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# **Political and Programmatic Decentralization in India's Health Sector: Insights from Karnataka**

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## Political and Programmatic Decentralization in India's Health Sector: Insights from Karnataka

Shreelata Rao Seshadri and Krishna Kothai

***Abstract:** While India has made progress in achieving important health sector goals, there is still a long way to go. The Government of India has adopted decentralization or devolution with the objective of promoting greater equity and supporting people-centred, responsive health systems. We report on a study that problematizes the idea of strengthening health sector governance through decentralization and that explores the intersection of the political goal of enhanced local-level autonomy and the programmatic goal of more responsive health service delivery. The study examines the extent to which both political and programmatic decentralization are functional at the village level; looks at the design and objectives of decentralization at the village level; and considers whether sustained and supportive capacity building can create the necessary conditions for more genuine de facto decentralization and empowerment of village-level functionaries. Our methodology included semi-structured interviews with village-level functionaries in two districts of Karnataka, based on which we designed an Action Research to strengthen coordination and synergy between the functionaries responsible for political and programmatic decentralization. We found that both political and programmatic decentralization at the village level are at risk due to a lack of convergence between the political and programmatic arms of the government. This is substantially due to problems inherent in the design of the decentralization mechanism at the district level and below. Sustained capacity building can contribute to the more effective application of decentralization mechanisms, but systemic issues regarding the decentralization mechanisms need to be addressed alongside. We were also able to identify some spaces where coordination between village-level functionaries is possible, and the steps that need to be taken to build on this potential.*

***Keywords:** Decentralization; National Health Mission; Village Health Sanitation and Nutrition Committee (VHSNC); Community Health Worker (CHW); Karnataka health sector*

# Political and Programmatic Decentralization in India's Health Sector: Insights from Karnataka<sup>1</sup>

Shreelata Rao Seshadri and Krishna Kothai

## Background

India has made significant progress on achieving health outcomes in the past two decades (Patel et al., 2015): per capita prevalence of disease as measured by Disability- Adjusted Life Years (DALYs) has been reduced by 30 per cent; Life Expectancy at Birth has gone up from 62.5 years in 2000 to 68.8 years in 2017; the Infant Mortality Rate has been halved from 68 to 34 per 1,000 live births during the same period; and the Maternal Mortality Ratio has fallen from 254 to 167 per 100,000 live births (2004/05–2011/13). India was declared polio free in 2014, and the spread of epidemics such as HIV/AIDS has been largely contained. However, there is still a long way to go, particularly with the emerging epidemic of non-communicable diseases and the growing gap in health outcomes based on the social determinants of health (Qadeer, 2008). In an effort to further improve health outcomes and make the health system more responsive to local needs, the government has pushed for decentralization of service delivery. Building on existing arrangements for political decentralization through various tiers of the Panchayati Raj Institutions (PRI), devolution of the management and implementation of health programs down to the Gram Panchayat (GP) level was initiated in all states.

Political decentralization through the PRI was established in 1957 (James et al., 2004), and later reinforced by the 73rd and 74th Amendments to the Constitution (1992). The Amendments reflected the government's resolve to empower the PRIs and provide them with the necessary wherewithal to perform their functions effectively (Gupta and Gumber, 1999; Chaudhuri, 2003; Singh, 2008); as well as recognized that decentralization could be a vehicle to encourage people's participation and health system's responsiveness (Murthy and Mahin, 2015; Dharmarajan, 1994).

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Globally, decentralization has received broad support both from the governments of developing countries and international agencies, with institutions like the World Bank suggesting that public goods and services such as health care should be provided by the lowest level of government, where local conditions can be taken into account when designing and implementing programmes (World Bank, 1993, 2003). This was felt to be particularly critical in India, where concentration of power and 'top-down' approaches persist even though health is a state subject under the Constitution (Pahwa and Beland, 2013).

The goal of decentralization in the health sector was strongly advocated in the Alma-Ata Declaration (1978) as a response to the observed growing inequities in health care between the developing and the developed worlds, and specifically in order to establish the principle that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Alma-Ata Declaration 1978, Article IV). India's National Health Policy (NHP) (Government of India, 1983) followed the call of the Alma Ata Declaration and made a strong argument in favour of decentralization (Duggal, 2001), with a focus on "universal, comprehensive primary health services relevant to actual needs and priorities of the community" (MoHFW, 1983: 3-4). However, operationally, the health system continued as it had since the 1960s, with the needs of the community being served by one male multipurpose worker and one female multipurpose worker (also called the Auxiliary Nurse Midwife or ANM) who is largely focused on the family planning programme and the control of epidemics such as malaria. The next NHP (Government of India, 2002) recognized that the ambitious goal of "Health for All by 2000" set out by NHP 1983 was far from having been achieved due to, *inter alia*, shortcomings in administrative capacity and gaps in resource allocation, and that, in fact, regional and social disparities in health outcomes had widened. NHP 2002 recommended (i) expanded programmatic decentralization at the primary level; and (ii) greater political decentralization, with a strong recommendation for the "implementation of health programmes through local self-government institutions" (Government of India, 2002, sections 4.4.1.1 and 4.6.1).

