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# Chapter VIII Governance for Human Development

## *8.1 Decentralisation and service delivery*

There is a general feeling that the basic services, such as health care, education, water and sanitation – all of which are the responsibility of the state – are better delivered in a decentralized system of governance than in a centralized one. Hence, improving service delivery has been one of the implicit motivations of decentralised efforts in most of the countries that have gone for decentralisation of governance to different extent. Increase in public spending by itself does not guarantee that people's health would improve or all the children would complete at least elementary education of reasonable quality. Public expenditure often fails to reach the poor as much as we expect it to do. One of the reasons why improving service delivery is behind most decentralization efforts is that these services are consumed locally. It is hoped that decentralization would strengthen the relationship of accountability between people and their political representatives, which in turn would strengthen other relationships of accountability between various levels of the government for service delivery.

Two problems are most frequently cited in the context. First, the lack of capacity at the level of local government to exercise responsibility for public services may constrain decentralization efforts; and second, decentralization often leads to misaligned responsibilities. Misalignment between the structure of the government bureaucracy and the assignment of service responsibilities to different tiers of the government often creates confusion regarding accountability and conflicts of interests. While the local officials of 'line departments' continue to respond to the incentives provided by upper-tier governments, local elected governments have little effective power to ensure accountability for service delivery.

Clearly, the higher level government has a key role in building local capacity. It can provide training in traditional, top-down ways, or it can create an enabling environment by responding to the needs of the local governments their experiences as decentralization proceeds. Decentralization to locally elected governments is likely to improve political incentives and service delivery outcomes if people are better informed and likely to use information about public services in their voting decisions for electing local governments.

In West Bengal, the three-tier Panchayat system is responsible for implementing various schemes related to poverty alleviation and livelihood security, besides its responsibility to provide a limited range of public goods. However, until recently, their involvement in delivery of such services as health care and education was negligible. Recent initiatives, such as Community Health Care Management Initiative (CHCMI), need careful attention in this context. In this chapter, based on a field study conducted by the students and faculty of IDSK, we present a few observations on how the Panchayats are managing on ground implementation of the most important employment scheme that the Government of India has recently launched, viz. National Rural Employment Guarantee Scheme (NREGS), and how the intended beneficiaries perceive the implementation process.

### *8.2 Awareness, participation and service delivery: observations from field*

An attempt is made here to understand the level of awareness of the people as well as the elected representatives with regard to services provided by the local government, their participation in the decentralised governance and the quality of service rendered by the decentralised governments by studying two *Gram Panchayats* from Birbhum district as case studies.

Like in many other Indian states, in West Bengal the decentralised (local) governance which functions below the sub-national government has three tiers. At the top, there are district-level local governments, known as Zilla Parishads. Below the Zilla Parishad, there are block level governments, known as Panchayat Samiti, at the lowest tier, there are Gram Panchayats. The rural part of Birbhum comprises 167 Gram Panchayats spread across 19 Blocks. Since Gram Panchayats are the lowest tier of local government and in charge of implementing most of the state and centrally sponsored welfare programmes on the ground, taking Gram Panchayats as basic units of investigation seems reasonable. Two Gram Panchayats were selected for the study – one backward and the other somewhat better off. The details of the criteria for selection of the GPs and households are given in the Appendix.

***Households' profile***

Alhough Talowan is more backward than Chandrapur[1], the GPs are comparable in terms of their household occupational composition (see Table 8.1). The share of agricultural labour households is 42 per cent in Talowan compared to 38 per cent in Chandrapur. Chandrapur has slightly higher share of self-employed in agriculture (38 per cent) as against Talowan (34 per cent). Surprisingly, share of agriculture dependent households is almost same (76 per cent) in both the GPs. Though average landholding is higher in Chandrapur (48 kathas per household) compared to Talowan (30 Kathas per household), the percentage of landless households is slightly higher in the former. The average household size is 5 in Talowan compared to 4 in Chandrapur. Substantially higher percentage of households (35 per cent) in Chandrapur has family members who are members of Self Help Group compared to only 9 per cent in Talowan. The level of education seems to be slightly better in Talowan. The average years of schooling of the highest educated male in the family is 7 in Talowan compared to 6 in Chandrapur. Similarly the average years of schooling of the highest educated female in the family is 6 in Talowan compared to 4 in Chandrapur.

**Table 8.1: Percentage distribution of households by occupational categories in Talowan and Chandrapur**

| household occupational categories | Talowan | Chandrapur |
|---|---|---|
| self employed in agriculture | 34 | 38 |
| self employed in non-agriculture | 3 | 5 |
| agricultural labour | 42 | 38 |
| other labour | 13 | 9 |
| others | 8 | 10 |

*Source: Primary Survey, IDSK*

***Awareness***

Table 8.2 shows respondents' exposure to print and electronic media. In both the GPs a very small percentage of respondents have regular exposure to radio, newspaper and television. It is interesting to observe that with relatively lower average level of education, Chandrapur fares much better than Talowan in terms of people's awareness about the schemes and programmes that their respective Gram Panchayats implement. In Talowan only 58 out of 102 households could name any scheme or programme, whereas in Chandrapur, out of 117 households, 86 households could name at least one scheme or programme that their panchayat was implementing.

[1] The share of socio-economically disadvantaged households is 71 per cent in Talowan compared to 61 per cent in Chandrapur.

