial coffers, however, does not always match the devolution of responsibility and has been a bone of contention among the different levels of government in the country since a long time. Therefore, many local health initiatives had previously collapsed because the pressure of greater responsibility was combined with fewer resources for program managers at the grass root level but recently a change in the stance of the central government regarding handing over of the financial rains to the lower levels has come about. Under the NRHM the local panchayats have been handed over some financial responsibilities as well.

The management of increased responsibility within the context of scarce resources is one of the biggest problems that arose from efforts to decentralise authority in health matters. There were a number of problems faced on the administrative front as well. Local public health and health-planning goals set by the government were previously found to conflict with each other and also with the rights of individuals pursuing their own political well-being and happiness and not being concerned with the larger goals set

for the benefit of the community as a whole. But NRHM has changed the scenario. Now both the state and the central government are working in collaboration to achieve the common health goals which emphasise on both the health of the individuals and of the communities as well.

The social fabric of many communities in India due to huge differences in social and economic statuses falls vulnerable and can be badly torn when local people engage in a decision-making process where there can be only one winner. For example, local communities across India like the schedule castes still face a biased approach from the other communities and decisions regarding their participation in the decision making process often make their experience bitter and emotional debates generate a sense of disempowerment for them as local groups and individuals. But through reservation in the PRIs for women, scheduled castes and scheduled tribes the government has tried to bring the marginalised sections in the mainstream of development.

Successful decentralisation of public health and health planning depends on the provision of adequate and appropriate assistance to local communities all over the country regardless of their physical positioning. It becomes very essential to provide resources including both expertise and time for successfully decentralising responsibility as successful governance can only be substantiated by providing these important ingredients. Many communities in the country lack the local resources to resolve the complex problems they face and have limited control over outside influences due to their own weaker placement in the social hierarchy of the society and hence they rely on political parties and outside actors.

In the previous scenarios one of the biggest issues arising between the government and the local masses were the issues of ownership and goals which became problematic when the central funding was provided for some other health problem and the local population wished to focus on a different problem that was not a priority for the central funding bodies. For example, a community group received funding from a research-oriented agency to examine health issues related to malaria while the community's priorities were focused on fighting alcoholism prevalent among the inhabitants. This was one

of the reasons i.e. the lack of sync of the central government with the ground realities of the masses in the health sphere that lead to decentralisation in health.

Similarly, many times due to absence of a collaboration between the NGOs and the panchayats on an officially recognised level, the true needs of the common masses not only pertaining to the health sector but also other spheres related to the everyday life of the common people were being side lined. These circumstances typically prompted a rush of technical assistance from central government to the local organisations even though this assistance was welcomed or not by the general public. Outside experts often do not know enough about local circumstances to be as helpful as the local experts of an area and so were not trusted by the local population.

This has paved the way for the officially recognised collaboration between NGOs and panchayats in the health sector as both the panchayat members and the NGO workers were from the local population. Even if some of the NGO workers did not belong to the local area they took time to create rapport with the local people. For eg.the NGO workers of MYRADA in Mandya took six months to create rapport with the common people of the Bydranahalli gram panchayat before imparting them information regarding various health aspects.

Decentralisation has been predicted to improve health sector performance in a number of ways, including the following[87]:

- improved allocative efficiency through permitting the mix of services and expenditures to be shaped by local user preferences;
- improved production efficiency through greater cost consciousness at the local level;
- service delivery innovation through experimentation and adaptation to local conditions;
- improved quality, transparency, accountability, and legitimacy owing to user oversight and participation in decision making; and

[87] Remy Prud'homme, *'The Dangers of Decentralisation'* in World Bank Observer, 10(2), 1995, pp. 201-220

- greater equity through distribution of resources toward traditionally marginal regions and groups.

Conclusion

In the end the most important question that arises is will public health and health-planning systems continue to pursue decentralised decision making and will it be successful. Economic recoveries in recent times in many countries have renewed hopes at the local level for increased revenue sharing between the central and the state governments to support public health and health-planning initiatives as is being observed in India recently. The Indian government through health programs like the National Rural Health Mission has tried to bring decentralisation both in the administrative and financial spheres of public health in the rural parts of the country. But the financial resources represent one part of the solution in giving a little power to the common people in the decision making process. It remains to be seen whether communities can develop sufficient capacity to take control over the determinants of their own health. That is where this study comes into the picture as it tries to explore the effects of decentralisation on rural public health through the collaboration of NGOs and Panchayats the impact of this collaboration on the community participation in programmes like NRHM.

CHAPTER II

GENESIS & DEVELOPMENT OF PANCHAYATI RAJ IN INDIA AND KARNATAKA

Introduction

India measures 3,214 kms. from north to south and 2,933 km. from east to west with a total land area of 3,237,263 sq. km. It has a land frontier of 15,200 km. and a coastline of 7,516.5 Kms. Andaman and Nicobar Islands in the Bay of Bengal and Lakshadweep in the Arabian Sea also fall under the territory of India. It shares its political borders with Pakistan and Afganistan on the west and Bangladesh and Myanmar on the east. The northern boundary is made up of the Sinkiang province of China, Tibet, Nepal and Bhutan. India is separated from Sri Lanka by a narrow channel of sea formed by the Palk Straits and the Gulf of Mannar. India has 28 states and 7 union territories and has a total population of 1,210,193,422.[88]

It is the seventh largest country in the world by area and the second largest by population. It looks across the seas to Arabia and Africa on the west and to Myanmar, Malaysia and the Indonesian archipelago on the east. Bound by the great Himalayas it stands apart from the rest of Asia. It lies to the north of the equator between 8' 4' and 37' 6north latitude and 68' 7'and 97' 25' east longitude. It is bound on the south-west by the Arabian Sea and on the south east by the Bay of Bengal. On the north, north-east and north-west lies the Himalayan ranges. Kanyakumari constitutes the southern tip of the Indian peninsula where it tapers away into the Indian Ocean.[89]

Even in terms of the Panchayati Raj Institutions it is the biggest example of having introduced the concept of decentralisation at such a huge scale. No other country in the world can match it in matters of both area and population covered under PRIs currently. The Panchayati Raj Institutions in India represent the existence and functioning of democratic institutions at the local

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[88] India 2009 A Reference Annual, Publications Division, Ministry of Information and Broadcasting , Government of India, 2009, 53rd Edition, p. 1

[89] Ibid.

rural level in the country as they give the local population the opportunity to participate in the decision making process. Their existence in the political stream of the country is the extension of democracy to even the remotest of the areas of India which were feeling alienated from the mainstream and were lacking in development in almost all the spheres. This notion is supported by both the government and the local population today as they each observe the rise in people's participation and development in their areas.

India has had the village institutions in existence for a long time. Even in the ancient times they were known as panchayats which was a council of five persons in a village. With the passage of time the autonomy of these institutions was lost as local civil, criminal and revenue institutions came into being. The Constitution of India however rightly recognised the importance of their existence in the developmental framework of the country and hence renewed them through the 73rd and 74th Constitutional Amendment Acts. Hence, providing Article 40 of the Constitution which enshrines the directive principle of state policy laying down that the state shall take steps to organise village panchayats and endow them with such powers and authority as may be necessary to enable them to function as units of self-government with legal backing.

This chapter aims to discuss the concept of Panchayati Raj in two parts: the first part deals with PRIs at the national level and the second part deals with them at the state level i.e. in the state of Karnataka. It attempts to cover the discussion of the concept from republican concept of the state in ancient India with special reference to the specifics of the Panchayati Raj as the original form of political structure to its status in the present modern times.

Importance of Panchayati Raj Institutions

The PRIs symbolise the very existence of democracy at the grass root levels in India. They are the ones which bring democracy to the remotest parts of our country. The majority of the population of India lives in the remotest of the rural areas and they can only experience the cherished ideals of democracy if the political system paves a way of materialising these ideals through the institutions of panchayati raj. As India is a vast country it becomes essential

that in addition to the central and the state government there is also a level of government which is in much proximity to the people. The answer to this type of government is the local self- government or the panchayati raj. Local self-government not only ensures reach of democracy to the remotest parts of the country but also gives the local population a chance at development through their say in the decision making process, decreases their feeling of alienation from rest of the country and forges closer relationship between the government and the governed.

Democratic decentralisation is a "concept based on the recognition of the right of the people to initiate and execute the policy-decisions in an autonomous way".[90] It is a tool for people's participation and acts as the foundation on which the whole edifice of local self-government rests. Democracy in its real form can only be experienced by the local population by participation in the decision making process. Therefore, the concept of democratic decentralisation is "liberal, democratic, political ideal-the concretised form of which is local self-government".[91]

The biggest argument in favour of the PRIs is that they stand for decentralised administration which is one of the cherished dreams of even the framers of our constitution. Decision making at any level has an influence on the lives of the people at large and hence, it becomes important that they should be a part of the decision making process. Decisions should not only be made on the basis and the one side view of the higher placed authorities as to what is correct for the masses but they should focus on the needs of the masses. For this to happen we need PRIs as they give a voice to the masses in order to fulfil their needs and demands.

Decentralisation in terms of "sharing the decision-making authority with lower levels of organisation" should be understood in the context of the institutional framework of division of power.[92] It provides the theoretical base for the

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[90] Prabhat Datta, *Major Issues in the Development Debate: Lessons in Empowerment from India,* New Delhi: Kanishka Publishers, 1998, p. 11

[91] Ibid

[92] S.S. Meenakshisundaram, *Decentralization in Developing Countries,* New Delhi: Concept Publishers, 1994, p. 10

decentralised political institutions that promote decentralised decision-making. Crook and Manor observe that, "Decentralisation combined with democratisation might provide greater transparency, accountability, responsiveness, probity, frugality, efficiency, equity and opportunities for mass participation".[93] Hence, it caters to a large number of the local population and brings about much needed transparency in the decision making process which had been elusive to the local population before the introduction of PRIs in the country.

Another rationale in support of decentralised governance is derived from the known drawbacks of centralised decision-making at the macro levels of governance.

> Under democratic decentralisation the underlying idea is to widen the area of democracy, by granting both authority and autonomy to the people at the lower levels. One could say that here the attempt is to create democracies within democracies. In contrast to this, under democratic centrism, the idea is to provide a democratic base to the gilded autocratic top.[94]

Thus, democratic decentralisation seeks to vest in the institution of local government effective power in a larger measure so that they may be developed into what Bryce describes as "the tiny fountainheads of democracy"[95] that make the local population feel a part of the cherished concept of democracy and tries to do away with the feeling of alienation felt by them for decades.

As the representatives of the people in these PRIs are elected from among themselves it gives a universal face to the power structure where no strata is left out and the success rate of fulfilling the demands and needs of the local masses is also higher. This gives the masses the confidence that their sentiments are not ignored or played with and provides freedom to them to be a part of the political fabric of the country. Evan Smith has argued that

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[93] Richard C. Crook, James Manor, *Democracy and Decentralization in South Asia and West Africa,* Cambridge: Cambridge University Press, 1998, p. 2

[94] Iqbal Narain, 'Democratic Decentralization'in *Indian Journal of Political Science*, Vol. XXI, No. 2, April-June 1960, p. 188

[95] James Bryce, *Modern Democracies,* New York: World Press, Vol. I, 1962, p. 147

decentralisation is beneficial for the functioning of the democratic institutions both at the national and the local levels.[96]

Further, the association between the PRIs and the NGOs help mobilize resources, especially voluntary labour for developmental activities and also facilitate the monitoring of the implementation process. Due to their active participation in the decision making process, a conducive atmosphere for development comes into existence and hence, more work is done as compared to time being wasted in useless clashesbetween the masses and the government. Due to the PRIs the masses are able to view themselves as part of the government and consider the policies of the government as their own. The PRIs are basically opportunities for all the sections of the society to try to uplift themselves and be more knowledgeable about the decision making process which is why reservation for the weaker sections of the society like women, scheduled tribes and scheduled caste is a very important step.

The PRIs are also able to set right any administrative malpractices prevalent and do away with the political manoeuvring of the political mighty. Hence, the PRIs make the government at the grass root level democratic in nature and due to the direct participation of the people the government at all the levels becomes more people friendly.The functioning of representative institutions at local levels leads such as PRIs make the man feel that he is not ignored and that his dignity and freedom have been accepted in the political fabric of the state.

Panchayati Raj Institutions and Health

Evidence collected in a study[97] conducted on the working of Panchayati Raj Institutions in four states has come with the conclusion that PRIs have a definite role in improving the quality of health care services. The participation of the local community ensures through a moral pressure that health care functionaries and the staff regularly not only come to work but do not shy away from their everyday duties. It has also helped in improving the supplies

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[96] Supra

[97] Supra

of resources to the local health care centres. The ever watchful participation of the people also brings to notice of the higher authorities the deficiencies in the services. This phenomenon is taking place in regions all over the country as decentralisation in the health sector specially through programmes like NRHM are providing the local communities a chance to themselves work for a healthy community as has been also observed during the field study conducted in Mandya and Mysore.

Genesis and Development

To many people it may seem that the concept of local governance in India is a very recent development but one would be surprised to know that local governments in India have been in existence since time immemorial. These local governments prevailed all over the country but differed widely from each other though they did signify a common form of government and their aims and objectives were similar to each other. For example, the 'Janpad', a widely prevalent form of local government which literally means a territorial society, was a settled self-governing community. On the other hand, the Buddhist literature is full of examples of republican states and precepts corresponding to them. The phrase 'Gana Rajya', was inspired by both the Buddhist and the Hindu scriptures and was institutionalised through Sabhas, Samitis and Panchayats, equivalent of councils, assemblies and local self- government.[98]

Hence, it becomes clear that PRIs have been a part of the indian political scene since ages and have been a part of regions all over the country. Due to lack of national political unity they were just known by different names. The genesis and development of PRIs is being carried on under four historic periods:

- The Ancient period
- The British Period
- The Post- Independence Period
- The Present Period

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[98] Pradeep Chaturvedi (Ed.), *Food Security and Panchayati Raj*, New Delhi: Concept Publishing Company, 1997, p. 11

The Ancient Period

India as a country is not new to the principles of governance or democracy. It can boast of a long tradition of democracy at the grass root level. In the words of Altekar, "from most ancient times, villages in India have been the axle of administration".[99] The institution of the panchayat is said to have guided and controlled the administration of the villages of India in her entire history. People's institutions bearing various names existed all over the country even in Vedic times.[100]

During the Rig-Vedic period ‘sabhas’ existed. With the passage of time these ‘sabhas’ became panchayats.These panchayats became the functional institutions of grass root governance in almost all the villages and had both executive and judicial powers. Above a number of such village panchayats there was a larger panchayat or council to interfere and supervise the work of these panchayats as and whenever deemed necessary.[101] The Mughal rule eroded the institutions of self- governance which finally were laid to rest during the British period as the Britishers introduced criminal and civil courts in India.

Pre-Independence Era

Panchayats in Olden times

The old village panchayats in India were considered as little village republics. They were not based on legislative enactments but were custom-based and tradition-bound institutions. These institutions had the interests of landlords on one hand and the farm tillers and labourers on the other. Both were tied together by ties of kinship. Ambedkar[102] has criticised these panchayats of the olden times as they were highly discriminatory towards the weaker sections of

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[99] A.S. Altekar, *Ancient India’s Administrative System*, Allahabad: Bharti Bhandar, 1948, p. 168

[100] Radhakumud Mukherji, *Local Government in Ancient India*, New Delhi: Motilal Banarsidas, 1958,p. 2

[101] Jawaharlal Nehru, *The Discovery of India,* Calcutta: Signet Press, 1964, p. 288

[102] Rajeshwar Dayal, *Community Development, Panchayati Raj and Sahakari Samaj,* Delhi:Metropolitan Book Co. Private Limited, 1965

the society and basically only served the interests of the village elites regardless of the fact that they should have been formed on the principles of equality and opportunity to all the people residing in the village. Jayprakash Narayan[103] was also of the view that these panchayats did nothing to find the solution to the problems of the village but were only there in existence.

These panchayats were basically either caste panchayats which were basically concerned with functions related to social customs, marriage and rituals. On the other hand, village panchayats comprised of elders of prominent households of the village and were concerned with adjudicating civil disputes related to land, administering criminal justice and performing regulatory functions related to village common land.

The British Period

In the British times the autonomy of the panchayats was done away with owing to the establishment of local civil and criminal courts, revenue and police organizations, the increase in communication, the growth of liberal democracy and the operation of the individual Ryotwari system. But the Britishers soon realised the importance of local institutions in the administration of the country and thus took several steps to establish an alternative system of local self-government in India.

Lord Mayo's Resolution, 1870

The British rulers abolished the institution of panchayats for administering justice and replaced it by the Indian Penal Code of 1860. Later on, Lord Mayo incorporated the concept of decentralisation in 1870 by making the provision for taxes being raised locally by municipal and rural bodies to meet their local needs.[104]

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[103] S.L. Amatya, *Rural Development through Decentralized Planning,* Honolulu: East West Centre Association, March 1988

[104] M. Venkatarangaiah and M. Pattabhiram, '*Local Government in India: Select Readings',* New Delhi: Allied Publishers, 1969

Lord Ripon's Resolution, 1880

Further on in 1880, Lord Rippon stressed on the need for training of elected representatives in particular and the local masses in general in order to make them realise the importance of participation in developmental activities. This philosophy influenced the formation of the Bengal Municipal Act of 1884 and the Bengal Local Self Government Act of 1885.[105]

Montague-Chelmsford Reforms, 1919

The Montague-Chelmsford reforms of 1919 constituted local bodies. The taluka/tehsil served as the basic unit for the local boards and dealt with the subjects of sanitation, education and health. It was finally under the Government of India Act, 1935 that the provincial governments enacted legislations on local self-government in order to devolve powers of local development administration upon the panchayats.[106]

The Independence Era

By 1947 the British introduced the 1947 Act due to changed political situations. This act established a Constituent Assembly to draft a constitution for free India. The Constituent Assembly appointed a Drafting Committee, with B.R. Ambedkar as its chairman, which worked on the original draft and produced the Draft Constitution. However, it may be pointed out that the framers of the constitution failed to find a place in the constitution for Panchayati Raj, a prestigious tradition of India.

It might not have been an accidental omission as evidenced from the views of Dr. B.R.Ambedkar who said in the Constituent Assembly that, "what is the village, but a sink of localism, a den of ignorance, narrow mindedness and communalism".[107] He thought that in the caste-ridden Indian social set up the village based Panchayati Raj would be a burden for the rural mass of the country and would not be successful. It was an act of omission on the part of the drafting committee that, in spite of the Indian villages having a history of

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[105] Ibid.

[106] Ibid.

[107] Constituent Assembly Debates, Vol. VII, P. 219

commitment to panchayats and above all Mahatma Gandhi's untiring campaign for the concept, the first draft constitution of the nation did not include even a single mention of the Panchayati raj.

Mahatma Gandhi

Mahatma Gandhi had strong faith in the establishment of the democratic system at the village level. It was he who, for the first time in the 20th century wished to revive the panchayats.

He wanted the common man of India to have a say in the decision making process. He looked at local self- government as having immense potential for democratisation of power. He believed that Panchayati Raj could bring about social transformation in the society as it catered to the social, economic and political life of a very large group of people. Thus, he demanded immediate attention on the part of the Constituent Assembly so that independence might reflect people's voice. The final result was the inclusion of Article 40 in the Directive Principles of State Policy of the Indian constitution.

Post-Independence Era

After gaining independence through a lot of struggle the Indians had an aspiration to live a life ruled by democratic principles and thus came into existence the country which is today known as the biggest democracy of the world. In order to follow these democratic principles it was essential that all the sections of the society had a say in the decision-making process. Hence, came the idea of introducing the PRIs at the grass root level in a more concrete way. Given below are the steps taken by the government in order to achieve ‘Swaraj’ through Panchayati Raj.

