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– Dr. Ramesh Kambargi

Not to be quoted

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Draft Report

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Introduction

Independent India inherited a well articulated system of central administration from the British. There was little change in this situation except to create States and charge them with the responsibility for establishing effective local governments. However, not much was accomplished in this direction as the states were more interested in protecting their own powers from encroachment by the Union Government than in divesting themselves of any portion of such powers for the benefit of untried, and probably highly inefficient, subordinate authorities.

For several years there was a lively, informed and sophisticated debate among the Indian intellectuals on development policy which was strongly critical about the centrist strategy of governance. The concept of "Community Development" was a reflection of this debate and the Community Development Programme which unfolded during the initial development plans (1952-61) was infact a major effort to attract wider peoples participation in development programmes. During the mid sixties the programme reached its peak when the then Ministry of Community Development proudly announced" the entire country is now covered by Community Development Blocks". But soon the Ministry was down graded to a department and was made a part of Ministry of Food and Agriculture and Community Development concept lost its aura. The Community Development wrote its own obituary in its annual report as "at this juncture redefining future approaches to community development and Panchayati Raj

appears very necessary" and CD was replaced by Rural Development and Panchayats as agency for carrying on development activities. Development became centralised and Integrated Rural Development Programme (IRDP) came in vogue with insignificant role to Panchayats.

The efforts of decentralisation through Community Development programmes that intended to give shape to Gandhijis concept of 'little republics' failed to make any headway. The concept of Gandhiji's little republics was vehemently opposed by none other than Dr.Ambedkar in a Constituent Assembly as "these village republics have been the ruination of India .... What is a village but a sink of localism, a den of ignorance, narrow mindedness and communalism". But the strong belief that the Indian village can be resurrected as a device for popular movement to accelerate pace of development still continued in some pockets.

Decentralisation in Karnataka

The reorganisation of States in the Indian Union in 1956 on linguistic basis brought in the State of Mysore by bringing together the erstwhile Mysore State, four districts of Bombay, three districts of Hyderabad, two from Madras Presidency and the Centrally administered district 'Coorg'. The State was renamed as Karnataka in 1973. The amalgamated districts had their own experience with decentralised governance though devolution of powers and resources were a shade better in the areas that joined the Princely State of Mysore. We will not deal with the details of their experience but focus on the development in the State of Karnataka which would be in·order.

The formation of the new State in 1956 based on language was followed by the release of Balawant Rai Mehta Committee Report that brought a new life in Panchayat Raj concept. The young State passed a bill "The Mysore Village Panchayats and Local Boards Act 1959' and a three tier structure was introduced – directly elected bodies at village and taluk level and indirectly constituted body at district level. All the presidents of taluk development board, elected members of the State Legislature, parliament and some officials constituted the District

level development council which was headed by the Deputy Commissioner. There were also nominated members from deprived section and women.

The creation of bodies of elected representatives was not accompanied by required resources and supporting political will that ultimately led to the visible decline in the new system. At national level Nehru's demise and the subsequent political change proved hazardous to the growth and development of decentralised governance.

The political scenario drastically changed – the emergency and the arrival of Janata Party to power at Centre revived the interest. The Centre was quick to appoint Ashok Mehta Committee whose report was published in 1978. In Karnataka the Janata Party ushered into power in 1983 with a view to "take power to the people". The preamble to the 1983 Act entitled "The Karnataka Zilla Parishats, Taluk Panchayat Samithis, Mandal Panchayats and Nyaya Panchayats Act 1983" notes "whereas it is expedient to provide rural areas of Zilla Parishads, Taluk Panchayat Samithis, Mandal Panchayats and Nyaya Panchayats to assign them local government and judicial functions and to entrust the execution of certain works and development schemes of the State Five Year Plans to the Zilla Parishads, Taluk Panchayat Samithis, Mandal Panchayats and to provide for the decentralisation of powers and functions under certain enactments to those local bodies for the purpose of promoting the development of democratic institutions and securing a greater measure of participation by the people in the said plans and in local and governmental affairs and for purposes connected with and incidental there to...."

The statement in the Preamble to the Act are significant in several ways i) It aims at promoting democratic institutions to act as government in their local areas ii) The institutions created would be entrusted with development schemes designed under Five Year Plans. These in turn would create greater opportunities for people's participation in the execution of the plans and in local governance. There will be decentralisation of powers and functions to enable Panchayat Raj Institutions to discharge responsibilities entrusted to them.

A careful look at the Act and its Preamble suggest that it was not just another superfluous effort made to enhance efficacy of programme implementation that had received severe criticisms from several quarters. But it visualised the PRIs as mini governments having a great deal of autonomy. Its nearness to the community was assumed to ensure greater transparency and also accountability to the people. Since the local governments are very much familiar with local problems and needs it was believed that planning process to become much more relevant and effective with due regard to priorities. Local government functionaries are closer to the elected representatives and hence supervision and accountability of bureaucracy would be enhanced.

It would be necessary to understand how the revolutionary process in governance was perceived when it was introduced by the group of visionaries – politicians and administrators together so as to realise the subsequent changes that have been brought in decentralised governance.

The PRI system in Karnataka vested powers in Zilla Parishads at district level and in Mandal Panchayats that covered a number of villages having 8 -12 thousand population. There was Taluk Panchayat Samithi in between Zilla Parishad and Mandal Panchayat that comprised the local MLA and Chairpersons of all the Mandal Panchayats in the taluk.

The Zilla Parishad was perceived to play a major role in planning and development of the entire district while Taluk Panchayat Samithis were perceived as essentially a co-ordinating body with no executive powers. The various personnel of all development departments including that of Health and Family Welfare were placed at Zilla Parishad's hands. The ZP administration was lead by Chief Secretary or Indian Administrative Service (IAS) Officer of senior level in the State. In order to carry the planning process at the district level and below a team of experts that included a statistician was formed.

The Mandal Panchayats were conceived as a plenary body and like ZP was constituted directly and was to operate mainly as an implementing body. It was to identify and select beneficiaries in relevant programmes and also to prioritise development works to be undertaken in their area.

The PRIs in Karnataka received finances directly from the State through the budgetary allocation passed in the legislature. Initially the share of PRIs in the State Finances accounted for about 33 per cent. "Public Health" was one of the important development activities of the Zilla Parishad. Section 182 of KPR Act provides "management of hospitals and dispensaries (excluding District Hospitals and those managed by Municipalities). There is a statutory requirement to constitute a "Health Committee" which was to perform the functions relating to health services, hospitals, water supply, family welfare and other allied matters".

The Mandal Panchayats also had to take the responsibility of sanitation and health. Maintaining sanitary conditions and it was mandatory to constitute an "Amenities Committee to perform functions in respect of "education, public health, public works and other functions of the Mandal Panchayat".

