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Role of panchayat (Local Government Institution) in access to Health Care Services in Rural Areas of Gujarat, India

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ABSTRACT

The role of Panchayat in health care services delivery is very essential because it is bridge between the local rural community and the state government when it comes to access of various schemes of health for Rural areas. There should not be a gap between the decentralize approach to health care delivery services on paper and in form it has taken on ground. However more important than all this, the paper calls attention to the need for high degree of commitment of panchayat and Sarpanch towards the health care delivery to the village, awareness in the Rural communities for health care needs. This paper examines the Role of Gram Panchayats in the delivery of the health care services in Rural Areas of Gujarat from both theoretical and empirical perspectives by collecting data from the people of the villages on various issues pertaining to Health care delivery services in the village.

Further the paper presents the comparative analysis of all the Health care services in all the four villages and at last the paper concludes that, Rural healthcare in India is characterized by a huge gap between supply and demand. In order to meet the growing demand of Rural health care it is important that the Village Panchayat should particularly focus more on a) formulation of local health plans based on community needs and assessment, b) mobilization and management of resources(financial, Human, material), c) communication and awareness generation and implementation of various health programs. If this aspect is taken care off we can except the better delivery of Health care especially in Rural Areas.

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Key words:
Community; Mobilization; Commitment; Empirical; Theoretical

1. Introduction:

Panchayati Raj is an ancient institution an antique as India. In fact, it has been the backbone of Indian villages since the beginning of recorded history. The institution of Panchayati Raj is specifically designed for rural population to take care of the problems of rural areas. The basic objective Panchayati Raj is to evolve a system of democratic decentralization and devotion of power with a view to ensuing rapid socio-economic progress and speedier and inexpensive justice (Shewta, 2010)

In the Indian federal architecture panchayat is the closest to the notion of direct democracy; distinct from the representative democracy of the Union and States, because of its nearness to the community it serves. The objectives of a panchayat include organizing common men in the process of developing themselves through their own efforts on a continuing basis, at the same time, enhancing their capacity and self-reliance. This is possible with 'citizen participation' in political processes and 'service delivery' of local public goods, e.g. potable drinking water, general sanitation, primary health, elementary education, maintenance of public properties etc. According to the report of the Balwant Rai Mehta committee (1957) and the subsequent 73rd amendment to the constitution of India, the Key objective of the Panchayat is to balance the two values of Citizen Participation and services delivery, therefore it holds true in case of the public health services delivery also. Therefore Panchayat has a vital role to play in the health care delivery services of the village (Alok, 2014)

The right to basic education and primary health care has been recognized as human rights in the UN charter of Human Rights prepared in 1948. India being signatory to the UN Covenent on human rights, it is the duty of the government to provide primary health care to every citizen of the country. Preventive health care is mostly ignored in rural areas where it is often considered unusual to visit a health personnel/center when a person is maintaining normal health. (Gill, 2000)

The right to health is generally seen as the state's obligation to deliver affordable and accessible health services to

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all Under the Constitution of India, public health care is a responsibility shared by the central, state and local governments. Active community participation through ownership and implementation of local health services is now gaining ground as a way of ensuring such influence (Ray S. , 2007)

The importance of decentralized health care delivery systems operating through elected local governments (Gram Panchayat) in which the rural people are not only liberated but also empowered. This Act, which paved the way for the creation of statutory institutional structures at the village level - Gram Sabha (GS) and Gram Panchayat (GP) - basically, aims at initiating a process of democratic decentralization of governance and accelerating the socioeconomic development of rural areas within a participatory framework. With the insertion of Part IX in the Constitution of India, the GP is empowered to manage health and sanitation, including hospitals, primary health centers and family welfare, which are among the twenty-nine vital ingredients of rural development, listed out in the Eleventh Schedule (Article 243 G) of the Constitution. (Ray S. , 2007)

