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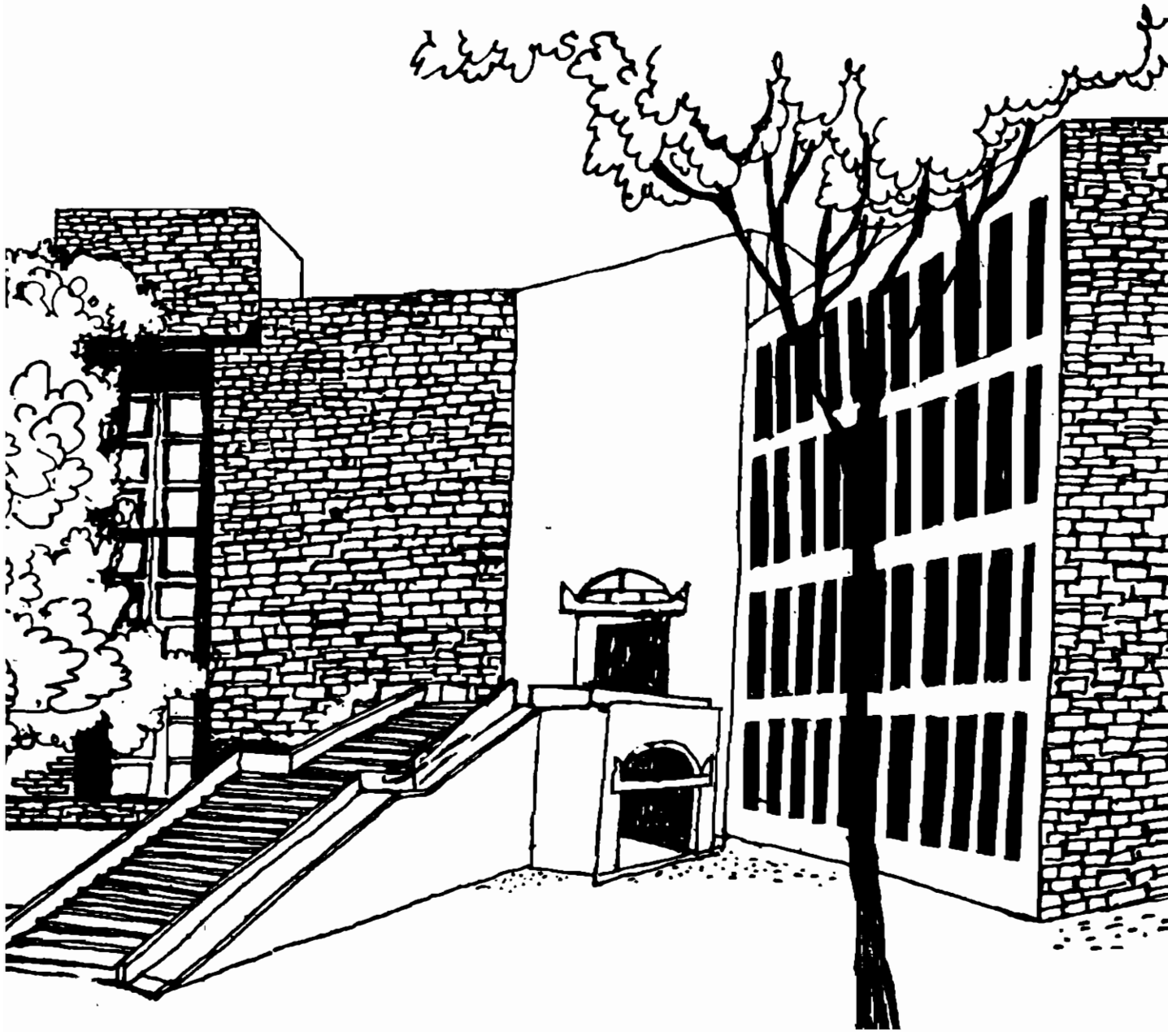

PRIMARY HEALTH CARE UNDER THE PANCHAYATI RAJ: PERCEPTIONS OF OFFICIALS FROM GUJARAT

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Primary Health Care under the Panchayati Raj: Perceptions of officials from Gujarat.[1]