It becomes clear from the above that Zilla Parishad was entrusted with the crucial role in monitoring health sector in the district while Mandala Panchayat's role was vague. And indeed 79 per cent of the plan and non-plan outlay for rural health services was transferred to ZPs during 1990-91 which accounted for four fifths of the health budget allotted for rural areas controlled by the ZPs.

The remarkable transition in power structure seen in Karnataka was not sustained. The state faced financial constraints and the situation was compounded by fluid political situation that adversely affected flow of resources to Panchayat Raj Institutions. The new born democratic institutions were deprived of the warmth and care of the state that would have had considerable positive impact on their growth and development in the appropriate direction.

The State government constituted a review committee to evaluate the impact of decentralisation on the administration of development programmes. The committee submitted its report in 1989 that noted "there had been significant progress in the area of medical and public health facilities. Besides a big improvement in the attendance of doctors and other medical personnel, steps have been taken to secure the supply of drugs and medicines more regularly in accordance with local requirements. Pressure from local governments has also

led the State Government to make substantial modifications in its medical stores purchase policy and ZPs have been able to procure more of their supplies locally more cheaply". Though the improvements brought in such a short period and attributed to decentralised governance by the eminent members of the committee is hard to believe the spirit behind appreciation is well taken.

The brief note above indicates the real intention of the then government to decentralise governance – the designation of head of the district administration as Chief Secretary and who was a senior level officer of Indian Administrative Service (IAS) suggest that he was indeed perceived as Chief Secretary of the government at district level and was senior to the Deputy Commissioner of the district is notable. The State government did not posses any powers of supervision and control over the ZPs. The preparation of the budget of Mandal Panchayat also was not to be approved by higher level structure but was limited by provisions of the act.

There was also a State Development Council constituted with Chief Minister as Chairman and Presidents of ZP as members. It included some important Ministers like Minister of Rural Development and the council provided a forum for exchange of views among the elected heads of the ZPs and their counterparts at the State. While there were indications of improvements in the functioning of primary schools, primary health centre and health care services fissures appeared in the political arena – factionalism and a weak resistance to the idealism of PRIs. The strong Janata Party was weakened with factionalism which had its own adverse impact on PRIs functioning. This ultimately resulted in loss of power and assumption of power by Congress Party in 1990. The neglect and reservation shown by the party in power led to postponing the elections and superseding the ZPs and Mandal Panchayats by appointment of administrators for these bodies.

The 73rd amendment to the Constitution was passed by the Parliament in 1992 and the Congress led government in Karnataka brought a new piece of legislation. "The Karnataka Panchayat Raj Act, 1993" came into existence from

10th May 1993. The act was passed in accordance with the constitutional amendments requirements and since then has undergone several amendments.

The new act brought many significant changes. Every village having 5000 – 7000 population will have a Gram Panchayat (2500 population in Hilly areas). The voters will elect one member for every four hundred population.

Every Taluk will Constitute a Taluk Panchayat and for every 10,000 population there will be an elected member. Members of Parliament and State Legislative Assembly representing the Taluk – wholly or partially would be members of the Taluk Panchayat. Among the Chairmen of Gram panchayats one in five will be members of Taluk Panchayats for one year by rotation.

The ZPs have one elected members for every 40,000 population (30,000 population if the district is hilly). Members of Parliament, State Legislature and all Adhyakshas of Taluk panchayats will be members of ZP by virtue of their office.

The reservation policy was strictly adhered to in electing the representatives. Reservation for Scheduled Castes and Tribes were proportional to their size in the population with a minimum of 15 per cent and 3 per cent respectively. 30 per cent were reserved for backward castes and 33 per cent for women.

The new legislation compared very poorly with the earlier legislation which perceived local bodies as local government where as they were reverted back as government controlled subordinate agencies. It is obvious that there is a reversal of decentralisation of the process set-in by the earlier Act of 1983. Naturally it was criticised in strong terms. When the new bill was introduced the preamble also did not mention about the concept of self-government. But the act contained powers of the government to inspect and control of the PRIs as contrary to the earlier provisions in 1983 Act. The President and Vice Presidents were considered as on par with the Minister of State and Deputy Ministers whereas the present law withdrew the provision. Similarly the ZP president was the Executive Head of the district and Chief Secretary was more powerful than the D.C. of the district which the new act did not provide for its continuation. Chief Secretary

was redesignated as Chief Executive Officer (CEO) an IAS Officer Junior to DC of the district and was empowered to withheld any action of ZP if it was inconsistent with the provision of law and seek governments' instructions to resolve. Thus the new act seems to strengthen the hands of bureaucracy and weaken PRIs influence.

It is important to note that the new Act introduced hierarchical relation in the power structure in the PRIs – ZP was authorised to enquire into the complaints of non-performance of duty by the Taluk Panchayats and Taluk Panchayats in turn that of Gram Panchayats. Establishment of health and maternity centers became obligatory function of ZP which was subject to the availability of resources.

The new act was amended several times and several Government Orders are issued in respect of functioning of PRIs. As rightly pointed out by a widely known expert on Decentralised governance, 'Panchayat Raj in Karnataka has turned into GO Raj now". As a result several far reaching changes were made. Important among them was the reducing the term of office of ZPs and TPs Presidents and Vice Presidents from a Five Year term to a mere 20 months period (Sept. 1996). Due to the increasing pressure from Presidents of ZPs and TPs and subsequent recommendation of Expert Committee (1996) an amendment was brought to confer `Executive Heads' recognition. Despite the mounting pressure the term of office of these elected representatives was not extended and as most of the ZPs are under Congress Party's control the move was weakened.

A careful examination of the devolution of powers and functions reveal that the State government through amendments is making efforts to weaken the democratic institutions at district, taluk and village levels. The State government has retained many controls – regulatory and supervisory powers and also some important functions like Public Distribution System. More significant for this study is to note the control over the personnel who are on deputation to the PRIs lies with the State government. The recruitments, transfers and regulatory functions – disciplinary actions are retained by the State government. Though the P R

Nayak Committee recommended that PRIs should have powers of transferring group 'C' and 'D' employees, the State government is yet to accept it.

The Present Study

In this background of one step forward and two steps backward policies persued during the last two decades the present study has attempted to examine the working of Public Health Care System under the contemporary Panchayat Raj System in Karnataka.

Objectives

The main objectives of the study are :

1) To identify areas of confrontation/friction between elected representatives and the officials of health departments at district level and below and identify the underlying causes as attitudinal, legal, procedural and others.
2) To examine the legal procedural factors that need modification for smooth effective functioning of PRIs and health functionaries.
3) To study the disparities in health indicators across the districts and across social class within the districts and how PRIs intervention can reduce them.
4) To study the delivary of public health care services, identify best practices followed that can be replicated in the state to improve the outreach services.