1.1. The Gujarat Scenario

Gujarat is one of the large states in India known for sustained levels of development (Shariff, 2011). The Population of Gujarat according to the 2011 census stands at about **60 million**, making it the 10th most populated state in India. The state makes up about **5%** of the country's population a figure which was about **4.8%** during the last census in 2001 (GOG, District Cencus handbook, 2011). About **57.4 %** of the total population of Gujarat lives in rural area **(Total Population-60,383,628)**(Directorate of Cencus Operations, 2011). The achievement of the state on number of health indicators is quite impressive. The infant mortality rate (IMR) of Gujarat is at **41** which is lower than the national average of **44,** the crude death rate is **6.7** which is lower than the national average of **7.1.** The Rural literacy rate of Gujarat is **73.0** % and this is much higher than the all India Rural average of **67.8 %.** (Directorate of Cencus Operations, 2011)

On the recommendations of Balwantray Mehta Committee, Gujarat Panchayat Act, 1961 was applied in the state since 1963. (GOG, Panchayat Rural Housing and Rural developement department , 2014)Panchayati Raj is being implemented in Gujarat with definite policy

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and intention to see that community at large may participate in strengthening Panchayati raj and in journey of development with government.

Three tier arrangements prevails in Gujarat state viz

1. Gram Panchayat
2. Taluka Panchayat
3. District Panchayat

The Gram Panchayat is the executive committee of the GS [1] consisting of minimum seven and maximum 15 members including Sarpanch and Deputy sarpanch. Seats have been reserved for women, Scheduled caste and scheduled tribe for women in Gram Panchayat. Under the Gujarat Gram Panchayat act, 1993 the Grampanchayat have been empowered to enquire and make report on the physical attendance and misconduct of certain public personnel including male and female health workers. The Grampanchayat have to keep tab on the functioning of CHC's and PHC's. The GP also have to keep watch on execution and monitoring of rural health and sanitation programme. The Grampanchayat have been made the appointing authority in respect of certain village staff like Anganwadi workers etc.

The paper examines how and to what extent the Gram panchayat is effectively able to carry out the assigned functions particularly in context of Rural health care initiatives of the Panchayat in Gujarat, this is sought to be looked at in this paper through field work data.

2. Objectives of the study

1. To study the role of the GP in health care delivery in the village
2. To know the perception of the people regarding the health care services provided and facilitated by the GP
3. To know the perception of people on the believe that effective involvement of GP would improve the health care services.

3. The Research context and Methodology

The paper presents primary data collected from four villages in two districts – Mehsana and Sabarkatha of Gujarat state. One Taluka from each district was selected randomly for the study – Talod Taluka was

[1] GS=Gramsabha

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selected from Sabarkatha district and Kadi Taluka was selected from Mehsana district.

Table: 1

Socio Demographic Profile of Sample districts

Sr. No	District	Sex Ratio*	Rank in 2011*	Child Sex Ratio*	Literacy Rate*	SC percentage*	ST percentage*
1	Mehsana	925	19	845	84.26	7.74	0.52
2	Sabarkatha	947	8	899	67.31	8.82	20.18

Source: *Directorate of Census operations, Gujarat, Ministry of Home affairs, Government of India*

Note: * Data pertaining to 2011 census; SC= Schedule Caste; ST= Schedule tribe

** Sex Ratio= No of females per 1000 males

As shown in table 1, **Mehsana district** is one of the **33** districts of Gujarat state in western India. Mehsana city is the administrative headquarters of this district. The district has a population of over **18 lakhs** and an area of over **4,500 km²**. There are over **600** villages in this district. It had a population of **1,837,892** of which **22.40%** were urban as of 2001. According to the 2011 census Mehsana district has a population of **2, 027, 727**, This gives it a ranking of **229th** in India **(out of a total of 640)**.The district has a population density of **462** inhabitants per square kilometer **(1,200 /sq mi)** .Its population growth rate over the decade 2001-2011 was **9.91%.**Mehsana has a sex ratio of **925 f**emales for every **1,000** males, and a literacy rate of **84.26%.** The percentage of SC population is **7.74 %** and the population of ST population is **0.52 %**.