This was soon followed by the National (Rural) Health Mission (NHM), launched in 2005, which implemented these recommendations by including specific interventions aimed at furthering the NHP's goal of decentralization/communitization of health service delivery (see Table 1). The interventions combined the objectives of political and programmatic decentralization contained in NHP 2002, creating institutional arrangements that required political and programme functionaries at the grass roots to collaborate and work synergistically.

**Table 1. Decentralization/Communitization under NHM**

Intervention	Location and Composition	Function
Accredited Social Health Activist (ASHA)	An additional community health worker at the village level 1 ASHA per 1,000 population	An incentivized outreach worker, responsible for increasing health awareness in the community; providing counselling on safe delivery, breastfeeding, immunization, contraception, and sexually transmitted diseases; facilitating institutional deliveries; providing primary care for minor illnesses (diarrhoea, fever); providing DOTS (Directly Observed Treatment, Short Course); promoting the building and use of household toilets
Village Health Sanitation and Nutrition Committee (VHSNC)	In each village, as a subcommittee/standing committee of the GP  Convened by the ASHA, with the Auxiliary Nurse Midwife (ANM), the Anganwadi Worker (AWW), GP members, and other community members selected by the GP and ratified during the Gram Sabha	Responsible for informing the community about health programmes; promoting community participation in the planning and implementation of health programmes; addressing the social determinants affecting health equity; facilitating the community to voice its health needs; equipping panchayats to provide leadership for collective action on health issues.
Enhancing the role of PRIs in health service delivery	In each village, through the Gram Panchayat (GP)	Responsible for instituting Village Health Committees, which are tasked with creating and implementing Annual Village Health Plans.
Arogya Raksha Samithi (ARS/RKS)	At each health facility, including the Primary Health Centre, Community Health Centre/Taluk Hospital, and District Hospital  Composed of local MP/MLA/PRI member (Chairperson), District Surgeon/Medical Officer in Charge (Secretary), other eminent members from civil society organizations and the community	Responsible for holding public health facilities accountable for quality of services, patient satisfaction, availability of essential drugs, raising funds from local sources, inclusion/health equity, and community participation in cash/kind.

Source: National Rural Health Mission documents.

How effective have these measures been in achieving the goal of programmatic decentralization? In the context of decentralization in the health sector, evidence shows that it could sometimes lead to negative consequences. Lieberman and Marzoekib (2002) cautioned that if not properly implemented, decentralization may lead to a deterioration in the provision of health services and consequently to poorer health outcomes. Some programmes like the provision of immunization services and the control of vector-borne diseases may not be better performed at the local level (Akin et al., 2005).

Only a few studies have been done in the Indian context, particularly by applying a rigorous analytical framework to empirically scrutinize the impact of decentralization. The consensus is that decentralization has been largely unsuccessful because of the reluctance of leadership at the higher levels to actually transfer “funds, functions, and functionaries” and its failure to empower lower levels of government, despite a general acknowledgement that these steps would improve the functioning of health systems and increase accountability (Mavalankar et al., 2005; Hutchinson, 2002; Singh, 2008; Ashtekar, 2008; Babu, 2009; Rao Seshadri et al., 2016). Panda and Thakur (2016) call for a more nuanced and contextualized understanding of how this type of “shared governance” actually works, given the wide scope of the subject and its complexity. This is true globally as well; there is limited empirical evidence on the impact of decentralization on improving delivery of health care services and health outcomes worldwide (Bossert, 1998, 2016; Bossert & Beauvais, 2002; Litvack and Seddon, 2000; Asfaw et al., 2007).

Health sector decentralization - both political and programmatic - needs closer study, since it is an important component of India's health policy. This paper contributes to the literature on decentralized health service delivery by unpacking the complex interrelationship between the parallel streams of political and programmatic decentralization that converge at the community level.

## Research Question

We selected Karnataka as the site for the research study for several reasons. First, panchayats have had a checkered history in the state. The report of the Mission Group on Decentralization and Governance constituted by the State Planning Board, Government of Karnataka (<https://www.karnataka.gov.in/spb/Reports/MissionGroup-on-Decentralization-SPB.pdf>) noted that Karnataka has been treated as a champion of decentralized planning in India, having passed the Zilla Panchayats, Mandal Panchayats and Taluk Samitis Act of 1983. The Act was implemented in 1987 and brought about significant administrative reforms, which “captured both international and national attention, and, in fact, were inspirational for the renewal of interest in decentralisation, which eventually contributed to the 73rd and 74th Amendments.”<sup>2</sup> However, the report goes on to trace the decline of local governance in Karnataka, despite the strong commitment expressed in the Karnataka Panchayat Raj (KPR) Act (1993), and the marginalization of the panchayats through changes in the political, financial, and administrative arrangements. Delays in the holding of successive panchayat elections in the mid-1990s, coupled with term limits imposed on the office of the panchayat Presidents and Vice-Presidents, eroded the commitment of panchayat leadership and constrained the prospects for the emergence of new leaders. However, a fresh round of reforms commenced in 2002 and important amendments were made to the KPR Act (1993), including the provision of greater financial and administrative autonomy to the different tiers of the panchayat, and, importantly, the strengthening of the Gram Panchayat to be the “cutting edge of local service