Data and Methodology

Considering the limited time and resources it was decided that the study would confine to three districts of the state. The required data was collected from various elected representatives at district, taluk and gram panchayat levels, from health staff working at various levels like District Health Officer, Taluk Medical Officer Medical Officer at PHCs, PHUs, CHCs, Para medical staff, staff dealing with administrative work and most importantly the general public from 31 villages randomly selected. It was focus group discussion on various issues that provided valuable insights for the study. The general public, however, was

administered a questionnaire to understand the extent of their participation in PRIs and their understanding of quality of health care services delivared.

At the outset we met the members of the Karnataka Government Medical Officers Association – a strong body of over 500 medical officers as its members. The discussion revolved around various issues confronting them in general like the reported corruption in the department – particularly charges against the medical officers, their perception of decentralised governance and its pros-cons on their functioning and the contemporary service conditions.

Emerging Issues : Confrontation

The prolonged discussion with the office bearers at the state brought out the issue of working under decentralised system of governance and their strong resistance to it. It was also revealed that in the current situation all the medical officers would not aspire for the post of District Health Officer as compared to the earlier days when there was a rush to hold the coveted post that carry not only enormous responsibilities but also a high status – equivalent to any other district level high officials like Deputy Commissioner. Today he is at the receiving end only – ZP will hold him responsible for every thing that may go wrong like a cholera cases, malaria cases detection in his area which rightly cannot be considered as his responsibility only. It is concerned with water supply or supply of DDT for spraying that cuts across the departments.

The health department officials also are harassed by the elected representatives as revealed by the Association of office bearers. It was told that DHO has left with little time to attend to his enormous responsibilities because of several meetings he has to attend during a month (at least 6 statutory) and there are visits from Ministers that need DHOs presence and there is hardly any time left for his work that results in poor supervision and monitoring the health programmes in the district. In addition, the elected representatives who are drawn from different socio-economic background and new to their work do not know how to conduct themselves with the bureaucrats who expect respect – regard from every one. The Association expressed strong reservation about the

way Medical Officers are treated by the elected representatives and reported that it was most inappropriate.

In addition to the above mentioned confrontations the Association was more disturbed with the way promotions were given, how a very junior medical officer became his senior boss because he possessed a Diploma / Degree in Public Health. Their view was that public health and its intricacies can be learnt by any medical officer through his experience and he may perform better than a person who possesses the degree/diploma in public health. It is not very relevant for this study to deal with this issue in detail as the ZPs or TPs are not authorised to deal with such issues which lies with the State government. It was clear from the above discussion that the strong resistance to work under PRI by the Karnataka Government Medical Officers Association was not on any ideological or legal – structural issue but based more on their stray – scattered experience with some elected representatives. The meeting, however, provided valuable insights for conducting the study.

The Study Area

The study was to be confined to three districts but another district was added to it based on the reported problems of confrontation between health bureaucracy and ZP there. The three districts were selected on the achievements in health sector. Udupi – a newly carved district is much ahead of most of the districts in the state in terms of education particularly female education, health and also other development indicators. Tumkur is situated in the middle level and Gulbarga district is still a backward district (Table 1).

Table 1 provides valuable insights in the existing disparities in the selected districts in terms of health and education. Udupi is an advanced district, whereas Gulbarga has retained its backward status during last five decades of reorganisation of States. Tumkur has performed better than Gulbarga but is poorer compared to Udupi. Thus the findings from this study would present a representative picture of the state.

Table 1 : Development Indicators in the Selected Districts

District/ State	Crude Birth Rate 1999	Percent women contra-cepting	Percent safe deliveries	Crude Death Rates 1990-91	Percent females literates 1996	Percent children aged 12-36 months immunised fully	Per capita income 1995-96 (Rs.)
	1	2	3	4	5	6	7
Udupi	19.7	63.7	91.5	7.0	78.5	86.0	2632
Tumkur	24.1	61.3	63.5	8.2	51.1	88.0	2047
Gulbarga	30.1	39.2	47.7	10.7	30.9	25.3	2431
State	22.5	58.1	68.2	8.5	52.7	70.5	2558

Source: 1,2,3 and 6. RCH Survey 1998 (Phase 1)

4,5 & 7. Human Development Report (Karnataka) 1999, p.78, 255, 212.

The presentation of the report will be in four sections. The first section would present the health status of people and highlight the observed disparities by social class and caste. The second part would discuss, given these disparities, what the PRIs can do to improve the situation and the third part would present the findings of the data collected from the PRI visits followed by summary of the findings and recommendations.

Section I

Health status of a population is determined by several factors including health care services. It is closely associated with genetic, social, economic, cultural and political factors. Although interaction among these factors is multidirectional and complex, it is increasingly being realised that an integrated approach to development would minimise conflicts and undesirable side effects of sectoral approach. But what should be the critical mix of these interventions to obtain the desired results is not very clear and planning in most of the countries and at states within the country is still dominated by sectoral approach. The significance of health care services is that they can reduce pain, sufferings and deaths many of which could have been minimised by an integrated approach to

development. The health care services have to ensure quality at an affordable cost to the population. There are differentials in access to health care services in India and also in the State of Karnataka by urban / rural residence Good health care services are concentrated in urban areas and do provide a choice to people – either avail public health care services – which are also relatively better in urban areas as compared to rural, or and also avail private health care services that are more concentrated in urban areas. Residents in rural areas have to increasingly depend on public health care services particularly deprived sections like Scheduled Caste and Scheduled Tribe population or those living in remote inaccessible areas where either private services are not existing or scarcely available. If public health care services are not easily accessible it will have more adverse impact on rural poor particularly the SC/ST population.

In order to improve the accessibility to public health care services the Central and State governments have been trying to expand these services hoping that all sections in rural areas are benefited from them. As a result it is observed that during 1960-61 on an average a Primary Health Centre (PHC) served 81,000 population whereas at present (1996-97) a PHC serves only about 21,500 persons. Similarly a female health worker (ANM) was serving about 8000 persons during 1980-81 while in 1996-97 she is serving only about half of that population. These public health care services are supposed to be free and therefore the poorer sections who may find private health care relatively expensive may use them more than the affluent rural population. Particularly the women belonging to SC/ST may benefit from the free care provided by the government. But intensive research studies carried out in the state present a different picture which is very disturbing.

It would be in order to note how the public health care services are delivared before presenting the observed disparities reported in the research studies. Looking at the disproportionately high mortality and morbidity among women and children at national and state level delivary of services are concentrated on women and children. The grassroot female health worker popularly known as ANM provides these basic services. In order to make child

births safe she is trained to provide antenatal care at the home of the pregnant women in her area that has about 4000 population. On an average there are 165 – 170 eligible couples per 1000 population. She has about 500 – 600 eligible women some of whom need this service. The ANC package includes a list of services that she is supposed to provide to every pregnant woman to ensure safe delivery, survival of woman and her baby. The following table provides some insights into how these services widely differ among the community by caste, economic status, education of the woman and by rural/urban residence in 10 districts of Karnataka.