Community Development Programme

While making his concluding speech in the Constituent Assembly on November, 26,1949, Dr. B. R. Ambedkar said, "It is quite possible in a country like India where democracy from its long disuse must be regarded as something quite new, there is danger of democracy giving place to dictatorship ....we must make our political democracy a social democracy as

political democracy cannot last unless there lies at the base of it, social democracy".[108]

Several measures were taken by the central as well as the state governments to reckon with the objectives of Article 40 of the constitution.[109] A notable step was taken by the central government on October 2, 1952, known as Community Development Programme. It was to bring about administrative and technical coordination among the different agencies of the government at the block level, the block headquarters were ultimately turned into a repository of multi-polar knowledge integrated at that level.[110]

It was a programme, which covered all aspects of the economic and social life of villages. The objective was to mobilise all institutions and voluntary organisations for rural development. Although there was no devolution of powers in Community Development Programme, it was considered as the first step towards decentralisation. "This programme is intended to take steps to ensure people's participation by organising non-statutory committees at the village and block levels".[111]

This programme was introduced so that it could deal with the social, economic and political aspects of the rural population of India but it failed to produce the desired results. Hence, a committee under Balwantrai Mehta was appointed in 1957 to evaluate the planned projects under CDP.

Balwantrai Mehta Committee, 1957

This committee was appointed by the Government of India in January 1957 in order to examine and report the working of the Community Development Programme (1952) and the National Extension Service (1953) and to suggest measures for their better working. This committee had Balwantrai G. Mehta as

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[108] R.S. Rajput and D.R. Meghe (eds.), *Panchayati Raj in India: Democracy at Grassroots*, New Delhi: Deep and Deep Publications, 1984, p. 24

[109] Ibid.

[110] S.K. Dey. 'Panchayati Raj in Independent India: Some Personal Reflections' in George Mathew (ed.), *Panchayati Raj in Karnataka Today: Its National Dimensions,* Delhi: Concept Publishing Company, 1986, p. 35

[111] Ibid.

its chairman. The committee submitted its report in November, 1957 which leadto the establishment of Panchayati Raj in the country.It made the following vital recommendations: the committee laid emphasis on the point that community development would be able to be effective only when the members of the community will be involved in the planning, decision and the implementation process.

The dream of community development could only be fulfilled only when the community understands its own problems, realises its responsibility towards finding solutions to these problems and other related matters, exercises the necessary powers at its disposal through its chosen representatives and eventually maintains a constant and intelligent vigilance on the omissions and commissions of the local administration. To fulfil this objective the committee recommended an early establishment of statutory elective bodies and devolved them with necessary resources, power and authority.

The report of the committee further underlined the important role that was to be played by the Panchayat Samitis at the community development block/ tehsil level being the basic unit of democratic decentralisation. The Zilla Parishads were awarded the advisory role. The committee laid a lot of importance and focused on the rural sector. It recommended that the functions of the PRIs should cover the field of agriculture, its development and all its related aspects, the promotion of local industries and other services such as road building, drinking water, etc.

The committee also recommended two set of officers for the panchayat samiti, firstly, at the block level and secondly, at the village level. All these officers were to be drawn from the concerned state cadres and were to be representatives of the state government in the panchayats samiti. For the speedy disposal of work, a necessity to have standing committees in the zilla parishad was also recommended.

Though the recommendations made by this committee were seen as the beginning of a new epoch, Panchayati Raj did receive some attention from a few state governments but the momentum was soon lost. The performance of the state governments was patchy and uneven. The ideas planted by this

committee never picked up and were not operationalized as the PRIs except in a small number of states were in a stagnant and declining state. Though a lot of discussion regarding the need for creating multi-level planning framework with envisaged devolution of definite powers, functions and finances took place in the country but no concrete steps were taken in this direction.

Till the mid-sixties, the Panchayati Raj system flourished in India but then it started declining due to the centralised tendencies of functioning all over the country.[112] Inefficiency, corruption, favouritism, uncertainty and irregularity in the working of the PRIs lead to its fast decline. Hence, arose the need for a new committee.

K. Santhanam Committee, 1963

The Balwantrai Committee was followed by the K. Santhanam Committee in the year 1963 in order to examine the issue of PRI finances. It made a number of recommendations related to a number of issues but the most important issues among them were that a Panchayati Raj Finance corporation should be set up to look into the financial resources of the PRIs at all the three levels, provide loans and financial assistance to these local institutions, the grants from the state level should be of untied nature and the panchayats should have more items that can be brought under tax-net.

Since 1957, regardless of the recommendations the working of the PRIs was marred with various shortcomings and the desired result was far from being achieved. There was limited participation by people in the activities of the PRIs. On the one hand the panchayats did not make any efforts to involve the local population in its decision-making process and on the other the people were not able to identify themselves with these institutions.

The introduction of panchayats was meant to give power to the weaker and the excluded strata of the society in the decision making but it was observed that in many panchayats regular elections were not being held. On the other hand, there was emergence of rural elites as power centres due to alliance

[112] Samsher Singh Malik, *The New Panchayati Raj: Rural Transformation in the State of Haryana,* Jaipur: Aalekh Publication, 2002, pp. 4-5

between the local representatives and the government functionaries at the local level. This state of affairs further affected the morale of the weaker sections and discouraged them from participating in the decision-making process. The state governments also did not take any positive steps in connivance with the local political elites to strengthen the local institutions.

In the mid-1960s it was observed that the funding to the community development projects was reduced considerably and hence the panchayats were not able to get enough funds. Hence, they were not able to give representation to women, members of the schedule castes and tribes as they remained financially weak for decades, superseded by the decisions of the district collector and without elections being held to re-constitute them.

Ashok Mehta Committee, 1978

Having observed and realized the pathetic conditions of the local institutions, the Ashok Mehta Committee was constituted in the year 1978 by the Janata government to firstly review the functioning of the PRIs and to make recommendations in order to revive these local institutions. The committee reviewed the operational and the structural aspects of the PRIs since 1959. It outlined the PRIs in three phases:

- the first as the phase of ascendancy (1959-1964);
- the second as the phase of stagnation (1965-69); and
- the third as the phase of decline (1969-1977)[113].

The committee found the following shortcomings, firstly, that the previous focus of all developmental activities flowing through the block level organisation was done away with and so, the PRIs were not given the opportunities to take up planning or implementation work on a large scale. It also found that the state governments were not in full support of the panchayati raj for some or the other reasons. The political elites also did not have a favourable attitude towards strengthening of the local institutions even at the higher level.

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[113] Ashok Mehta Committee Report, Government of India, 1978

It was very shocking to observe the lack of enthusiasm of Members of Parliament (MP) and Members of Legislative Assembly (MLA) in some states as they perceived a threat to their political stature and leadership position in their political constituencies from the elected local representatives. The field officers and the staff also did not have a positive set of mind about the role of panchayats in development. The PRIs were dominated by the economically or socially privileged sections of the society. The functioning of the PRIs was deeply hampered by the inefficiency, corruption, ego-clashes, lack of appreciation for procedures, undesirable interference in day-to-day administration, political loyalties etc. and hence it had an adverse effect on the village development. The village development was in shreds as the working of the PRIs was hugely vitiated by political factionalism.

The committee made the following recommendations; firstly, it recommended the grouping of a number of villages in order to constitute a 'mandal panchayat' which would cover a population of 15,000 to 20,000 so that a balance could be maintained between the technological requirements of the panchayats as well as create possibilities for the meaningful participation of the people. This would end up in not only ensuring administrative and economic viability but also facilitate the necessary linkages needed between the villages and the gram panchayats.The block level panchayat samitis were to become non-statutory executive committees of zilla parishad and the mandal panchayats were to carry out the developmental programs.

These mandal panchayats were to be responsible for the implementation of the schemes and projects assigned by the zilla parishad. The implementation of the programs, initiating community action and project formulation were some of their duties. There was to be a team of experts constituted to look after planning at the district level for the preparation of district plans. The PRIs were to have powers which would facilitate them in taking their own decisions and prepare plans according to the local needs and demands. The zilla parishads were to discharge the function of planning as an exclusive function. Lastly, the scheduled tribes and the scheduled castes were also to be given representation on the basis of their population in the PRIs.The states of Andhra Pradesh and Karnataka tried out the system of mandal panchayats.

G.V.K. Rao Committee, 1985

The decades of 1970s and the 1980s saw a huge decline in the state of the PRIs and so the G.V.K. RAO Committee was constituted in 1985 to examine the various aspects of the PRIs. The committee made the following recommendations after evaluating the functioning of the local bodies: the integration of rural development was recommended. All economic and social development activities handled by different agencies at the field level were to be encompassed.

Restructuring of planning and the implementation machinery at the district level was also recommended. It further suggested that the PRIs should be made active and provided ample support in order to become effective organizations and play their role in local development to the hilt. It was also suggested that elections to the PRIs should be held on a regular basis. Lastly, that though the district should be the basic unit for policy planning and programme implementation yet, the block development officer should be given pivotal role in the rural development process.

Singhvi Committee, 1986

The Rao Committee was succeeded by the L.M. Singhvi Committee in 1986. It was constituted by the Department of Rural Development, Government of India. It made the following recommendations: the committee recommended that the PRIs should be constitutionally recognized. It further recommended to view the PRIs as institutions of self-government which were constituted in order to facilitate the participation of the local people in the process of planning and development as a concept of self-government. The view that PRIs should be directed to achieve community and social mobilization by transcending the barriers of caste, religion, sex and disparities of wealth and social disabilities was also upheld by the committee.

THE 73rd & 74th Constitutional Amendments

The 73rd Constitutional Amendment Act, 1992 came into force in 1993 with the assent of the President of India. The Act brought about the establishment of panchayats in every state. It was in such a background that the Seventy

Third Constitutional Amendment Bill, 1992, meant for the establishment of a uniform three-tier system of Panchayati Raj for the whole country was introduced in the parliament. It was passed by the parliament and came into effect on 23rd April 1993. This Act inserted part IX in the constitution. This part contains Articles 243 to 243O, dealing with panchayats.

Panchayati Raj in Karnataka

The State of Mysore was renamed as Karnataka in 1973. It came into existence in 1956 by bringing together the erstwhile princely state of Mysore districts of Bombay, three districts of Hyderabad, two districts of Madras and the centrally administered territory of Coorg. Today, the state of Karnataka consists of 30 districts and is considered as one of the pioneer states in the devolution of decentralized power. This successful trait can be attributed to the rich tradition of decentralized governance having its existence in the state of Mysore in the pre-independence era. The story of the development of local self-governments in the old Mysore state is not very different from the development of local self-governments in India as a country.

Pre-Independence Era

Indian Rulers

The old Mysore state was ruled by a number of dynasties since the 6thcentury. According to the historical records it was ruled firstly, by the Shatavahanas (121 BC to 174 AD), then came the Kadambas (360AD to 565AD), then the Gangas (350 AD to 1050 AD), then the Chalukyas of Badami (375AD 793 AD) and lastly, the state was ruled by the Rashtrakutas (735AD to 973AD).

Historical inscriptions dating back to 1005 AD have provided considerable information on the emergence of PRIs in the state. As has been the case with India, the tradition of village bodies is not new to Karnataka too. It has a long and strong history connected to the existence of PRIs. In the ancient times local self-governments were known by different names like Grama, Agrahara, Nadu and Vishaya. These kinds of local governments were especially powerful and prevalent during the time of Cholas.

The two instituions of Grama and Agrahara were autonomous in nature. In Agrahara villages, the assembly of the Mahajans (head of the families of learned Brahmins) served as the local body. In those times, the village assembly was known by a numerical suffix as in the case of aivathu okkalu (50 families) or muvathu okkalu (30 families) depending on the number of families being a part of the assembly. The functions of the village assembly included maintaining temples, arranging festivals and running chaultries and aravattiges which were centres for distributing water, collecting tolls, conferring gifts for meritorious services, installing statues of heroes who died in defending the village from any kind of threat during raids by enemies and bandits, maintaining families of such deceased heroes by grant of land and settling disputes.[114]

The Yadavas and Hoysalas

The rule of Yadavas of Devagiri and Hoysalas (between1200 AD to 1336 AD) was one of the important periods in the history of Karnataka. Though, both these dynasties did not pay much attention to local governments but still the local self-governments worked efficiently on their own. This state of affairs continued till the beginning of the rule of the Vijayanagara Empire. There were examples of flourishing assemblies during this period which was completely opposite to the state of affairs preceding it.

The Odeyars

The Odeyars ruled the state of Mysore from 1610 AD to 1761 AD. It was from 1761 to 1799 that Mysore was ruled by Hyder Ali and Tipu Sultan. IN 1810 AD, it again came back under the rule of the Odeyars. Mummadi Krishnaraja Odeyar ruled until the year 1862 AD. There were no major changes observed in the history of local self-governments during this period and it remained pretty much the same in structure and functions as it had been under the previous rulers of the state of Mysore.

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[114]George Mathew, *Karnataka Panchayati Election: Process, Issues and Membership Profile,* New Delhi: Concept Publishing Company, 1997

British Rule

The next radical change in the Panchayati Raj system was brought by the colonial British rule. As the British consolidated their rule, they realized their wrong doing of doing away with the institutions of local self-government and so they once again introduced these institutions to the people of the country but their functions and powers were set according to the needs of the needs of the British rule. The British government marked the beginning of modern local governments in year 1874, when they established the Local Fund Committee in each district. However, the biggest drawback of this committee was subordination by the bureaucracy and membership being entirely restricted to officials. Hence, they could not be referred to as an institution of local self-government at all.

Lord Rippon's resolution on local governments in the year 1882 is another important development in the history of Panchayati Raj not only in India but also in the state of Karnataka. Even though it was not based on much of liberal ideology, it tried to bring some element of democracy in institutions of local governments. This law introduced by Lord Rippon paved way for the formation of the Mysore Local Boards Act, 1902.

Mysore Local Boards Act, 1902

The Mysore Local Boards Act came into force from November 1, 1903, creating a three-tier local government system for the first time in the history of Karnataka. It provided for a Union (village) panchayats who was to be a nominated chairman, a Taluk Board with a Sub Divisional Officer as president, and a District Board with a Deputy Commissioner as the president.[115]The Act of 1902 functioned for nearly a decade.

Ura and Iyanger Committes, 1914

Since there were several problems in the act, the government of Mysore constituted two Committees in the year 1914 to solve the problems, first, the Local Self Government Committee under the chairmanship of M. Kantharaj Urs and secondly, the Local Finance Committee under the chairmanship of

[115] Ibid.

Dewan Bahadur C. Srinivas Iyanger. These Committees went into the question of liberalizing the constitution and increasing the powers of local bodies to make them more effective and efficient. They recommended an elected majority in all districts and taluk boards and independent working for the taluk boards.

Conference of 1915

In the year 1915, a conference on local self -governments was held under the chairmanship of the Ex-Dewan of Mysore, K. P. Puttanna Shetty. This conference recommended that the local self-governments needed to be made more effective. [116]

Mysore Local Boards and Village Panchayati Regulation Act, 1918

The above developments paved the way for the formation of the Mysore Local Boards and Village Panchayati Regulation Act of 1918. It provided for the establishment of village panchayats with enhanced powers and participation by elected members. Infact, it can be considered as the first concrete step in establishing self -governing bodies in the rural areas of the state.

The Mysore District and Mysore Village Panchayat Act, 1926

The Mysore District and Mysore Village Panchayati Act of 1926 was another very significant development in the history of Panchayati Raj in the state of Karnataka. Between 1919 and 1948, 20 native states passed acts for the establishment of panchayats as local self- governing bodies based on the ideals of democracy. The Mysore state was one of the state which enacted the act. It provided for the district boards with adequate powers and functions and resources. The act abolished the taluk boards and for the first time provided for the appointment of a secretary among its members. It gave voting rights to people above 20 years of age. But women were still not given opportunity to contest gram panchayat elections. This discriminatory practice continued till the year 1952.

[116] Ibid.

Post-Independence Era

In the wake of India's independence after a long and hard struggle India wanted itself to be established as a democratic nation. To see each and every strata of the indian society live their lives according to democratic ideals it became necessary to give the people the right to participate in the decision making process. Mahatma Gandhi's idea of "Grama Swaraj" was the answer. This idea had its own impact on Karnataka. After independence, the princely state of Mysore came under the newly formed India and fell under category 'B' state in the Indian Union. Later, with the reorganization of states, several areas were added to the state of Mysore and was renamed as Karnataka in the year 1973.

Venkatappa Committee

As the erstwhile princely state of Mysore tried to adjust itself to the changed conditions and the requirements of the new political system, the government formed a Committee under the chairmanship of V. Venkatappa in the year 1949. Its work was to suggest measures regarding the changes to be brought about in the local governments. This integration and coordination committee recommended two- tier systems that would have gram panchayats at the local level and the District Committee at the district level. The committee submitted its report in 1950.

Mysore Village Panchayats and District Boards Act, 1952

On the basis of the above report, the Mysore Village Panchayats and District Boards Act, 1952, came into existence. But the act was a total failure.

D.H. Chandrashekariah Committee

In the year 1953 with the intention to strengthen local governments a Local Board Enquiry Committee popularly known as D. H. Chandrashekariah Committee was formed. This committee submitted its report in 1954 and suggested the three-tier system with Taluk Boards being added at the intermediate levels to the earlier system. But the suggestions of this committee were not implemented.

Mysore Village Panchayats and Local Boards Act, 1959

The recommendations of the Balwantrai Mehta Committee report provided a new impetus to the system of Panchayati Raj in the country. Taking note of this committee as well as the historical evolution of local government institutions in the state, a new local self-government set up was introduced known as The Mysore Village Panchayats and Local Boards Act, 1959.

The act for the first time introduced the three-tier Panchayati Raj system with directly elected bodies at the village and taluk levels and indirectly constituted body at the district level. A directly elected village panchayat was constituted at every village or group of villages with an average population of 2500 people. Members of the taluk Development Board ranging from 15 to 19 in number were also directly elected. Seats were reserved for scheduled caste and schedule tribes at both the taluk and village levels. According to the population in the area, for the first time two seats each were reserved for women at both levels. The district development council consisted of both the women members and district government officials.[117]

The District Developmental Council was basically a co-coordinating and supervisory institution. Under this Act, about 8,411 Village Panchayats, 96 Town Panchayats, 175 Taluk Developmental Boards and 19 District Developmental Councils were established throughout the state. Comparatively, this new act was an improved attempt at strengthening Panchayati Raj Institutions. But this act had its own defects. It did not make provision for financial autonomy and development programme for local institutions. The District Council was only an advisory, supervisory body and taluk became the basic unit of administration.

Kondaji Basappa Committee

Due to the failure of the 1959 act, a new committee on Panchayati Raj was formed under the chairmanship of Kondaje Basappa. The committee recommended the constitution of an executive body called zilla parishad with a non-official chairman as its head, devolution of more powers to the taluk

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[117] *Karnataka Socio-Economic Profile, Status of Panchayati Raj in the States and Union Territories of India,* Institute of Social Science, Concept Publishing Company, 2000

Development Boards (TDB) and to provide for consolidated relationship between the village panchayats and TDBs. It excluded Member of Parliament and Member of Legislative Assemblies from Panchayati Raj Institutions and provided a provision for the establishment of nyaya panchayats. On these recommendations a bill entitled 'The Mysore Panchayati Raj Bill 1964' was introduced but the bill could not be passed due to political factors.

The Karnataka Zilla Parishads, Taluk Panchayat Samithies, Mandal Panchayats and Nyaya Panchayats Act, 1983

The year 1983 is considered a golden year in the history of Panchayati Raj in Karnataka as it paved way for serious refurbishing of the concept of PRIs in the state. For the first time, the Congress party lost power in the state and the Janata party formed the government. The then Chief Minister, Ramakrishna Hegde was committed to implement the slogan of "power to the people" started a new experiment on local governments based on the recommendations of the Ashok Mehta Committee. The Janata government introduced a bill patterned on the recommendations of Ashok Mehta Committee, in the state assembly in 1983.

The Janata government enacted a legislation called as, The Karnataka Zilla Parishads, Taluk Panchayat Samithies, Mandal Panchayats and Nyaya Panchayats Act, 1983. The Act received the assent of President of India on the tenth day of July, 1985. The objective of the act was to provide for the decentralisation of powers and functions to these local bodies for the purpose of promoting the development of democratic institutions and securing a greater measure of participation by the people in the governmental plans and in local and governmental affairs.[118] The act was regarded as a landmark in the history of local self-governance in India.

Though Panchayati Raj was declared as one of the strategies of decentralised governance in India, in the early few years very few states took serious steps to operationalise this objective. Till the mid-eighties, the system adopted in Karnataka was one of the very few states that had taken serious steps for the

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[118] The Karnataka Zilla Parishads, Taluk Panchayat Samithies, Mandal Panchayats and Nyaya Panchayats Act,1983, Government of Karnataka, pp.1.

development of PRIs as strong pillars of local self-governance.[119] Karnataka government for the first time showed willingness to make local governments a "real centre of power". The act was brought into force with effect on 14th August, 1985. Karnataka was the second state after West Bengal which had proclaimed its full faith in the devolution of authority on Panchayati Raj.