<sup>2</sup> <https://www.karnataka.gov.in/spb/Reports/MissionGroup-on-Decentralization-SPB.pdf>: 9

provision”<sup>3</sup>. Alongside this, a concerted effort was made to build the capacity of the panchayat members at all levels. Despite these efforts, the evidence indicated that local bodies in Karnataka continue to suffer from inadequate power and limited resources (Rajasekhar and Satapathy, 2007). Rajasekhar and Satapathy (2007) show that out of 29 items, only 14 items were transferred to the GPs in Karnataka. Subsequently, based on the recommendations of the Karnataka Panchayat Raj Act Amendment Committee (2014), the Karnataka legislature passed the Karnataka Gram Swaraj and Panchayati Raj Bill (2015), which gave sweeping powers to the Gram Sabha as the basic unit of self-governance and which ensured the direct participation of community members in the planning, implementation, and monitoring of government schemes. However, a recent assessment by Babu et al. (2018) concludes that in terms of fiscal autonomy, the situation in Karnataka can at best be described as “partial decentralization”, with persistent problems relating to limited resource base, weak accountability, and lack of monitoring hampering the achievement of genuine autonomy in decentralized governance. This assessment is in contrast to the findings of reports from Kerala, another state that has been at the forefront of decentralization in the country, where a “big bang” approach has been adopted, with a high degree of fiscal decentralization and discretionary power being the hallmarks of the decentralization process, accompanied by a high level of local accountability (Venugopal and Yilmaz, 2009).

Second, we build on previous work on decentralization in Karnataka undertaken by Rao Seshadri et al. (2016), which uses Bossert's (1998) framework to look at decentralization at the district level and to analyse the level of autonomy and decision space that programme managers at that level perceive for themselves. The paper in particular examines the experience of Karnataka in two areas: (i) whether the decentralization implemented under the National Rural Health Mission (NRHM) is truly perceived as being empowering and as promoting autonomy in a range of functional areas for those working on health care delivery and outcomes at the district level and below; and (ii) whether the perception of greater autonomy at this level actually results in better managed health systems.

The findings present a mixed picture: of the five dimensions on which autonomy or the decision space were measured (finance and budgeting, contract management, human resource management, performance monitoring, and access rules), both PRIs and programme managers scored uniformly high only on performance monitoring. On all other dimensions, the autonomy exercised under both political and programmatic decentralization was limited, with the predominant perception being of a strongly top-down approach. Interestingly, PRI members scored worse than programme managers on all dimensions, raising concerns about the feasibility of ever achieving the goal of people-centered health systems through communitization, as envisioned by the NRHM.

<sup>3</sup> <https://www.karnataka.gov.in/spb/Reports/MissionGroup-on-Decentralization-SPB.pdf>: 11



The paper empirically establishes the complex nature of decentralization at the district level and challenges the notion that decentralization can be achieved through administrative fiat. It concludes by recommending that for decentralization to progress from being *de jure* to *de facto*, there is a need, *inter alia*, to capacitate district-level teams to better understand their roles and responsibilities, and to empower them to function with greater autonomy. The call for (i) greater clarity about the prescribed roles leading to better coordination of activities; and (ii) the need for capacity building of lower-level functionaries echoes the recommendations of several previous studies (Gupta and Gumber, 1999; Dutta, 2001; Sekher, 2001; Behar and Kumar, 2002; Kalita et al., 2009).

The present study specifically looks at the functioning of the Village Health Sanitation and Nutrition Committee (VHSNC) for two reasons: (i) it is a key part of the NHM's decentralization/communitization strategy and, by the very nature of its membership and role, aims to bring together the political and programmatic arms of decentralized governance; and (ii) given the larger political commitment to decentralization in Karnataka, particularly at the village or GP level, how this measure has played out in the context of the health sector is of interest. This paper extends Rao Seshadri et al.'s (2016) analysis of decentralization and decision space at the district level down to the village level: Do the issues and challenges encountered at the district level persist down to the village level? It also tests the widespread understanding that a key reason for the failure of decentralization in the health sector is the lack of awareness and capacity of functionaries working in the field. Several studies have documented efforts to build the capacity of VHSNCs to strengthen their functioning and bolster their impact on health outcomes at the community level (Mohan et al., 2012; Srivastava et al., 2016; Ved et al., 2018). Their findings indicate a mixed picture; while capacity building has been found to be effective in improving the performance of VHSNCs, there are indications that (i) these improvements may be difficult to sustain in the absence of intense support from either an external agency or from higher levels of the health system; and (ii) the effectiveness of village-level entities (including VHSNCs) depends critically on their relationship with the higher-level political and administrative levels. Keeping in mind these insights, this study sets out to explore the following issues:

- (i) What are some of the issues encountered in the NHM's effort to bring about convergence between political and programmatic decentralization through the VHSNC?
- (ii) Can sustained, supportive capacity building create the necessary conditions for more genuine *de facto* decentralization and empowerment of village-level functionaries?