Table 2 : Access to Antenatal Care by Social and Economic Background of Women in 10 Districts of Karnataka 1998

Sl No	Type of service	Residence		Caste		Education		Type of House	
		Rural	Urban	SC/ST	Others	7th 8th	SSLC +	Kuchha	Pucca
1)	No ANC	12.9	5.6	17.0	8.9	18.9	0.6	22.6	3.4
2)	First ANC visit during								
	a) First Trimester	52.6	72.0	48.5	62.0	42.7	84.1	37.9	80.4
	b) Second Trimester	28.9	20.1	29.4	25.1	31.7	14.5	32.4	15.0
	c) Third Trimester	5.6	2.3	5.1	4.0	6.8	0.8	7.1	1.2
3)	All 3+ ANC visits	74.0	88.0	68.7	81.0	65.3	95.9	58.9	92.6
	Percent women								
4)	Whose weight was taken	41.7	77.5	37.1	56.1	32.9	58.7	23.5	80.9
5)	Whose B/P was recorded	57.2	86.3	49.8	70.3	46.3	78.0	39.7	90.4
6)	Who were given IFA tablets	72.5	72.5	66.9	75.2	65.9	77.7	61.1	78.0
7)	Who were given 2TT injections	65.0	78.7	58.9	72.3	56.5	75.0	49.0	84.6
8)	Whose abdominal check-up was done	72.2	91.9	74.4	84.2	69.7	97.4	65.3	93.0
	Total No.of women	2222	896	772	1811	1571	692	685	619

The data clearly brings out the differential access to the public health care services in the State. It is the Scheduled Caste women, illiterate and those who

live in kuchha house, in other words 'poor' are relatively more deprived of these essential services. Though we do not have data on infant mortality and maternal mortality the NFHS II reports very high IMR in rural Karnataka areas for SC/St and illiterate women.

The information on place of delivery also reveal differentials by caste. While for the state as a whole RCH First Phase reported 52.4 percent institutional deliveries it was only 42.4 percent in rural areas while it was 77.3 percent in urban areas. Among Scheduled Caste women only one in 3 deliveries were in an institution whereas it was 57 percent among others. Out of those who lived in kuchha houses only 29.6 percent were able to go for delivery to a health facility while those better of 81.7 percent delivered in a health facility. It is worth noting that the home deliveries of SC women mainly were attended by neighbours/relatives or untrained dai (74 percent). In other words, even those who give birth at home are deprived of ANMs' or trained dais' services that increase the risks associated with child-birth among the poorer sections.

The new born babies are protected against killer diseases by vaccinations. The data provided by the RCH Survey reveal wide disparities in its utilisation and poor accessibility.

Table 3 : Accessibility to Immunisation Services in Karnataka by Social – Economic Background of Children Born During 1.1.1995 to 10.6.1997 (percent not received)

Type of Service	Residence		Gender		Caste		Education		Housing	
	Rural	Urban	M	F	SC/ST	Others	Illit-	10 yrs+	Kuchha	Pucca
1) O Polio	61.8	30.8	53.0	53.0	69.7	50.0	72.6	22.9	75.5	22.9
2) BCG	18.5	9.4	13.7	18.2	27.6	11.5	26.6	1.3	34.6	4.7
3) DPT	18.3	11.3	14.7	18.1	26.6	12.6	26.7	1.1	32.6	5.2
4) Polio	11.6	8.2	9.0	12.3	17.3	8.2	17.8	1.4	21.7	3.7
5) Vitamin A	52.8	49.2	49.8	53.9	59.1	48.0	61.2	35.6	66.1	39.7

The differentials observed at state level hide the regional differentials which are more pronounced. The following table provides these differentials in the selected districts.

Table 4 : Access to Antenatal Care in the Study Area by Socio-Economic Background of Women 1998 (per cent not received)

District	Residence		Caste		Education		Housing	
	Rural	Urban	SC/ST	Others	Illit.	10 years +	Kuchha	Pucca
Udupi	2.0	00	5.2	00	4.7	00	2.2	00
Tumkur	4.8	2.4	5.9	3.8	8.5	00	4.8	00
Gulbarga	34.0	14.8	28.5	26.8	35.5	3.1	32.1	27.2

The tables 4 and 5 are self explanatory and in this background it was not surprising that the RCH survey reports maximum number of infant deaths in Gulbarga district (17) during the reference period and all in rural area whereas Tumkur reported 9 deaths – 8 in rural areas whereas Udupi reported only 3 infant deaths all in rural areas.

Table 5 : Access to Immunisation of Children Born During 1.1.1995 to 30.6.1997 (per cent not received)

District	Residence		Sex		Caste		Education		Housing	
	Rural	Urban	M	F	SC/ST	Others	Illit.	10 yrs+	Kuchha	Pucca
Udupi	15.0	8.0	17.0	10.0	20.0	13.0	17.0	4.4	15.0	14.1
Tumkur	13.0	6.0	11.4	12.8	16.0	11.5	13.7	3.00	20.0	4.5
Gulbarga	80.0	53.6	76.0	73.3	78.9	73.8	83.4	25.0	72.3	45.2

The information for 10 districts of Karnataka and the 3 districts in the study area bring out clearly that delivary of public health care services do not reach all those who need them because of various factors. Given the skewed distribution

of basic health care services related with maternity and child survival it is not surprising that health outcomes differ widely among districts – regions and also social class in the state.

Reasons for such poor delivary of public health services in Gulbarga as compared to other districts were not difficult to understand. The Research Teams' visit to Community Health Centres, Primary Health Centres and Sub-Centres revealed that many of these health centres do not function regularly. Infact, the day of our visit to selected health institutions in Gulbarga they were locked and we learnt from the villagers that medical officers are very irregular in attending to their work. Similarly the ANMs instead of visiting the households in the sub-centre jurisdiction expect that women or children with problems should come to them. No PHC had displayed the scheduled travel programme of ANMs as is done in other districts. It is not, therefore, surprising that old women in the neighbourhood or village 'Soolagitti' (village untrained dai) conduct most of the deliveries in rural areas (every 3 of 4).

The problem is more complicated by the large number of vacancies particularly of ANMs which is crucial in ensuring delivary of health care services. When the vacancies of ANMs by taluks and PHCs within taluks were obtained from the DHO's office and examined we were in for several surprises. In the district of Gulbarga about 28 per cent – more than one in four positions were vacant for ANMs (see table 6) and the LHVs. Supervision of their work and monitoring the performance has stopped for several years. The result of such an apathy is very clearly reflected in several indicators reported earlier. One of the major cause for poor performance reported by the staff at PHC/CHC was the existing poverty in the rural parts of the district where traditional practices still dominate and the department cannot be blamed for all the ills in health sector.