***Table 8.2: Household's exposure to electronic, print media and other information***

| Percentage of respondents | Talowan | Chandrapur |
|---|---|---|
| Regularly listen to radio | 7.2 | 16.1 |
| Regularly read news paper | 4.7 | 6.7 |
| Regularly watch TV | 22.8 | 19.0 |
| Know about cheap toilet | 68.3 | 87.6 |

*Source: Primary Survey, IDSK*

Almost all the people know about NREGS in two study GPs, though NREGS is known to people as *100 days work* or *Job Card*. Many individuals, who worked under NREGS, do not know such details as the application process, the provisions for compensation for delay in paying wages or about facilities to be provided in places of work. Only 26 per cent of the respondents (30 per cent in Chandrapur and 24 per cent in Talowan) have some vague ideas about how much money the Panchayat has received under NREGS. About 22 per cent of the respondents have some idea about how Panchayat spends the money received under NREGS.

Almost three-fourths of the respondents in both the GPs reported that they were interested to know how much money panchayat received for various programmes. A higher percentage of respondents were interested to know how their panchayats spent the amount in Chandrapur (88 per cent). In Talowan they are fewer (68 per cent).

The purpose of various comparisons made here is not to demonstrate how good is one panchayat vis-à-vis the other. It is expected that the level of awareness in Talowan will be lower than Chandrapur because of its relative backwardness. However, it may be interesting to see if the same marginalized group is better off in terms of awareness in a relatively better GP. Take for example STs and Muslims and their knowledge about schemes and programmes implemented by GPs and feasibility of building cheap toilet with assistance from GP. It is observed that they are more aware in Chandrapur than in Talowan (see Table 8.3). The point that we make here is that the population sub-groups which are known as disadvantaged are better informed in the advanced GP than in the backward GP, although their socio-economic status may be more-or-less the same.

**Table 8.3: Households' knowledge of GP schemes and NREGS by socio-economic classes**

| | | SC (%) | ST (%) | Muslims (%) | Others (%) |
|---|---|---|---|---|---|
| Some knowledge about Panchayat's funds for NREGS | CHAND | 76 | 83 | 67 | 60 |
| | TAL | 74 | 86 | 71 | 83 |
| Some knowledge about Panchayat's spending on NREGS | CHAND | 78 | 88 | 74 | 71 |
| | TAL | 70 | 90 | 71 | 90 |
| Interested about Panchayat's funds and spendings in: | CHAND | 71 | 54 | 67 | 88 |
| | TAL | 83 | 67 | 71 | 77 |
| Knowledge of cheap toilet | CHAND | 90 | 63 | 89 | 96 |
| | TAL | 65 | 14 | 75 | 80 |
| Knowledge of schemes and programmes in the Panchayat | CHAND | 76 | 71 | 70 | 76 |
| | TAL | 61 | 52 | 54 | 60 |

*Source: Primary Survey*

Many of the respondents from households did not have clear idea about the duties and responsibilities of the Panchayat. In many cases they mentioned certain services and assistance, which Panchayats cannot provide in reality, for example, helping them in case of daughter's marriage.

Panchayat members are more or less clear about their duties and responsibilities in both the GPs. It is clearly evident from the interview of panchayat members that poor access to health care, poor road conditions, problem of drinking water, problem of housing are the major problems in both the panchayats. The situation worsens during rainy season. However, on opinions about major problems, we observe more convergence among the members in Chandrapur than in Talowan. Lack of convergence between what people think about the major problem of the Panchayat and what members think can jeopardise the very basic objective of decentralised governance.

There is a convergence of opinion among male and female members on the problems related to women and children. Members feel that lack of health care facilities is the major problem faced by women. Low literacy rate among women is major cause of concern to many members. Members of both

the panchayats feel that drop out rate among girls at primary level of schooling is unacceptably high. Early marriage, household activities and poverty are the main reasons for drop-out. Parents in rural areas consider marrying off their daughters as more important than education.

***Participation***

Nobody from a significant percentage of households did participate in the last Gram Sansad meeting (68 per cent in Talowan and 50 per cent in Chandrapur). The reason for not attending meeting is multiple. In Talowan the most frequent cited reason was not getting information about the meeting. However, in Chandrapur the most frequent reason was non-availability of time for attending such meetings. Many people in both the GPs did not attend the meeting as they perceived it useless and wastage of time.

Since Gram Sansad meetings are an important event where people get to know more about programmes and schemes implemented by the Panchayat, staying away from such meetings not only make them unaware of government programmes and schemes, it also undermines an important process of the functioning of decentralised government, that is participation. In a system of democratic decentralised governance, participation itself is perceived as an important outcome indicator. A Gram Sansad meeting is also a place where beneficiaries for various schemes are selected on the basis of discussions and some sort of agreement. However, a particular Panchayat or Gram Sansad cannot always be blamed for people's non-participation in Sansad meetings. There can be other reasons such as political factors, people's preoccupation with income earning activities which make people away from attending those meetings.

The Gram Sansad meetings are supposed to be the place where people of the Sansad areas raise the problems they are facing. As far as raising issues are concerned, it was observed that Muslims in Talowan and SCs in Chandrapur were more vocal in raising issues in the meeting. Here we need to remember that Muslims in Talowan and SCs in Chandrapur are relatively more powerful groups in terms of their share in the population.