## Methods

Qualitative data was collected in two phases:

- (a) The first phase (2014) involved collecting data based on focus group discussions (FGDs) with about 100 respondents in Kodathi Gram Panchayat (Bengaluru Rural District) comprising members of the Zilla Panchayat, members of the GP, members of VHSNCs, members of Arogya Raksha Samithi, Block Education Officers, Social Welfare Officers, Tahsildar, members of the Taluka Panchayat, Anganwadi Workers, Village Accountant, and community members. The objective of the interviews was to examine the possibility of convergence between political and programmatic decentralization and to gauge the ability of Community Health Workers (CHWs)—including the Auxiliary Nurse Midwife (ANM), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW)—and PRI representatives to engage fruitfully with one another. This phase of the research unpacked the respondents' understanding of their roles and responsibilities relative to other actors in contributing to health outcomes.<sup>4</sup>

**Table 2. Focus Group Discussion Participants**

Members of Zilla Panchayat	8
Members of Gram Panchayat	18
Members of Arogya Raksha Samithi	4
Members of VHSNCs (other than CHWs)	15
CHWs	23
Community members and others	32

- (i) Based on the understanding emerging from the qualitative data collected in Phase 1, an Action Research was conceptualized (between February and April 2017) and implemented in Udupi District. The main focus of the Action Research was to strengthen coordination and synergy between the functionaries responsible for political and programmatic decentralization through role clarification and capacity building. The selection of the district for the Action Research was determined by (i) the buy-in of the district administration to participate in such a programme; and (ii) the availability of a local implementation partner with a good rapport with local communities. In addition, the two districts (Bengaluru Rural and Udupi) both figure among those districts in Karnataka where all GPs perform above the state average on various human development indicators (Shivashankar & Prasad, 2015).

<sup>4</sup> These findings were presented at the Health Systems Global conference (2014) in Cape Town, South Africa (Rao Seshadri, S., Kotte, S., and N. Latha, Political decentralization and programmatic devolution: A realist evaluation). The authors acknowledge the useful comments and feedback received during the presentation, which contributed to refining the objectives and design of the ongoing research programme.

## Key Findings

### Baseline FGD content analysis

We first report on the FGDs conducted with PRI members and CHWs in 2014, in Kodathi Gram Panchayat, which were aimed at assessing their understanding of their relative roles and responsibilities in achieving desired health outcomes. For the purpose of comparative analysis, we organize the responses as follows:

#### Box 1. Perception of PRI Roles

Roles of PRI members as per NHM guidelines: PRI members who are part of the VHSNC (including the Chairperson of the VHSNC) are expected to (i) ensure that the VHSNC meets regularly; (ii) take the issues raised by the VHSNC to the GP; and (iii) lead the preparation and sharing of the Annual Health Plan generated by the VHSNC at the Gram Sabha. The GP itself (consisting of non-VHSNC members) is meant to raise community health issues, to ensure that the VHSNC responds to these issues, and to provide leadership to promote collective action to improve health outcomes.	
PRI members' views on their own roles	CHWs' views on the role of the PRI
<p>Overall, PRI members did not really see a very direct role for PRI in health, had poor awareness of health programme implementation and monitoring arrangements, and felt that this is the primary responsibility of the Health Department.</p> <p>They did, however, feel that the VHSNC should play a more active role in the following areas:</p> <p>Community needs assessment and programme planning;</p> <p>Provision of safe drinking water, sanitation, and epidemic control;</p> <p>Strengthening of health infrastructure;</p> <p>Ensuring necessary funds for health activities according to NHM guidelines;</p> <p>General monitoring of, and support for, programme implementation, largely focused on monitoring the progress of civil works.</p>	<p>The CHWs saw the PRI as having quite a limited role to play in the health sector. The main areas they identified were:</p> <p>To extend financial and manpower support to health activities whenever the need arose;</p> <p>To conduct limited activities cooperatively, such as health surveys or immunization drives;</p> <p>To provide additional incentives for ASHA workers.</p> <p>It was the CHWs' opinion that the cooperation extended by the PRI so far was quite adequate and they did not have a greater expectation of them.</p>

Interestingly, there was substantial convergence in the views of the PRI and the CHWs on the role of the PRI in health programmes.