Sabarkatha is a district in Northeast of Gujarat state of India. The district comprises **7** Talukas. It is spread across an area of **7390 km**. It has a gender ratio of **947** females per **1000 men,** and the literacy rate for the district is **67.31%.**According to the 2011 census Sabarkatha district has a population **of 2,427,346**, This gives it a ranking of **183rd** in India (out of a total of 640).The district has a population density of **328** inhabitants per square kilometer (850 /sq mi) Its population growth rate over the decade 2001-2011 was **16.56%.**Sabarkantha has a sex ratio of **947** females for every **1000** males and a literacy rate of **76.6%** (Table 1)

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Table 2

Socio-demographic profile of Sample Block/Taluka

Sr. No	Block/Taluka	Talod(Sabarkatha)	Kadi(Mehsana)
1	Population	15424	341407
2	Male	79739	177698
3	Female	74685	163709
4	Literacy Rate	69	65.8
5	Male Literacy	76	78.55
6	Female Literacy	48	52.02
7	Schedule Caste	11874	29521
8	Schedule Tribe	1118	534

Source: Directorate of Census operations, Gujarat, Ministry of Home affairs, Government of India

Note: * Data pertaining to 2011 census

As per 2011 census Talod has population of **154424.** Total number of males is **79739** of the population and females are 163709. The male literacy rate of Talod is **76%**, and female literacy is **48%.**, the number of people belonging to schedule caste are **11874**, and Schedule tribe are **1118**.

As per 2011 Census Kadi Taluka has population **341407**, total number of males are **177698** of the population and females are **163709.** The male literacy rate of Kadi is **78.55 %** and female literacy rate is **52.02 %,** the population of schedule caste is **11874**, and schedule tribe is around **534.**

From each of the sample District(Sabarkatha and Mehsana) , two Grampanchayat were selected for detailed study and total number of GPs is four in this two districts. In each GP of the village following category of respondents were covered total of 54 respondents (Households) from each village , Sarpanch and the deputy sarpanch.

- In order to collect the data both the conventional and participatory tools was used for collection of data:

I. Information on functioning of Rural health programs and services, the perception of villagers on the role and functioning of GP in access to Rural Health care services and this data was collected by distributing specially designed Questionnaire among the sample villagers.

II. Data on the constraints which are faced by the GP in managing and implementing the health care programs were collected from the Sarpanch and from the Talati (Panchayat Secretary) with the help of specific schedules and informal discussions

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Table 3

Socio Demographic Profile of Sample

Village – Karanagar, Talod Taluka (Block) Sabarkatha District

Block /District		Panchayat
Sr.No	Talod Taluka(Sabarkatha District)	Karanagar
1	Population	10725
2	Male	3000
3	Female	7725
4	Health Infrastructure	PHC
5	Health Worker	MPHW
6	Anganwadi Center	1
7	NGO	-
8	Mahila Mandal(SHG)	2

Source: Field Survey and Personal communication with the Sarpanch

Table 4

Socio Demographic Profile of Sample Village – Achrasan, Talod Taluka (Block) Sabarkatha

Block/District		Panchayat
Sr.No	Talod Taluka(Sabarkatha District)	Acharasan
1	Population	2079
2	Male	1045
3	Female	1034
4	Health Infrastructure	CHC
5	Health Worker	
6	Anganwadi Center	1
7	NGO	-
8	Mahila Mandal	-

Source: Field Survey and Personal communication with the Sarpanch

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Table 5

Socio Demographic Profile of Sample Village – Nanishiholi, Kadi Taluka (Block) Mehsana

Block/District		Panchayat
Sr.No	Kadi Taluka(Mehsana District)	Nanishiholi
1	Population	700
2	Male	300
3	Female	250
4	Health Infrastructure	1
5	Health Worker	-
6	Anganwadi Center	1
7	NGO	-
8	Mahila Mandal	-

Source: Field Survey and Personal communication with the Sarpanch

Table 6

Socio Demographic Profile of Sample Village – Punsari, Kadi Taluka (Block) Mehsana