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Introduction:

Of late interest in Panchayats has increased due to the 73rd and 74th amendments to the constitution which makes it mandatory for states to introduce the Panchayat Raj (PR)system of governance and recommends that Panchayats be given wide powers in many developmental areas[1] . In many fora there is a lot of optimism that many problems of governance will solved if the Panchayati Raj system is introduced. It may be useful to review the experience of some states which have tried to implement PR system for a long time before the new constitutional amendment introduced in 1992. Unfortunately not many such studies are available. National Institute of Rural Development, Hydrabad has done a study of implementation of the Panchayati Raj Act in 10 states, unfortunately the information on effect of PR system on health in this study is very limited [2] . This paper looks at the experience of Gujarat in implementing primary health services via the PR system.

Gujarat was one of the first states to implement the PR system in India. Gujarat Panchayat Act was implemented in the state on 1st April 1963 and a three tier Panchayat structures was established in the state. Currently the state has 19 District (Zilla) Panchayats (ZP), 182 Taluka (sub-district / tehsil) Panchayats (TP), 139 Nagar (city) Panchayats (NP), and 13,216 Gram (Village) Panchayats (GP). The Act provides for transfer of various functions including "Family Planning", "Public Health and Medical Relief" to the ZP along with several other developmental functions such as education, agriculture, animal husbandry, social welfare and tribal welfare. Under the same act it is mandatory for the ZP to constitute 10 committees including a Public Health committee. The GP gets 30% and TP gets 15% of the land revenue collected by the state. Panchayats also can and do impose house tax, water tax, octroi (entry tax for goods) and other taxes.[3]

ZP is some what removed from the concept of grassroots governance, but it is the first step towards that. ZP is much closer to the people than state government. Secondly many powers are delegated from ZP to the TP level, thus making it even closer to the community. People can have easier access to TP than even ZP.

Under the Panchayati Raj Act in Gujarat all the Primary Health Centers (PHC) were handed over to the ZP in 1964. And since then the ZPs are responsible for running of

[1] A paper prepared for special issue of *Social Change* on Grassroots Governance, published by Council for Social Development, New Delhi.

the PHCs. The staffing of the PHC system in Gujarat is similar to the country. But the class III and IV employees including the male and female health workers and their supervisors are employees of the ZP. They are recruited and posted by the ZP. While the class I and II employees such as the Medical officer of the PHC and the District level health officers are employees of the State Government and are deputed to the ZP. See the organizational chart. The Chief District Health Officer (CDHO) heads the PHC organization in the district. He reports to the District Development officers (DDO) who is an officer of the Indian Administrative Services (IAS). DDO is responsible for all the developmental programmes in the district while the more senior IAS officers - called the Collector looks after the Law and Order and Revenue functions in the district. The DDO is accountable to the President of the ZP. Even though the PHCs and dispensaries are under the ZP, the higher level health institutions, such as Community Health Centers (CHC), District Hospitals and Medical College hospitals, are all under the health department of the state directly with no control of the ZP over them.

This paper is based on our observations in two districts of Gujarat where our projects related to PHCs are going on for last 5 years. The projects provided us the opportunity to interact with the district health organization and observe the functioning of the PHC system. On occasions we have also interacted with a few political leaders of the district, taluka and village Panchayats. We have discussed and interviewed some senior health officials to get their perspective and experiences about the role of Panchayats in the health department. One of the authors (VMP) has worked in the health department for more than 30 years in various capacities and has the insiders view of the system. We have not systematically tried to interview or collect data from district level or other Panchayat members about their side of the story and hence it is likely that this paper may only give what the officials and staff of the health department perceive. We will be doing a separate study of the Panchayat members to understand their perceptions about the control of PHC by ZP.

Observations and Discussion:

From our experience and interview several themes emerge. We have grouped the observations under various major themes and they are presented below.