- Both groups saw the role of the PRI as being limited, confined to providing stop-gap support to the CHWs in the performance of their duties.
- The PRI did see that clean drinking water and sanitation are priorities, but the CHWs did not acknowledge this.

- Neither of the groups saw the PRI as playing any role in ensuring accountability in health service delivery. Indeed, the PRI explicitly felt that the monitoring of health activities is the responsibility of the Health Department, and that they had no role to play there.
- The PRI's intervention in terms of providing a voice to the community was restricted to data collection through surveys for specific programmes (construction of toilets or identification of BPL families) and participation in the annual planning exercise.
- The most important instrument to strengthen "communitization" provided under the NRHM, that is, the VHSNC, was not mentioned by the CHWs, even though the ASHA is the convener of the committee. The PRI representatives stated that they would like the VHSNC to play a more active role, but without acknowledging that it is their own responsibility to activate the VHSNC.

#### Box 2. Perception of CHW Roles

Roles of CHWs as per NHM guidelines: The ASHA is the convener and is responsible for calling meetings, raising issues, maintaining records, and managing untied funds. Other CHWs are meant to share data and information relating to their specific programmes, activities, and outcomes (ANM on health services, AWW on nutrition services), and to implement the decisions of the VHSNC as they come under their purview.	
CHWs' views on their own roles	PRI's views on the roles of CHWs
<p>The main role that the CHWs see for themselves is in service delivery. This includes:</p> <p>To provide services according to the NRHM guidelines and according to the schedule;</p> <p>To maintain patient records and update them regularly; and to report the data to the appropriate authority within the Health Department;</p> <p>To support the community in accessing health services such as the 108 Emergency ambulance;</p> <p>To coordinate with the PRIs in the event of a public health emergency.</p>	<p>The PRIs focused their views largely on the Health Department as such and had little to say about the CHWs and their roles and responsibilities.</p> <p>However, the PRIs expressed clear views on hospital improvement, including the following areas: (i) posting of an adequate number of qualified staff; (ii) availability of water; (iii) maintenance of hospital timings; (iv) maintenance of facilities, including cleanliness; and (v) maintenance of infrastructure, especially the need for building additional rooms.</p> <p>None of these is within the purview of the CHWs' assigned activities.</p>

- In the case of CHWs, they had very clear views on the boundaries of their role: the need to deliver the services mandated by the NRHM and to report regularly to their designated superior *within the Health Department*.
- CHWs saw no role for the PRI in monitoring their activities or in providing day-to-day supervision or support (although this is mandated under the NHM guidelines as a key responsibility of the VHSNC).
- CHWs did, however, rely on the PRI for support in the event of emergencies (outbreak of dengue, etc.).
- The PRI saw the CHWs as only the lowest-level functionaries of the Health Department. They had few issues or reasons to talk about their role or performance. They did not see the CHWs as being their partners in providing a critical social service to their community.

- The PRI clearly saw the Health Department officials at a higher level as being much more critical to the availability, accessibility, and quality of health services. They did not see the CHWs as having much of a decision-making role regarding these issues.

### *Design and Implementation of the Action Research*

The above-mentioned exercise highlighted the limited understanding of field-level functionaries of both the political and programmatic arms of decentralization and pointed to the critical need for establishing role clarity and undertaking building capacity to help fulfil their roles and responsibilities satisfactorily. This led to the conceptualization of the Action Research based on these findings. The main focus of the Action Research was to strengthen coordination and synergy between the functionaries responsible for political and programmatic decentralization through role clarification and capacity building. The research design was arrived at in conjunction with the Zilla Panchayat and the district administration (Udupi District) over the course of about 22 joint sittings of various functionaries with the research team, and in consultation with two identified GPs and two VHSNCs in each GP. The intervention was planned for a period of one year (April 2017–June 2018) and consisted of the following:

- A two-day workshop for CHWs, PRI/VHSNC members, and community groups (self-help group (SHG) members, for example) to increase awareness of the roles and responsibilities of various functionaries in respect of health service delivery. District-level functionaries, including the Chief Executive Officer of the Zilla Panchayat and the District Health Officer, attended the meeting and spoke to the participants about the importance of working synergistically to enhance health systems performance. A detailed plan was drawn up for handholding by the research team; and
- Handholding of the functionaries of two selected GPs by the research team to streamline and strengthen the operations of CHWs and PRI/VHSNC members commenced following the workshop. This was done over the duration of a year through regular meetings, observation of monthly CHW meetings along with discussion of feedback, review of records, etc. Detailed notes were maintained of each meeting, and appropriate follow-up was recommended.

In the next section, we report on the implementation of the Action Research.