Table 6 : Vacancies of Female Health Workers (ANMs and LHVs) in Gulbarga District by Taluks

Sl. No.	District/Taluk	Per cent Vacant			
		P – V	ANMs	LHVs	Per cent
1)	Gulbarga Dist.	484/134	27.7	83/40	48.2
2)	Gulbarga Taluk	58/00	0.0	6/0	00
3)	Jevargi	39/2	30.8	10/2	20.0
4)	Aland	57/18	31.6	6/4	66.7
5)	Afzalpur	40/11	27.5	9/7	77.8
6)	Chincholi	41/10	24.4	8/1	12.5
7)	Chitapur	57/15	26.3	10/5	50.0
8)	Sedam	35/13	37.1	7/2	28.6
9)	Shahpur	48/17	35.4	7/5	71.4
10)	Surpur	56/18	32.1	10/7	70.0
11)	Yadagir	53/20	37.7	10/7	70.0

Note: P = Total Positions: V – Vacant Positions.

But the traditional practices have to continue because the modern health services provided by the public services have miserably failed to entrench in the society. It was repeatedly emphasised that rural people prefer to conduct deliveries at home and ANMs are helpless. But when there are so many uncertainties in the services – medical officer may not be there, drugs may be in short supply and ANMs posts are vacant and naturally people stick to their traditional practices. The positions of specialists in the district showed that 37 per cent positions were vacant.

In Udupi district also about 30 per cent of ANMs positions were vacant but easy accessibility to quality care in Private Sector Hospitals either free or at an affordable cost has not made any adverse impact on the health of women and children. Most of the births about 92 percent take place in institutions that has sharply reduced Infant Mortality Rate in the district (lowest in the State). The ANMs working in sub-centre reported that most of them have not conducted a single delivery during last 5–6 years as there are maternity homes run by

missionaries, Manipal group and other private trusts that provide a choice to everyone irrespective of their economic position. The public make an informed choice of public and private services and have benefited to a large extent as revealed by several indicators.

Tumkur district placed in between these two extremes provide different problems. The public health care providing institutions generally work regularly. Our visits to several PHCs, CHCs and Sub-Centres convinced us that there is regularity in attendance of the staff to a large extent except in a few pockets. But accessibility to the services is severely restricted to the poorer sections because of corrupt practices in these institutions. The Medical Officer in a PHC working for more than 15 years, people reported, has ensured that the Lady Medical officer's post remains vacant. A child birth conducted in this PHC will cost about Rs.1000/-. If there is a LMO this income will be reduced to a large extent. In another PHC it was found that LMO frowns at ANMs if they conduct home deliveries and insists that they should bring delivery cases to the PHCs and charges a minimum of Rs.500/- per delivery. Efficient and competent ANMs complained of harassments by the MOs and LMOs. With Malaria incidence still high in some pockets spraying of DDT has been stopped for 3 years and water sources like wells have not received chlorination to make them safe for drinking. The public health measures have affected badly.

The vacant positions in the department has its own adverse impact but is not severe as there were only 15 percent ANMs' and about 20 percent LHVs' positions were vacant for varying periods some for 4–5 years that has compounded the problem of outreach services in the district. Even then there is some semblance of service in the district. The buildings and other infrastructure are in poor shape and are begging for some action to improve but not received any attention from authorities.

What the Panchayat Raj Institutions Can Do?

The decentralisation of governance in Karnataka in its first 'avatara' came with the perception of "Power to the People'. The 1983 Act was based on the

principles enunciated in the Ashok Mehta Committee Report. The objectives of the Act were to give highest priority to rural development, increase agricultural development, eradicate poverty and bring in overall development. To attain these objectives the Act provided maximum degree of decentralisation both in Planning and implementation.

But there were unresolved issues, with the planning structure at the national level and state level is it feasible to have district planning with the consent of people and their participation? If not how the PRIs would participate – only implementation of the plans that come from the State with resources? Who would ensure 'good governance' at lower levels? And How? are not cleared yet. But the State government that provides resources to PRIs – resources that have reached four to five fold increase during the decade believes that there has to be greater transparency, social justice and accountability in PRIs to achieve the twin goals of development and social justice. The voluminous writings on decentralised governance at sub-state level are more concerned with reservations, elections, provisions of rules, rights and procedures to be followed than assessing what positive changes the new system has achieved and how to improve it further. which can reduce the 'politics only' attitude observed at PRIs. Despite our serious efforts to find some special studies that have examined functions of the health sectors under decentralised system we could not trace a single except the evaluation report submitted in 1989 that praised PRIs eloquently for the good changes they had observed.

We conceptualise a very simple mechanism that exists in PRI system to a large extent useful in streamlining the functioning of health·care service delivary system and bring in much needed discipline in the sector. The importance given to 'holding gramasabhas' of village voters who are ultimately the masters can be exploited. Already in six districts "Citizens Initiatives in Elementary Education" an NGO initiative to activate Grama Sabhas to improve primary education is going on. People who are not happy with the delivary of services, can bring it in the meeting which will be passed on to Gram Panchayat that in turn can reach Taluk and Zilla Parishad for action. The ZP based on the resolutions passed by the

Gram Sabhas can keep themselves abreast of developments in health sector and plan for its improvements.

The Zilla Parishad also has a statutory Committee called "Standing Committee on Health and Education" that includes elected ZP members and also some experts co-opted. They have to meet once a month and transact business pertaining to health. However, the role of Zilla Parishad in decentralised governance and planning is one of a facilitator and co-ordinator. Integrating plans submitted by Taluk Panchayats, approving employment generating action plans, allocation of resources to development programmes and monitoring functioning of Taluk and Gram Panchayats. The President and Chief Executive Officer (CEO) have been endowed with powers to supervise and inspection. However, CEO has upper hand (section 180) to ask any record from TPs and GPs pertaining to property, recovering arrears of land revenue, and supervise and control the execution of ZP works.

Gram Panchayats are entrusted with regulatory, licence - giving, prohibitory, supervisory and sanctioning powers. They have powers for taxation and acquire movable and immovable properties. Providing civic amenities, promoting health and educational services are other responsibilities entrusted with Gram Panchayats.

The Taluk Panchayat have controlling and supervisory powers over Gram Panchayats. They are perceived as highly resourceful and powerful intermediary level institutions. They approve employment generating action plans, they give concurrence to action plans pertaining to education, health and family welfare etc. The executive officer can supervise in functioning of PHCs, Sub-centres and report to DHO for action. He does not enjoy powers to take disciplinary action on health staff.