Pace of general administration:

The general impression of the ZP rule in the health department is that work progresses very slowly. That is why some workers we interviewed satirically call Zilla Panchayat as "Dhilla Panchyat" meaning "slow or weak" Panchayat. We have seen instances of this where we work. For example for last few years a doctor who has obtained training in sterilization which is the programme of highest importance but is unable to start operating as his name is not sent by the district to the state for inclusion in the panel of approved surgeons. Another doctor who is operating for many years and is an expert in sterilization has also not been enlisted in the panel of surgeons. This indicate the slowness of the administration at the District level. In ZP it take months for employees who retire to get their dues, while in state government it is done in days or weeks. Health workers we interviewed also provided several examples of slowness of the administration of ZP. On the other hand it is also true that in some areas state

government's administration is even weaker. For example if one looks at the management of Community Health Centers (CHC) it is even worst than PHCs which are under ZP.

Local recruitment of health workers:

All the male and female health workers and their supervisors are by and recruited by the ZP from that respective districts and hence are local. They know the district well and are similar to the community in the socio-cultural background. This is a positive point as it helps build quick rapport with the community if the worker wants and tries to do that. The idea of recruiting the workers locally was that they will live in the villages of their postings. This is very important for it makes the worker accessible in time of emergencies and increases the time he or she can spend in the community. Unfortunately this does not seem to have happened. In spite of being local many workers do not stay at the head-quarter village or in any village in their work area. They prefer to stay in a sub-district town or city in the district. There are no exact data at state level on this but estimates are that 50-80% of the workers may not be staying at their areas of work. The PR system has failed to impose this discipline on the workers. This is equally true for the Medical Officers of the PHCs as many of them also do not stay at the place of PHC. In one of the two districts which we are working 26 out of 53 medical officers stay at the PHC village while in the other district only 1 out of 48 medical offices is staying at the PHC village.

As workers are local from that district they have better relationship with local politicians at the TP and ZP. Since the doctors and the CDHO are from the cities or other districts and hence they do not have that close contact with local politicians. This means that workers can effectively protect themselves from punitive actions by bringing political pressure on the CDHO or the DDO via TP and ZP members or the president. Secondly as the workers are ZP employees the worst possible punishment for them is transfer to an undesirable place in that same district as they can not be transferred out side the district. It has been also reported that if a CDHO is very strict and does not yield to the pressure from political side then the ZP political leaders may bring pressure on to the state government to remove him. On the other hand it is also reported that some district level officers' actions related to transfers of workers and medical officers are not just or above suspicion. There are instances when DHOs have been suspended or sent on long leave due to involvement in such activities.

Thus by handing over the PHCs to the ZP there has not been much benefit even though the workers are local. On the contrary the workers can get away with less work due to their political contacts at TP and ZP level. The brunt of this situation is to be borne by the village people as they are denied the services. This happens because the GPs are not very active and are not able to pressurize TP or ZP who protect the nonperforming workers.

Control of the State and Center continues:

Even though the PHC system is under the ZP in Gujarat it runs mostly as per the central and state guidelines as almost all the money comes from the center or state and there are guidelines for implementation of all the key programmes. Thus there is not

much flexibility at the District level to innovate and adapt the PHC system at the district level. The second reason for continued state and central control is that at the district level there is inadequate technical leadership or political will to modify the PHC programme to suite the local needs. The DHO and MO PHCs being the employees of the state, generally follow the state pattern of doing things. The usual contribution of the ZP politicians is in deciding the place of new PHCs or SCs that are to be opened and in postings and transfer of the panchayat employees. The former also has to be approved by the state government. In spite of the technical nature of services and dominant funding from centers and state governments, local leaders can play active role in ensuring that the benefits of the services planned reach the community and can help motivate the community to take full advantage of the programmes. They can also suggest operational modification to make implementation more effective based on their understanding of the local conditions.