At the outset, a series of discussions was held with the personnel of the Department of Health and Family Welfare Services and the Department of Women and Child Development. At the same time, members of the Zilla, Taluk, and GPs were also contacted. These discussions confirmed the baseline findings: (i) departmental functionaries (CHWs) were expected to deliver a prescribed set of services, in keeping with the norms of the NRHM. They were expected to report on their activities regularly to their parent department and to attend periodic meetings with their departmental superiors to discuss their performance; (ii) the Panchayats saw the CHWs as being under the jurisdiction of their respective line departments and took little interest in their activities. The Panchayats had also

made no attempt to form or run VHSNCs, although this was part of their responsibility under the NRHM, and they were aware of this mandate; and (iii) in the absence of the active participation of the PRIs in operating the VHSNC, the Medical Officer (MO) of the Primary Health Centre (PHC)—also a functionary of the line department—had made it her responsibility to bring about some structure and functioning to the VHSNC.

Subsequently, the two-day workshop was conducted in April 2017, where a plan for regular handholding by the research team was agreed on. This included:

- working with the GP to constitute the VHSNC in accordance with NRHM norms;
- ensuring that the VHSNC met regularly (once a month);
- structuring an agenda for the meeting in consultation with VHSNC members;
- ensuring that the meeting was conducted in a formal and orderly manner, with the minutes duly recorded, etc.;
- ensuring that the meeting ended with an agreed date for the next meeting.

This plan was then implemented over the next year. Within three months of the commencement of the capacity-building exercise, the research team noticed a material change in the operation of the VHSNCs. For a start, the VHSNCs were constituted in accordance with NRHM norms. It was found that the meetings were being conducted regularly and systematically. Even though not all members were always present, those who attended were active participants, including the CHWs. Women members, especially members of SHGs, were keenly interested in raising and discussing issues. Some of the positive outcomes during this phase were: (i) increased literacy and awareness levels of community members; (ii) active interest of the VHSNC members in making a positive contribution; (iii) increased interest of the district-level administration (in the Health Department) in rejuvenating the VHSNC and making it a success, and even in making Udupi into a “model” district in this respect; and (iv) the assessment by the research team that with capacity building and guidance, the VHSNC could become an effective advocate for better health outcomes for the community. The negative outcomes were that the interest of the PRI machinery in this activity was negligible, and even the PRI members of the VHSNC were not held accountable for their contribution (or lack thereof) to the VHSNC's performance.

Unfortunately, after three months of sustained effort by the research team, it became evident that the structural problems identified at the baseline were rather intractable, as detailed below:

- The functioning of the VHSNC continued to be constrained by little support from the higher levels; the taluk- and zilla-level panchayats did not take cognizance of decisions taken at the village level. Indeed, at the GP level itself, the President, the Secretary, and others failed to understand the importance of deliberations of the VHSNC. They were not aware of either the structure or the function of the VHSNC. The issues raised by them were not discussed in the Gram Sabha.



- (ii) On the other hand, the departmental machineries (both Health and Family Welfare as well as Women and Child Development) were deeply engaged in the work of the CHWs, monitoring the activities of their respective functionaries closely, holding regular reviews of reporting formats and monthly meetings. Even though there were gaps in their knowledge, the departmental staff at the district level and below were generally aware of the functions of the VHSNC since it was part of the NRHM programme. But it was not in their power, despite their keen interest in implementing and reporting on all NRHM initiatives, to make the VHSNC a success without the active engagement of the PRIs. This led to peculiar forms of subversion: for example, meetings between the CHWs and a couple of PRI members for operational reasons would be recorded and reported as a VHSNC meeting.
- (iii) At the completion of the 12-month period of support by the research team, the chain of linkage between the CHWs, the VHSNC, the larger PRI machinery, and the Gram Sabha continued to be weak, for the reasons recorded above. With consistent capacity building, it was possible to substantially improve the functioning of the VHSNC in terms of regularity of interaction, following procedures, reporting, and follow-up. Activities that fell within the purview of the VHSNC were benefited by this effort. However, this did not translate into VHSNC members being able to influence the larger context within which they operated. In terms of enhancing ownership of health activities by the local leadership or raising the profile of health issues either at the Gram Sabha level or at the higher levels of political governance, there was little progress.

## Discussion

We began our study with two questions: (i) What are some of the issues encountered in the NHM's effort to bring about convergence between political and programmatic decentralization through the VHSNC? (ii) Can sustained and supportive capacity building create the necessary conditions for more genuine *de facto* decentralization and for the empowerment of village-level functionaries?

We found through the baseline FGDs on the perceptions of political and programmatic functionaries at the village level that a key decentralization strategy, that is, the empowerment of the VHSNC, faces numerous challenges and constraints. An analysis of the themes emerging from the discussions with health functionaries and community leaders indicates the following:

- (i) Political and programmatic decentralization have differing measures of success:** CHWs are very closely aligned to their programme objectives and reporting requirements. Routine reporting on specific formats is a central part of their duties as they see it, and regular review meetings are a regular feature as well. The incentive payment of the ASHA workers depends on the delivery of very specific services, regular documentation of their activities, and the following of proper reporting procedures. For the PRIs, on the other hand, delivering highly visible basic amenities such as drinking water and sanitation is seen as more politically valuable. The benefit here is to the community as a whole rather than to women and children (the basic

targets of the NHM) or to those who are sick and in need of medical attention (a relatively small proportion of the population at any given time). Other recipients of PRI funds include buildings and infrastructure in all sectors, including health facilities, equipment, and drugs, all of which are tangible inputs for which the PRI can claim credit.