There is a mechanism to receive the public grievances regarding health care services through the powerful Grama Sabhas for further action to improve the equity and accessibility – both if there is a desire. In addition the Taluk Medical Officer has supervisory powers to report for action to DHO. DHO is head of the department and is responsible officer at district level. In addition

there is Executive Officer at Taluk Panchayat with supervisory powers and report his findings to DHO. It is very clear from the above that there are enough ways and means to improve the health care services directly through PRIs, through the live of control existing in the departments and also more importantly through the Grama Sabhas. Given the situation described in the study area it would be in order to examine how they work.

The Grama Sabha

The Gram Sabha is a statutory requirement that provides a unique opportunity to village residents to vent their grievances which will reach the concerned authority for redressal. It also provides an opportunity to the voters to make their elected representatives accountable to them. One of the main architects of decentralisation in Karnataka considered Gram Sabha as a "more powerful weapon created for the sake of accountability is Grama Sabha which will not be elected nor has it vested with any executive power. But it is going to play a crucial role in real politics because of their voting power and all elected members are accountable to Grama Sabha". It is mandatory on the part of PRIs to explain their activities within the jurisdiction of the village. It also leads to right to information.

Section II

How the Grama Sabhas are conducted if at all they are conducted? Whether people bring their grievances to the forum? The Household Survey conducted in the study area enquired from the randomly selected 82 heads of the households whether the Gram Panchayat, Taluk Panchayat or Zilla Parishad of their area are taking any interest for the improvement of the local PHC? Not surprisingly in Tumkur and Gulbarga districts the response was an emphatic 'No' from each head of the household (100 percent in negative). They were very firm about their view. But in Udupi district one in four felt that they are trying to improve further the services in PHC (Table 7).

The selected heads of the households were also asked whether there was any discussion in the Grama Sabha meeting held recently on the functioning of the ANM, LHV, PHC doctor and PHC. The findings of these are presented below.

Table 7 : Peoples Assessment of PRIs interest in Public Health

Sl No	Activity	Districts							
		Udupi		Tumkur		Gulbarga		Total	
		Yes	No	Yes	No	Yes	No	Yes	No
1)	PRIs try to improve the PHC	23.0	77.0	00	100.0	00	100.0	11.0	89.0
2)	Gram Sabha Discussed about the Functioning								
	i) Of ANMs	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0
	ii) Of LHVs	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0
	iii) Of MO in PHC and PHC	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0

It is clear from the data that public view of PRIs interest in improving health care service delivery of PHC level or about the functioning of crucial personnel like ANM, LHV or MO of PHC is extremely poor. An important route to bring critical assessment of health services for improvement was found to be very insignificant.

The Bureaucracy

There are multiple authorities who are supposed to supervise functioning of their subordinates, monitor the performance and enforce discipline in the health department. They are Taluk Medical officers, Executive Officers at Taluk Panchayats, Chief Executive Officer, President at ZP and also DHO the Head of the department of health at district. In addition to all these levels of supervision, there is another Deputy Secretary 1 in ZP who is entrusted with supervisory powers who will report to the CEO.

With so many authorities entrusted with powers to ensure free flow of services it was surprising that Public Health Care Services are of so poor quality

in the two districts of the study area viz. Gulbarga and Tumkur. Our discussion with the young and energetic CEO in Gulbarga was surprising. He was unaware of the way PHCs are functioning in the district. On the contrary he said often he receives representations from people to retain some Medical officers in their place and cancel the transfer order issued that gave him an impression that the MO must be good and therefore people want to retain him. We met the Deputy Commissioner of Gulbarga also and briefed him about our observation. Both the CEO and DC asked for a copy of our findings for initiating action against erring officials in the health department. Similarly we discussed with the Deputy Secretary (Dy S 1) and briefed him of our observations and he was non-commital. Our discussion with the Secretary ZP Council, Gulbarga was little revealing. He reported that the meetings of the Standing Committees on Health and Education mainly deal with approval of plans, proposals and programmes. There is hardly any scope to discuss about the services their quality or its out reach to all sections of the society. How well the DHO is informed about the happenings in his department? Does he also think that everything is fine with the functioning of PHCs, CHCs and Sub-Centres in his district? Our discussion with him was frank and free. He is aware about the irregular attendance of Medical officers and has initiated disciplinary action against one or two. But taking disciplinary action takes a very long time. There are interference from higher authorities, elected representatives to thwart these initiatives because the authorities take a benevolent view of such things and consider it on humanitarian grounds – the person accused is married and have children why punish him/her? The whole work culture in the district reflects that even for a petty issue there is interference from the highest authority. Every one in public service has links upward and use it to save himself from any punitive action.

Tumkur district was slightly better as the Executive Officers at Taluk level also visit some PHCs and reported that if the MO is absent on the day it will be reported to DHO for treating it as leave without pay. But whether DHO acts on that report or not was not clear. DHO Tumkur is aware about corruption that is making public health care services inaccessible to the poor in the district but

reported like Executive Officer at Taluk level that they have not received a single complaint from people in this regard and hence cannot act without evidence.

It was in Udupi that the in-built mechanism of monitoring and supervision was working. Even the MOs appointed on contract basis are regular in their work and provide service to the people. If there is regularity in the functioning of health institutions that itself satisfies the clients who arrive there for relief. Our visit to PHCs, CHCs and some remote-placed Sub-Centres was very satisfying. Perhaps if one wants to see what is equity and accessibility to health care services should visit this part for getting acquainted with. The results are visible.

ZP Presidents

The Executive Head of the district is the President and certainly they can make considerable impact on the quality services provided and their accessibility to people. The Presidents of the ZPs in the study area were very enlightening. In addition to 3 ZP presidents of Udupi, Gulbarga, and Tumkur, we met ZP President of Kolar. They were all young, educated and enthusiastic about their office that they were holding only for few months. The women presidents of Tumkur and Udupi were keen to improve health services. One of them was very young, just married with no experience of either politics or holding a public office. But her father was a leader and was holding a public office by getting elected. The other was having some experience at Gram Panchayat. Tumkur ZP President was keen to learn the ropes of administration to act and improve. She had visited some PHCs and believed that women still prefer to give births at home as it is more convenient. She was aware that some MOs and ANMs are not regular and was planning to discuss with the administration for possible action.

The Gulbarga ZP president was very open and said that "MOs not only are irregular but also sell the medicines in the open market. For days they do not visit PHCs. But I do not have powers to set things right". The President said that he would set things right in two weeks if he had powers. He was sorry that the State Government that belongs to his party is not receptive to their views.

The ZP President of Kolar was more dynamic and when we met he had visited a PHC (where he had gone for attending a public function) on the request of the public who complained that the MO is very irregular. Indeed MO was absent when the ZP president visited the PHC. He called DHO to know how they can take action against such officials. He reported that he is new (like other 3 presidents) to the intricacies of the administration and though he attended some training programmes organised for ZP presidents he has a long way to go to master the art. He had kept a Rule Book prepared by the state government and would refer to it often when he had some confusion. He was also of the opinion that ZP has little scope to bring in discipline among the staff working in the district on deputation. He often requests the DHO to be strict and wants to support him in improving the health services for the benefit of the people.