Amendment to the Panchayati Raj Act has ensured reservation of seats for the women. It is disappointing to observe that the presence of women is remarkably low in the Gram Sansad meeting. It seems

that the majority of them have to give domestic work the highest priority. Even if they attend the meeting, they are remarkably less vocal in raising issues in the meeting. There could be multiple reasons for behaviour on the part of the women. Many of them are either shy of speaking in male dominated Gram Sabhas or even when they raise their voice due importance is not given to their concerns. It is observed that the pro-active role played by women self help groups have helped increase women's participation in the Gram Sansad meeting.

***NREGS on ground***

The most important feature of NREGS as a demand driven employment programme is exhibited by its capacity to provide work for those who demand along with an open-ended nature of resource support from the state. In both the study GPs, the coverage of households under NREGS in terms of providing job cards to households belonging to vulnerable socio-economic groups appears quite inclusive and impressive. However, if we move from 'coverage' to 'creation of person days of work', then results show a different reality.

In Talowan the landless section of the sample households have on an average worked for only about 11 days. The marginal farmers got work for around 9 days. There is not much variation in average mandays for different socio-economic categories. For example, the average number of days worked by the SC, ST, Muslim and other communities are 9, 10, 11 and 11 days respectively. The situation is much better in Chandrapur. On an average the landless households reported to have worked for 38 days and marginal farmers 30 days. The average number of days worked by SC, ST, Muslims and others are 38, 23, 33 and 33 days respectively.[2]

From discussions with villagers it became clear that when introduced the beneficiaries had welcomed the scheme with expectations and enthusiasm. However, availability of only a few days of uncertain work has dampened the initial enthusiasm and trust. Poor or sub-optimal implementation of NREGS can be due to a number of factors apart of non-availability of funds in proper time. The reasons behind sub-optimal implementation of NREGS range from lack of planning and inappropriate planning to inadequate staff and infrastructure.

[2] Averages are calculated based on households' reporting of number of days they have worked under NREGS. We are aware of the possibility that households may have a natural tendency to understate the number of days they have got employment, especially in a situation when they are not happy with the work of the Panchayat. Another problem is that households' reporting may not be confined to a single financial year. However, the estimates on an average are fully in line with the data we have gathered from the Panchayat with minor difference.

**Table 8.4: Some selected indicators of NREGA performance from households' point of view in the selected GPs in Birbhum**

| | Backward GP (Talwan) | Advanced GP (Chandrapur) |
|---|---|---|
| ***Percentage of household applied for job card*** | | |
| SC | 90 | 68 |
| ST | 67 | 71 |
| Muslim | 81 | 73 |
| Others | 79 | 80 |
| ***Percentage of households reported to have applied for work*** | | |
| SC | 26 | 43 |
| ST | 21 | 24 |
| Muslim | 45 | 26 |
| Others | 33 | 35 |
| ***Percentage of job card holders keeping the job card at home*** | | |
| SC | 73 | 70 |
| ST | 5 | 35 |
| Muslim | 29 | 81 |
| Others | 68 | 72 |
| ***Percentage of households worked continuously for two weeks*** | | |
| SC | 5 | 28 |
| ST | 6 | 21 |
| Muslim | 8 | 40 |
| Others | 9 | 11 |

*Source: Primary survey, IDSK, 2007*

"Too much paper work for NREGS" was cited as a problem by many GP members including the Sachibs. Schemes like NREGS involve huge amount of paper work which require dedicated technical (computer literate) staff, computer and photocopying machines. NREGA stipulates that GPs are required to prepare annual report containing the facts and figures on achievements regarding implementation of the scheme within its jurisdiction and a copy of the same is to be made available to the public on demand. All accounts and records related to the scheme are to be made available for public scrutiny. Also a copy of the master rolls of each scheme or project under NREGS must be made available in the office of the GP for inspection.

**Table 8.5: Households' response to different aspects of NREGA implementation in the two study GPs in Birbhum**

| | Backward GP (Talwan) | Advanced GP (Chandrapur) |
|---|---|---|
| ***Percentage of people came to know about '100 days work' for the first time*** | | |
| Media | 17 | 17 |
| Panchayat Office or Panchayat Member | 44 | 66 |
| Others | 39 | 16 |
| ***Percentage of households applied for job card*** | 81 | 74 |
| ***Percentage of job card holder who actually applied for work*** | 33 | 35 |
| ***Percentage of people who went to enquire with Panchayat*** | 41 | 10 |
| ***Attitude of the GP staff in providing necessary information and other help*** | | |
| Very cooperative | 25 | 41 |
| Moderately cooperative | 41 | 43 |
| Not cooperative | 34 | 16 |
| ***Who filled up the form*** | | |
| Applicant / somebody from applicant's family | 31 | 16 |
| Panchayat officials or members | 50 | 62 |
| Others | 19 | 22 |
| ***Percentage of households keeping job card in the house*** | 46 | 66 |
| ***Percentage of respondents continuously worked for 15 days*** | 7 | 21 |
| ***Percentage of respondents reported delay in disbursing wage beyond 15 days*** | 57 | 49 |
| ***Percentage of respondents who said work provided within 15 days of applying for work*** | 15 | 37 |

*Source: Primary Survey, IDSK, 2007*

It is not the only failure of NREGS that all households were not offered 100 days of work. There are other failures too, such as the failure to provide unemployment benefits in case the Panchayat could not provide within a stipulated time the job demanded. It was also reported that wages were often disbursed long after the work was done thereby violating the stipulation of the maximum permissible time lag.