Block/District		Panchayat
Sr.No	Kadi Taluka(Mehsana District)	Punsari
1	Population	5200
2	Male	2375
3	Female	2025
4	Health Infrastructure	1
5	Health Worker	MPHW
6	Anganwadi Center	1
7	NGO	-
8	Mahila Mandal	2

Source: Field Survey and Personal communication with the Sarpanch

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- Primary data had been collected from respondents and Sarpanch, by administration of structured schedules and discussion with respondents and Sarpanch , secondary data and information were obtain from various reports of the state and central government and other published sources and websites, wherever feasible, with due acknowledgement . The study was carried out in June-July, 2014.

3.1. Background Characteristics of Respondents:

As shown in **(Table 7)** all the four villages which were selected for the study the percentage of males were higher than females(**Karannagar**- Male-**72.2%**, Female-**27.7%**, **Acharasan**- Male-**59.25%,** Female-**40.74%,Nanishiholi**-Male-**70.07%,** Female -**25.92%,Punsari**-Male-**68.51%,** female-**31.48%).** About **37%** of the respondents were in the official BPL category and rest **62 %** of the respondents were in the Non-BPL category for **Karannagar village**. In **Acharasan village** about **55 %** of the respondents were in the official BPL category and rest **44 %** of the respondents were in the Non BPL category. In **Nanishiholi 69%** of the respondents were in the official BPL category and **37 %** of the respondents were in the Non BPL category.

In **Punsari village 12 %** of the respondents were in the BPL category and rest **77 %** were in the Non BPL category. As far as the literacy is concerned there are about **48 %** of the respondents are literate and **44 %** of the respondents are illiterate in Karannagar village. In Acharasan village **40%** of the respondents are literate and **59 %** of the respondents are illiterate. **27 %** of the respondents are literate and **72 %** of the respondents are illiterate in Nanishiholi village. In Punsari village **64 %** of the respondents are literate and **35 %** of the respondents are illiterate. Therefore comparatively the rate of literacy is higher in Punsari then other 3 villages. Out of **54 respondents** from Karannagar village **49** belongs to **General category**, **1** from **OBC**, there were no respondents who belonged to ST category and just **1** respondent belonged to **SC** category. In **Acharasan** out of 54 respondents most of the respondents i.e. **23**

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belonged to **OBC category** , **11** belonged to **General category**, there were no respondents who belonged to ST category, **30** respondents belonged to the **SC category.** In Nanishiholi village out of **54** respondents, most of them belonged to SC category i.e. **30 respondents**, **10 belonged** to **ST category**, **6 b**elongs to **OBC category** and **8** respondents belong to **General Category**. In Punsari village most of the respondents belonged to **General category** i.e. **31** respondents, **1** belonged to **OBC,3** belonged to **ST** and **15** belonged to **SC category**

Table 7

Background Characteristics of Respondents

Villages	Sex			BPL Status			Literacy		
	Male	Female	Total Respondents	BPL Status	Non- BPL	Total Respondents	Literate	Illiterate	Total Respondents
Karannagar	39(72.2)	15(27.7)	54	20(37.03)	34(62.96)	54	26(48.14)	24(44.44)	54
Acharasan	32(59.25)	22(40.74)	54	30(55.55)	24(44.44)	54	22(40.70)	32(59.25)	54
Nanishiholi	40(70.07)	14(25.92)	54	34(69.96)	20(37.07)	54	15(27.77)	39(79.22)	54
Punsari	37(68.51)	17(31.48)	54	12(22.22)	42(77.77)	54	35(64.81)	19(35.18)	54
Total	**148**	**68**	**216**	**96**	**120**	**216**	**98**	**118**	**216**

(Table continued)

Villages	Caste							
	SC	Total Respondents	ST	Total Respondents	OBC	Total Respondents	Gen	Total Respondents
Karannagar	1	54	0	54	1	54	49	54
Acharasan	20	54	0	54	23	54	11	54
Nanishiholi	30	54	10	54	6	54	8	54
Punsari	15	54	3	54	1	54	31	54
Total	**66**	**216**	**13**	**216**	**31**	**216**	**99**	**216**

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4. Findings of the study

- **Role of Gram Panchayat:**

In context of Health the Role of PRI's is to: 1. Bridge the Gap between the exiting Health care providers and people needing the services. 2. Make Health services Responsible to the Need of the People. 3. Be accountable to the People by making the process Participatory. 4. Focus on local problems (bottom-up- approach) (Leela Visariya, 2011).