The Vice Presidents

The Vice Presidents also echoed the views of their Presidents. ZP cannot take any action. They have to write to the Government for action and there are long delays or no action. Vacant positions in the Health Department is reported routinely to the Government for filling but nothing is heard from them. The CEO position was vacant for 2 months and during that time DC was incharge CEO. One can imagine how things will move. It was clear that transfers, recruitments or suspension of any health staff is not vested with ZP. Under the circumstances poor accessibility and inequity in health care services become the order of the day and both elected representatives and the bureaucracy become used to it.

It is to be noted here that none of top leadership in ZP – elected members, members of the Standing Committee on Health and Education, CEOs and DCs were totally aware of the disparities that exist in the health status of people in different districts, by gender, caste and economic status within the districts. The next line of authority Deputy Secretary 1 were also equally ignorant of health outcomes, indicators and job responsibilities of various categories of staff. The Administration at Taluk and Districts were busy with construction of new structures, equipments or drugs more than their use for public good. There was

a unanimous demand in Tumkur, Kolar and Gulbarga that there is need for training to make them more informed and effective. Why the DHO does not provide them the insights of the Department? He has no time as all his time is spent in the meetings. The DHO also has several constraints. Since he has hardly any time his visits to Primary health Centres have reached minimum. It is only when a dignitary like District-in-charge Minister (another authority over all the happenings in the district) has a public function he may visit a PHC. The staff at PHC could recall the past practice of frequent visits of DHO for supervision. It was not only to their PHC but even to a nearby PHC would keep them alert with a chance visit to their PHC on the way back. This practice has almost disappeared now.

This brief description provides how the in-built mechanisms to ensure accessibility to health care services have become ineffective. It is not surprising that the health status of people in health poor districts continue to be poor even though public resources – more valuable looking at the scarcity, become less and less productive. One of the important reasons for the observed delay could be the faster expansion without consideration to the enormous resources needed for it. Earlier the quality of services, as reported by senior staff was much better. Now even though the scarcity of equipment, maintenance of assets etc. is reported to the authority may not be heard that leads to the weakening of the authority because of the inability to solve it quickly. The only positive change is the improved drug supply after decentralisation. Rest every thing is highly unsatisfactory in health poor districts.

Section III

Areas of Conflicts

Given the situation described so far where lies the conflict between the health bureaucracy and ZP or PRIs? The focus group discussion often led to mudslinging exercise. That PRIs arrival have lead to more corruption and harassment of personnel. To start with, the bottom line ANMs complained that elected representatives demand service on priority basis, call the ANMs to their

residence even for headache and stomach ache and demand medicines free and often ANMs have to bear the costs. As most of them (elected representatives) are not educated their behaviour is curt and without etiquettes and manners that hurts ANMs. The MOs at PHC complained similarly in addition they reported that the elected representatives question them if an ANM is not posted in a sub-centre which is not under his powers. The DHOs office complained of interference in day to day administration by the Elected Representatives.

A Taluk Medical Officer complained that there was out break of cholera because of the contaminated water supply by the Taluk Panchayat. When he reported that water supply has to be improved by taking some measures like chlorination, he was abused for dereliction of his duties. When they send a proposal to repair a collapsing building to DHO with a copy to ZP the CEO just does not bother. Medicines are not supplied regularly. They dump several useless drugs which are of no use. PHC and MOs indent is often ignored.

The Quarters of ANM built by the PRI are of extremely poor quality. An ANM was in tears to report how she has to cover the roof with polythene sheet to protect her from leakage and to re-do the electrification to save from the shocks spent Rs.3,700 from her pocket. Complaints made to DHO, ZP and TPs were of no use. She was told that she has to stay there the Quarter on which lot of money is spent to make it according to the specification given.

A meeting with all medical officers of a Taluk brought out their vent against elected representatives. A LMO reported that new PHC was built but the quarters for staff are not. The PHC is in the outskirts of a village and no body dare to stay there in the night not even a watchman. If they had constructed housing along with the PHC it would have facilitated. Another LMO who commutes to PHC every day from Gulbarga complained that the people and elected representatives harass her to stay in the PHC quarter which she has not occupied because there is no water, electricity and building is 25 year old needs repairs. They are not keen to do anything to facilitate the services. Most of the drugs that ZP supplies are about to expire and become useless.

The months Feb-March are two months when ZP administration is too busy to approve medical reimbursals of staff of Health Department and they not even consult the DHO. Registers required to compile statistics are not supplied for over a decade. All files move only if currency notes are enclosed with them. RCH building fund of Rs.10 lakhs is lying for over an year but even the plan is yet to be made and approved. Nothing moves.

Taluk Medical Officer has to write to DHO who in turn has to forward to ZP for any action. Taluk Medical officers can not even sanction Travelling bills of his subordinate staff and those who approve it may not know whether the travel was made to those places. ZP sanctions all such TA bills with a cut of 10–20 percent.

Even the DHO's office in Gulbarga has several stories of delays. Power connection to his office is not done though they have spent Rs.37,000 for it about 19 months back but ZP is still silent. The list is endless.

What ultimately emerges is that the conflict arise from multiple points of authority with not a single source taking any interest in improving things. The question that arise is who should set things right with quick decision to solve the problem. It is only CEO who is authorised to act after waiting for instructions from the Government on any of the complaints made. We did not come across any such action except issuing a memo or deducting a days salary in some one or two complaints against ANMs. But suspension orders can be issued only by the Government. Generally when there is such a serious complaint against a MO or other officials. ZP elected members or a Minister interfere and nullifies all efforts. Some ZP Presidents had complained against unclean PHCs and a couple of staff coming late when they had visited.

The PRI elected members have many stories against the health staff. Irregularity, showing unconcern and asking money were very common. It was surprising a lady member of the Standing Committee on Health and Education whose husband (aged 44 years) died on Jan 4th 2001 because of the neglect of MO in treating him. He died of massive heart attack and MO had given him treatment for acidity the previous day to his death. He did not check his blood pressure nor examined him. But she did not complain as he is well connected.

But the elected members of such statutory high power committees also are ignorant as reported by many about the health situation – no idea about death rate, infant deaths or maternal mortality which are very high in their area and there was a strong demand to enlighten them on health issues to strengthen them and to improve the situation.

In addition the bureaucrats at ZP believe that Medical Officers at PHC, CHC and district office lack badly administrative skills and management skills to work in a team. The lack or absence of such skills go on accumulating and turn into major issues. We also believe that managing the staff is an art that many medical graduates who join the service as MO at PHC may not have and already some programmes to train them as managers of PHC is on.