In Chandrapur out of the 161 recorded responses, 37 per cent of the respondents said that employment was provided on time, but in cases of delay, unemployment allowance was not provided. In Talowan too, out of 88 responses, 82 per cent said that there was no provision of unemployment allowance. Compared to Chandrapur, Talowan was less prompt in providing work after receipt of application.

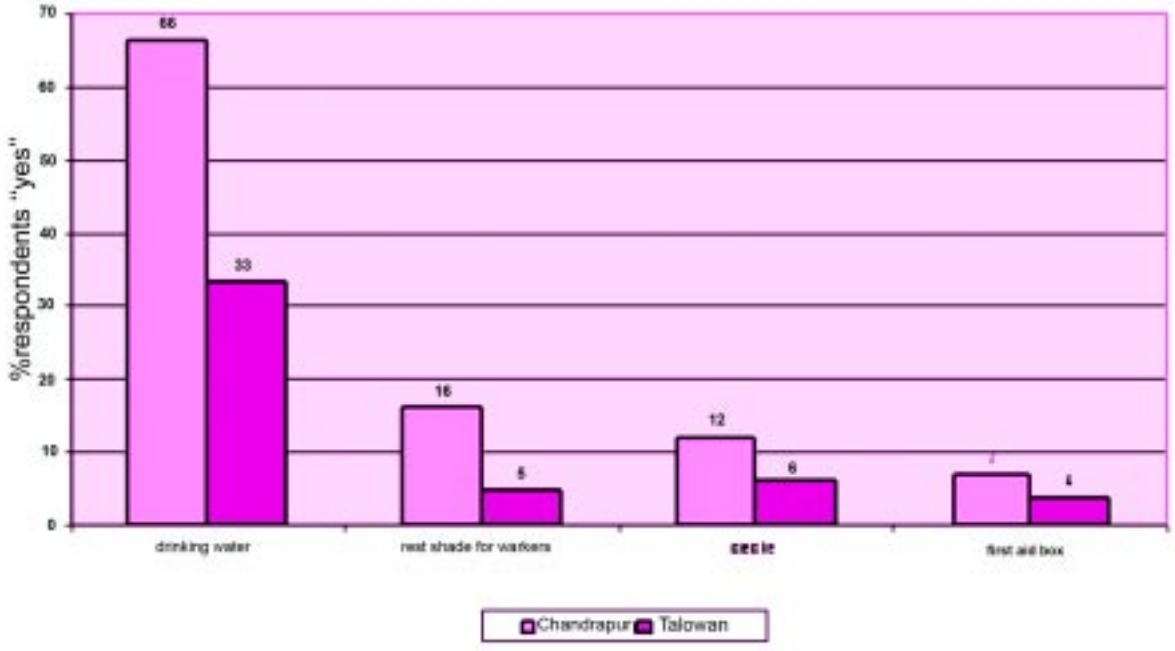
In Talowan the beneficiaries were disadvantaged in terms of not only being deprived of unemployment allowance but the average number of mandays created was also low.

A particular clause of NREGA (Clause 7.5 which is based on Payment of Wages Act 1936) entitles the beneficiaries to demand compensation in case there is any delay in payment of wages. Though a significant number of respondents reported delay beyond 14 days in getting wages, none of them reported receiving any compensation. Sachibs of the Panchayats admitted that the delay was due to the delay in receiving funds and longer time taken by the bank to en-cash cheque, not a fault on the part of the Panchayat as commonly assumed.

***Facilities at the work place***

According to the NREGA guidelines, certain basic facilities should be provided to the workers at the worksite. For example, there should be arrangement for drinking water, rest shade for the workers, crèche for children and first aid box. Figure 1 shows availability of facilities at the work place (the last site they worked) as described by the respondents.

**Figure 8.1: Facilities at the worksite**




The near absence of crèche facilities for infants (even in an advanced GP like Chandrapur) is really a matter of concern. This could probably result in low participation of poor women having young children. If older children are taken to the worksite for looking after their younger siblings, it definitely

affects the education prospects of the former. The absence of a rest shade and a first aid box reflect that such simple provisions are not valued by the GPs. It could not have cost much but it could make the workers feel that they are well taken care of and that the Govt. has been sensitive to such requirements. Manual work is strenuous and sometimes hazardous. Rest shades to relax in the Indian summer between work and first aid in times of emergency should not be compromised. GP functionaries said that scarce funds could not be used to construct rest shades in worksites where work would not continue for long.

***Creation of assets under NREGS***

The respondents' general remarks on the usefulness of asset creation are found to be more or less positive. In Talowan nearly 73 per cent of the respondents credited the creation of assets under NREGS. They also expressed in the interview that the work done on a road under '100 days work' has helped to make the road suitable for all weather. They expect the panchayat to undertake many such useful projects. However, the construction of a small bridge could not be completed due to exhaustion of funds and that has caused discontent among the workers. There were not many projects undertaken in Talowan and the respondents do not have much to share but they do believe there are good potentials for much more work which will be useful to the area and people. In Chandrapur, the response is much more positive. As Chandrapur ranks among the top ten GPs in terms of its performance in the implementation of NREGS, the number of projects completed under NREGS is also higher in number. The respondents were happy to have the new ponds dug, the old ones renovated and guard walls constructed around the ponds. They said more water was now available for irrigation and the problem of water logging due to overflowing of ponds during rainy seasons was solved. Projects of aforestation and maintenance of roads were undertaken in the villages of Chandrapur and such programmes have been welcomed by the residents. People of the Panchayat expressed satisfaction that '100 days' work' not only provided employment but also improved the infrastructure and amenities of the villages.