- (ii) The functionaries of political versus programmatic decentralization have unequal power:** CHWs are—and indeed perceive themselves to be—at the lowest rung in the ladder of power in the health sector. This is clear from their own description of their roles and responsibilities, their lack of power to take independent action even in emergencies, and their low expectations of receiving help and support from the PRIs. CHWs are not aware that the PRIs are accountable for all aspects of community welfare, including health, nor are they capable of mobilizing the PRIs to be accountable for delivering this mandate. The intermittent, sporadic, and issue-based support that is extended to the CHWs by the PRIs is received with gratitude, and any further support that is requested or expected is only of a monetary nature and is voiced more as a wish list rather than expressed as a legitimate expectation.

PRI members, on the other hand, see themselves as being in the “drivers’ seat” when joint decision-making is required. They decide if and when they will solicit the help of the CHWs, and also decide if and when they will offer the CHWs help and support. They do not see any need for routine engagement in the activities and concerns of the CHWs. However, if a situation were to arise where the community as a whole is affected and there is a need for a visible response, they will step in and partner with the CHWs. Such occasions are few and far between, and in the absence of such urgent need, the CHWs do not feature on the PRIs’ radar screen. The PRIs would rather be in dialogue with the Health Department at a much higher level, discussing matters pertaining to infrastructure, human resources, and service quality.

- (iii) Gender is an important consideration that needs to be addressed:** CHWs are usually young women, who are easily dominated by PRI members who are mostly older men. The poor functioning of the VHSNC, for example, could be seen as a symptom of the problematic gender equation; the fact that the convener is the ASHA worker may be the reason why so little interest is evinced by other PRI members in the functioning of the committee. When the issue of requesting PRI members for additional assistance was raised, the women expressed a general reluctance to do so; they did not feel comfortable making demands of senior male members of the community.

These findings seem to conform to the conclusions of earlier studies on contestations between bureaucratic and traditional forms of power and authority. Price (1999), in her study on corruption in south India, characterizes Indian political culture as a contestation between bureaucratic principles and traditions that still carry “marks of attachment to western-style notions of universal law codes and regulations of bureaucratic procedure” (Price: 317) inherited from a colonial past, and as a political culture that has developed different ways of exercising power and authority over a long history of decentralization. She contrasts this with Western European models where

political culture is also built around informal networks of power and authority, but which abide by constitutional and bureaucratic procedures or due process. This clash between the values of a rule-based administrative machinery and a network-based political culture finds expression in numerous forms of discord. This aspect merits a more substantive study in the present context.

Through the Action Research, we found that the dysfunctionality of both political and programmatic health institutions is compounded by larger structural problems. These include:

- Primarily, the design of decentralization mechanisms—both political and programmatic—cannot be prevented from being subverted and/or driven by state- and district-level agendas. For example, if a programme such as the Swachh Bharat Abhiyan is made a priority at the state or district level, it becomes the priority of the village-level functionaries as well. GPs (and by extension, VHSNCs) are not genuinely empowered to set their own agendas; this is a larger issue of the nature of state-level decentralization. Due to this, agendas are already set at the district or state level, and the GP is used as an instrument to implement these priorities. This is perhaps the reason for the reduced interest in, and the limited commitment to, taking local initiative. Unlike Kulkarni et al. (2012), our findings did not indicate greater visibility of health concerns in Gram Sabhas; indeed, it was quite the opposite.
- Second, such state- and district-level priorities not only set aside and override local priorities, but they also undermine the government's existing community-based programmes. This happens in two ways: (a) the time and energy of field-level functionaries is diverted towards the prioritized programme, to the detriment of their normal activities; and (b) additional funds and resources are provided for the high-profile implementation of the prioritized programme, which makes the already meagre funding provided to the field functionaries appear even more negligible and trivial.
- Third, the departmental requirements for CHW activities are rigid and target-driven. The satisfactory completion of these activities is the sole objective of the field worker, but these activities do not include a requirement to collaborate or coordinate with their political counterparts. Despite being the community-level mediators between the system and the community, their responsibility to the community they represent seems less of a concern. Instead, they see themselves as agents of the bureaucracy, responsible for a finite set of actions for which they are held accountable. Their partnership with the PRIs is tenuous, and, in their minds, very weakly defined. Essentially, the cross-cutting nature of political and programmatic decentralization is not recognized in the work programmes or the reporting formats of the CHWs. Hence, they do not push for the VHSNC to be active, since they consider their job to be completed once they file their reports to their reporting department (either the Department of Health and Family Welfare Services or the Department of Women and Child Development). In contrast, there is no requirement for the PRIs to either undertake or report on health-related activities; as a result, the activities of the VHSNC receive no supervision or monitoring.