The proceedings of the Standing Committee on Health and Education of Tumkur District however reflects what we noted about the district. It says "..... administration in health department has collapsed and DHO has no control over his department" (page 4 of 24/10/2000). It also notes the ZP Presidents suggestion that priority should be given to patients in rural areas by the Medical Officers. It also questions about MOs saying that there is no medicines in the PHCs and prescribing drugs to be purchased by the patients in the market.

The proceedings of Udupi ZP's Standing Committee that meets every month regularly reveal that there is evidence of some efforts to improve the services further. PHCs in Udupi display boldly that if the visitors to PHC have any complaint to make about the functioning of the PHC they are provided a post card free and they can mail it to the concerned authority for action. Based on such complaints the Committee resolved to examine such complaints and recommend action to be taken (either terminate the services of contract MOs or transfer them). It also instructed the DHO to recruit group 'D; employees on temporary basis in place where there is need to ensure cleanliness of health institutions. It notes of disciplinary action by issuing show cause notice to unauthorised absence of a Taluk Medical Officer to consider his absence as leave without pay. These resolutions certainly indicate the efficient mechanism

of receiving complaints and quick action within the limitations of ZP which are worth emulating by other ZPs in the State.

The proceedings of Gulbarga ZP is silent on the situation in health service delivary system in the district but emphasise more on building model Primary Health Centre, resource mobilisation, etc. that shows there is no in-built mechanism of receiving public grievances or they are ignored.

Section IV

Summary of the Findings and Recommendations

The intensive study carried out with time constraint has been able to effectively explore a complicated area ignored so far in academic circles. The policy statement issued recently on population by the Government of India has given the prominence to PRIs that they deserve. It is brought out by the study that multiple power centres and poor co-ordination among them for effective decision making is hampering the smooth functioning of ZP and Health Department at district level. Appointment, transfer, suspension are the crucial areas where ZP acts only as a Post Office. Unless the State Government approves they cannot act. The key post of DHO has been weakened because of interference of elected representatives. Even simple act like posting a Laboratory Technician from a place where there is no serious demand for his services to a place where there is an out break of an epidemic is resisted by highest authority. Infact instructions come to him if he acts in his way he will be in trouble. Such instances have demoralised him. Transferring an ANM to another place has become just impossible. Time constraint is imposed by several meetings he has to attend. This was the view of all high officials also in Bangalore that they find little time to work in their office.

The Grama Sabha – a most powerful instrument the people have to air their grievances for redressal and which is given lot of importance in decentralised system of governance is almost non-functional as found in the household survey responses. People complained in Gulbarga and Tumkur districts that meeting is not announced by Tam-Tam (drum beating) and contrary

it is held when most of the residents go for work and only few whom they want attend it and non complaints are entertained. The Udupi District that is in the forefront in health sector has developed a good system of receiving public grievances directly by the authorities concerned and redressal is quick. In other two districts complaints are unheard and neglected on the ground that there are no written complaints.

Decentralisation is still in infancy in the state and suffers from several constraints to be effective government at district level. How to monitor the functioning of the system of health care services delivery? Is not known to even top officials like CEO, Dy. Secretary 1 and other officers at Taluk levels. Official inspections are more ceremonial and unproductive even though such inspections by different categories of authority are rare and routine. There is no effort to understand the problems and solve to improve the performance is not seen any where except in Udupi. Therefore there was a strong demand to enlighten them with one day programme at ZP for all concerned officers. The officers in health department were not even aware of research finding that should guide them in their work.

The guiding principle of any public health care service delivery is equity and universal accessibility. The state has a very very long way to go to achieve it. Even then equity and universal accessibility will not be an automatic fall back from expanding services or bringing in a semblance of quality in care. It can be achieved by monitoring crucial services like basic primary care which is absolutely missing at ZP level. There is need to intensify the efforts, if already there are, to reach the goal of equity. For this there is need to equip PRI elected members, general public about the importance of health and its effective utilisation. The elected representatives have to develop responsibility towards their activities. They come from diverse socio-economic and cultural background and over the years grow as leaders. They have started asking questions about services which is in the right direction. Health personnel who were used to departmental control are perturbed over the authority of representatives. They

will have to realise that their services are for them and they are the real masters in a democratic system. There is nothing to worry.

But till the PRIs become more effective in their functions the department has the crucial role to play. Efficiency and quality care and ensuring its outreach of services have to be managed by them which will go a long way in building of credibility of the department which is at a very low ebb now. PRIs will be happy and stop interfering if they are convinced about good services to all.

The main questions that still remains to be answered is how decentralised the state is really? Can ZPs be considered as Local Self Government? A short term study such as this would not try to explain the extent of decentralisation in the state today. It seems there is a make–believe effort to show we are decentralised while all the powers are centralised with the state (because of several reasons stated and believed). One of the important factor for the mess in health department is the multiple power centre without any direction – pulling the cart in different direction. The lost aura of DHOs and reluctance of efficient Medical Officers to occupy this role reflects very clearly the situation. If health care services are to be improved his position has to be strengthened. Such studies ideally need at least an year but an effort is made here to bring out several complex issues that a longitudinal study should explore in the future.

Recommendation

1) There is an urgent need to make ZPs to consider health sector as an important input in development and to educate officials ranging from Chief Executive officer to Executive Officer at Taluk level on monitoring health services and on health indicators that reflect it. There is unbelievable ignorance in the administration and also in the health department who are major health care providers in rural areas on the status of health of their people.
2) The Elected Representatives from Gram Panchayat to ZP level also need to be educated about importance of health and their role in monitoring

health outcomes. Only ensuring presence of doctor or supply of drugs is not adequate to achieve equity. Monitoring plays a crucial role and it is totally absent at all levels.

3) The Health Department should be made responsible in improving health care services in the districts and they should be ensured the support of ZP, TP and GP in carrying out their responsibilities efficiently. For this there is need to build-up the credibility that is lost. The health services would be considered good if the indicators of health improve and become comparable with the best in the state to start with.

4) There is an urgent need to establish fool proof mechanism to receive public grievances for redressal as is effectively done in Udupi District. Strengthening Grama Sabhas would play an important role if they are conducted properly. PHCs in health poor district should provide free post cards to public who should mail it to responsible authority for redressal and quick action on the complaints will strengthen this mechanism in due course of time.

5) Whether ZP Presidents should be fully empowered for taking any action or not is a wider question we would avoid answering here. But they can play an important role within the powers they enjoy now. Just calling an erring officer and reprimanding him in public will do the trick. Even an indication that they are serious will go a long way than proceeding on legal terms.

6) The ZP and health bureaucracy at district level should learn to respect each other and the need to understand their complimentary role. Health is a technical subject best known to health staff and they need all the support, encouragement and appreciation when they do a good job. Health staff should realise that elected members to PRI though may not be educated represent peoples views and respect them for that. There is need to meet informally for achieving this by both.