In short, residents of both GPs appreciated the projects undertaken under NREGS for their twin values – creation of employment and creation of assets for the community. The experience and evidence suggest that to get better results, the GP members must themselves choose projects which most accurately address the problems of the villages, so that the limited resources and funds are utilised in the best possible manner. Excavation of old and new ponds could be combined with cooperative effort in sustainable use of the ponds for income generation. For example, those who worked on the

pond could be given the same pond on lease so that they can use it for fish production. The NREGS can be aimed at other burning issues of the village such as poor road connectivity, poor or lack of infrastructure for primary schools and ICDS centres.

***NREGS and migration***

Studying migration and the impact of NREGS on migration at the district level would require a different type of sample design and large sample size, which is obviously beyond the scope of the present report. In the absence of the feasibility of having direct estimates on migration and impact of NREGS on migration, we tried to gather indirect evidence in the form of people's and panchayat members' impression/perception about migration and NREGS's impact on migration.

Most of the household respondents have fair idea about the status of migration taking place in their localities. They also have rough idea about where people are migrating to and what kind of work the migrated people do at the destination place. Though it is found that people migrate to within West Bengal as well as outside West Bengal, the former (within West Bengal) seems to be the pattern for the majority of the workers. Migration is not only confined to the unskilled agricultural labourers but also to the skilled or semi-skilled labourers (especially, stonemasons and bricklayers). In West Bengal, apart from Asansol, Midnapur, Kolkata, the district of Burdwan is the most frequently cited destination place, especially for the agricultural labourers. Outside West Bengal, people go to Mumbai, Bangalore, Surat, Benaras and Delhi. In Chandrapur GP the most of the people who migrated belong to SC community. They migrate seasonally to work as agricultural labourers in places like Suri and Burdwan. On the other hand, in Talowan GP, a good number of migrant workers are from Muslim community and many of them migrate to cities like Mumbai, Kolkata, Delhi, Surat to work as skilled and semi-skilled workers in the construction sector.

Opinions of the households and Panchayat members in two GPs suggest that migration has not come down significantly after the introduction of NREGS, though the impact seems to be slightly stronger in Chandrapur GP (see Table 8.6). Uncertain and fewer days of work under NREGS and higher wages at the places of migration are major reasons why unskilled and semi-skilled workers still continue to migrate even after the introduction of NREGS. In Talowan, NREGS could not generate workdays adequate to meet the demand of its large population. Therefore, it was obvious that it would have little impact on the 'migration for work.' In Chandrapur too, despite its success NREGS could not

significantly bring down distress migration to a significant level. Most of the GP members are of the opinion that NREGS is less likely to bring down distress migration as it does not offer regular job. It is observed that both regular and seasonal migration take place in both the GPs, although the share of seasonal migration is significant. Though it is expected that NREGS will not be able to curb the migration of the skilled or semi-skilled labourers, insignificant change in the quantum of unskilled agricultural labourers is a matter of grave concern. Comparison between Chandrapur and Talowan with regard to NREGS performance and impact of migration clearly shows that NREGS has the potential to bring down migration of unskilled agricultural labour if it is implemented more effectively. However, it is interesting to observe that higher wage and more certain work are not the only consideration for migration of agricultural labourers (especially ST agricultural labourers who migrate to the district of Burdwan and Hoogly every year during sowing and harvesting season). For them, these are the only two occasions in a year they could go in a group outside their villages. This kind of non-monetary pleasure value should not be ignored.

**Table 8.6: Views of households, GP members and Sachibs on the effect of NREGS on migration**

| Views | Talowan | | Chandrapur | |
|---|---|---|---|---|
| | Households | GP Members | Households | GP Members |
| Great Effect | 6 | 0 | 19 | 13 |
| Some Effect | 11 | 27 | 38 | 38 |
| Insignificant Effect | 15 | 18 | 19 | 13 |
| No effect | 60 | 45 | 20 | 13 |
| No idea/ No response | 8 | 9 | 5 | 25 |

**Figures along a column indicate percentages to total respondent households; they may not add up to 100 because they are rounded off*

*Source: Primary Survey*

### *8.3 Impact of Community Health Care Management Initiative*

The Panchayats and Rural Development Department (P&RD), Government of West Bengal, launched the Community Health Care Management Initiative (CHCMI) with support from UNICEF and the Department of Health and Family Welfare, Government of West Bengal, in 2004, with the overall aim of promoting community involvement in improving people's health. It has been three and a half

years since the initiative was formally launched. Even though the impact of such an initiative should ideally be judged in terms of its consequences on people's health, three-and-a-half years seem rather short for the intervention to have its full effect , especially because in this kind of programme a good deal of time is required for the programme to be implanted. However, one can take a rigorous analytical look at the achievements and pitfalls at this point in order to inform the policy makers while planning the future course of action in the area of decentralized governance and health.