To obtain the data on the Role of Panchayat in delivering the health care services and also to know the level of satisfaction among the people of the village regarding the role of Panchayat in Health care services a specially designed schedule among the sample village was circulated. In (Table 8), there are responses on the different questions which were asked to the Respondents from all the 4 villages (Karannagar, Acharasan, Nanishiholi, and Punsari).

I. Satisfaction of the health care services facilitated by the Panchayat:

In Karannagar most of the Respondents i.e. **42** out of **54** **(76%)** are satisfied with the Health care services facilitated by the Panchayat, 12 out of 54 respondents are not satisfied with the Health care services facilitated by the Panchayat i.e. **(24%)** of the respondents are not satisfied. In case of Nanishiholi village, the health care services provided by the Grampanchayat is not at all satisfactory as most of the respondents are not satisfied with the health care services provided by the panchayat and this is evident from the data given in the table below(Table 8) In Punsari village the scenario is much better than the other 3 villages here people are much satisfied with the health care services provided by the Panchayat, **38** out of **54** respondents **(70%)** of the respondents are satisfied. Maximum people in the village are getting the benefits of all the schemes

II. Discussion of Health Issues in Gram Sabha by the Sarpanch :

The 73rd Amendment included the Gram Sabha or village assembly as a deliberative body to decentralized governance along with a three-tier structure

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of Panchayat from village to the district. Article 243(b) defines Gram Sabha as "a body consisting of persons registered in the electoral rolls relating to a village comprised within the area of the Panchayat at the village level" (Buch, 2012).

Gram sabha provides a forum to meet, discuss, debate and analyze the development of the village and administrative actions of the elected representative, it is also important that Health issues which are of major concern in the village should be discussed in the Gramsabha, along with the discussion of the major health issues, it also important to discuss various drawbacks or dissatisfaction regarding the Health care services by the Panchayat. In Karannagar **31** out of **54** respondents i.e. **(57%)** agrees that there is a discussion of health issues in the Gramsabha by the sarpanch and the rest **23** out of **54** respondents i.e. **43 %** does not agree that there is a discussion on health issues in the Gramsabha by the Sarpanch.

In Karannagar the major issues which are discussed includes mainly the Infrastructure Development of the local Primary health care center, to avail maximum benefits for the village population of different health related schemes from the state etc. In case of Acharasan village most of the respondents disagrees on the fact that sarpanch ever discusses the health issues in the Gramsabha, **34** out of **54** respondents i.e. **(63%)** does not agrees with the fact that Sarpanch ever discusses the health issues in the Gramsabha meeting and only **20** out of **54** respondents i.e. **(37 %),** agrees that the Sarpanch discusses does discuss the health issues in the Gramsabha meeting. Portable water and sanitation seemed to be the most discussed issue in the Gramsabha meeting of Acharasan village, there were also feedbacks from the respondents about the continuous absence of Sarpanch in the Gramsabha meeting. In case of Nanishiholi village, just **10** out **54** respondents i.e**.(19%)** reported that the sarpanch does takes up issues of health and hygiene in the village rest **44** out of **54** respondents i.e**.(81%)** of the respondents are of the view that the Sarpanch does not discusses the critical issues relate to health. In case of Punsari Village people are of the view that health issues are discussed regularly in Gram sabha meeting, the data given in the table below (Table 8) supports this argument **(40 out of 54 respondents (76%).**

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The issues which are most discussed are issues awareness on critical diseases like AIDS and Cancer specially targeting the youth of the village, awareness on different schemes of the state health department on health so that the people of the village become aware and avail maximum benefit, discussion on organizing health camps etc. (Table 8)

III. Discussion of Health issues by the people of the village with the Sarpanch

A strong Panchayati Raj Institution system can provide different forums and platforms for discussing health needs of people and formulating health plan for its respective area**.**(John, 2012)

It is indeed necessary people discuss the health issues with the Sarpanch because sometimes some health issues are such which an individual might hesitate to speak in public specially in Gramsabha meetings, therefore for Sarpanch it is necessary that he or she should be sensitive and alert towards such Health issues and the Sarpanch should also try to maintain the confidentiality for the issues of such people.