Features of the Act

- The Act envisaged a three-tier Panchayati Raj system. It made provisions for the establishment of Zilla Parishad for each revenue district in the state, thus replacing the District Development Council under the earlier Act. The Zilla Parishad was based on direct election. It was made fully responsible for the planning and implementation of development programmes in the district. The president and vice-presidents were accorded the status of Minister of State and Deputy Ministers respectively. The Taluk Panchayat Samities at the intermediate level were a coordinating body without executive powers and Mandal Panchayats for revenue villages or group of villages was established.
- The act also provided for the establishment of nyaya panchayats for each mandal. The Zilla Parishads and Mandal Panchayats had clearly defined jurisdiction for formulating schemes and program for promoting rural development.
- It allotted 25% reservation to women members, including SCs and STs and OBC women in local bodies.
- A gram sabha for each village consisting of the adults of the village was set up. The gram sabha was expected to meet at least twice a year to discuss the implementation of developmental programmes in the village, approve new programmes of development and to select the beneficiaries.

[119] B.K. Chandrashekhar, *Panchayati Raj in India Atatus Report,* Rajiv Gandhi Foundation, New Delhi, 2000

The implementation of the Act provided a new phase to the Panchayati Raj system in Karnataka. The Act has been hailed in the press as "revolutionary in concept and wide in its sweep". The Act was able to generate a considerable amount of debate in the political, intellectual, and academic circles. The then Prime Minister of India expressed an explicit interest in Panchayati Raj Institutions. On August, 1985 he wrote to all the Chief Ministers requesting them to hold regular elections to these bodies and give them administrative and financial support. The then Vice President of India, R. Venkataraman, while delivering the 10th Govinda Ballab Pant Memorial Lecture, pleaded for amending the Constitution to make it mandatory to hold elections to the panchayats.[120]

The Panchayati Raj Act 1983 of Karnataka attracted nationwide attention because of its radical provisions relating to the devolution of powers to the district and the villages and the reservation provided to the women. The enactment of the 1983 Act has no doubt been a landmark in the evolution of Panchayati Raj, not only in the history of Karnataka alone but in the country as a whole. It was just a beginning in democratic decentralization. The newly elected members took office immediately after the elections. Studies have shown that the Act was able to initiate changes in the Panchayati Raj functioning. However, it could not substantially alter the panchayat leadership. The system remained the domain of upper income land owners and dominant caste members.[121]

Inadequate devolution of financial and administrative powers, lack of commitment on the part of bureaucrats and political leaders, lack of training for the elected representatives of the Panchayati Raj Institutions were the reasons cited for it falling short of expectations. The Mysore Village Panchayats Local Boards Act, 1959 had provided for reservation of two seats for women at both the village and taluk levels. But the Act of 1983 provided for reservation of 25% seats for women in both the zilla panchayat and mandal Panchayat. This was a major initiative in favour of women. This was a major

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[120] *Hindustan Times,* 14th December, 1985

[121] J.S. Sadananda, 'A Note on the Theme: Local Self-Government in Karnataka" in *Journal of Karnataka Studies,* May-October 2004, pp. vi-xv

development and it was in fact considered as the beginning for subsequent developments in favour of women at the national level. [122]

Karnataka Panchayati Raj Act, 1993

The passing of the Constitution Act of 1993 (73rd Amendment) by the Parliament gave constitutional status to Panchayati Raj Institutions. It made holding of elections to the Panchayati Raj Institutions mandatory on the part of the state governments. It appended the 11th schedule to the constitution which broadly defined the functions of these bodies. It also laid down formula for reservation of seats and defined the powers of state government vis-a-vis the Panchayati Raj Institution. In fact Karnataka was the first state to implement it. The Karnataka government introduced the Karnataka Panchayati Raj Act 1993 in the legislature on 1st April, 1993. With the approval of both the houses it came into effect from 10th May, 1993. The Act established three-tier Panchayati Raj Institutions with zilla panchayat at district level, taluk panchayat at taluk level and gram panchayat at village level. The Act which received the governor's assent on 13th April, 1993 reads as follows:

Other salient Features of the Act are as follows:

- It established a three-tier Panchayati Raj system in the state, based on the population as ascertained in the preceding census of which the figures have been published. It envisaged elected bodies at all the three levels.
- It provided reservation for one third of the total seats at all levels for persons belonging to the backward classes who had an annual income below Rs. 10,000.
- Offices of chair persons at all levels were also reserved in favour of scheduled casts, scheduled tribes and backward class. Women got not less than one third seats in the reserved and unreserved categories of adhyakshas (presidents) and upadyakshas (vice presidents).
- It provided for reservation of seats in favour of scheduled castes and scheduled tribes in proportion to their population and for reservation of not less than one third of total seats for women at all levels.

[122] George Mathew, 1997, op. ci.

- It envisaged the Constitution of a State Election Commission to conduct elections to the panchayats. It recommended constitution of State Finance Commission once in every five years to review financial position of panchayats and District Planning Committee in each district.

The Three-tier Panchayati Raj System

Gram Panchayat

According to the Act, a gram panchayat is constituted for a population between 3000 and 5000. The area covered by a gram panchayat includes group of villages. There will be one member for every 400 persons. The adyaksha and upadyaksha (president and vice president) are elected from among the elected members. There are three Standing Committees in the gram panchayat, namely:

- Production Committee
- Social Justice Committee
- Amenities Committee

A secretary is appointed by the government as the administrative head of the gram panchayat. The main function of the gram panchayat is to promote economic and social welfare, education and health in the gram panchayat.

Taluk Panchayat

According to the act, for each taluk, there shall be a taluk panchayat consisting of local representatives from the state legislature and parliament apart from one fifth of the gram panchayat presidents in the taluk are chosen by lots every year (in rotation). Members are directly elected from the separate territorial constituencies at the rate of one member for every 10000 population. The elected members of taluk panchayat must choose two members from among themselves to the post of president and vice president. The taluk panchayat has the following Standing Committees:

- General Standing Committees
- Finance, Audit and Planning Committee
- Social Justice Committee

Group A officer of the state civil services is the administrative head of the taluk panchayat. Taluk panchayats are empowered to supervise the activities of gram panchayats in their jurisdiction.

Zilla Panchayat

According to the act, each district will have a zilla panchayat consisting of members of parliament and the legislature from within the district, the presidents of taluk panchayats in the district and elected members in accordance with the scale of one member for 40,000 of the population. The elected members shall choose two members from amongst them to the post of president and vice president. The zilla panchayats will have the following Standing Committees:

- General Standing Committee
- Finance, Audit and Planning Committee
- Social Justice Committee
- Education and Health Committee
- Agriculture and Industries Committee

A chief executive officer, not below the rank of Deputy Commissioner is to be the administrative head of the zilla panchayat. The Act reduced the powers of zilla panchayat substantially. It may be noted that the Janata Dal government, through an ordinance made the presidents of zilla and taluk panchayats executive heads and gave them executive powers.

Gram Sabha

According to the act, the gram sabha is a statutory body of gram panchayat today. It is obligatory on the part of the gram panchayat to convene grama sabha meeting at least once in six months. All the adults who are in the voters list of the village are the members of the gram sabha. Thus confirming to the mandatory requirement of the 73rd Amendment, Karnataka became the first state to implement the Panchayati Raj Act on the basis of this amendment and holding elections to the panchayat under the act. Since its enactment, it has been amended on many occasions, leading to some important changes in the act

Nayak Committee, 1995

The Janata Dal party which came to power in 1994 constituted an expert committee called the Nayak Committee in the year 1995 with the intension to revamp the Panchayati Raj act of 1993 and to restore autonomy of the kind obtaining under the earlier 1993 Act. The committee recommended many changes to the Act which were incorporated in the year 1997.

- It incorporated provisions for consequential arrangements with regard to the position of the new bodies, division of funds and liabilities. In the year 1998, seven new districts were formed. Therefore, the number of zilla panchayats had gone up from 20 to 30.
- A more significant development has been the issue of an ordinance in February 1999, reducing the number of gram panchayats. Under the ordinance, the population limit of a gram panchayat was raised to 10,000 to 16,000 as against 5000 to 7000 people. The reason given by the government was that under the earlier pattern the zilla panchayat was too small. They had limited financial resources and manpower and they were not capable of becoming effective instruments of development.

This historical journey regarding the evolution of panchayati raj both in India and Karnataka has given us a glimpse of the growth of panchayati raj since the ancient times to the modern times. The PRIs play a very important role in this study as it is under them that the concept of decentralisation works.

Criticism of Panchayati Raj Institutions in India and Karnataka

It is erroneously believed in this country that by simply enacting a legislation regarding the introduction of PRIs, all problems related to the lack of democracy at the grass root level could be done away with. But in reality it is not so. The PRIs regardless of having a legal backing have not been able to provide the local population with democracy in its purest of forms.

The main claim behind the passing of the Amendment Act relating to the strengthening of Panchayati Raj institutions was that it would ensure the participation of poorest of the poor in the process of development. But in reality it is hard to find the poorer sections finding their way to enter the

Panchayati Raj institutions through elections. The PRI elections have also become as politicised as possible. All major political parties of a region support candidates for standing in the PRI elections even though the elections are supposed to be conducted on a non-party basis. For exampleall of the gram panchayat officials interviewed during this study were either affiliated to some political party or were being supported by some political party regardless of being independent.

Huge money and manpower is being spent while campaigning for these elections and so it is not possible for a poor man to stand for these elections on his own. He or she has to have the backing of some political party not only for standing in the election but for trying to win it. When even a highly capable intellectual cannot aspire to enter a state legislature or Parliament unless he is backed by a powerful political party and is able to contribute sizable amounts to the party funds, then one can imagine the pitiable condition of the poor gram panchayat inhabitants.

The upper castes of all over the country are able to dominate these bodies and only those women and members of the Scheduled Castes and Tribes who would toe their line are allowed to contest elections. Allowing the members of Parliament or the state legislature to contest elections to the Panchayat bodies is also not at all a healthy step in as much as these personalities are likely to vitiate the atmosphere in the Panchayat as they have much more money and political clout as compared to a village inhabitant.

Though the election of the chairperson of the Panchayat at village level is direct, the elections to the posts of chairpersons at the intermediate and district level is not direct which should be done way with as it supports corrupt practices in PRIs.The duties expected to be performed by the Panchayat bodies are so vast that they may require secretariat assistance for carrying out their activities which may result in appointment of officers and staff at various levels increasing the financial liabilities of both the Centre and the states.

The possibility of the members of the Panchayat bodies splitting into a number of groups and the group enjoying the majority support taking advantage of the increased flow of money in the pipeline cannot be ruled out which may create an imbalance amongst the people residing in the Panchayat area. The elected panchayats should not assume powers that are not actually vested in them and act as the 'nyay' panchayats which are functioning as dispensers of justice.

The Panchayati Raj institutions have been vested with a lot of power and money in the coming years thanks to the Amendment Act. The activities and the functioning of these bodies will have to be closely watched and monitored so that they do not overstep their limits and cause irreparable damage to those living in their jurisdiction.

After conducting the field survey and going through literature on Panchayati Raj the following recommendations are being made for the improvement: Regular elections should be held for the PRI’s every five years so that the people at the village level regularly get a first-hand opportunity to take part in the decision making at the local level and take training in politics. The PRIs should be entrusted with sufficient powers and functions so as to make them institutions of self-governance in the real sense of the term. The government should be liberal in passing on the share of taxes collected by the states to PRIs in proportion to the population for local development works. Panchayats should be empowered to impose local taxes like house tax, toll tax, entertainment tax, sanitation tax, water tax, etc. compulsorily to raise their own resources for development.

Incentive in the form of matching contribution equal to the taxes and other own resources raised should also be provided by the states so that the PRIs can become more self-sufficient. Sufficient staff should be placed at the disposal of the Panchayats to implement the decisions taken at local levels. The capacity building of the newly elected people’s representatives, especially the women, SCs and STs, through intensive training and orientation programmes must be made a regular feature so as to develop local leadership and ensure efficiency and social justice in development. The

political will at the state level and the top bureaucracy is also a precondition for the successful implementation of the Panchayati raj in the true spirit.

The Gram Sabha, as the Lok Sabha of the village, can ensure full participation of all the adult voters as well as train villagers in democracy. Hence, powers should be vested in the Gram Sabha to ensure real 'Gram Swarajya'. The decisions of the Gram Sabha should be made binding on the Panchayat as the cabinet is bound by the decisions of the parliaments. The Gram Sabha, as a vigilance body for social audit of the Panchayat, should exercise ownership of the natural resources of the village and have control over all the social service institutions and their staff. Both the Members of the Parliament, the Legislative Assembly and the Ministers of the State should not snatch the powers and resources of the PRIs but give them full support to develop as real institutions of self-government.

If all these short comings are taken care of the PRIs can ensure grass roots democracy in true spirit, provided that all the powers and functions regarding rural development, along with proper resources and staff, are vested in them. This would undoubtedly pave the way for Gram Swaraj in India.

Conclusion

The evolution of Panchayati Raj both in India and Karnataka has a long history originating from the ancient times. The system has undergone considerable changes since then. The history of democratic decentralisation has generally been of promise and hope, although there are certain disappointments. The functioning of Panchayati Raj Institutions show that they have not fully emerged as people institutions and still a lot of work has to be done. New class of power centres usually occupied by elite have emerged. In the recent years any change in government has resulted in changes in Panchayati Raj system. Every government seeks to strengthen its support at the grass root level against the opposition.

Decentralisation of powers and functions to the local bodies has been a successful experiment regardless of a number of short comings. The 73rd Amendment, setting aside the limitations has lead to significant advancement in local governments. The Karnataka Panchayati Raj Act 1993 was also built

up on the excellent earlier initiative taken in 1987 regarding decentralization. Apart from Sikkim, Karnataka is the only state that has transferred fund, functions and functionaries with respect to 29 subjects in the 73rd Amendment. The Act has given impulse to panchayats to promote all round development in terms of poverty elevation, improving living condition, infrastructure, health, education, sanitation in rural India.

The PRIs in the country and the state have given an opportunity to large number of people at the grass root level to participate in the local administration. A substantial number of scheduled caste, scheduled tribe and backward class representatives have got an opportunity to actively evolve themselves in local administration which was otherwise a domain of upper castes and classes. Significant developments have taken place in the representation of women too. Participation of women has gone up sharply at all levels.

Mandating one-third reservation for women in membership as well in the position of chairpersons of panchayats at all three levels has given an opportunity for women to take the position of leadership. Today, rural women are able to participate in the decision making process. The emergence of these institutions has brought governance closer to the people. From the history of Panchayati Raj system in India and Karnataka it can be confidentially said that this long history of decentralisation through Panchayati Raj Institutions makes clear that it is not a contemporary phenomenon.

CHAPTER III

NATIONAL RURAL HEALTH MISSION

Introduction

One of the most important objectives of Indian planning since the very inception of the five year plans has been the improvement in the standard of living and health status of the citizens of India. International aspirations in the health sector have always had an influence on India's vision which has been a signatory to these aspirations from a long time through international organizations like the United Nations and its various sister organizations like the World Health Organization. The National Health Policy, the National Population Policy, etc. are all reminders of this commitment towards this vision of providing health for all. These above mentioned goals can only be achieved by improving the access to and utilization of health services, nutrition services and Family welfare with special focus on the historically excluded women, children and other weaker sections of the society.

Thereby, in order to recognize the importance of health in the process of economic and social development and to improve the quality of life of the citizens of India, the Government of India launched the National Rural Health Mission so as to carry out the necessary architectural correction in the basic health care delivery system. Hence,

> the mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards in each block of the country.[123]

This chapter dwells extensively on the National Rural Health Mission in full detail. The chapter is divided into two parts: the first part caters to the mission in India as a country. It gives details regarding the vision, goals, strategies,

[123] National Rural Health Mission (2005-2012), Mission Document, Government of India, 2010

important components, institutional mechanisms, technical support, role of state governments, PRIs and NGOs in the mission. The second part of the chapter gives details of the mission in the state of Karnataka.

National Rural Health Mission in India and Karnataka

The Hon'ble Prime Minister of India launched the National Rural Health Mission on 12th April, 2005 throughout the country with special focus on the 18 states including eight Empowered Action Group (EAG) states, the North-Eastern states, Jammu and Kashmir and Himachal Pradesh to provide "accessible, affordable and accountable quality health services to the poorest of households in rural India. The thrust of the mission has been on establishing a fully functional, community owned, decentralised health delivery system with inter sectoral convergence at all levels to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality".[124]

Components of National Rural Health Mission

NRHM consists of a various number of components. All of these components are being mentioned below in reference to both India and Karnataka.

Public Health Infrastructure and Human resources

NRHM provides basic health infrastructure to the local population all over the country through Community Health Centres (CHCs), Primary Health Centres (PHCs) and Health Sub-Centres. According to the Common Review Mission 2012 report, gaps have been found in the sanction of adequate number of facilities. These gaps are the highest in Uttar Pradesh and Bihar. At the PHC level the problems have been found to occur due to lack of proper location as in the case of the surveyed Karakakette PHC. Lack of residential accommodation for the medical staff at most of the health centres as was observed in the survey as well is a huge hindrance in providing 24*7 regular service to the specially in the remote areas.

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[124] Supra, p. 81

Karnataka has 19 district hospitals, the rest are medical college hospitals. There are 153 hospitals, 326 CHCs, 2193 PHCs, 8870 health sub- centres in the state.[125]**Table1:**

Funding source	Type of Facility	Total no. of buildings undertaken	Building already handed over	Buildings to be handed over in 2011-12
NRHM	ANM Sub-centres	85	55	25
	PHCs/ CHCs	196	67	129
	Total	**281**	**122**	**154**
SICF Component	ANM Sum-centres	152	150	2
	PHCs	35	28	7
	ANM training centres	9	6	3
	Drug ware hoses	13	6	7
	Total	**209**	**190**	**19**
12th Finance	District Training Centres	22	18	3
	Trauma Care Centres	137	131	6
	Total	**159**	**149**	**9**
	Grand total	**960**	**617**	**364**

(Source: DoHFW, Govt of Karnataka)

As shown in Table 1 there has been considerable improvement in health structure in the state and much more infrastructure is going to be in use in the year 2012 according to the Department of Health and Family Welfare, Karnataka. The state has been utilising the funds provided under various sources like the NRHM, 12th Finance Commission, state budget, Zilla Panchayat budgets for the up-gradation of the infrastructure and the human resources.

The states like Himachal Pradesh, Karnataka, Chattisgarh, Rajasthan etc., by ensuring compulsory rural service for medical graduates through their respective state legislative acts have increased the human resources under NRHM in the country. Given below is the number of individuals working in different capacities under NRHM at various health centres around the state according to the state department of Health and Family Welfare. The state has also created a special cadre for medical specialists under the state act for recruitment through the Karnataka Public Service Commission. Though gaps

[125]www.nhsrcindia.org/pdf_files/resources_thematic/Health_Sector_Overview/NHSRC_Contribution/Karnataka_468.pdf

are still present in the availability of specialists especially gynaecologists, anaesthetists and paediatricians.[126]**Table2**:

HR AVAILABILITY: 2005 Vs 2011

Sl. No.	Category of staff	Sanctioned strength	Status as on 2005 (base-line)		Status as on 2011			% increase over 2005
			Regular	Cont	Regular	Contractual	Total	
1.	Medical officers	2586	1104	-	2285	59	2344	52.9
2	Specialists	2600	1107	-	1557	65	1622	31.8
	AYUSH Doctors	-	-	-	-	563	563	100.0
3	Staff Nurses	7810	4965	-	7295	4264	11559	57.0
4	ANMs	10025	6795	-	8356	643	8999	24.5
5	MPW	5810	2715	-	3990	100	4090	33.6
6	LHV	1432	370		1162	-	1162	68.2
7	LT	2197	1345	-	2044	136	2180	38.3
8	Pharmacist	2691	1643		2318	-	2318	29.1
9	X Ray Tec.	568	338	-	565		565	40.2

(Source: DoHFW, Karnataka)

Health Care Service Delivery (Table 3)

Deliveries

Year	Institutional deliveries	Public sector deliveries	%	Deliveries in private accredited facilities	%	C-sections	%
2009-10	837453	687262	82	150191	18	96685	12
2010-11	717648	650062	91	67586	9	100902	14
2011-12 (till Sept)	384869	288639	75	96230	25	65006	17

(Source: DoHFW, Karnataka)

One of the basic objectives of NRHM is to provide healthcare service to the mother and the child through JSY as can be seen in the table (Source Dohfw, Karnataka). **Table 4**:

Sn.	Budget Head	Physical Progress (Apr-Sept 11-12)			Expenditure (Apr-Sept 11-12)		
		Planned	Reported	Variance %	Planned (Rs. lakhs)	Reported (Rs. lakhs)	Variance %
1	JSY incentive paid for home deliveries	10000	1357	-86.4	50.00	54.10	8.2
2	JSY incentive paid for institutional deliveries						
	Rural	150000			1050.00	810.23	-22.8
	Urban	50000	107499	-50.0	300.00	156.83	-47.7
	C-sections	15000			225.00	314.04	39.6

[126] Ibid.