The CHCMI follows a well-formulated set of objectives. If the ultimate objective is to improve people's health, there is no obvious way in which strategies can be designed to achieve that goal. Until recently the focus of the government's health policy had almost exclusively been on the financial allocation through government departments, such as the department of health and family welfare, to directly provide health care services of curative as well as preventive and promotive kind, on the presumption that it would be automatically translated into improved health of the people. With the advent of the Panchayati Raj as the formal institutional form of decentralized governance it was increasingly realised that the Panchayati Raj Institutions (PRI) could be involved in delivery of public health services. Yet the conventional wisdom has so far not gone beyond using the Panchayats only for occasional campaigns such as Pulse Polio programmes which require mass participation.

Perhaps for the first time in the history of decentralised governance in West Bengal such a comprehensive programme as CHCMI has been planned with the aim of involving the community in monitoring its own health. To involve the community, specific steps had to be designed, the first and foremost of which was identification of the key agency at the local community level. The key agency here is the elected *Gram Panchayat* (GP), and the specific steps include regular meetings of GP functionaries with health care delivery workers, including ICDS workers and supervisors, training GP functionaries to sensitise them about health issues and develop capacities to manage the system of monitoring. The meetings are held on the last Saturday of every month, and are supposed to deliberate on the important health issues and concrete steps that need to be taken to address those issues. The discussions, and the decisions that follow, must be based on quantifiable data on nutritional status, mortality, morbidity, different aspects of safe motherhood, and various public health issues such as sanitation, drinking water and so on. Special emphasis has been on safe-motherhood-related awareness generation and capacity building in the community.

The most important aspect of CHCMI is that the monitoring initiative is supposed to be based on a comprehensive *population-based* set of data. The data generated by the government departmental sources are essentially supply side data on facilities and the numbers they serve. Solely from the information on how many have availed the government facilities it is impossible to draw a complete health profile of a population, and hence make specific plans covering the whole population. CHCMI seeks to remedy this by focusing on the need for population-oriented data base. To achieve this, progress has to be made in the direction of institutionalization of the system of monitoring, which, in turn, requires identification of key functionaries and assignment of specific tasks and responsibilities. To what extent CHCMI has progressed in this direction is what the IDSK study examined[3].

The study was based on primary data collected from six districts: Dakshin Dinajpur, Malda, Murshidabad, Birbhum, Purulia and Bankura. From each district, six GPs were selected from those which had prepared Action Plans on CHCMI ('focus group'), and three GPs were selected at random as 'control' where Action Plans are yet to be prepared. Altogether fifty four GPs were thus selected. Separate questionnaires for the following informants were used: GP *Sachib*, *Sanchalak* (Convener) of *Swastha O Siksha Sthaee Committee* of GP, ANM, *Dai*(s), ICDS supervisor(s), and ten randomly selected women who are currently pregnant or have children aged below one year. Both the process of implementation and the outcome of the initiative have been analysed.

A composite index of achievement on implementation ('process score') was constructed from select indicators and GPs were ranked. There are well-performing GPs and poorly performing GPs in all the study districts, and none of the districts seems to have a disproportionate share of either. Among the top twenty GPs fifteen belong to the focus group and five belong to the control group. It implies that preparation of the Action Plan is a necessary first step in the implementation process, and the GPs that have prepared their Action Plans are more likely to make progress on other parts of the implementation process.

No common explanation can be found as to why some GPs have taken more interest in CHCMI than others. It ranges from motivated GP leadership combined with active SHGs to existence of a good NGO as facilitating agent. The correlation between the process score and an outcome indicator,

[3] For details see Chakraborty, Achin, Subrata Mukherjee and Bidhan Kanti Das *An Evaluation Study on Advocacy of Safe Motherhood under CHCMI*, Institute of Development Studies Kolkata, 2007.

namely, the percentage of institutional deliveries, is found to be positive and not too low (0.39), which shows that a GP with a high process score is likely to show a high percentage of institutional births.

The most prominent element of CHCMI is the 'Last Saturday Meetings' that the GPs hold every month to discuss public health issues. The meetings are being held regularly in all the 54 GPs. The minutes of the recently held meetings show that a variety of health related issues, most of which on safe motherhood, have been discussed. However, there are indications that not all the GPs and GP members are equally involved in the meetings. In most of the meetings either the *Pradhan*, or *Upa-Pradhan*, or the *Sanchalak* is present, besides the almost regular others from the Health Department, and sometimes ICDS. In a very few GPs more than one GP member was present at a time in the meeting.

The proceedings of the meetings in most cases are recorded in very general terms such as "people should be made aware of the health and hygiene practices". If specific points are not noted, it is not possible to record in the subsequent meetings the 'actions taken'. However, no matter how casually they are done, the last Saturday meetings undoubtedly have influenced the PRI functionaries. They now at least feel the importance of having information on birth and death, safe motherhood and other health related information including child under-nutrition.

GPs are supposed to set up a Sadar Sub-Centre with certain facilities close to the GP office. In 18 out of 54 study GPs were the Sadar Sub-Centre set up. Out of these 18 only 7 have electricity and 6 have water facility. In none of them child delivery has taken place, even though the idea was to equip them for child delivery. In 40 GPs information on institutional delivery was available. Only 12 GPs could provide information on number of deliveries attended by trained Dais, and 24 GPs could report how many trained Dais the GP had. In the data compilation and transmission process many GP functionaries are yet to take active interest. Even though 68 percent *Sanchalaks* said baseline surveys by SHGs were conducted in their GPs, most of them failed to say anything about the findings of the surveys.