In Karannagar village **47x**out of **54** respondents i.e. **(87%)** were of the views that they discuss such issues with Sarpanch, and **7** out of **54** respondents i.e. **(13%)** were of the views that they do not discuss any such issues with the Sarpanch of the village, the reasons being hesitation, nature of the disease, and other social stigmas etc. In Acharasan village **5** out **54** respondents i.e. **(9%)** said that they do discuss such issues with the Sarpanch and most of the respondents said that they do not discuss any such issues with the sarpanch reason being sarpanch is not interested in listing to the issues secondly like in the case of Karannagar people are more faltered to discuss such issues. In case of Nanishiholi also just **12** out of **54** respondents i.e**.(22%)** said that they do discuss such issues with the Sarpanch and most of the respondents reported that they do not discuss such issues with the Sarpanch **(42 out of 54, i.e.78 %).** In case of Punsari village **45** out of **54**respondents **(83 %)** said that they do discuss critical health issues with the sarpanch and rest **9** out of **54** respondents **(17%)** said that they

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do not discuss such issues with the Sarpanch .(Table 8)

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Table 8

Villages	Satisfaction in the health care services facilitated by the Panchayat		Regular Health and awareness camps in the villages by Panchayat		Discussion of Health issues in Gram Sabha by Sarpanch		Discussion of Health issues by people of the village with GP(Sarpanch)		Complaint about the health staff of CHC/PHC to GP /Sarpanch		Registration of Birth and Death by GP		Believe on the effective involvement of GP would Improve the health care services			Satisfaction with the performance of Anganwadi worker	
Responses from the respondents	Satisfied	Not Satisfied	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	No Idea	Satisfied	Not Satisfied
Karannagar	42(76)	12(24)	31(61)	23(39)	31(57)	23(43)	47(87)	07(13)	17(31)	37(69)	38(70)	16(30)	46(85)	5(9)	3(6)	41(76)	13(24)
Acharasan	16(31)	36(69)	10(19)	42(81)	20(37)	34(63)	05(9)	49(91)	36(67)	18(33)	18(33)	36(67)	4(7)	10(19)	40(74)	03(6)	50(94)
Nanishiholi	21(39)	33(61)	14(26)	40(74)	10(19)	44(81)	12(22)	42(78)	33(61)	21(39)	10(19)	44(81)	12(22)	5(9)	37(69)	23(43)	31(57)
Punsari	38(70)	16(30)	41(87)	06(13)	40(74)	14(26)	45(83)	09(17)	17(31)	37(69)	37(69)	17(31)	20(43)	09(19)	18(38)	37(69)	17(31)

Source: Computed from the Primary data collected from the field

Note: Percentages in Parenthesis*

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6. Discussion:

> *Despite the huge differences between developing and developed countries, access is the major issue in rural health around the world. Even in the countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. All countries have difficulties with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas*'. -R. Strasser (2003) PP: 457

Health and population stabilization are included among the various development activities assigned to the PRIs since 1993 but they were operationalized only around the middle of the first decade of this century. Until then, PRIs were neither equipped to take health planning and monitoring functions nor did the health system see a role for PRI in healthcare delivery. Both the National Population Policy 2000 and the National Health Policy 2001, recognized and reiterated the need for decentralization and convergence of health service delivery at the village level and for the PRI to be the key and appropriate agency for the purpose. It was in August 2003, that the central council of ministers of health and family welfare resolved "*that the States would involve PRI in the implementation of health and family welfare programmes by progressive transfer of funds, functions and functionaries, by training, equipping and empowering them suitably to manage and supervise the functioning of healthcare infrastructure and manpower*".