The institutional delivery % for the state has gone up from 60% in 2004-2005 to 93.3% in 2010-2011. This high rate of institutional deliveries can also be observed in Table of the field survey. The state has taken many steps to increase the demand for institutional deliveries in addotion to JSY, it is running the Thayi Bhagya and Madilu programmes for mother and child health welfare.[127] Regular weekly immunisation camps are run by the health sub-centrs around the state as has been mentioned in the next chapter also, for the benefit of the mother and the child.

Various Health Programmes under National Rural Health Mission

The staff nurses and ANMs in the facility and ASHA and AWW in the community are aware about early breast feeding, weaning, and exclusive breast feeding practices. There is a State level supervisory board under the chairmanship of Minister of Health and Family Welfare, Government of Karnataka. There is State level Appropriate Authority headed by Project Director (RCH), DHFWS, Bangalore. There is a special cell at the Directorate of Health and Family welfare Services monitored by Appropriate Authority – Deputy Director, Department of Health and Family welfare Services, Bangalore. The state is also working towards combating various diseases as mentioned in the **table 5**also.[128]

National Disease control Programmes:

Parameter	Expected outcome	Outcome of the Mission in the State
Malaria mortality reduction rate	60% by 2012	11 confirmed deaths during 2010 (25 during 2006)
Dengue mortality reduction rate	50% by 2010 and sustaining that level until 2012	6 during 2010 (7 during 2006)
Cataract operations	Increasing to 4.6 million	2.1 lakhs upto Sep 2011 against 4 lakhs target
Leprosy prevalence rate	Reduce from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter	<1 (0.46)
Tuberculosis	Maintain 85% cure rate through entire mission period and also sustain planned case detection rate	12 districts have the cure rate of 85% and more, the remaining 18 districts have cure rate of less than 84%. Kodagu has the highest CR of 95%. Yadagiri has the lowest DR of 72%.

[127] Supra, p. 84

[128] Ibid.

Recommendations for NRHM in Karnataka

The State should analyse FRUs' functioning in the districts and put these districts on high focus in terms of following parameters: availability of 24x7 Emergency, especially availability of EmOC at night, posting of personnel (gynaecologist, paediatrician, and anaesthetist) and blood bank/storage linkage. The state may also track referrals from the FRUs and the reasons for referral. The State further needs to capture all the maternal deaths (almost 42% is still not being captured) through its facility and community based MDRs. A thorough review of the causes is required for each case. The profiling of maternal death vis-à-vis parity and BPL status (against the backdrop of most GOI and state schemes limited to BPL and first two live births) may also be taken up to see whether most of the maternal deaths are happening in 3 and 3+ births. In such a scenario the state needs to relook at all the concessions being given upto first two live births.[129]

The VHSCs need to be transparent about the funds and their utilization. This may be done by displaying the availability of resources/ funds given, names of the members, meetings conducted and work done on a black board or notice board for the general public. The State may also look into the financial propriety of withdrawing the entire untied funds at one go in Sub-Centres. Best practices and good book-keeping may be shared with all the SC ANMs to encourage them to spend the untied funds and keep accounts properly. The State should aim for focussed outcome oriented supportive supervision needs at sub-district level. The officer given the responsibility to monitor a particular facility may look into matters ranging from assured service delivery (as per the level of facility) to team –building.[130]

The Arogya Raksha Samiti should be given proper orientation for improving utilization of untied funds. The new members (whenever there is a change) should be oriented as early as possible. The District Health Mission is to provide broad policy guidelines whereas the Executive committee is to take the decisions about expenditure and program. The State should review the

[129] Supra, p. 85

[130] Ibid.

current system of monthly meetings of ZP and DHM so that it can contribute more constructively. The State should also reconsider the deliveries at SCs to be treated as institutional deliveries or alternatively the state may consider accrediting high caseload SCs and treat the deliveries at accredited SCs as institutional deliveries. This will not only increase the percentage of institutional deliveries but also enable the ASHAs to benefit monetarily which is quite low at present. As the Madilu kits are meant for the mother and the new born, the State may consider providing Madilu kit to all deliveries including SC deliveries. The state transfer policy should have a clause for exceptional Medical Officers (MOs) or facility incharges to promote them speedily to the next level of facility (e.g. sub-taluk to Taluk, Taluk to district).[131]

Criticism of the National Rural Health Mission in India and Karnataka

In analyzing the role of NGOs and *Panchayats* in the management of rural health, the relationship between decentralisation and civil society forms the framework of the study. The argument which has been defended here is that it is the collaboration between the NGOs and the Panchayats in the management of rural health that affects the participation of the people in the National Rural Health Mission. In this study the underlying argument is that it is these two actors together and not the state alone through Panchayatsthat can bring about improved outcomes in public participation in the field of rural public health.

For explanation and justification, decentralisation has been taken as the theoretical base. It is the concept of decentralisation which has the strength to bring the two important actors i.e. the state and the civil society on the same platform to work for the welfare of the larger good. Decentralisation serves as the theoretical base because it is the state by applying the concept of decentralization through Panchayats in collaboration with the NGOs that determine the role and the scope and level of participation and decision making of people in the management of rural health and also explains to us that how far the institutions have been able to fulfill the local needs.

[131] Supra, p. 86

The type of user group, its size, economic and social conditions, agents of decision making at the grass root level, historical legacy of the institutions involved, status of the institutions involved, degree of level of participation of people, the organisational pattern and work done by the state, *panchayats* and the NGOs are the factors which have been factored in analyzing the role of the NGOs and panchayats in the two concerned districts of *Mandya* and *Mysore.* It is only by looking into such factors that a holistic understanding of the reasons for the success or failure in achieving the goal of increasing the participation of people in management of rural health through NRHM can be accounted for.

Rural public health in India has become one of the top priorities of both the central government as well as the state governments in order to bring about wholesale development of their particular areas. Most of the Indian population is rural in nature and so the central government has come up with NRHM in order to raise the health standards in the rural areas but it is the state governments that have the primary responsibility for the implementation of the mission in their states. The Central Ministry of Health and Family Welfare with the help of the Ministry of *Panchayati Raj* and Rural Development has the responsibility for the functions that are national in scope and hence has come up with the framework of the mission to cater to the health needs and demands of the rural population. The state governments have the primary operational duties regarding the mission.

Though the state governments can also formulate their own health policies but that must be in congruence with policies issued by the central government. Many state governments have attached their already running health programs with NRHM in order to increase the area of their influence. The working of the *Panchayats* is left mainly to the state governments. The state governments have employed the services of the NGOs with the *panchayats* in order to effectively run the mission. Even the mission statement mentions the role of this collaboration can play in order to bring about a rise in the rural health status.

The interventions of Panchayati Raj Institutions with collaboration of the NGOs are successful to a great extent for making the health personnel

accountable to the public. The absenteeism among doctors and paramedical staff and their rude and bad behaviour towards the helpless patients specially the poor ones were some of the major reasons for the poor functioning of PHCs and lower utilization of health facilities in the state previously. Medical Officers lacked the zeal to serve the people and were never ready to respond to local situations and requirements and used to spend considerable time on private practice either in a clinic or at home specially the ones who were posted in interior areas. The interest shown by the local GPs and the mobilization initiated by both the GPs and the NGOs have been able to ensure the availability of doctors and ANMs in their area. During a visit to the Community Health Centres and PHCs it was observed that there is significant improvement in their functioning and doctors were not only conducting their everyday work with zeal but were also found to be very enthusiastic and willing to listen to the public, particularly poor. They were found to be highly punctual and devoted to their work.

Karnataka has relatively better health infrastructure in terms of number of sub centres, PHCs and CHCs in proportion to the population as per the norms prescribed by the central government under NRHM. As we can understand that the mere existence of a health Institution in an area does not ensure its satisfactory functioning and utility to the common man. Many of the PHC visited were found to be lacking in basic facilities like electricity, water, telephone, vehicle and staff quarters. Some Gram Panchayats took initiative in improving the health infrastructure by mobilizing funds locally. But specially due to lack of proper staff quarters a large number of medical staff has to travel daily from their homes which results in wastage of time and energy specially for female staff. Many patients have to visit the district hospital in case of emergency which sometimes results in death.

One common complaint which the government has tried to address regarding the public health system in India is the lack of medicines mainly due to pilferages and irregular supply. Cases of drugs supposed to be given to a number of patients free of cost have been found to be sold out or charged and bribery has become a normal thing in the day-to-day functioning of government hospitals all over the country. Many Panchayat members during

discussions claimed that they were able to contain these practices and it was also found that the beneficiaries that they were being provided with regular medicines. But due to lack of refrigerators and electricity many medicines were getting wasted. Under the watchful eyes of local leaders and the NGO workers who are in constant touch not only with each other but also with the PHC staff, the corruption in drug purchase and supplies has been controlled to a great extent.

In Karnataka nearly 60 per cent of the total budget allotted for the purchase of drugs and equipments has been given to the Zilla Panchayats. The DHO in consultation with other officers prepares the inventory of items to be purchased and sends the list to the ZP Standing Committee for deliberation and approval. This ensures that the available funds are properly utilized for the purchase of good quality medicines, which are really necessary. It was found that the NGO workers through their access to the common people let the medical staff know about the diseases prevalent in the area and thus medicines needed are mentioned to the GP members and to the ZP members.

In 2001, nearly 24 per cent of the posts were vacant in Karnataka health department. However, in certain crucial cadres the vacancy position was alarming. Nearly 50 per cent of the pharmacist posts and 39 per cent of the Lab technician posts were lying vacant. Even in the case of medical officers, the vacancy level was around 17 per cent. One immediate solution to overcome the rampant vacancy position is contractual appointment at the district level. The State government has given permission to district administration to fill up vacancies locally on contract basis. Taking advantage of this provision many panchayats have been able to get health personnel appointed from the locally available persons, which also ensured their regular attendance in health centres. But there are still posts which are vacant even though they are needed to run a PHC to its full capacity.

Any meaningful involvement of grass root level leaders can only be possible by creating health awareness and by imparting training about their duties and responsibilities in the provision of the primary health care of the communities. Given the relatively lower educational attainment of panchayat members, lack

of exposure to any kind of governance outside (majority of the women members are housewives and belong to deprived communities) and political inexperience, their participation in the PRI system and ability to discharge their responsibilities would not be very effective. Most of the GP members were not attending the office regularly and were found to be lacking in basic knowledge about NRHM and their functions as GP members.

They need to be sensitized, and motivated about the health problems in their area, existing health programs and how they can help their electorate. The evaluation of a health-training program in Karnataka revealed that the training contributed significantly not only towards enhancing the level of awareness and self-confidence among local leaders but also towards improving their performance with regard to the provision of 21basic health care in rural areas. In Karnataka, television was used as a powerful medium to sensitize the grass roots leadership on health issues. Informal channels such as television proved effective in initiating important attitudinal and behavioural changes at grass roots level, where a majority of the people may have had little formal education. It was also found that regular health care camps were being conducted by the NGOs to increase the awareness of both the masses and the GP members regarding NRHM. They were found to be successful to quite an extent.

There are many overlapping of functions between the three tiers of local bodies and this can be a source of confusion and administrative delays in program implementation. To overcome this problem, the state government has come out with activity mapping wherein specific responsibilities have been identified at three levels. A particular job/responsibility has been given to a particular level so that overlapping can be avoided. The distribution of responsibilities of PRIs with regard to health and sanitation including hospitals, primary health centre and dispensaries has been vividly mentioned by the government. With regard to health care, the ZP is responsible for providing physical infrastructure, coordination of communicable diseases programmes, school health programmes, IEC campaigns and planning of rural sanitation programmes.

The specific activities identified for the GP include chlorinating of village tanks and wells, spraying of DDT, construction of sanitary latrines, cleaning of roads and drainage, formation of village health committees, and mobilization of people for family planning and immunization camps. GPs are also responsible for the supervision of activities of ANMs. They are also supposed to report the outbreak of epidemics and help emergency medical relief services. It was also found that if the ASHAs missed any of the health problems in their areas, it was the NGO workers who were letting the PHC staff know about it or brought the patient to the hospital on their own.

During the field trips and discussions with officials, it was observed that women panchayat members took more interest in monitoring the health facilities. Many women leaders felt that in most cases the health needs of women got neglected and were attended to only when it became a crisis. Some women members asked the health workers to regularly visit their villages for providing the ante-natal care. The women panchayats members have started motivating the untrained dias in their villages to undergo the training at the PHCs.

There is a need to simplify the administrative procedures, particularly those involving the ZP and Health Department. DHO needs to obtain the permission of ZP on all matters. Many times these administrative bottlenecks have caused delay in taking necessary actions. It was also observed that the medical staff also complained of having problems with the GP members regarding funds due to lack of understanding between both of them.

Though village health plans are being drawn up by the GPs for improving the local environment in a systematic manner. To begin with, these plans should contain a domestic waste disposal system; plans to remove water logging conditions; build community level public convenience, organize ‘clean village days’ at least twice a year; organize vector control programs as per schedule; ensure testing of water quality as per schedule; and produce a charter of citizen rights. Regular sanitation camps are being held by the GP and the NGOs in collaboration with the PHCs.

The GPs are responsible for enforcing public health laws such as Anti-Food Adulteration Act (with laboratory support at the district level). But there is very little understanding of the implications of this responsibility at that level. There are no standard formats for issuing licenses, no checks, no efforts to improve the quality. Actually the GPs could insist on the condition that any new house/ building that is constructed should have adequate sanitation facilities. Such requirements should become part of the GP bye-laws and the necessary instruments for enforcement of the obligations should be provided to the GPs by the state level authorities. The model bye-laws need to be framed at the GP level for enforcing the requirements relating to sanitation and food safety. Mechanisms to implement these obligations under the bye-laws need to be constantly reviewed and support mechanisms developed.

The GP level amenity committee is one forum to monitor the health conditions in the village. This forum should optimally use the services of health personnel. The GPs at present lack the necessary outreach to mobilize the community for the public health programs on a sustained basis and they may also not be a forum to provide continuous interaction with the community. For example, the members of GP who get elected may not be the best people to undertake tasks relating to public health. The GP therefore forms a Health Committee or a Health Club, which is a community organization with specific agenda. In addition, the organization is free to carry out works relating to health issues. The community organization is encouraged to raise their own additional funds. Women are provided with a special role in these organizations. These Health Clubs are responsible for the implementation of the Health Plan for the village and all the panchayats were happy that they had been formed.

At present there are no systematic monitoring mechanisms to assess the working of the amenities/facilities from the point of view of their impact on health. It is necessary to develop a systematic mechanism by which information is available to decision-makers to act and improve the situation. The PHC should send Health Compliance Report upon execution of any project like water supply, toilet facilities and construction of drainage to the

PRIs. PHC should also send water test reports (bacterial contamination) on monthly basis to PRIs. PHC should file vector control reports regularly indicating the possibility of epidemic outbreak and required measures to prevent such calamities. The standing committees/GPs should discuss the reports and initiate action. The co-ordinated efforts of PHCs and PRIs can prevent epidemics and improve health situation, without any additional financial resources.

Various inter–sectoral forums that exist at different levels in the PRI system need to be activated. The diseases surveillance committee at the district and taluk levels should be made functional. At the GP level, the amenities committee should have the active participation of PHC staff. The ASHAs were found to be very active in their roles in most of the panchayats. The beneficiaries were able to recognize the ASHA workers of their areas and their contribution towards making them aware about NRHM and various other health programmes being run. Even the panchayat members were aware of their good work. The medical staff at all the PHCs was found to be highly dedicated specially the doctors. Though a number of vacancies need to be fulfilled immediately specially at the sub-centre levels.

The beneficiaries, panchayats members as well as the health officials and workers were aware of the presence of the NGO workers in their areas. They were personally known to each other. Their work was appreciated by all the three sections and these workers were held responsible for increasing the awareness regarding health among the local people. They were also looked up as the extra hands of the health officials in combating health threats increasing the access of health services to the common man.

Conclusion

In conclusion, the Integrated Health Policy, Karnataka which is in which is in tune with National Health Policy and with additional support from NRHM is placing health high on its agenda. “Health is Wealth” will be translated into action by allocating adequate human and financial resources, by good governance and institutional capacity building. The state will play a role of facilitator in harnessing resources, energies and ideas from the private and

voluntary sector. It will work towards equity, integrity and quality in health and health care.

CHAPTER IV

A COMPARATIVE STUDY OF THE DISTRICTS OF MANDYA AND MYSORE

Introduction

The delivery of health services in India remains inadequate and poor particularly in the rural parts of the country. The chief reasons being lack of proper infrastructure and human resources, lack of awareness regarding the various health issues among the people, lack of funds, poor accountability and transparency in the running of the government health sector as a whole. Though over the years both the central and the state governments through various programmes and networks of the department of health and family welfare have tried to spread healthcare to every nook and corner of the country, one still does not have a clear picture regarding the availability and utilization of the health services.

In this situation the question arises specially after the initiation of the NRHM to get a clear picture regarding the health status of the local population in the country. India is a huge country and as it cannot be taken up as the universe for a field study to be conducted by an individual, the districts of Mandya and Mysore (three gram panchayats from each district) have been chosen to study the role of the NGOs and panchayats in making a difference in both the delivery of the health services and in increasing the participation of the common masses in the NRHM.

The aim behind providing essential services including health under the supervision of the local elected bodies is to achieve an overall improvement both in the delivery of the health services and increasing the participation of the local masses in availing these services. This study aims to study the relationship between the NGOs and the panchayats and their role in making the health services responsive to the local needs. It seeks an answer as to does their constant contact with the local population by focusing on local problems, having knowledge about the various health related requirements and being able to generate public demand for services and efficient use of

available resources make a difference in the level of participation of the people in NRHM?

Nearly two decades have passed since the 73rd Constitutional Amendment Act brought into place the PRIs and so many questions need to be answered such as: How PRIs can be improved to ensure better delivery health services and rise in health standards? What is the nature of linkages between the health department, NGOs and the PRIs in ensuring better participation of the people? What is the nature of interaction among the masses, PRIs and NGOs and how does it affect the basic health services? This field survey attempts to explore these issues in the context of the districts of Mandya and Mysore in the state of Karnataka which is considered to be a pioneer in both decentralization and in complying with very high standards set by NRHM.