Augmentation of resources by ZP:

It was originally visualized that the ZP will put it its own resources to augment the funds received from the state and the center for running the PHC system. Unfortunately there is not much evidence that the ZP are putting additional resources for improving the PHC system generally. In some ZP, for example Kheda, which are rich due to well developed agriculture and dairy industry have allocated additional funds for PHCs. Unfortunately some times these additional funds were not utilized due to lack of initiative of the Health system. But generally most Panchayats' financial status does not allow additional allocation to the PHCs. In the past during 1970s and 1980s some ZPs did provide additional resources to provide 'incentives' to acceptors of sterilization to fulfill their targets and show better performance during the FP campaigns. Recently also Panchayats have played active role in other campaigns such as Pulse Polio Immunization (PPI) and school health campaign. But these have been more in terms of mobilization of human resources from other departments under ZP rather than direct financial contribution.

Funds flow and other financial matters:

In the PR system the funds from the center and state are given to ZP and then ZP gives them to TP and the MO PHC withdraws it from TP and then pays the workers. This adds further layers to the funds flow channel thus increasing the possibilities of delays and diversions of the funds at various levels. We have seen instances where workers are not paid salaries for 20 days as the funds have not come or are not available. This decreases the morale of the workers.

Secondly, TA/DA, other allowances bills and other reimbursements for PHC staff are to be checked and "passed" by the TP clerk. It is reported that very often the money for such bills are not easily available and the clerks wields lot of power on the PHC staff as they can create many "queries" and stall the payment of bills. Such obstructive attitude and behavior of the TP clerk results in the PHC MO and staff not doing the required expenditure for the fear of not getting their money back. It is also reported that some of these clerks also take their commission for passing such bills.

For larger amounts of expenditure the bills have to go to the district and that adds to further delay and disappointment among the staff.. It is also reported that some times central and state money reach to the district only by the end of the financial year and hence they are not able to spend them or are spent without proper planning. One CDHO reported that as unused money lapses in the state budget hence the state dumps large sums just before 12 mid night on 31st March because the districts can use that money in the next year. This is in some sense beneficial to the district but on other hand the money is not available for use during the year when it should have been.

It is also reported that funds given to the ZP for health are not sheltered or protected and the accounting procedure are also very cumbersome. Hence at times funds are not used or may get diverted to other purposes. To guard against delay in fund release and diversion now more and more centrally assisted or donor assisted projects are forming district level societies under the Societies Act , for example for blindness, leprosy, now TB, AIDS and even Reproductive health, which will receive the money and the members of the society will control the many. The society is generally presided over by the collector or DDO and CDHO or other district level health officer is the member-secretary. Such systems may be speedy in using money but generally by pass the control of the ZP and the usual audit procedures. Such societies are double edged swords! But if this proliferate and most money for health is diverted through such societies then it will under mine the spirit of Panchayati Raj and control by people.

Role of the health committees of Panchayats:

The role of the health committee in ZP is to oversee the functioning of the Health system under the ZP control. Its has one chair person, some members and the meetings are attended by the CDHO and other district level health officers. The committee is to provide ZP's input in the health development in the district and help solve problems. Unfortunately the experience with health committees is not uniform. In some district they function collaboratively with the District health office and play a positive role by helping solve problems of the health department, while in others the committee meetings are dominated by constant bickering over petty matters and at times matters of personal interest to the members rather than overall health development of the district.

In theory the villages should have a health committee which should help in delivery of health services and in monitoring of the health services at the village level. Generally in most villages the health committee is not constituted and where it is constituted it is mostly not active. There have been some notable exceptions. One very active DDO in Mehsana district asked the district administration, especially the TDOs to make efforts to form village level committees in all villages. Due to such interest and motivation of the DDO the committees were formed. He also monitored their activities personally so as to see that they remain active. This shows that if there is active interest from the top level then the village health committees can function.

Political Control of PHCs and its impact:

PHCs are directly under the ZP and hence in many ways the PHC work is affected by the political processes in the ZP and TP. We have discussed that location of the PHCs

and SC is decided by the political and administrative inputs at the ZP level. With lack of clear guidelines on location of the PHCs and inability to foresee the consequences of opening new PHCs at non-strategic places within the district, PHCs were opened in small villages due to political pressures and due to the rush to open new PHCs in mid 1980s. This meant that many such PHCs were not at the hub of transportation and road network and hence were very difficult to reach from other villages of that area. Thus in Gujarat sizable number of PHCs are opened in very small villages (3,000-6,000 population) and are not very accessible. Secondly when the PHC is located in a small village, due to lack of availability of other civic facilities like good school, water and electricity doctors and other staff do not want to live in the PHC village and prefer to commute from the nearby town or far off city. This meant that the staff is not available 24 hours in the PHC hence services such as delivery, emergency treatment of pneumonia or diarrhea is not available at the PHC after the office hours or even at times after 12 noon or 1 PM. Once the staff is not staying at the PHC the regular working hours also become short as the staff is dependent on the public transport and hence comes late and goes back early. We have known some PHCs where no one is there before 11 am and after 3-4 pm. One of the DHOs remarked in the meeting of the PHC MOs that in many PHCs "I am too early if I reach at 11 and too late if I reach at 1 pm". Panchayat has not been able to address this issue of work ethic and access as well availability to PHC services. Perhaps Panchayat members are not concerned about this problem. We have not heard any place where Panchayat action has solved this problem. This seems to be a wider problem. One neighboring state secretary of FP (where PHCs are under state government) remarked that their PHCs are manned by "ghosts" meaning that the staff are posted but they are never fount there. Hence the blame can not be but entirely on the fact that PHCs are under ZP in Gujarat. It is reflection of overall deterioration of work ethic in Public system.

There are rare examples of ZP presidents who have taken active interest in health and help solve some operational problems of PHC medical officers. For example an active ZP president and chairman of health committee of ZP always provided needed support to the PHCs, even by allocating additional resources to health department in Bharuch district where the Hansot PHC is located which is one of the best in the whole of the state[4]. In the past efforts were made to involve Panchayats in the Family Planning programme with very good success in terms of increased acceptance of FP methods [5]. But unfortunately such special efforts to involve Panchayats into health campaigns did not take strong roots in the state.

Political control of PHCs by ZP is also reflected in the political pressure that is brought on DDO and CDHO for appointment, postings and transfer of the workers. There are innumerable example of such acts of interference which each CDHO can recount. The worst which a very senior health official recounted was of a doctor who was not going to the PHC where he was posted as he was staying in a far off city and has political connections. An epidemic broke out in that PHC area and was reported in the news papers. As reaction to this situation the administration decided to transfer the doctor to a far off district as punishment for not attending to the PHC work. Unfortunately this action could not be take as the doctor moved his political contacts and brought pressure from a person no less than the health minister himself so that finally instead of punishing him he had to posted at a hospital close to his place of residence in the city. Even though such incidents may be very few but they break the morale of the

administration and erode their authority in the eyes of the workers.[6] There are also other examples where the officers have stopped payment of salaries of workers for neglecting their duties. They have been pressurized to pay salaries.

District health office also has to purchase equipment, drugs and furniture etc. We have seen some examples of in appropriate equipment and drugs being purchased. For example in one district they had recently purchased Graffenberg ring inserter and removers which are the instruments to introduce and remove a silver ring which was use as intra-uterine contraceptive device in the 1950 and 1960s. In the same district they had bought and supplied about 200 endotracheal tubes to PHC which are only needed in a district hospital or medical college where major surgery is done. These could not be possibly mistakes. Such things indicate that purchasing in the districts is not monitored by any competent authority to stop wastage and perhaps blatant misuse of power by vested interests. The unofficial story is that some of the key officials of the Panchayat are also party to such purchases. The political persons may not be involved but it shows that even under Panchayat system such blatant misuse of resources is possible without it being detected by any of the agencies including the auditors, technical officers of the state, media or politicians.