The role of the PRI has been engineered into the basic structure of the NRHM, which has refrained from creating parallel mechanisms, and instead, provide scope for the existing social infrastructure to be used and strengthened. PRIs are, therefore, seen as critical to the planning, implementation and monitoring of health delivery and meeting the NRHM goals. The Panchayat is expected to act as a community level accountability mechanism to ensure that people's health needs are met. The structure created in every village as a representative body to coordinate the health

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delivery is the VHSC[2]. It is constituted to function as a link between the gram panchayat and the community.(Leena Visariya 2011:61)Health performance of Gujarat viewed in terms of the Human Development Index (HDI) portrays it as a medium performer in the country. However, the index of health component for Gujarat is found to be positively contributing to the HDI ranking of the state. (Shrikant, 2014)

According to "India Human Development Report 2011" the human development index of Gujarat was **0.527 in 2007-08**. Between 1999-2000 and 2007-08, the human development index increased by **0.06** points. According to the sample registration system of the government of India, Gujarat had a death rate of **6.7** death per **1000** persons in the year **2011** compared to the national average of **7.1**. Similarly the infant mortality rate in the state **(41 infant death per 1000 live births)** is only marginally better than the national average **(44 infant death per 1000 live births)** In terms of expectation of life at birth also, the difference between Gujarat and India is only marginal (**66.8 years and 66.1years respectively**). (Government of Gujarat 2013:10). Gujarat is one of the first states to adopt the Panchayati Raj system or Primary Health care. (Balakrishnan, 2011).

Among the four Panchayat which were taken for study the overall picture that emerges is that the village panchayat of Acharasan and Nanishiholi have not paid very much attention to the health functions and hence the PHC are no better under Panchayat then they might be under state control, where else the village panchayat of Karannagar village and Punsari village presents a very glorious picture about their functions and health care delivery to the people of the village, both the Panchayat are able to add substantially to the resources available from the center or the state in order to Improve services. The comparison of all the 4 Panchayat in terms of ESSENTIAL services are given below:

[2] Village Health and Sanitation committee

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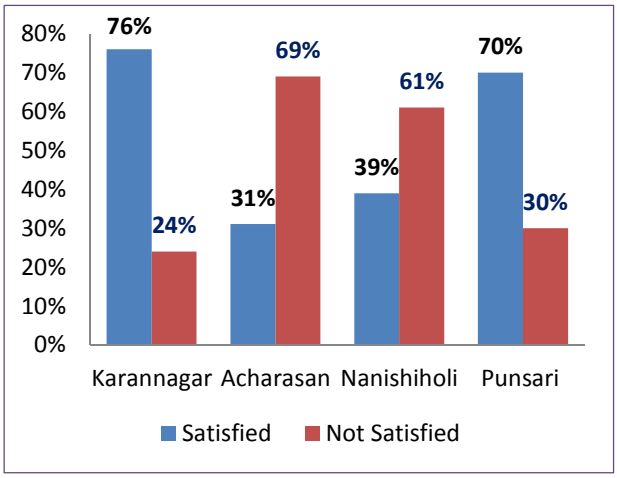
Figure1

Comparison of Panchayat in terms of Health care services provided by the Panchayat