Rationale of the study

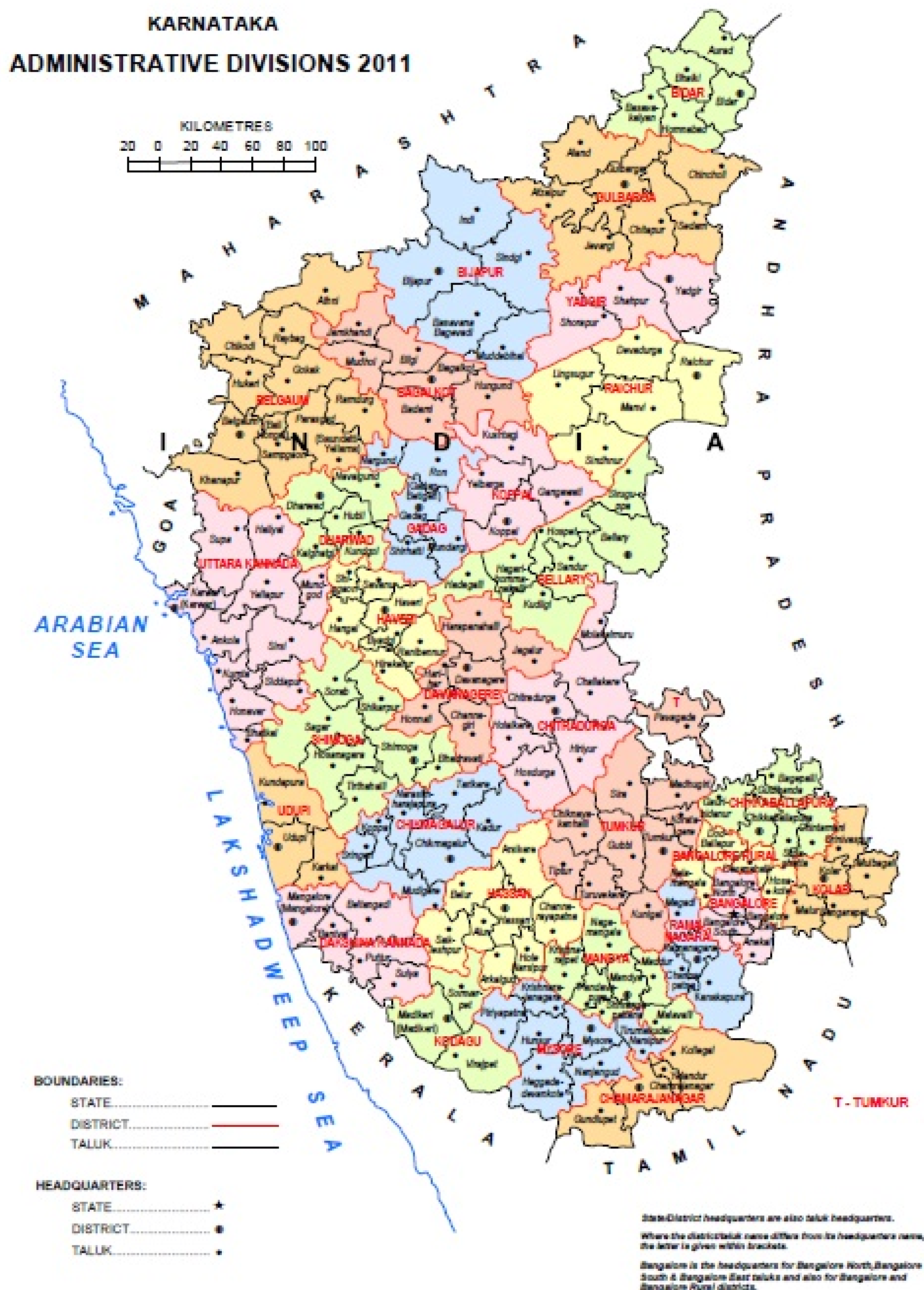
With the changing times civil society has started playing an active role in local governance by creating awareness among the masses regarding the benefits of decentralization and their participation in panchayats. Under civil society institutions, non-governmental organizations have been able to carve a niche for themselves by working for the common man in different fields. Especially after the passing of the 73rd Constitutional Amendment Act, it has realized that it can work to bring about a change in the lives of the people in collaboration with Panchayati Raj Institutions (PRI).

Hence it has been realized that due to failure of the governments in public delivery systems, it is the non-governmental organizations that can play a positive role in bringing about transparency and accountability in the working of panchayats. Especially in the area of health, by creating awareness among the masses regarding the various schemes run by government and fighting against diseases like AIDS, tuberculosis, etc. The National Rural Health Mission (NRHM) has and in the near future through the Community Monitoring Project can benefit hugely through the participation of civil society groups.

This study becomes important as not much work has been done on the role of non- governmental organizations and panchayats in connection with

management of rural health. The positive or negative influence of these NGOs in one particular area can open the doors for it in other spheres of local governance too and it can also be replicated in other parts in order to make the health services reach every strata. If the effects are found to be negative then measures can be taken to rectify their role and bring about changes in the working of panchayati raj institutions.

The Field: Karnataka



Source: census.gov.in

Location

The state of Karnataka was created on 1st November, 1956 (11°30´ North and 18°30´ North latitudes and 74° East and 78°30´ East longitude) with the passing of the States Reorganization Act. It was originally known as the State of *Mysore* and was renamed as *Karnataka* in 1973. *Bengaluru* is its capital. *Karnataka* is bordered by the Arabian Sea to the west, *Goa* to the northwest, *Maharashtra* to the north, *Andhra Pradesh* to the east, *Tamil Nadu* to the southeast and *Kerala* to the southwest. The total area covered by the state is 191,976 square kilometres (74,122 sq mi.) or 5.83% of the total geographical area of India, thus making it the eighth largest state by area in the country.[132]

Demographic Description

According to the census of 2011[133], the state has a population of 6,11,30,704 million inhabitants of which 61.43% are in the rural area and 38.57% live in the urban area. This makes it the ninth largest state of the country by population. The literacy rate of the state stands at 75.60%. Its sex ratio is 968.It becomes essential to mention the demographic details of the state of Karnataka as NRHM caters to beneficiaries belonging to all strata of the society. It has set targets where it wants to stabilise the fertility rate, decrease infant and maternal mortality rates, institutionalise deliveries, provide immunisation to all children under the age of 5 years, decrease the growth in the number of HIV AIDS cases and TB and other communicable diseases covered under it.

Administrative Setup

Karnataka is now divided into 30 districts and 4 administrative divisions. Districts are administered by a District collector, and divisions are administered by a Divisional Commissioner.

Karnataka as a state has been considered as one of the pioneers in the process of devolution to *Panchayats* since 1983. It was in this year that the

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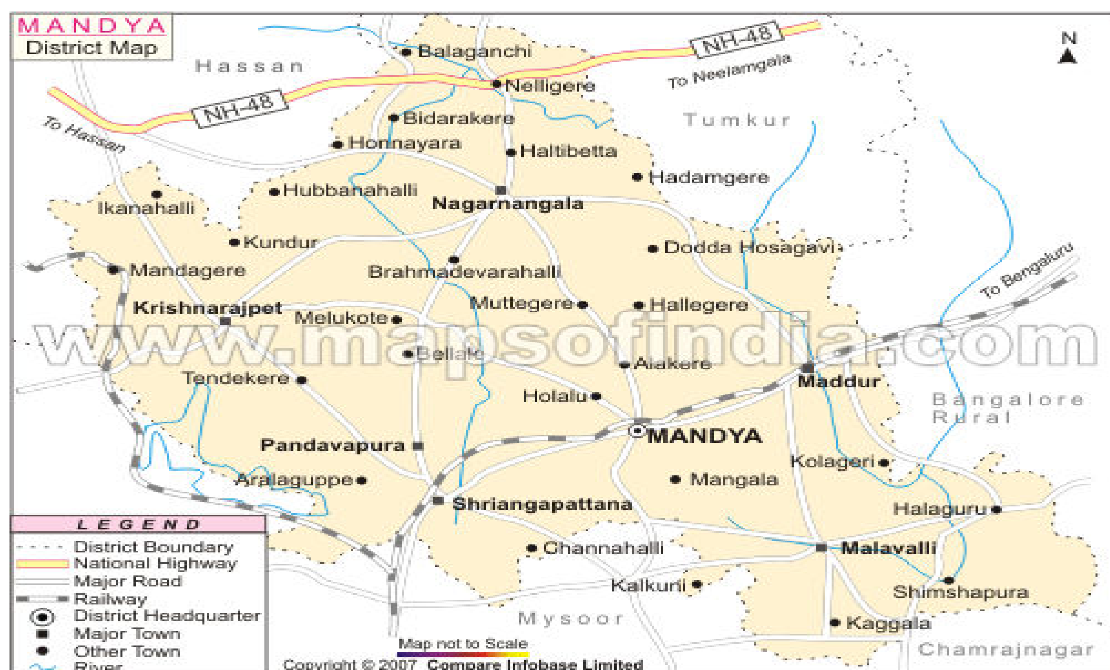
[132] India 2011, A reference Annual, Publications Division, Ministry of Information and Broadcasting, Government of India, pp. 1069-1073

[133] www.censusindia.gov.in

state government passed the landmark law setting up a two-tier *Panchayat* system consisting of *Zilla Parishads* and *MandalPanchayats*. There also existed an intermediate tier known as the *Panchayat Samiti* but this was not directly elected and consisted mostly of Presidents of the *Mandal Panchayats*. The state government also reserved 25% of the total membership in Panchayats to women. It also awarded the *ZillaParishad* president the status of a minister. This framework for the *Panchayati Raj* system was conceived and piloted by Mr. *Abdul Nazeer Sab*, the then state minister for Rural Development and *Panchayati Raj*. After four years of the waiting for securing the Presidential assent, the first elections to the *Zilla Parishads* and the *Mandal Panchayats* were held in January, 1987.

Each of the *gram panchayats* have a number of villages under them and these *panchayats* formulate a number of plans and look after the effective working of the NRHM in their particular areas. Making sure that the mission and the people concerned with the mission work effectively is one of the primary functions of the members of these *panchayats.* These *panchayats* also collaborate with the NGOs in order to increase the effectiveness and the reach of NRHM.

Mandya District



www.mapsofindia.com

Source: mapsofindia.com

Location

Mandya is about 90 Kms. from Bangalore on Bangalore-Mysore State Highway - 17. Earlier Mandya was part of Mysore District. Mandya district came into existence on 1st July 1939. Mandya district is located between north latitude 12°13' to 13°04' N and east longitude 76°19' to 77°20' E. It is bounded by Tumkur district to the northeast, Ramanagara district to the east, Chamrajnagar district to the south, Mysore district to the west and southwest, and Hassan district to the northwest. It has an area of 4,961 square kilometres. The administrative centre of Mandya District is Mandya city.[134]

Administrative divisions

Mandya district consists of 7 taluks grouped under 2 subdivisions. The Mandya subdivision comprises Mandya, Maddur and Malavalli taluks and the Pandavapura subdivision comprises Pandavapura, Srirangapatna, Nagamangala and Krishnarajpet Taluks.[135]

Demographic details

According to the 2011 census Mandya district has a population of 1,808,680. Mandya has a sex ratio of 989 females for every 1000 males and a literacy rate of 70.14 %.[136]

Health Facilities

The district has 1 district hospital at Mandya and 72 PHCs, 7 allopathic hospitals and 5 Ayurvedic hospitals.

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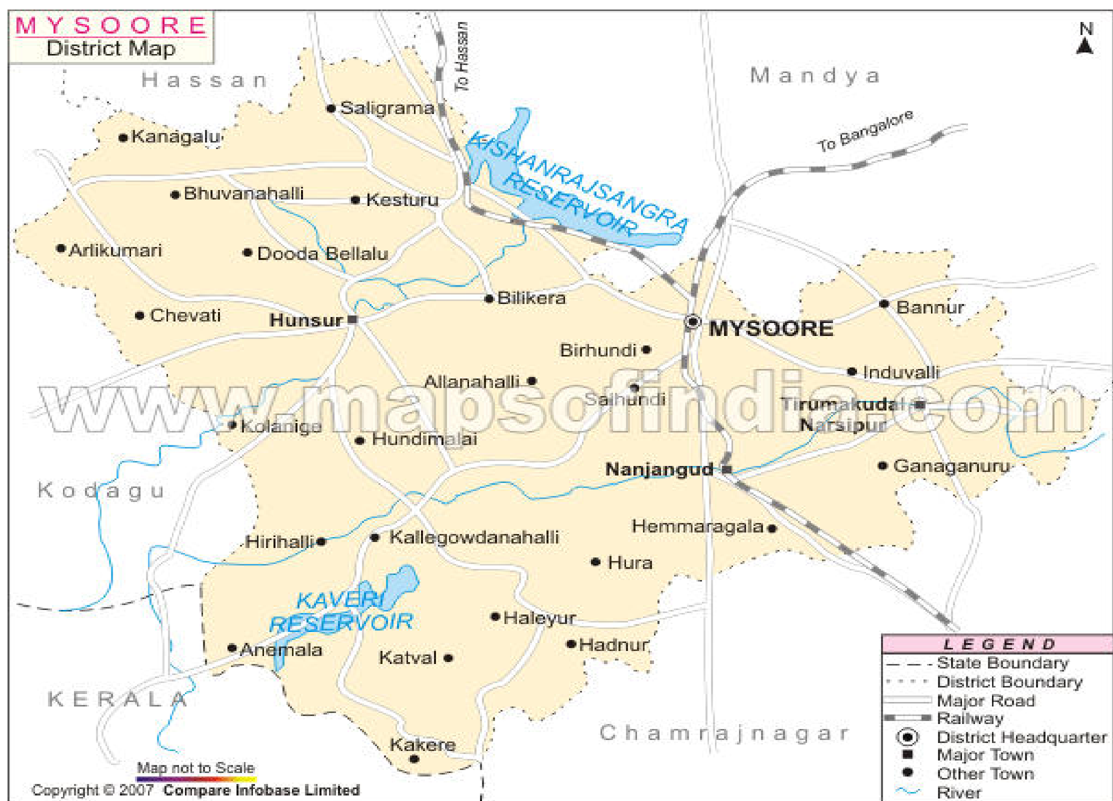
[134] www.mandya.nic.in

[135] Ibid.

[136] Ibid.

104Mysore District



Source: Mapsofindia.com

The State of Mysore now known as Karnataka is a new state which came into existence on 1st November, 1956 under the State Reorganization Act of 1956. The Part b State of Mysore and the Part C state of Coorg as they existed immediately prior to 1st November, 1956 have been entirely included in the new state of Mysore and parts of State of Bombay, Hyderabad and Madras as they existed immediately before 1st November, 1956 have also been included in the new State of Mysore.

Location

Mysore district, which is situated in the southern part of Karnataka State, lies between 12°-70´ and 11°-60´ North latitude and 75°-90´ and 77°-77´ East longitude. It forms part of the deccan plateau with elevation of little more than 2,000 ft. (610 metres) above the sea level. It is surrounded on the north by Hassan and Mandya districts, on the east by Salem and Coimbatore districts of Tamil Nadu, on the South by Nilgiri district of Tamil Nadu and on the west by Kodagu district. The district has an area of approximately 12,000 sq. kms.

about 6.2% of the total area of the State. It ranks fourth in size among the districts of the state.

Demographic Details

According to Census 2011[137] the district has a population of 887,446 million. It has an astonishing sex ratio of 100%. The literacy rate is 86.84%.

Administrative Setup

For the purpose of administration the district is divided into seven sub-divisions, viz. Heggadadevana Kote, Hunsur has four taluks, Krishnarajanagara, Mysore has three taluks, Nanjangud has four taluks and Piriyapatna.

With the advent of Panchayati Raj system a number of changes have been introduced in the rural administration. The Deputy Commissioner is the chairman of the District Development Council (the top tier of the Panchayati Raj system). He is assisted by the District Development Assistant. In Mysore district there are 635 village Panchayats, 4 town panchayats, 11 taluk development boards and one district development council.

Health Facilities

It has 6 taluk hospitals and 135 PHCs of which 25 are 24*7.

Non-Governmental Organisations

There are a number of NGOs that work in the health sector in the state of *Karnataka* in its 30 districts in close proximity to both the district administration and the *panchayats* in order to raise the standard of rural health in the state. Many of these voluntary organizations are given yearly projects related to the different aspects of NRHM. Funds are also provided by the district administration and the state governments for the smooth functioning of the projects. Most of these NGOs involved in such projects are answerable to the government officials for their working and also publish monthly progress reports.

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[137] www.censusindia.gov.in

Due to the narrower scope of the study this study will confine itself to the role of only the two actors i.e. the NGOs and the *Panchayats* in the management of rural health in the two district of *Mandya* and *Mysore* in the state of Karnataka.

MYRADA, Mandya

Mysore Resettlement and Development Agency (MYRADA) was founded in the year 1968 in order to help the government of Karnataka in resettling the influx of Tibetan Refugees. In the year 1973 the state of mysore was renamed as Karnataka. The resettlement Tibetan program came to an end in the 1980s. By 1982, MYRADA had moved out of resettlement and started focussing its attention on the poor and marginalized sections of the society in the rural areas. During this time MYRADA was involved in chalking out a mission in order to guide its strategy and this search involved a deep analysis of the causes of poverty, intensive interactions with the village people and debated among the organization. It lead to the emergence of a mission statement of MYRADA in the year 1987. The acronym MYRADA has since then become the organisation's logo and is commonly used.

It is presently directly managing 18 projects in 20 backward and drought prone districts of Karnataka, Tamil Nadu and Andhra Pradesh. It has also collaborated with the governments of the states of Haryana, Assam, Meghlaya, Jharkhand and many more through bilateral and multilateral programs by contributing to program design and supporting implementation of these programmes through regular training, exposure and deputation of staff.

MYRADA has been promoting Village Health and Sanitation Committees and their convergence with the GP to foster a holistic approach to health and HIV/AIDS since 2000. It has also promoted participative management of water and waste in small towns and semi-urban areas since 2000. It has been working with Gram Sabhas and Panchayats to promote good governance since 2005. It has also promoted convergence in the PRIs that fosters effective, appropriate and timely health care and education and addresses the issues related to gender, HIV/AIDS/STIs, maternal and infant mortality rates

and water borne diseases in a holistic and sustainable manner as per the NRHM guidelines.

S.B. Education Trust, Mandya

The trust was founded in 1998 and is basically related to educational activities but it does work in the health sector in some selected GPs of the Mandya district. Two of these GPs Basaralu and G. Bommanahalli have been chosen for observation under this study. The NGO has been involves in the Non-Curative Primary Health Care Services of Reduction in MMR project under the Karnataka Health syatem Development and reform project for Mandya, Nagamangala and K.R. Pete taluks of Mandya District. The project lasted for a duration of two years i.e. from 17th March'10 to 16th March' 12.

The objectives of the NGO under this project have been to increase the ANC, make pregnant women register themselves with the health centres at the earliest, providing 100% ante natal check ups, motivating pregnant women for safe and institutional deliveries. They also provide all the knowledge about government facilities available to the pregnant women. Through their work in the GPs they plan to reduce maternal mortality rate and neonatal mortality rate.

The NGO also aims to improve the nutritional status of the mother, enhance the quality of the maternal care programme, utilise the integrated diagnostic facilities for all pregnant women, provide good IEC activities and MCH care. It also provides knowledge about family planning methods to pregnant women, conducts awareness campaigns for health check up by gynaecologists, physician & distributes iron folic acid calcium supplements to all pregnant women. It breeds familiarity and educates the local population about district health authorities,108 ambulance and blood banks. It conducts surveying in mobile unit for anaemia, rotten blood pressure & blood sugar level.

It has established a string of social circle to assist in any emergencies. It even does HIV counselling and conducts regular check-ups of patients free of cost. It covers 11 PHC, 40 health sub-centres and 287 villages in the three taluks of the Mandya district. It also motivations spacing methods, and conducts contraception counselling regularly among the local population of the district.

Swami Vivekanand Youth Movement (SVYM), Mysore

It was in the year 1984 that a group of young medical students led by R.Balasubramaniam at the Mysore Medical College (in Karnataka State, India) started to feel that the career in medicine which they had dreamt of pursuing was very different from the practice of medicine around them. They believed that they had in them to make a difference and make a positive impact on the lives of the poor and the marginalized. And so, they started the Swami Vivekananda Youth Movement (SVYM) based on high ideals and a determination to work for the poor.

Their initial intention was to provide rational, ethical and cost-effective medical care to the needy. They started small by collecting physician samples of medicines and distributing them to poor patients, organizing blood donation camps and weekly rural outreach clinics around Mysore. In 1987, they headed to Heggadadevanakote Taluk, the home of the displaced and dispossessed forest-based tribes. These indigenous people, belonging to five different clans – Jenukuruba, Kadukuruba, Yerava, Paniya and Bunde Soliga – had been displaced twice from their natural habitat by development projects of the Government, namely ‘Project Tiger’ and ‘Kabini Reservoir’, and were forced to live in penury on the fringes of the Bandipur National Park.