On the outcome side, when asked about what the ideal age at marriage is, 32 percent of women reported an age less than 18. There is no significant difference between the focus and control GPs on this. However, if we focus only on the non-literates among them, women in focus GPs seem more

aware than their counterpart in control GPs. Similarly, the percentage of illiterate women who said that a family should have two or fewer children is 51 in focus GPs compared to 43 in control GPs.

**NGO as facilitating agent: How Abinashpur GP did it?**

Abinashpur GP in Suri II block of Birbhum district has 10 gram *Sanshads* for 13 villages under its jurisdiction. Out of the 13 villages, 5 are Integrated Tribal Development Project villages. This GP has a total population of 11,954 (as per 2001 Census) out of which 34 percent belong to SCs and 32 percent to STs. There are 17 Anganwadi centres. The GP tries to ensure 'spot feeding' at the centres.

The base-line survey in this GP had been conducted even before CHCMI was formally launched in other GPs in the district. The Action Plan was prepared with active assistance from CARE – an NGO working in the area. The NGO organized training for members of the SHGs, GP members and officials on survey procedure, compilation of data and how to write report. The action plan has very detailed information on problems of public health, education, early marriage, and so on. The action plan clearly spells out the possible ways to address the problems that emerged out of the survey, and how the responsibilities for action and financial sources can be fixed.

From the base line survey, several important issues emerged, such as problems of drinking water sources, status of sanitation facility and drainage system, prevalence of marriage at below 18, early pregnancy, very low rate of institutional deliveries, incomplete vaccination in children, family planning, fewer than normal prenatal and post natal check ups, incomplete birth and death registration, problem of malnutrition and basic infrastructure. The GP seems to be good at keeping records and information dissemination is one among its important activities. For example, at the entrance of the GP office, the chart on the public health status in the GP is prominently displayed with most of the cells filled in.

As far as achievements go, the condition of antenatal care is now satisfactory in this GP. Most of the pregnant women are getting up to the third check up. A part of the money for *Janani Surakshya Yojana* is given to the mothers to improve their nutrition. This is one of the very few GPs where the expenditure on specific items of public health is clearly identified and easily obtainable. In the last financial year (2006-07) this GP spent around 25 per cent of its untied and Finance Commission funds on public health. Furthermore, this GP has provided a Trolley Van to one person in each village with an innovative arrangement. The person is responsible for carrying the patient to the nearest facility whenever such need arises, and during the rest of the time he can earn a livelihood by using the van for transportation.

Although the observations made above relate to all six study districts, they are applicable to Birbhum as well as it is one of them. In our overall assessment, the record of success of CHCMI has so far been somewhat mixed, which is not surprising, since it is too early to have the full effect of the

initiative felt. The amount of work that has gone into planning and designing the initiative is quite remarkable. If one goes through the series of notifications containing detailed instructions on various components of CHCMI one can hardly doubt the internal consistency of the design and the assumptions on which various components have been built. The study, however, identifies a few key areas where some rethinking combined with a bit more effort at implementation can bring about better results.

***Suggestions***

The main challenge is to motivate those PRI functionaries who are yet to take active interest. At the core is of course the general lack of capacity to comprehend and implement various instructions flowing down from above, which is not specific to CHCMI. Apart from the general capacity building, which is perhaps beyond the scope of CHCMI, sensitisation workshops should be strengthened by involving *experienced motivators*.

However, sensitization alone cannot be effective unless they are combined with some incentives. While in the orientation programmes successful cases should be repeatedly mentioned to instill a sense of competition among the GP functionaries, a small number of specific targets can be thought of, which are somewhat feasible to attain. The GP may be rewarded if certain targets are reached.

To institutionalize the initiative adequate financial provisioning is necessary. The overall financial allocation for the programme has so far been rather small, and much of the resources had to be managed from sources other than the standard earmarked government budgetary sources. Some of the stated goals of the National Rural Health Mission are quite in line with the objectives of CHCMI. While the NRHM has made substantial financial allocation to achieve the stated objectives, CHCMI provides a kind of blueprint for working towards these objectives without financial backing. The complementarities between the two are so obvious that it would be unfortunate if it remained unexploited for a lack of initiative at the upper echelons of the government to transcend the departmental boundaries.

Money is needed for financing additional manpower needed to build capacity at various levels. There is clear indication that the presence of a Programme Coordinator in a district makes significant difference, as it is evident from the record of progress that Murshidabad and Birbhum have made. Neither has

a Programme Coordinator, and in terms of our process scores they lag behind others, despite sincere efforts by the Secretary to Zilla Parishad in the former and the Nodal Medical Officer in the latter.

Money is also needed to sustain motivation of the SHGs as well. An honorarium is more a symbol of recognision than anything else. It is almost impossible for anyone to keep up motivation on a sustained basis if one's work is not recognized as valuable. SHG members may be motivated by the recognition that they are doing valuable work for the community. But this feeling of pride and self-respect has to be nurtured by the GP leadership. Some GP members tend to think of the SHG members as inferior beings incapable of delivering the job they are expected to. The sensitization programmes should address this too.