On the other hand the bureaucratic purchasing procedures in many districts delay the purchasing process of essential items. Some times such purchases are not even possible. For example in one of the districts we found that there was no cotton and gauze in the PHCs for dressing. On inquiring we found that that state government did not do the Rate Contracts (RC) for these items, probably again because of political or administrative problems. At the district level, even though it has some 25 percent of the total budget for drugs under its control, the rules do not allow purchase of item not in rate contract. One can imagine the situation in PHCs when there is no gauze or cotton for dressing. ZP did not do any thing in this situation and PHCs had to pull on for months without these essential materials. Similar thing happened in case of Iron and folic acid (IFA)which is needed for each pregnant women. The supply from central government did not come for many months (again suspected political interference in tendering procedures or administrative delay in purchase at central level), the state did not buy these essential tables to bridge the gap as the state officers were not sensitive or proactive enough or were unable to do so due to rigid rules. The districts could not buy because the rules don't permit as IFA is a central supply. No one seem to be bothered in the district also, that pregnant women were not getting the IFA tablets. Not getting IFA in pregnancy could be very serious in a population who is already anemic. But rules are more important than life of pregnant women! Because if a pregnant women dies no body is bothered in the administration. For that matter death of a pregnant women is not even recorded as maternal death and counted as such. But if an officer decides to buy IFA locally (it is one of the cheapest medicines - 20 Rs per 1000 tablets) then he may be in trouble as the auditors may object. Unfortunately our local Panchayat members were not even aware of the situation or they tended to ignore it. One would have imagined that under ZP control the PHCs would be more responsive to people's needs and would have the flexibility to respond to the needs.

Of late we have also seen instances of political clashes between ruling party in ZP and ruling party at state if they are from opposite camp. For example recently one of the ZP presidents was suspended by the state government on what seems to be technical

grounds. The underlying reason could be that she belonged to the opposition party and the state government failed to pull her down in the ZP by defections in her party. We also hear that such partisan politics between the ZP and the state government is increasing. All this does have an impact on the functioning of the health department at the ZP level.

People's access to officials and potential for accountability:

Paul has identified 'Voice' and 'Exit' as two mechanisms to improve accountability in public systems. 'Voice' means people have capacity and avenues to voice their grievances against the public system. 'Exit' means people have option to leave one provider and go to other is they are dissatisfied. Given the nature of rural health services where 'Exit' is not possible, especially to the poor, as there are no other free health care providers near by. Thus, 'Voice' is the only mechanism left to the community [7]. Given the fact that CDHO and DDO are under the ZP, in theory and to some degree in practice the people have better access to the policy maker and key managers to vent their grievances and express their 'Voice'. Both these offices do get some complaints against health workers, doctors and other staff from the Panchayat members. They also do take corrective steps in some cases. But as there is not as high level of political awareness in the community in Gujarat as is there in Kerala, such complaints are few and far in-between. Some times false complaints and false alarms about epidemics area also sounded by the political or community leaders to divert attention or penalize a sincere worker or officers who is not obliging the local leaders by refusing to go against the rules and favor some person.

Given the low level of health awareness and priority to health in the mind of the community and their representatives, the health system gets away with lot of poor services or no services at all. We have also seen that the health system does not systematically make efforts to inform the community what services are due to people thus avoiding building up of pressure from the community. For example most people and even the political leaders don't know what are the working timings of the PHC, SC and out reach of the workers and what services are supposed to be available at what centers. For example many PHC open late and close early, doctors are irregular and do not stay at the PHC. The ZP and TP are not able to take much action against such things. On the contrary if the district level officers take action local panchayat members interfere and block such disciplinary steps.

Coordination between the health functions of the state and ZP:

As discussed earlier the CHCs, District Hospitals and the Medical colleges are under state government where the patients have to be referred if needed. ZP has no control over these institutions and hence there is lack of adequate coordination and cooperation between the PHC system which is under the ZP and the higher level health care under state government. For example many serious cases of infectious disease such as cholera, typhoid or jaundice may finally land up in infectious disease hospital or medical collage hospital in a city. These hospitals do not properly inform the district health office the details of the cases reported as a result the district health office who has the vast network of PHCs can not take any preventive action in the villages where the cases have happened. Many a times there no proper referral systems set up and

there is no special treatment to referred cases. Many referral centers under the state government such as CHC and First Referral Units (upgraded CHCs) are non-functional. Thus they can not provide support to the PHCs.