The medicos set up a clinic at a tribal hamlet named Brahmagiri, at a distance of about 80 km from Mysore city, with a little help from the Mysore District Administration. Realizing early that medical care by itself was not enough and hoping education to be a panacea, they opened an informal school for the tribal kids in a cow-shed in Brahmagiri. They were able to sail through the initial days of extreme uncertainty and struggle with help from unexpected quarters and their zeal to carry on. As days passed, more people joined hands and the work took a definite shape. Socio economic empowerment activities were added to health and education and the rural poor were also brought under the ambit - as the organization moved from the role of a ‘provider’ to a ‘facilitator’. A 10-bed hospital was started at Kenchanahalli, along with a host of community-based programs in Health and Education. As the medicos returned in batches after completing their post-graduation, the

multi-specialty Vivekananda Memorial Hospital took shape at Saragur, with generous help from donors, friends and well-wishers. The organization continued to grow and expand in the 90s, with a definite vision and strategic direction and today caters to a large number of people in the district of Mysore.

SVYM aims to sustain the quality of health care by providing equitable care with the involvement of community and in alignment with the organizational interpretation of the core values. The timeline of SVYM's health interventions dates back to 1984. From a modest beginning with a basic health care clinic at Thumnerale village in Nanjangud Taluk of Mysore District, to the 80-bed well-equipped multi-specialty hospital at Saragur, SVYM has developed a multitude of programs and projects that comprehensively address the health needs of the community.SVYM has been involved in a number of health activities pertaining to the guidelines set by NRHM and has joined hands with both the government and the panchayats in improving the health standard, access of health facilities and awareness in the masses.

Selected Gram Panchayats of Mandya district

Bydranahalli Gram Panchayat, Malavalli Taluk, Mandya District

NGO working: MYRADA

The taluk Malavalli in the district of Mandya consists of 32 villages. The head quarter is the Malavalli city. It has a total population of 7342, of which are males and are females. The literacy rate of the taluk is , of which male literacy rate is and female literacy is . It has 23 anganwadis. It has two health sub centres population wise. The famous Muthathi settlement is situated on the banks of the Kaveri river near Malavalli city. it is surrounded by a dense forest which is the home of the Kaveri Wildlife Sanctury. Malavalli is divided into two gram panchayats: Gollarahalli: It consists of 625 households. It has a population of 3478. There are 10 villages under it's jurisdiction. It has 5 anganwadis. This gram panchayat was not selected for the field survey.

Bydranahalli is a remote panchayats of Mandya district. It is situated 56 kms. Away from Mandya head quartes. It has a household population of 912. It consists of a population of 3864. There are 22 villages under the jurisdiction of

this gram panchayat. It has 18 anganwadi. It can be accessed by road, both the Karnataka State Regional Transport Corporation (KSRTC) and private bus operators run regular buses to the gram panchayat. Wild animals especially elephants are found in abundance in this area due to the wildlife sanctuary and the forest area where Muthathi is situated. Deaths due to elephant trampings have been reported from the nearby village of Birota.

Karalakette is the PHC for the gram 117anuary117t of Bydranahalli as it is situated in the middle of the Bydranahalli and Halgur, which is the 24*7 PHC with an ambulance facility. The sub-centre is accessed by both pregnant women and children. The sub-centre has no facility for delivery and hence women go to Halgur to deliver. The sub-centre only does immunisation of the children on every Thursday when an immunisation camp is held and PNC and ANC is also done here. The children are provided with all the immunisation except the BCG which is provided at the birth place. Due to the regular conduction of these immunisation camps not all over the state the immunisation status of the state has increased.

It was initially given the status of a primary health unit (PHU) which now has been converted to a PHC in 2007. At the time of the survey the very existence of the PHC was in danger as the Government of Karnataka had decided to cancel its status of a PHC due to non-fulfillment of certain essential conditions by the gram panchayat. These conditions are:

1. The local population of the gram panchayats where the PHC is situated should deposit a sum of Rs. One lakh with the government of Karnataka.
2. The gram panchayat has to provide two acres of land to the state government free of cost where the PHC is to be located.
3. The gram panchayats has to provide a building on this land for which no rent is to be paid by the state government.

The Karalakette PHC has been able to fulfil the last two of the essential conditions but the first condition for the land had not been fulfilled at the time of the survey. To add to the land not being provided by the panchayat as the local population has not been able to collect the money required for

buying two acres of land for the construction of the PHC due to the local people being poor and the current value of the land ranging from 20 to 30 lakhs which makes it highly expensive. The panchayat has also been unable to hold a meeting for collection of the required money though the medical officer had written a letter to the local gram panchayats to fulfil the conditions and let the PHC gain its legal sanctioned status.[138]

The M.O. is of the viewpoint that the government should do away with the requirement of 2 acres of land as even 100*80 feet of plot of land would be fine for running a PHC. The state government should also look into the condition of investing 1 lakh rupees by the GP people for a PHC as its ultimate aim is to provide health facilities for the poor and if they are unable to fulfil any of the conditions then they should be shown compassion and not left in the lurch as has happened in the case of the Karalakette PHC.

This decision of the state government had further been strengthened by the decision of the Supreme Court of India in a case that no health centre is to be situated near a pond and hence the government of India passed the order of either shutting down such health centres or shifting them away from such water bodies, ironically, Karalakette means pond in Kannada. According to the medical officer, due to the decision of the court, the state government had decided to cancel the status of this PHC due to its location near a pond and had not been providing any financial aid since its existence from 2007. Though thorough research was conducted no such case was found. The PHC has only been provided with a staff and their salaries by the state government. All financial aid has been provided only under the NRHM funding.

The Byadarahalli gram panchayat is an endemic malaria area. There were 24 reported cases of malaria in the year 2010 in the area which has come down to 6 cases in the year 2011. According to the medical records available at the PHC no new cases of malaria have been reported at

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[138] The letter had been attached to the official correspondence by the medical officer in his office.

Karalakette PHC since August 2011 to the date of the visit to the PHC foe the conduction of the field survey. The medical staff of the PHC had worked to control malaria in the area through biological control i.e. by introducing Gambuise and Guppi varieties of fish in the pond to eat away the mosquito larva. It also ran regular awareness camps with the local NGOs to create awareness among the masses regarding safeguard from malaria.

The staff consists of one Medical Officer. This is his first posting as a medical officer since joining the health services. He works in the PHC from 9:30 a.m. to 4:30 p.m. every day except on Sunday. He has not been provided with any accommodation and so lives at Halgur. He has been working here since August 2010 to the present day i.e. 31st January'12 when the PHC was visited for the field survey. Other than him, the staff consists of 2 ANMs, 1 Contract Group D, 7 ASHA workers and 23 anganwadi workers.

There is acute shortage of staff and medical resources in the PHC. Even the staff that works here is on deputation. Both the male health worker who belongs to the staff of D.K. Halli and the senior health assistant who works for 15 days at this PHC and the next 15 at some other PHC fall under this category. The PHC is not being sanctioned any drugs due to its status being in jeopardy but the M.O. has been getting them under a official quota from the PHCs at Huskur and D.K. Halli by requesting them in writing regarding the requirement of the GP.

Previously 1 AC HIV case had been reported at this PHC. The female patient has delivered the child and the treatment has been completed. The follow up treatment is being carried on at ART, Mandya. At the time of the survey no new HIV cases had been reported.

The GP was facing to serious health issues in the past: the first one was there was a high percentage of home deliveries taking place in the GP as there is no facility for delivery at the PHC but since it has been attached to the PHC at D.K. Halli there have been a sharp rise in the number of institutional deliveries. There has been such a huge change that no home deliveries were recorded for the whole taluk in the month of 119anuary'12. The second health

concern is regarding Malaria which is now under control due to the dedicated work and awareness campaigns of the PHC, the panchayat, the NGO and ASHA workers.

On being interviewed regarding the role of the NGO in their GP the health officials, medical staff and the ASHA workers remarked that there is co-operation among all of them as they work together to raise awareness among the local population regarding different health issues in the GP. Both the NGO workers and the ASHA workers pay regular door to door visits specially in getting pregnant women for ANC and PNC to the PHC.

Regular awareness camps are run by the PHC in collaboration with the NGO and the panchayat regarding prevention and cure from malaria and promoting institutional deliveries. The NGO is also involved in creating awareness among the people of the GP in sanitation, etc. An NGO known as the Adhyana Trust runs a mobile health unit in the GP which consists of a staff of 1 doctor, 1 staff nurse and a pharmacist. They travel all around the GP offering medical treatment. This unit was found in front of the PHC on the day of the immunisation camp as to cater to a large number of people.

The workers of MYRADA visit all the villages of the GP regularly. They were found to have good relations with the medical staff, health officials, panchayat representatives and the local population. The M.O. of the PHC has written a letter to the District Health Officer regarding the bad condition of the PHC and how he is not in a condition to run it without adequate financial and human resources. The PHC doesnot have any of the basic amenities like electricity, toilet facility for the staff, water, etc. The building is also in a very bad condition. Though the staff tries to keep it neat and clean yet there is not even a proper bed at the PHC.

The local population has a lot of problem at the PHC though the medical staff is trying to run it as efficiently as possible with the NRHM funds but without the state financial support it is not possible. The local population is not even able to travel to the D.K. Halli PHC as there is no direct road from the GP connecting the two. This PHC has requested to be bifurcated from the D.K. Halli PHC but the request was not entertained by the government.

According to the official medical records of Jan.' 12 available at the PHC there are 87 cases of ANC registered at the PHC. Upto the time of the survey being conducted 94 live births had taken place in the GP.

The Karlakette PHC Building

The PHC is never visited by any kind of a specialist. The M.O. refers the patients in need of a specialist to other government hospitals. There was no mention of the NGO bringing any kind of a specialist for health camps.

The health officials and the medical staff were found to be in support of NRHM. A number of advantages and positive changes were mentioned by both. Under the NRHM, the VHC funds were being used on the anganwadis. The PHC was also running on the funds provided by the NRHM. The health services under NRHM have improved specially the infrastructure and its maintenance atleast in other PHCs. In this PHC a garbage disposal concrete dustbin has been constructed under the NRHM (can be seen in the picture below).

The Garbage Disposal Bin provided under NRHM at the Karalakette PHC

The M.O. remarked, “whatsoever work is being carried on in this PHC is due to the funds provided by NRHM as the state government is not providing any financial aid anymore”. The facilities provided to the patient and the staff are good. NRHM is providing extra staff for better medical facilities. Under NRHM the health facilities are able to purchase both medical resources and fulfil the need for basic amenities. The state and central government has been providing funds for health facilities at all the government run health facilities.

Though NRHM has been able to provide a lot of benefits to the patients it has some drawbacks which are being felt specially by the medical staff. The work load has increased a lot on the staff but there is a shortage of staff. Hence, more human resources should be provided by the government. Computers should be provided at the PHCs so that the staff can concentrate on its primary function of providing health care as compared to spending time on doing paperwork.

The medical staff, panchayat representatives and the local population want the PHC to not only carry on working in the GP but be provided with adequate government support by the state as it not only caters to the general population

but also to the tribal population from nearby Soligara area which is situated in the middle of the forest. The tribals visit this PHC for regular ANC, PNC and immunisation of their children. These tribal areas have the largest number of home deliveries under the GP and hence it becomes essential for the state government to upgrade the PHC and provide it with the required medical facilities urgently.

The workers of MYRADA who have been working in this GP are totally aware of the pathetic condition of the PHC and visit it regularly. They also pay regular visits to the villages under the GP regularly in order to keep a tab at the health status of the local population. The NGO workers when interviewed remarked that it took them atleast six months to create a rapport with the people of the GP and earn their trust. The GP members, the medical staff and health officials of the GP and taluk are helpful towards the NGO and have collaborated with each other in the health sector through awareness camps, village visits, etc.

MYRADA sends regular reports on its progress in the health sector to the District Health Officer and the Executive Officer of the Taluk Panchayat. It is alos a part odf the project where the local M.O. of a PHC guides it to provide medical assistance according to the needs of that particular area. All the NGO workers are aware of the shortage of medical facilities at the Karalakette PHC but a san NGO is not legally allowed to provide medications to a government run PHC they are helping the PHC by providing man power through its workers. According to the workers of MYRADA it is only recently that the work of the NGO has started showing its effects as the number of home deliveries and the cases of malaria have decreased enormously.

Basaralu Gram Panchayat, Mandya Taluk, Mandya District

NGO working: S.B. Education Trust

The Basaralu Gram Panchayat is situated in the Mandya taluk of the Mandya district. It is about 22.9 kms. away from the district head quarter. the PHC from the GP of Basaralu is situated at the village Basaralu. This PHC is in total contrast to the one discussed above as can be observed from the picture

given below. The Basaralu PHC is one of the best PHCs of the entire district both in infrastructure and medical facilities.

Basaralu PHC, Basaralu Gram Panchayat, Mandya

It caters to the local population of about nine thousand inhabitants of four villages of Basaralu, Baby, Muthegere and Doddagarudanahalli or D.G. Halli. It has three health sub-centres under it. The staff consists of two medical officers of which one is female and the other is male, 3 ANMs, 3 staff nurses, 2 lab technicians, 1 pharmacist, 3 Group D attenders, 1 trained mid-wife and 1 senior health inspector. It has ambulance facility too. There is only 1 ASHA foe the village of Basaralu though 4 posts have been sanctioned. The other three left the job and hence the positions have been lying vacant.

The PHC is highly well maintained and has all the essential infrastructure and the medical facilities. It even has delivery facility though lacks labour room emergency drugs, ECG facility but lacks an ultrasound machine.

The PHC runs an awareness camp once in three months on its own for the local population at the PHC level. An awareness camp is run at the health sub-centre level once in a month. The ANMs along with the NGO workers visit the villages regularly for home to home visits. Hence, the level of awareness

has arisen. The common diseases found in the villages are depression, Gastro Entritis Case, peptic disease, migraine, anaemia and general body ache.

There are two NGOs which are working in this gram panchayat Adhyana and S.B. Education Trust (the one observed under the study). Though the NGO is working really well, there is lack of man power in all the NGOs working in both the districts. Regardless of being a very well facilitated PHC there are still some shortcomings that have to be taken care off. The M.Os of the PHC want a vehicle for them to travel around the GP. The rush of population is quite high in the PHC hence atleast three doctors are needed for proper working of the PHC, currently only two are there.

The M.Os complained about the partial support of the panchayats towards their work. Most of the gram panchayat members donot attend the regular programmes run by the PHC or the NGO in the GP. NRHM has been highly beneficial to the population at large specially the Arogya Raksha and the JSY scheme. Due to NRHM there is no dearth of medical drugs anymore as compared to times before the implementation of the mission. As the PHC is a 24*7 working PHC it is seen as a feeding centre. All the neighbouring PHC shut down so all the patients turn up at this PHC.

There is still lack of proper drainage system and waste disposal system at the PHC. The M.Os want the percentage of state and central budget spent on health to be increased. They also remarked that though they are working under the central schemes for health, they are not being provided with central pay perks. Sometimes there is a personal threat to security of the medical officers due to misunderstanding of the medical procedures by the illiterate village inhabitants.

The medical officers agree that due to the working of the NGO in the GP the awareness level regarding health had risen not only among the local population but even among the staff. The NRHM is funding is good and is made mostly on time by the central government. Some minor construction has taken place under the NRHM funds allotted to the PHC. Though drugs are being provided under NRHM but sometimes there is a shortage of drugs due

to the extra load of patients from other villages coming to the PHC due to its high level of facilities.

The medical officers donot want the GP members to have any kind of control over the working or issuance of funds to the PHC. They complained regarding the interference of some GP members in the proper functioning of the PHC. Most of these members donot take any interest in any of the health or awareness camps run in the GP.

The GP has a stage III anganwadi (AW) in the Basaralu village. There are 4 anganwadies in the whole GP. At the time of the survey there were 28 children enrolled in the Basaralu anganwadi with one anganwadi worker (AWW) and one teacher. Both have been appointed by the GP or the Child Development officer. The worker has no idea about NRHM but knows about VHSC. The worker is involved in picking up the children from door to door in the morning, cleaninf the anganwadi, preparing lunch for the children and also looks after the personal hygiene of the children.

The children at the AW belong to the age group of 2 to 5 years. The AWW frequently visits the houses of ANC and PNC requiring women, houses with young children and even the houses of the elders to keep a tab on the well-being of all of them and give them the required information regarding any health issue. She has taken her training from the CDPO at Mandya, each branch has a sub-branch of the CDPO too. She visits the houses under the village once in 2 to 3 days though according to the official rules she should visit them once every day.

Anganwadi at Basaralu village, Basaralu Gram Panchayat, Mandya

According to the new rules of the state government the AW became eligible for pension six months ago from the date of the interview. She earns Rs. 1500 per month though at the time of taking up the job she was promised Rs. 2500 as the salary. The teacher earns Rs. 4500 per month. Both the AWW are aware of the NGO working in their village. They themselves get involved in the health camps run by both the PHC and the NGO by raising awareness about them in the village and getting the women and children to attend them.

G. Bommanahalli Gram Panchayat, Nagamangla Taluk, Mandya District

NGO working: S.B. Education Trust

The gram panchayat of G. Bommanahalli in the Nagamangla taluk of Mandya diatrict consists of about 27 villages. It even has a tribal village of Soligarakopallu falling under its jurisdiction which is situated about 3 Kms. away from the main Bommanahalli village. There is a anganwadi at Bommanahali and three health sub-centres under the GP.

Health Sub- Centre at Soligarakopallu, G. Bommanahalli Gram Panchayat, Mandya

The GP has a number of NGOs working in the health sector. The S.B. Education trust has been working on the MMR project. The Adhyana Vidhya Trust helps out in the working of the VHSC. The NGO STEPS runs a mobile health clinic in the GP. All the NGOs are working in collaboration with the health sub-centres for creating awareness among the masses regarding NRHM. They conduct street plays, health camps and awareness camps “Jagriti Mela’ regularly in the GP. The NGO also reviews the working of the VHSC and other NGOs in the area. The junior health assistants in the various sub-centres of the GP are regularly contacted by the NGO to report any health hazard. All the sub-centres under the GP collaborate with the NGO in various activities.

The attitude of the GP members and the local population has been supportive of the work of the NGO. Their health camps cater to a large number of people and are held at regular intervals. The member of the GP were happy with the working of the health centres and the NGO in their area.

Selected Gram Panchayats of the district

D.B. Kuppe, H.D. Kote Taluk, Mysore District

NGO working: Swami Vivekanand Youth Movement

H. D. Kote is situated about 50 kms. southwest of Mysore. It is the head quarter of the H.D. Kote taluk. It is one of the most backward taluk in the district of mysore. Its population consists of a large segment of both tribal and non-tribal inhabitants. It is faced by a unique set of problems arising out of resettlement and inadequate rehabilitation of the tribal population. Poor literacy rate, inadequate employment oppurtunities, poor transport and communication facilities have all contributed to the backward ness of the taluk. It has a population of about 250,000 people of which about 140,000 are tribals. Nearly 20% of the taluk is thickly wooded forest and forms part of both the Badipur and the Nagarhole (Rajiv Gandhi National Park) national park area.

It has about 11 PHC, 5 PHU and 2 mobile health units of the government for the disposal of health care facilities in the taluk. The taluk head quarter has a 50 bed general hospital with OT and an X-Ray unit. The utilization of these

facilities are hampered by lack of necessary manpower. Similar situation can be found in other PHCs and PHUs. There have been instances where a single medical officer has held the charge of more than 1 health centre at a given time. The supporting services like the lab and dispensary are also in disarray. The worst hit is the health service at the grass root primary health level.

D.B. Kuppe gram panchayats is situated 1 km. away from the kerala border and takes about 1 and a hours from the nearest town of Handpost to reach. It is situated in the Rajiv Gandhi National Park and hence is frequented by wild elephants daily specially after 5 p.m. It does not have frequent bus service and the last bus leaves the panchayats at about 2:30 in the afternoon. There are 13 villages under the gram panchayats of which 11 are tribal villages. Its total population is 5993 of which 3091 are males and 2902 are females. There are 95% ST and about 5% mix of muslims and OBCs residing in the villages. There are 1288 "kutumb" i.e. houses in the 13 villages.[139]

The last GP elections were held on 29.06.2010.The gram panchayats consists of 14 members including the president and the vice president. The president at the time of the survey was an independent. There was no vice president as the seat is reserved for an SC but as the whole gram panchayat does not have any member of the SC community living there the seat remains vacant. The local administration and the state government has been intimated about this problem but no step had been taken.