Can sustained, supportive capacity building create the necessary conditions for more genuine de facto decentralization and empowerment of village-level functionaries? Strategies that focus mainly on local-level capacity building and strengthening can be useful, but the expectation of transforming decentralization mechanisms needs to be realistic. Without addressing the larger structural issues around decentralization mentioned above, capacity building can have only a limited impact. There is also the issue of sustainability of such intensive support, and how it can be built into the existing support systems. Ultimately, such support needs to be concretely redesigned and incorporated into the design of both political and programmatic decentralization.

## Recommendations and Conclusions

The motivation to enhance the effectiveness of decentralization arises from three related objectives: (i) both the political and administrative machinery are committed to implementing decentralization universally and are convinced of its ability to create more people-centred and responsive systems; (ii) political decentralization is meant to amplify the “voice” of the community and to evoke an appropriate response from the health system. This is intuitively a laudable outcome: that people exercise their right to be heard, and that the system fulfils its civic responsibility; and (iii) in the health sector, particularly, the next big leap is possible only if decentralization lives up to its promise: supporting communities to take ownership of their health resources, and holding the functionaries (both political and programmatic) accountable for providing communities the health services that they need.

While our study has focused on two GPs in Karnataka, the findings and conclusions will have implications for addressing the situation prevailing in many other states. We identify several issues pertaining to the challenges faced by decentralization at the village level, yet there are some glimmers of hope; we were also able to identify some spaces where open dialogue between CHWs and PRI members is possible, to understand each other's expectations and lived experience, and to develop mutual understanding and openness to undertake joint action. Achieving these possibilities will take work, and future strategies should include the following:

- Opportunities for dialogue between functionaries of the two arms of decentralization need to be promoted, and this interchange could indeed begin with a joint visioning exercise of how they could fruitfully collaborate and build on each other's efforts. This would also help to find common ground between two sets of functionaries with very different perspectives on their relationship with the community they serve, and different strengths and capacities that they bring to their task.
- The design of decentralization mechanisms at all levels should mandate active collaboration between the political and programmatic functionaries. On paper, fostering this collaboration is meant to be the responsibility of the VHSNC. However, for the reasons discussed above, there is little interest in fulfilling this responsibility. One answer would be to appoint the PRI as the nodal agency responsible for monitoring and supervising the activities of the CHWs. This is not



a new idea; Gupta and Gumber (1999) had suggested putting in place a system that functionally linked the PRI and the Health Department. Whether this would be practically and operationally feasible would need to be tested.

- (iii) Currently, the monitoring and reporting is almost exclusively undertaken by the departmental functionaries through their line departments. Another benefit of collaboration would be the building of joint monitoring and reporting mechanisms that would ensure a sharing of responsibility and information. It would also reduce the option of working in silos, as happens now (other than when faced with an emergency or disaster).
- (iv) VHSNCs have the potential to build synergy between the political and programmatic arms of decentralization. However, they are often conspicuous by their absence, or are largely inactive even when notionally present. As indicated earlier, this is largely because the stakes are very low. Successful decentralization of service delivery in the health sector would be more likely with greater autonomy and incentivization at the lower levels of governance.
- (v) Finally, capacity building does play a vital role in the effective functioning of decentralization mechanisms, but it should be seen as part of a larger package of interventions that includes the recommendations mentioned above. Rather than treating capacity building as a training opportunity that builds the functionaries' ability to perform their assigned roles, the focus should be on capacitating both political and programmatic community workers to cooperate and collaborate with their respective counterparts, and to utilize opportunities to deploy their interdependency effectively.

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## About the Author

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### **Shreelata Rao Seshadri**

Shreelata is Professor in the School of Development at the Azim Premji University and anchors the Health, Development and Society program. She has spent the better part of the last 30 years working on public health issues in India, other parts of South Asia and Africa. Her professional interests are largely focused on health policy, programs and systems and has published numerous books and articles. She has also written in the Kannada press on issues of maternal mortality, childhood malnutrition and health sector governance. Shreelata has explored decentralization in the health sector at the district-level and below both theoretically and through field work.

### **Krishna Kothai**

Krishna Kothai has been in the field of development for over three and a half decades, now. He started his career as a Development Banker, occupying positions like - Agricultural Field Officer, Agricultural Project Officer, Principal, Staff Training College, Specialist Faculty, Apex College, Manager, HRD, etc. He was the Founder Director and Founder Executive Director of an organization named Rural Development and Self-employment Training Institute(RUDSETI) in the country which won various awards. These institutes have been accepted as 'model institutes' by the State and Central Governments to be replicated in the other parts of the Country.

After serving 25 years in the bank, Kothai joined Manipal University as the Founder Director of the Centre for Rural Studies and continued for 12 years.





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