The state is supposed to provide district level health officers on deputation to the districts. We have seen that for last several months and in some case for more than an year, in the two districts we are working the several key posts such as Additional DHO, District Immunization Officers, CDHO, Programme Officer ICDS are vacant. This undermines the efficiency of the district health office as supervision becomes weak. ZPs seem to be powerless against the slow progress of promotions and postings from the state level. State also has several other powers such as designating doctors on the panel of surgeons for FW programme and recognizing centers and doctors for medical termination of pregnancy. Lack of coordination between the ZP and the state government causes delay in these areas.

Similarly all the training functions are in the hands of the state government. Thus the coordination and interaction between the training institutions and the PHCs is very limited resulting in training becoming divorce from reality. We know of one instance when the ZPs, due to political considerations, declassified the Field Practice Areas of all the Regional Health and Family Planning Training Center (RHFPTCs) in the state which were well developed and providing testing ground for many innovations and took back the administrative control of the PHCs designated as field practice areas for the FHFPTCs. The State Institute of Health and Family Welfare, which is the apex training institute in the state also does not have any field practice area of its own as all the PHCs in the district are under ZP and urban areas under municipal corporation. Many a times it is observed that the ZP does not release the doctors for training at these centers.

Maintenance of PHC infrastructure under the ZP:

Our observations indicate that the overall physical maintenance of the PHCs in Gujarat is poor. This may be due to several reasons. Firstly the quality of PHCs constructed is poor and hence they need more money for maintenance. But the state government has been allocating very meager resources for maintenance. In one district over the last 5 years the state has allocated only Rs 100,000-200,000 lakh per year for maintenance of nearly 50 PHCs where as per the state government norm it should have been about Rs 1,000,000 per year. ZPs do not have their own resources to maintain the buildings and hence many PHCs languish in poor shape at times without water or electricity. The condition of the subcenters is even worse. Even simple white washing is also not done regularly. On the other hand there are unnecessary expenditures also done because money is available for specific purpose. For example in one PHC we observed that construction of a separate postmortem room was being done. In this PHC the doctor was not staying in spite of having quarters and perhaps no postmortem has been done in last several years. There are also several PHCs and Sub-centers where quarters are constructed but no one is staying there. For example in one taluka of one district where we are working only 4 out of 16 subcenter building are occupied by ANMs. This is also a lost investment. The maintenance is poor in spite of the fact that Taluka Panchayat has a full time deputy engineer and supporting staff. It has been also reported by an engineer from the government that at times there is diversion of money

within the district where by the money is disproportionately spent on bunglows of the key administrators in the district and circuit house etc where higher officers stay, hence much less money is left to maintain buildings in the periphery such as PHCs or schools. ZP is not able to control such misuse of the maintenance funds. Poor maintenance makes the quarters so bad that they become unlivable. Poor design, construction and maintenance of the PHC buildings leads to regular water leakage from the roof in the monsoon thus making unusable.

DDO, CDHO, TDO and MOPHC: Their inter-relationship and control:

DDO being IAS officer is considered superior than CDHO who is a doctor specialized in public health. Most of the times DDO is younger in age and experience than CDHO but still the latter has to obey his commands as most powers are concentrated with the DDO. This hurts the pride of the CDHO who is technical officer. We have seen that every now and then the CDHO has to run to the DDOs office to get his signature on files as he is the final authority in the district. Similar and perhaps even worse situation exists in the Taluka where the medical officers of the PHC is considered under the Taluka Development Officer (TDO). TDO is from the state administration cadre and hence much less qualified than the MOPHC. We have seen a case in one district where an block extension educator who works under the MOPHC passed the state exam for TDOs and became TDO thus superior to all the MO in the taluka. This also brings in lot of hurt feeling among the doctors. TDO is much more powerful because he controls all the departments in the taluka and also looks after the land records and revenue. It is also reported that at times Deputy DDOs, who have no understanding of health work, preside over meeting of medical officers and staff of the PHC and direct their work. In Panchayati Raj system such subordination of the technical officers by general administrators is bound to happen. Unfortunately there has not been ways found to respect the technical officer's competence in technical matters.