The last gram panchayat meeting was held on 31st Jan.'12. There is a meeting every six months which is attended by the local population of the gram panchayat and the elected representatives. The members of the GP meet once every month. This general meeting is called by the president and is attended by all GP members, the Panchayat Development Officer (P.D.O), secretary, waterman and the office staff. A special meeting is held once every two or three months which is attended by all the above mentioned people and the nodal officer of the agriculture, fishery department and the forest ranger officer. The district Taluk officer calls the special meeting. Public notices regarding all of these meetings are put around the gram panchayat.

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[139] All these figures are according to the panchayats records.

The president of the GP visits the GP office five days in a week, Saturday and Sunday are holidays. If need arises or the local population wishes to meet him then he comes to the office on Saturday also. The other ten members of the GP come to the office for 5 days. The other two members visit the office for 2 or 3 days each week according to the notice put by the president. Nearly the same kind of description regarding the working of the GPs was provided by the GP members in the other five panchayats too.

D.B. Kuppe PHC, H.D. Kote Taluk, Mysore

D.B. Kuppe GP has a PHC since 1999 and four health sub-centres. They are situated at D.B. Kuppe A, D.B. Kuppe B, Balle and D.B. Kuppe Tribal. The PHC has been sanctioned 1 medical officer, 1 pharmacist (vacant), lab technician, 4 female Junior Health Assistant (2 posts are lying vacant), LD Clerk (vacant) and I Group D worker. Though the M.O. has been regularly writing to the state government for filling the vacant posts no step has been taken till today. He has even made a presentation to the Health Secretary at Bangalore but to no avail. The PHC is currently using the old sub-centre building as most of the tribals do not have land to donate for a new building. Even the one lakh rupees have not been deposited with the state government.

The GP has not been able to deposit this money as they say that they are not in a condition to do so.

Kadkola Gram Panchayat, Mysore Taluk, Mysore District

NGO Working: Swami Vivekanand Youth Movement

The Kadkola GP is situated about 16 kms. away from the city of Mysore. There are no other villages under this GP. It has a 24*7 PHC. It consists of 4 health sub-centres. Its staff consists of I M.O. and 10 ASHA workers. It has 10 VHSCs. At the time of the visit it was observed that it gives excellent delivery services to a population of about 25,000 people. It has a well-equipped delivery room. The required medicines for various diseases are always in stock and provided to the local population as per their needs. The premises of the PHC are clean and beautiful as observed in the Basaralu PHC in Mandya district. On an average about 15 to 20 deliveries take place in this PHC and due to the rigorous work of the ASHA and the NGO workers the number has increased gradually of these institutional deliveries.

The staff was found to be very diligent and hard-working especially in preventing mother and infant deaths. A special clinic is run in the sub-centre every month regularly on a fixed date.. the anganwadi children are given a regular health check up every three months by the M.O. the M.O. also conducts regular health awareness programmes in collaboration with the panchayat and the NGO every Thursday for mothers and pregnant women. It is one of the 14 model PHCs of the state which has been selected to run the health education programme.

Doddajjaur Gram Panchayat, Hunsur Taluk, Mysore District

NGO Working: Swami Vivekanand Youth Movement

Hunsur is a Town in Hunsur Taluk in Mysore District in Karnataka state. It is located 39.5 km distance from its District Main City Mysore. The taluk has 192 inhabited villages.Hunsur taluk is one of the seven taluks of Mysore district. It is bounded in the north by K.R.Nagara taluk , in the south by H.D.Kote taluk, in the east by Srirangapatna & Mysore taluk and in the west by Periyapatna

taluk & Kodagu district. The total geographical area of the taluk is 897 Sq.Kms. It has one town, 4 hoblies , 30 gramapanchayats and 213 villages.

One of the gram panchayats of the Hunsur taluk id Doddajjaur. It consists of 24 villages of which 12 villages are revenue villages and 12 are tribal. One of the oldest villages in the gram panchayat is Veernahosalli. It is situated near to the Nagarhole national park. It has a population of 625 inhabitants out of which 449 inhabitants are tribals.

It has a PHC which is 6km. away from the Hunsur town. The PHC is not only understaffed but it lacks basic infrastructure as well. There are no laboratory facilities and it doesnot work 24*7. Hence, most of the people of the GP travel to Hunsur for medical treatment as it is not easy to access it as well. Under the NRHM programme, special emphasis has been laid on institutional deliveries. The ASHA workers distribute common medicines from home to home. There is an effective family planning service and tuberculosis prevention programme running under the PHC at the time of the survey.

The anganwadi lacks basic physical structure. The competency of the AWW is under doubt. The attendance of the children is low and the coverage is also very limited. It was not found to be working efficiently. But it has been able to play a positive role in eradication of pulse polio from this area of the GP as all the children and their mothers are provided information regarding the immunization drive by the AWW.

The gram panchayat consists of 17 elected members including one President and One Vice- President (11 males + 6 females) and 14 government officials (13 males + 1 female).President and vice President are elected from members for 15 months on rotation wise. The gram panchayat consists of 7 general (4 M+3F), 4 SC (3 M+1 F), 4 ST (2 M+2F) and 2 BC (Muslim male) members. At present President is General male and Vice-President is tribal female.

The major health plan implemented by the gram panchayat has been the total sanitation programme. VHSC is also there.

Research Methodology

The objective of this comparative field survey is to assess the role of the NGOs and Panchayats on the participation of the common people in the management of rural health in reference to NRHM in the districts of Mandya and Mysore in the state of Karnataka. This survey aims to observe the positive or negative impact of this collaboration on the participation of the people. A study of this nature demands not only information and inputs from macro levels but also insights from the grass root level. Therefore, four sections of respondents were interviewed to gather information.

To begin with, interviews and discussions were carried out with health functionaries at the district level i.e. from the District Health Officer to ANMs and ASHA in the villages. Institutions such as district and taluk hospitals, community health centres (CHCs), primary health centres (PHCs) and sub-centres were visited and their functioning examined. Functionaries of the Panchayati Raj Institutions at the Gram Panchayat level and even the Chief Executive Officers of Zilla Panchayats were interviewed in order to elicit their views and concerns. Three panchayats each from the districts of Mandya and Mysore were selected for detailed investigation with one being close to the district head quarter, one having high health indicators and one interior in its geographical placement in order to cover a variety of beneficiaries.

The study conducted here is basically an attempt at an exploratory analysis. Both primary resources i.e. various national and state government reports and surveys on National Rural Health Mission and the districts of *Mandya* and *Mysore*, interviews of common people, government health officials, *Panchayat* and Non-Governmental organization functionaries were included. On the other hand secondary resources comprised of books, journals and articles which focused on decentralization, *Panchayati Raj,* civil society, Non-Governmental Organizations and rural health.

Design: The study was based on the case study method. The research was conducted in the two districts of *Mandya* and *Mysore*, situated in the state of *Karnataka*. The study was comparative in nature and hence, three *gram panchayats* from each of the districts were chosen. The role of three Non-

Governmental organizations of *Mandya* and *Mysore* district who were working in the health sector and were trying to increase the reach of the National Rural Health Mission activities to the rural population in collaboration with the concerned *gram panchayats* were evaluated.

Sampling Method: Stratified simple sampling was adopted while conducting the research as NRHM basically caters to people of all ages, strata and economic conditions. The study widely relied on primary data collection through structured questionnaires and interviews of the people accessing the health services via NRHM. The official actors as well as NGO functionaries were included in the sample through purposive sampling.

This data was then segregated into different tables regarding different factors which influenced the work of Non-Governmental organizations in collaboration with *gram panchayats* on people's participation in NRHM activities. It eventually led to conclusion regarding the effects of the NGOs and *gram panchayats* on the participative tendencies of the people.

Evaluation and Analysis

Based on the observations made during the field survey in the six gram panchayats of both the districts and conducting interviews of the beneficiaries, health officials, medical staff, ASHA workers, anganwadi workers, NGO workers this study has come up with data regarding the different aspects of NRHM and the participation of people in it due to the collaboration of NGOs and panchayats.

The Access to NRHM

The basic objective of NRHM is to provide the access to all rural beneficiaries to health services particularly the poor, scheduled castes and the scheduled tribes on a regular and affordable basis. It becomes very essential that the rural population is able to access these health services through government run health centres all over the state of Karnataka. Given below are tables showing the access of beneficiaries of different strata accessing the NRHM.

Table 6: Percentage Distribution of Beneficiaries who are accessing NRHM

Background Characteristics	Mandya	Mysore

Sex

Female	47.7	59.4
Male	52.3	40.6

Education

No Education	38.0	41.2
Less than 5 years complete	15.1	17.9
5-7 years	15.1	16.3
8-9 years	15.1	12.4
10-11 years	08.5	07.2
12 or more	08.5	05.0

Economic Status

Below Poverty Line (BPL)	82.2	86.3
Above Poverty Line (APL)	17.8	13.7

Source: Field Survey

In both the districts of Mandya and Mysore a number of beneficiaries as mentioned above in Table 1 (both male and female) were interviewed in order to throw light on the role of the NGOs and panchayats in impacting the participation of the local people in NRHM. It was found that most of the beneficiaries belonged to below poverty section of the society in both the districts. The hospitals were being accessed by both males and females in both the districts.[140]

[140] About 300 local respondents were interviewed in both the districts for the field study.

Regardless of the beneficiaries in both the districts lacking formal education especially in case of females as was the case with this female respondent[141] who lacked basic education but had both her deliveries in a hospital, it was found in the interviews that the female respondents had gone for institutional deliveries in most of the cases. The ones who could not go for an institutional delivery were the ones who had problems accessing roads and transport means. Due to the cash incentives attached with institutional deliveries under JSY both the female respondents and their families were found to be interested in institutional deliveries more than before.

Another female respondent[142] in G. Bommanahalli had visited the PHC regularly for PNC and ANC and had also followed the immunisation calendar in case of both her children. Though it was due to the home visits of the NGO workers of J.B. Education Trust that she had been regular in her visits as mentioned by her in the interview. Had now sought help from her local ASHA worker for family planning.in the district of Mysore.their accessing the health facilities specially the government health facilities had increased to quite a high percentage as most of them reported that before NRHM came into being they used to go to private clinics regardless of them being expensive as the health facilities specially at the PHC and the sub-centre levels were of very poor quality.

One of the male respondent[143] interviewed remarked that he used to travel to Mandya city in order to visit a private clinic for treatment previously but now visits the PHC due to the dedicated staff. He was also very content with the regular visits paid by the ASHA workers and the NGO workers regularly in his village. But he wanted the government to provide some more facilities at his village PHC.

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[141] Age: 25 years, Place of Interview: Kadakole Gram Panchayat, Mysore District, Date of Interview: 13th February'12

[142] Age: 25 years, Place of Interview: Soligarakopallu Village, G. Bommanahalli Gram Panchayat, Mandya District, Date of Interview: 30th Jan.'12

[143] Age: 35 years, Place of Interview: Karlakatte, Bydranahalli Gram Panchayat, Date of Interview: 18th Jan.'12

Most of the women who were interviewed were young in age and belonged to an age group of 19 to 25 years with most of them having delivered atleast one child in the previous year or were pregnant at the time of the interview. Though it was observed that regardless of many of them having married at an early age of 16 years, they had waited to complete atleast 18 years of age for giving birth for the first time.

For eg. a female respondent[144] who was interviewed was found to be uneducated and had gotten married at the age of 17 years but had waited to conceive and at the time of interview had a four month old baby boy. She further elaborated that she had delivered the baby in a hospital and that it was her husband and the ASHA worker of her area who had kept a tab on her pregnancy. She had been provided with regular PNC and ANC and her child was being regularly immunised on every immunisation day held on thursday. She was also acquainted with the NGO workers of her area who regularly visit her home. Most of the young female respondents provided similar feedback to their interviews in Mandya district.

But in case of a female respondent[145] interviewed in the district of Mysore it was found that though they did visit the PHC for regular check-ups but she had delivered her child at home due to the fact that she lived in Rajiv Gandhi national park as was a tribal where the residents are always in fear of attack of wild elephants and the PHC of her village had closed down at 5 p.m. She also did not have much knowledge about the ASHA as she had never been visited by one nor was she aware about NGOs working in her area or the work done by the gram panchayats. All the information that she had about the health facilities in her area was due to the medical officer and his staff in that particular area.

This low age of marriage in women has been found to be both because of the societal norms prevalent in the state as well as about three of the panchayats in both the districts combines falling in tribal areas where education level is

[144] Age: 20 years, Place of Interview: Karlakatte, Bydranahalli Gram Panchayat, Mandya District, Date of Interview: 16th Jan' 12

[145] Age: 21 years, Place of Interview: D.B. KUppe Gram Panchayat, Mysore District, Date of Interview: 3rd Feb.'12

low. It was also observed that regardless of being located in the tribal areas these locals were regularly accessing the health facilities specially the pregnant women for post and pre natal care. The sex ratio was also found to be really good. Most of the female respondents interviewed in the villages in both the districts had married at very young ages but nearly all of them had waited to attain the age of majority to give birth.

Awareness regarding NRHM

The beneficiaries interviewed belonged to all the four categories i.e. general, other backward classes, schedule castes and schedule tribes. Two of the gram panchayats in Mysore were nearly 100% schedule tribe populated and one of the panchayats in Mandya had a high ST population. The rest of the population was mostly either SC or OBC with a pinch of general category the level of awareness among the OBCs, STs[146] and SCs was found to be quite high regarding the health facilities.

This level of awareness was corroborated by a female respondent who lived in the Muthathi village which is about 20 kms. away from the Karlakatte PHC of Mandya district and is situated in the middle of a forest and had come to the PHC for her regular pregnancy check-up. She was also aware about the ASHA and the NGO workers of her area and had visited the PHC regularly for any ailments in the past too. She even planned to deliver her child in a hospital.

Most of them accessed the health facilities on a regular basis and many had heard about NRHM. All of them were aware about these health facilities through either ASHA[147] workers or NGO workers who visited even the most far flung villages under a gram panchayat on a regular basis i.e. atleast once in a week and kept the locals aware of the health facilities available to them. They even brought people in urgent need of treatment to the nearest PHC or

[146] Age: 19 years, Place of Interview: Karlakatte PHC, Mandya District, Date of Interview: 17th Jan.'12

[147] All ASHA workers visit their respective PHCs compulsorily every Thursday for the immunization programme.

health sub-centre on their own or report any emergency to the medical officer or ASHA as the need may arise.

The government health officials, the NGO workers and the panchayats functionaries[148] who were interviewed were very happy with the upliftment of the health facilities in their districts due to NRHM. Regular medicines are being provided to the patients and throughout the state for the first time due to the funds provided under NRHM even far flung tribal areas were able to have their own OHCs and health sub centres. All the strata of the society which had had demarcations between them based on economic and social differences were being treated equally.

Though there were a number of grievances reported by all the parties. The medical staff at a number of health centres complained of the stuck up attitude of the panchayats members in some matters specially in matters of spending the joint money. The NGO workers remarked that the local people were not interested in their activities till some incentive is provided. They see every opportunity as one to cease cash from any source that is available.

Table 7: Percentage Distribution of Beneficiaries according to their knowledge about health personnel in their gram panchayat

Health Personnel	Mandya	Mysore
Knows ANMs/ MHW	24.7	23.4
Only ANMs	74.0	74.5
Only MHW	00.1	1.0
Not heard about either	01.2	1.0
Anganwadi worker	100.00	100.00

Source: Field Survey

[148] Interviews of all the government health officials, NGO workers and panchayats functionaries of each of the six gram panchayats were conducted from 16th Jan.’12 to 18th Feb.’12.

NRHM consists of a number of important components specially a long list of various level of health workers who are given the responsibility for raising awareness among the local masses both regarding NRHM and the facilities being provided by it to all the sections of the society with special emphasis on the marginalized section through the collaboration of GPs and NGOs. The respondents were able to have knowledge about atleast one of the health personals specially knowledge about the ANMs was high through either panchayats or the local visits to their homes by the ASHA workers or the NGO workers.

It was found that regardless of the age or social and economic status of the respondents for eg. a male respondent[149] did not have any knowledge about ASHA workers or NGO workers but like all of the respondents he knew about the anganwadi worker. As anganwadi it is one of the oldest institutions prevalent in both the districts all the respondent knew about the anganwadi worker. All of them were able to name the anganwadi worker of their area. The anganwadis that were visited were found to have a regular attendance of young children and appropriate food was also being provided to them. But some of the anganwadi are in dire need of new infrastructure.

Role of NGOs and Panchayats in knowledge about NRHM

Table 8: Percentage Distribution of Beneficiaries According to Knowledge of Regular Visits

Regular Visits	Mandya	Mysore
Both ANMs/MHW	06.8	07.8
Only ANMs	62.3	57.2
Only MHW	00.4	00.8
ASHA	100.00	70.00
NGO Worker	100.00	75.00

[149] Age: 60 years, Place of Interview: Basaralu Gram Panchayat, Mandya District, Date of Interview: 23rd January'12

Both	100.00	45.00

Source: Field Survey

To create awareness among the local masses regarding the various health facilities available under NRHM and to increase the participation of the people it is essential that they are provided information regarding the health services. As observed earlier before the commencement of NRHM at such a high level in the state even the poor people were going to the private clinics for treatment even if they had to take a loan for it. But with the increase in local health facilities and a level of transparency being achieved due to the control of funds by the GP the participation of people and the trust in the government health sector has increased tremendously. This all has come along due to the regular visits by different government appointed health workers and NGO workers in paying door to door visits regularly even in far flung areas that the participation of people has increased tremendously.

It was found that Mandya is doing really well in both visits by ASHA as well as NGO workers in creating awareness among the masses as compared to Mysore (see Table 3). Some of the ASHA workers in Mysore are not reporting regularly to their PHCs and are not that regular in their visits also. NGOs in both the districts are trying their level best to create awareness though the work in Mandya is better as more people were appointed by the NGO in the particular GPs investigated as compared to Mysore.

The local people are also aware about the various health camps that are conducted in collaboration with the NGOs and panchayats in the various GP in both the districts. A large number of local people access these health camps where both the PHC doctors as well as specialists invited by the NGO for special consultations treat the patients. The NGOs in their monthly reports to the government provide all details regarding these camps and even after the camp comes to an end they keep an eye on the registered patients and their health through regular home visits specially in case of pregnancy or diseases like AIDS and TB, in order for these patients to take their medicines regularly and not leave it in between as they try to eradicate these diseases

from their particular areas. More health camps were observed to be conducted in Mandya as compared to Mysore at the time of this observation.

Impact of NGOs and Panchayats on participation of the local population in NRHM

Table 9: Percentage Distribution of Beneficiaries aware about Various NRHM activities

NRHM Activity	Mandya	Mysore
ASHA	100	100
JSY	85	70
VHSC	16.7	27.1
HIV/AIDS	82.7	77.6
Institutional Delivery	96.4	75.1
Delivery at home	3.6	24.9
Received ANC/PNC	98.5	98.8
Immunization	100	100
DOTS	19.7	09.6

Source of Information

Panchayat	30	25
NGOs	40	45
Medical Staff	40	45
Anganwadi Worker	40	45

Source: Field Survey

NRHM consists of a number of programmes and components being run to target the health needs of the different kind of patients who access the government health services. It was observed that all the beneficiaries were accessing the health services being provided under NRHM due to different reasons. Their awareness regarding the different components of NRHM in order to provide treatment to them was based on the knowledge provided to them either by the panchayats , NGOs, anganwadi worker or on their visits to the hospitals. In both the districts it was observed that the concept of ASHA was known to all the beneficiaries. Karanataka is one of the states of India with the highest number of HIV AIDS patients though it is not prevalent in the districts of Mandya and Mysore at such a large scale, a very large number of beneficiaries were aware of it and its method of transmission.

Two cases of AIDS were reported to the local NGO in the district of Mandya in the past year. Regular tab was being kept on the two patients by the NGO though one of them died and the other one is taking his medicine regularly.

Though the panchayat functionaries were able to provide input regarding VHSC, it was found that most of the respondents did not have an idea about the VHSC per se. They were aware of some or the other function performed by the VHSC. Before the commencement of NRHM delivery of children at homes was a huge concern in the health sector. But due to the regular visits of ASHA workers and the NGO workers the number of home deliveries has come down considerably in both the districts. Both women and their families have shown great awareness and take great interest not only in pre and post natal care due to the Janani Suraksha Yojana (JSY) but have made sure that the delivery takes place in a hospital in order to give the best of health facility both to the mother and the new born baby. This change in attitude towards institutional deliveries and also brought down both the infant mortality rate as well as the maternal mortality rate in the state.