The cascade mode of training and sensitization does not seem to have been working the way it should be. This does not mean that the cascade mode itself is flawed. This mode of training would be more effective if the goal of training was to impart *well-defined technical knowledge*. But in the case of CHCMI the training programmes must be aimed at arousing interest in the GP level functionaries about community orientation in matters of people's health. The district coordinators or the persons in charge of organizing the training programmes should be given the freedom to deviate from the norm about who can be the district level trainers and invite people who are known for their abilities to motivate. A CMOH – II, for example, having a good stock of knowledge on safe motherhood but poor ability to communicate is no better than a well-respected local school teacher who knows how to motivate and sensitise. But a strategic balance has to be made. Involving CMOHs and DPOs of ICDS in the training programmes makes good strategic sense, for CHCMI cannot succeed without the involvement of these officials from different departments.

In Blocks the Joint BDOs are usually in charge of CHCMI. This middle tier seems the weakest link in the chain, as the Joint BDOs seem rather overburdened with various other responsibilities. A Block level coordinator similar to the District Coordinator may be a possible solution.

The data on population health collected and compiled at different levels must attain the desired standard of quality. With more effort in monitoring at different levels it is possible and most desirable to improve the quality of data. More importantly, the GPs are yet to be sensitized about the difference between the nature of data that the health department would provide and the kind of data they need for planning

action. The crucial difference is between 'client oriented' and 'population oriented' data. GPs must be sensitized to keep as much information as possible on the *excluded* people.

In one district, the *Zilla Parishad* on its own initiative conducted a small survey of children and found that the data on undernutrition routinely reported by ICDS centres frequently suffer from gross underestimation. The ZP then introduced a nutrition supplement programme and in six months' time obtained impressive results. This type of questioning of the data received from ICDS and Health Department sources and reworking on them for effective intervention must be encouraged in other districts.

## Appendix

***Selection of GPs and households***

Two Gram Panchayats were selected based on the following three criteria: (a) their performance in the implementation of NREGS; (b) backwardness assessed in terms of concentration of socio-economically backward population, and remoteness - measured by the distance from district/sub-divisional headquarter; and (c) prevalence of migration as perceived by the block and district offices.

Performance of a GP in the implementation of NREGS was measured using three indicators (i) average number of man-days created per job card issued; (ii) percentage of completed schemes out of total number of schemes proposed; and (iii) utilised funds as a percentage of available funds for NREGS. All these three indicators were considered for the financial year 2006-07. These indicators were then converted into scores using the method which UNDP uses for ranking the countries according to their human development indicators. In the next stage three individual scores were added up to get the final scores giving 50 percent weightage to the first indicator and 25 per cent weightage to each of the other indicators. Finally GPs were ranked in ascending order according to the value of the total scores.

Once all 167 GPs were ranked, we picked up 10 best performing GPs and 10 worst performing GPs. Chandrapur was chosen from the list of 10 best performing GPs considering other factors such as its close proximity to Sadar Sub-division and lower degree of backwardness. Talowan was chosen from the list of 10 worst performing GPs considering the same factors as in the case of Chandrapur. Unlike Chandrapur, Talowan is quite remotely located, very poorly connected by road transport and

it is a backward GP too. Chandrapur GP belongs to Rajnagar block and Talowan GP is in Mayureswar block. There is some evidence that a good number of people from these two blocks migrate out for work. This gives us an additional advantage of studying some migration related issues in these two GPs.

In each GP we identified with the help of GP functionaries Sansads with a good number of people from SC, ST and Muslim community, and which could also be considered as representative. In each GP, we stratified the representative Sansad's households into four strata: SC, ST, Muslims and others. Attempts were made to interview 30 households from each strata in two GPs. Sample households were selected from sample frame using random number generated by MS Excel (this is considered as substitute of random number tables). Although attempts were made to interview 240 households, we ended up interviewing 219 households due to unavoidable reasons. Table ** shows total number of households and sample households belonging to each stratum in two study GPs. Since the strata vary from each other in terms of their share in the population, taking equal number of households from each stratum imposes the problem of over-representation / under-representation of some groups in the sample. This problem was corrected by calculating appropriate weights for each stratum in two GPs so that the effect of over or under representation in the sample is neutralised. It is evident that while Muslims dominate in Talowan GP, both SC and others have almost equal share (in terms of number of households) in Chandrapur GP. Apart from interviewing the selected households, we interviewed all GP members who were available and GP Sachib.

**Table 8A1: Total and sample number of households and weights in two GPs**

| No. of households | SC | ST | Muslim | Others |
|---|---|---|---|---|
| ***Talowan*** | | | | |
| Population | 922 (22) | 417 (10) | 1605 (38) | 1231 (29) |
| Sample | 23 | 21 | 28 | 30 |
| weight | 40.09 | 19.86 | 57.32 | 41.03 |
| ***Chandrapur*** | | | | |
| Population | 1104 (39) | 500 (18) | 122 (4) | 1115 (39) |
| Sample | 41 | 24 | 27 | 25 |
| Weight | 26.93 | 20.83 | 4.52 | 44.60 |

(1) Figures in the parentheses stand for share in total number of households in the GP; (2) weight for $i^{th}$ stratum in th $j^{th}$ GP = (Population size of $i^{th}$ strata in jth GP)/(sample size of $i^{th}$ stratum in the $j^{th}$ GP).
Source: Data provided by the respective Panchayat officials and Primary Survey