With new PHC system coming in to effect from mid 1980s when new PHCs were created at the norm of 1 for 30,000 population (and 1 for 20,000 in case of tribal areas) instead of one for 100,000 population the number of PHCs suddenly tripled. Now in any one district in Gujarat there are 30-98 PHCs. This has made the span of control very wide for the CDHO and other district Officers. It is even physically impossible for him to visit all the PHCs in one year given his administrative commitments. This has happened because there is no Taluka level medical officers in between the PHC MO and the CDHO. If such a post is created then the management and control will become more effective. And then the Taluka Medical officers can be the authority where the MO PHCs will report. Unfortunately this has not happened in Gujarat in spite of PR system.

Neglect of some basic functions such as Water supply and Sanitation:

Male health workers are supposed to promote environmental hygiene including clean water supply and sanitation. Health in rural areas largely depend on water and sanitation. Unfortunately, under the PR system these basic functions have been neglected - especially the sanitation promotion. Still most people in villages do not have toilets and defecate in open. As per 1991 census only 9% of rural and 66% of urban population use toilets in Gujarat and rest go for open defecation. This causes lot

of environmental contamination. Water sources are also not very well protected. We found that simple thing like water chlorination is also not done in most of the villages on regular and scientific way. Disposal of waste water and storage of clean water is also not done properly leading to mosquito breading. Solid waste management is equally poor and in each village one sees mounds cow dung dumped in open which provides ideal place for flies to breed. Due to such a neglect of environmental sanitation various epidemics of communicable disease are common in the villages. Panchayats do not have the resources and the political will to improve the water and sanitation situation. This is a major constrain on health situation in the state. Unfortunately even health department at the state and central has also neglected this vital subject as they do not consider it as their responsibility any more.

Conclusion:

The above observations and discussion point to several conclusions related to working of the PHC system in Gujarat under the Panchayati Raj system.

1. Even though Gujarat was one of the first state to adopt the Panchayati Raj system for primary health system it is not clear that the benefits out weigh the risks.

2. There are many negative consequences such as increased political interference, of the transfer of PHC system to ZP. And in future care should be taken to minimize these.

3. Inspite of the control of PHC system by the ZP, accountability of the system to the people is limited.

4. ZPs have not been able to add substantially to resources available from the center or the state to improve the services. This may be probably due to the fact that the health department has not been able to motivate the ZP to give due priority to the PHC functions as done in the past for Family Planning and Pulse Polio Campaign.

5. In spite of being under the Panchayat, the PHCs do not have much flexibility in operations to meet the specific needs of the local communities.

6. Over all the picture that emerges is that Panchayats have not paid very much attention to health function and hence PHCs are no better under Panchayat control as compared to possible scenario under state control.

Implications for Reproductive and Child Health programme:

Given the above experience of the PHC system under Panchayati Raj, here we discuss what implications it has for the new Reproductive and Child Health Programme (RCH) which is being launched in the country with external assistance.

a. PHC services will have to be strengthened and the PHC staff will have to be made more accountable to the community by the district health managers using the

Panchayati Raj system. Only then the RCH programme can hope to add new services in an effective manner.

b. Village Panchayats will have to take up more active role with formation of health committees preferably composed of women to motivate women to use RCH services and put pressure on the providers to provide the services. Only handing over PHCs to ZP will not be enough, especially when policy decision is taken by the government to adopt "Decentralized Participatory Planning Approach" under the new Target Free Approach.[8]

c. Efforts will have to be made to orient Panchayats at all levels to focus on community and women's needs and keep watch on availability and quality of services.

d. Panchayat at village level can take up the role of monitoring of the health workers' work routines and village level provision of care. They will have to ensure that health services reach people and are accessible as per design of the PHC system.

e. Panchayat will have to serve as an link between the community and the care providers. It will have to make efforts to change the behaviour of the community and the provider so that the unmet need for curative and preventive services will be reduced.

f. To do all the above a strong and well designed system of orienting and training panchayat members will have to be taken up under the Reproductive and Child Health project.

As panchayats take more active role in health of the community we can expect to see major change in the health status of the community. But this process of involving panchayat in planning, implementing and monitoring health and family welfare programme has to be steered well and in the right direction, otherwise we may still see the sub-optimal performance and perhaps some undesirable outcomes.

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