Immunisation of children is also one of the most important health aspect that has seen a high rise in its percentage specially after the commencement of NRHM in the state. On every thursday an immunisation camp is held in all the health centres in both the districts. All the ASHA and the NGO workers work together with the medical staff to bring the mother and the child to the centre

to get immunized. Most of the females had their children immunized and also had their immunization cards.

Table 10: Percentage of Beneficiaries aware about VHSC and VHND

	Mandya	Mysore
VHSC		
Yes	10.5	15.2
No	59.4	54.3
Cant Say	30.1	30.5
VHND		
Yes	93.7	92.7
No	06.3	07.3
Cant Say	00.00	00.00
Sources		
ASHA	100	70
NGO	100	90

Source: Field Survey

Table 11: Percentage of GPs having VHSC and preparing a health plan

	Mandya	Mysore
Yes	100.00	100.00
No	00.00	00.00

Source: Field Survey

Table 12: Percentage of various actors acknowledging NRHM, panchayats and NGO for improvement in health standards and participation of people

Various Actors

Government Officials	100.00	100.00
Gram Panchayat	100.00	100.00
NGO	100.00	100.00
Beneficiaries	100.00	100.00

Source: Field Survey

GPs and NGOs play a very positive role in creating awareness among the masses regarding the health facilities that are available to them under NRHM. This mission has provided a lot of funds to the state government in order to better both its health infrastructure and its resources. The GPs have VHSC which has both ASHA as well as NGO workers as its members. One of the most important task of VHSC is to make a health plan for the panchayats. All the panchayats in both the districts had constituted a VHSC and had also made their health plans.

Eventually, the interviews that were held consisting of all these four different sections of the society deeply concerned with the working of NRHM have given their cent percent nod to the fact that the collaboration between the NGOs and the panchayats has increased the participation of the people in NRHM. The government health officials were of the view that it is due to the ground level work done both by the GPs and the NGOs that the common people are gaining confidence on the health facilities provided by the government.

Conclusion

The field study finally came to the conclusion that the participation of the local people in NRHM has increased due to the role played by the NGOs and panchayats in collaboration with each other. They have been able to raise the level of awareness among the local population regarding health issues and

hence the health status of both the districts. As it is a comparative study the district of Mandya has performed better on most of the benchmarks as compared to the district of Mysore but the difference is not much of consideration as can be corroborated by the various tables mentioned above.

CONCLUSION

Over centuries the state has epitomized itself into the all-powerful nurturer of the common people. Hence, it is the one that looks after the welfare of its people through various social-economic welfare schemes and projects. But over the time, it was observed that the government was getting out of touch with the needs and demands of the common people. The power was getting centralized and the people had no say and way of participating in these welfare measures which most of the time were way off the mark and did not fulfill their urgent needs and demands.

Many times it was observed that the needs and demands of a particular area and its local population were totally different to the resources that were sanctioned by the central or the state government. Hence, decentralization in the form of Panchayati Raj, by the 73rd Amendment Act of the Indian constitution was introduced in order to bridge the gap between the government and the governed. To felicitate this transformation of power into the hand of the common man, civil society organisations have come forward as helping hands of both the government and the Panchayats.

This study has tried to make an attempt to explore whether the collaboration of Panchayats and civil society through Non-Governmental Organizations (NGOs) has improved the participation of people in decentralization especially in the context of management of rural health.As the process to understand and analyse comes to its conclusion, one can without any doubt claim to have a better understanding of the concepts of decentralisation, civil society and rural health. These three concepts though totally different from each other are able to influence each other's working in such a positive manner as can be corroborated by the results of this study is an amazing conclusion in itself.

Decentralisation, Civil Society and Rural Health

Owing to the critical problems associated with the public service delivery system such as inefficiency, poor resources and lack of adequate citizen participation there has emerged a consensus for public-private partnership to promote an efficient and effective delivery system. This has brought into focus

the institution of civil society, which is supposed to demand better performance and accountability and monitor public service provisioning.

Civil society associations have made important contributions to greater democratic accountability in not only global governance but also local governance. Already these activities have reached a notable scale and considerable opportunities exist to broaden them further. Moreover, accountability through civil society interventions is a fairly immediately available way forward, inasmuch as it requires no major constitutional reorganisation of local regulatory arrangements. On the other hand, the state after having realized the importance of civil society has itself tried to incorporate it with its developmental work.

Such good non-government advocacy work actually tends to strengthen and not weaken state capacity. But for that to happen it becomes essential that there is backing of the government. This is the view held by Neera Chandhoke who states that "firstly, civil society agents are just not in a position to summon up the kind of resources that are required to emancipate Indian citizens from poverty and deprivation. It is only the state that can do so through widening the tax net and through monitoring the collection of revenues to fund social sector programs"[150]. Hence, it makes the collaboration between state and civil society all the more important.

Mishra[151] has also pointed out that the lives of Panchayati Raj Institutions depend on the whims and policies of the state government and so does the role of civil society groups. Many state governments see these groups as a hindrance in their enjoyment of political power as these groups demand transparency and accountability from them. Specially, in vital areas like health the NGOs are much more active as it concerns the lives of the individuals and tries to take the government to task for any lapses whether under the NRHM or its own state policies.

All these different factors such as cultural, social and political can be observed wonderfully in the state of Karnataka which is the eighth largest state of India

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[150] Neera Chandoke, '*Putting Civil Society in its Place',* Radical Politics Today, August 2009

[151] S.N. Mishra and S.S. Singh, Roads to Modern Panchayati Raj, New Delhi: Mittal, 1993

and has a population of about sixty one million people according to the Census Data of 2011. It is the first state in the whole of the country to give reservation to women in panchayati raj institutions way back in 1983. It also has a high density of HIV cases in the country and the maternal mortality rate is also very high. As such health issues are of great importance to the state and the role of civil society becomes very important in the state in order to create awareness among the masses.

During the study conducted to understand the role of the NGOs and Panchayats in management of rural health in the districts of Mandya and Mysore, it was observed that the government specially under NRHM had itself realised the importance of the role of NGOs in impacting the participation of the local population in the state. In all the gram panchayats where the field survey was conducted it was observed as the data in the previous chapter also corroborates that all the PHCs visited during the field survey run regular health and awareness camps in their particular gram panchayats in collaboration with the NGOs.

It is this mobilisation of the local population that provides an important reason behind the current concern with collaboration between NGOs and Panchayats. These organisations are being supported by the state as is the case in NRHM. It is due to the fact that the acts of mobilizing local population and harnessing it together with other resources can only be performed by the NGOs basically. Usually, as has been found in the study NGOs that have a local origin can tap legitimately and accountably into the cultural and social resources of the society. Evidence collected in this study also corroborates a similar conclusion. These NGOs are more likely to draw upon local traditions of coordination and cooperation compared to other organisations or the government that are set down from above and hence are able to reach to a larger stratum of society and influence their participation.

The above viewpoint has been corroborated by a number of studies like a study [152] which studied the linkages between activities of the health and family

[152] H.C. Srivastava, Ram F. Paswan, and D.A. Nagdeva Involvement of the members of Panchayati Raj Institution in health and family welfare programs: A case study of Bharatpur

welfare programs and *Panchayati Raj* Institutions (PRI). The specific objectives were to study the functions and roles of the members of the PRI with regard to health and family welfare activities. The involvement of the PRI members in health and family welfare programs is certainly a good endeavor for the multi-dimensional rural development, and this novel approach may yield better results at the grassroots level. The study advocates better understanding and co-ordination between the PRI members, and health and family welfare personnel, which they believe would result in improved health and family welfare services addressing the needs of the masses in the country.

Further, the involvement and participation of the rural people in health and family welfare programs has led to a dramatic improvement as compared to the earlier state, where all the developmental projects were discharged by the bureaucrats of the government[153]. The additional role of civil society can itself help in answering the questions raised by this study. It can form a bridge between the PRIs and the health personnel as to what is needed for improving the health services.

The NGOs since a long time have been combating and working towards fighting and creating awareness among the masses in all these spheres and so are highly beneficial to the PRIs as both joining forces would lead to achieving the health goals at a faster rate. Hence, one can very easily observe that health issues pose a huge threat to people of this country and specially Karnataka. It becomes an additional responsibility on the shoulders of the NGOs to create awareness among the masses in order to fight these deadly health issues and bring about a social change as well as the state suffers from high level of castesism and other social vices.

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and Udaipur districts of Rajasthan, Population, Health and Development in India: Changing Perspectives, Udaipur and New Delhi: Rajat publication.

[153] Ghatak M. and Ghatak M. ``Recent Reforms in the Panchayat System in West Bengal: Towards Greater Participatory Governance," in *Economic and Political Weekly*, January 5 2002, 45—58.

But it is not as if everything is rosy with decentralization and civil society. Many of the gram panchayat members were found to have no idea of an NGO working in their area. Many of them did not even have idea about the work being done by their panchayats in the area. This collaboration between civil society and panchayats can only work if there is no conflict between the two regarding their impact on the local population. Many times it has been observed that the NGO workers and their work is not taken seriously by the members of the PRIs. But it has to be agreed eventually that it is essential for the development and management of rural health that a collaboration between NGOs and PRIs remains forever.

National Rural Health Mission

The above mentioned role of both the state through Panchayats and NGOs is finally important as the Hon'ble Prime Minister of India on 12th April, 2005 launched the National Rural Health Misison to provide "accessible, affordable and accountable quality health services to the poorest of households in rural India. The thrust of the mission has been on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality".[154]

The National Rural Health Mission is an attempt on the part of the government to bring basic health facilities at the door step of the rural population and over the years after its launch a lot of positive changes have been observed but government alone cannot bring about an overall change in the attitude and the people's zeal to access the health services and hence the role of NGOs and Panchayats comes handy. The mission caters to the population on five health issues. The latest NRHM framework document mentions 'Right to Health Care' since it places people at the center of the process of regularly assessing whether the health rights of the community are being fulfilled or not.

[154] NRHM : The Progress so far, Government Of India, www.mohfw.nic.in/NRHM_The Progress_so_far.pdf

The whole idea of decentralised governance is based upon some key factors like people's participation, accountability, transparency and independence in fiscal transfers. The observations from the state of Karnataka in the districts of Mandya and Mysore indicate that placing health services system especially NRHM under the control of Panchayati Raj institutions in collaboration with NGOs has resulted in an overall improvement in the not only the services delivery but has also increased the access and awareness of the common people. Being closer to the people, both the PRIs and the NGOs are in a position to meet the needs and project the preferences of the people to the higher authorities. The health personnel were found not only to be accountable to the people but also very dedicated to their work. In most of the panchayats specially in Mandya district the attendance of doctors and paramedical staff in discharging their duties was regular not only under the watchful eyes of the local leaders and NGO workers but also on their own.

This has resulted in better functioning of PHCs and CHCs and improved utilisation of public health care facilities. Karnataka has been one of the states where decentralized governance has been pursued more aggressively by transferring functions, funds and personnel to the PRIs. The state government has tried to form a collaboration between the local administration, health officials and workers, PRIs and NGOs to increase the awareness and participation in NRHM of the local people. And one can say that it has been successful in doing so to quite an extent. The people are a more aware lot today and share very good relations with all these three above mentioned sections. Due to the personal touch of the NGO workers and their regular visits to the local villages NRHM is working fantastically even in the interior parts of the districts.

Though the experience so far is encouraging there has arisen a necessity to streamline the administrative procedures and evolve mechanisms for better coordination between line departments on the one hand and PRIs and line departments on the other. The coordinating mechanism between the line departments and decentralised bodies still remain ambiguous in many aspects. The recently developed activity mapping in Karnataka where specific responsibilities were assigned to each tier of decentralized bodies, has helped

in significantly reducing the overlapping of functions between GP, TP and ZP. These functions have become more demarcated and have increased the speed of resolving conflicts specially in the health sector.

But it is also necessary to orient and train the PRI members and health functionaries about their roles and responsibilities in providing better health services and filling up the vacancies specially the lack of proper para-medical staff in some health centres the remuneration for the ASHs also needs to be increased as it was a common demand made by the respondents throughout the survey.

Given its reasonably good track record in the decentralisation of power, authority and finances, Karnataka provides a good opportunity for PRIs to demonstrate their capability in improving the health service delivery for the benefit of the poor through their collaboration with the NGOs. We need to wait and see how effectively this collaboration can be used as a vehicle for better health service delivery and increasing the access and participation of the common man in the NRHM. This, to a great extent, depends upon the cooperation, coordination and mutual trust between health bureaucracy and Panchayat leadership and civil society.

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Annexure I

Survey Questions

Types of individuals to be interviewed or questioned:

1. Beneficiaries both men and women who access the hospitals/health centres situated in the surveyed Panchayats.
2. Local Panchayat members of the committee dealing with health issues under the National Rural Health Mission (NHRM) or any other health mission or health scheme running in that particular Panchayat and working of the Public Health Centre (PHC).
3. Non-Governmental Organization volunteers or members working in these Panchayats related to the health sector.
4. Health Professionals consisting of the local doctors, health workers and other officials related to NHRM.

Common Section

BACKGROUND INFORMATION:

Name:

Sex:

Age:

Permanent Address/Location:

Educational Qualification:

Profession/Occupation:

No. of family members:

Religion:

Caste:

Marital Status:

Role in the Health System:

Instructions: Your opinion is important to us. Your replies would be kept strictly confidential and used only for summary statistics. Please carefully read the questions and then answer.

Section for Beneficiaries

1. Do you have a hospital in your Panchayat?
2. How far is it from your home or work place?
3. Have you ever accessed it?
4. When, why and for whom?
5. Who was present there when you went there?
6. Did you get appropriate medical treatment?
7. Was the doctor and other staff present?
8. Where the medicines and other equipments available?
9. If not then why and from where did you get them then?
10. How many women doctors are there?
11. When are the OPD days and specialist visits?
12. How was the behaviour of the medical staff?
13. What was the outcome of the medical treatment?
14. Do you have any idea about the founding of the health centre?
15. How did you come to know about it's existence?
16. Before the local health centre was founded from where did you get medical treatment?
17. Has it been beneficial to you and your family?
18. If yes then why and If no then why?
19. Do you have any idea that you have a Panchayat?
20. Did you vote in the last Panchayat elections?
21. If Yes then can you name any of your elected representatives?
22. Are you happy or sad with the working of the Panchayat?
23. What have they done for you in the health sector?
24. What have they done in the other sectors?
25. Will you vote in the next Panchayat elections?
26. Have you ever heard about Non-governmental Organizations?
27. If yes then which ones?
28. Do they work in your Panchayat?

29. How did you come to know about them?
30. How have they helped you?
31. Do you know about National Health Rural Mission (NHRM) or any other such mission or health schemes started by the central or your state government?
32. If no, then why?
33. If why then which ones?
34. How did you come to know about the above mentioned schemes?
35. Has anybody from the local NGO tried to make you aware about any of the health schemes provided by the government or services you can avail to?
36. If yes, then which ones?
37. Did you avail any of them?
38. If no, then why and if yes, then why?
39. For whom did you avail them for?
40. Did they benefit you?
41. Does the panchayat members and the NGO members work together? Do you have any idea about it?
42. If yes, then when and for what?
43. If no, then do you think that they should?
44. What difference has their working together brought about: in health sector and also in the other sectors?
45. Have you ever suffered any kind of discrimination because of your sex or caste or any other reason at the health centre. Panchayat or NGO?

Annexure II

Section for Panchayat Members

1. When was the first time you got elected to the Panchayat?
2. Are you an independent or affiliated to any political party?
3. What was the motive behind standing for the elections?
4. Whom all did you defeat?
5. Are you the first member of your family in politics?
6. If no, then who all from your family have held any political post till date?
7. Who are the other Panchayat members?
8. Do you have regular meetings?
9. Do you attend those meetings?
10. When was the last meeting held?
11. When was the last meeting you attended?
12. What all development work have you done for the Panchayat?
13. What have you done regarding the health sector?
14. Do you know what NGOs are?
15. Does any NGO work in your area?
16. If then then which and in which sector?
17. Do you like it that they work in your area?
18. If yes then why and if no then why?
19. Have you ever collaborated with any of these NGOs in any field?
20. Have you ever collaborated in the health sector?
21. What is the attitude of the local administration towards your developmental initiatives specially in health?
22. If yes then how have they helped you and if no they how?
23. Do you have any idea about the National Rural Health Mission (NHRM) of the central government or any other health scheme run by the central or your state government?
24. If no then why and if yes then from where did you come to know of it?
25. What is the current health status of your Panchayat?

26. Have you ever received complaints from the local people regarding the local health centre, the NGO and the Panchayats development work?
27. If yes, then when and what was the complaint?
28. Have you ever collaborated with the local NGO workers in order to create awareness among the local people regarding helath initiatives provided by the central or state governments or local administration or by your own Panchaya?
29. If yes then when, for whom and what was the outcome?
30. If no then why and would you like to?
31. Do you have the present data indicating the position of the various health indicators of your Panchayat?
32. If no then why and if yes then when was it collected?
33. What have you done to bring about a change where your area lacks?
34. Do you interact with your local citizens on an everyday basis?
35. Are all citizens of your area able to access the health services?
36. If no then why?
37. Do you want more funds in the health sector?
38. Do you regularly meet the local health officials?
39. If yes, then when and what do you discuss and if no then why?
40. Do they work on your instructions?
41. Do you want any changes or additions to the local health centre?

Annexure III

Section for Non-Governmental Organisation Volunteers

1. Since when have you been associated with the NGO sector?
2. In which all sectors have you worked?
3. Why did you choose to associate yourself with the voluntary sector?
4. In which Panchayat do you work?
5. Why did you choose this particular Panchayat?
6. What all do you do here?
7. What is the attitude of the local people towards you?
8. Do you have any idea about the local social and economic condition of the area?
9. What is the attitude of the Panchayat members towards you?
10. What is the attitude of the local administration towards you?
11. What is the attitude of the local health professionals towards you?
12. Do you have any idea about the National Rural Health Mision (NHRM) or any other mission or scheme or facilities provided by the central or state government or local administration or NGOs working here including yours or the local Panchayat?
13. If yes then which ones and how did you come to know of them and if no then why?
14. Do you try to create awareness among the general masses regarding any of the above mentioned measures?
15. If no then why and if yes then when and how?
16. Are the local people able to access the local health services?
17. If no then why?
18. Does the local centre work properly?
19. Are any class of people ever discriminated against in being provided with the health services?
20. Can you cite any such incidence?
21. Do you know the performance of the Panchayat in the health sector?

22. Have you ever collaborated with the local Panchayat or the local administration in creating awareness among the people regarding the health initiatives?
23. If yes then when and why and if no then why?
24. What changes or more facilities are needed in this area?
25. Do the Panchayat members work efficiently?
26. Have you suffered any kind of hindrance in your work here?
27. What is the state of women and children health wise in this Panchayat?
28. Have you yourself ever accessed the local health centre for medication?
29. Do specialist doctors visit the local health centre?
30. If yes then when and if no then why?
31. Is OPD available?
32. Is more funding by the government required in the health sector?
33. If yes then where?

Annexure IV

Section for Health Professionals

1. When did you join the health sector?
2. Why did you choose this particular field?
3. Do you enjoy your work?
4. If yes then why and if no then why?
5. Since what time have you been working in this particular Panchayat?
6. Do you enjoy working here?
7. Do the local people visit you regularly?
8. If no then why?
9. Do you live here or somewhere else?
10. Do you have any idea about the National Rural Health Mission (NHRM) or any other such scheme or mission run by the central or state govt. or local Panchayat or local administration?
11. If no then why and if yes then which one and how?
12. Do you know the local elected Panchayat members?
13. Do they visit you?
14. If yes then for what purpose?
15. Do they interfere in your work?
16. What is the attitude of the local people towards you?
17. Has any of the above mentioned schemes brought about any change in the % of people accessing the local health centre?
18. Is everyone able to access the health services here?
19. What is the most common medical complaint that you tender to?
20. Do you know the performance of your Panchayat on all the health indicators?
21. If yes then please mention and if no then why?
22. Is the local administration helpful?
23. Do you want more funding for the health sector?
24. If no then why and if yes then why?