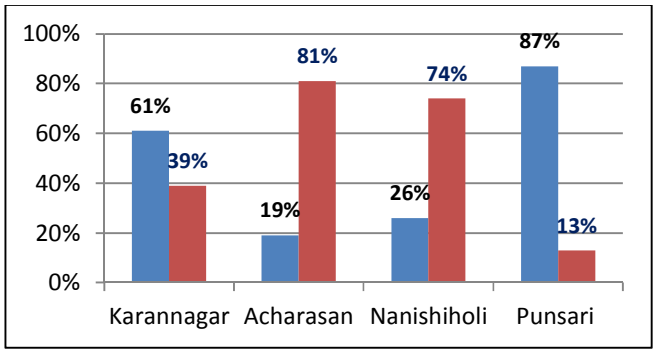


Source: *Computed from the Primary data collected from the field*

The above figure (Figure 1) shows the comparison of all the four villages in terms of satisfaction in terms of health care services provided by the Panchayat. It can be concluded from the above data that the health care delivery by Karannagar Gram Panchayat is better than the three other Panchayat because **76 %** of the people are satisfied with the health care services provided by the Panchayat. In terms of dissatisfaction, the panchayat of Acharasan village performs the worst because about **69 %** of the people are dissatisfied by the health care services provided by the Panchayat.

Figure 2

Comparison of Panchayat in terms of organizing of Health and awareness



Source: *Computed from the Primary data collected from the field*

The above figure (Figure 2) shows the Comparison of Panchayat in terms of organizing of Health and awareness camps and the results shows that maximum health and awareness camps are organized in Punsari village i.e. **(87%)** of the respondents reported that the village panchayat organizes health and awareness camps and **(13%)** of the respondents reported that the village does not take interest in organizing any such camps in the village. The least number of health and awareness camps are organized by Achrasan Grampanchayat and it is evident from the data (81 **%**) of the

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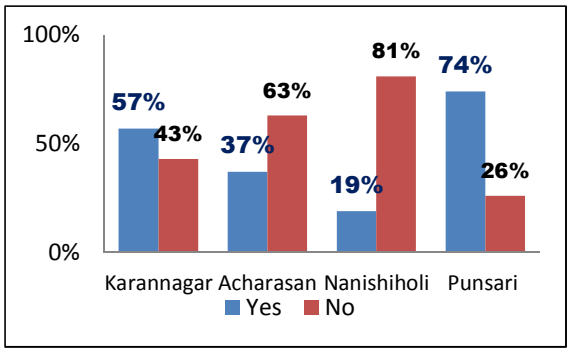
respondents at Acharasan village reported that the village does not organize any such health and awareness camps in the village.

Figure 3

Comparison of Panchayat in terms of Health issues discussed by the Sarpanch in Gramsabha

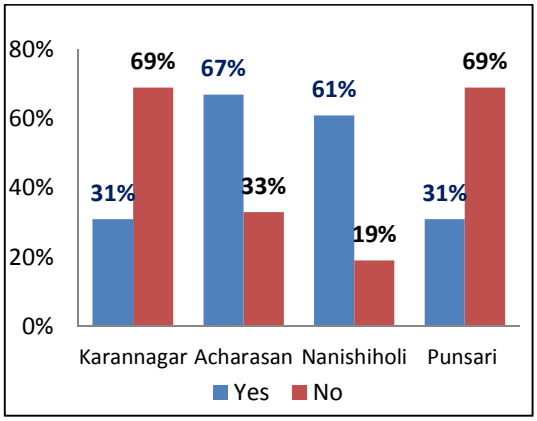


Source: *Computed from the Primary data collected from the field*

The above figure (figure 3) shows that most of the respondents **(74%),** in Punsari village reported that the Sarpanch frequently discusses various critical issues related to health and hygiene of the village community, where else contrary to Punsari, most of the respondents of Nanishiholi **(81%)** reported that there is no discussion by the sarpanch regarding the health issues of the village community.

Figure 4

Comparison of Panchayat in terms of complaints received regarding the staff of CHC/PHC



Source: *Computed from the Primary data collected from the field*

The above figure(figure 4) shows the complaints which is received by the Panchayat from the people of the village, in this figure the panchayat which receives the highest number of complaints i.e **(67%)** of the respondents complains about the health staff of the local community center, so it can be concluded that the people are highly dissatisfied with the behavior of the health staff and the least number of complaints are received by the panchayat of Karannagar and Punsari village **69 %** and **69 %** respectively.

This comparative analysis shows that there is still much to be done in the villages

where even today there is no proper Heath care delivery and the state government should make utmost efforts to decentralize the health care delivery and assure that each and every single individual of the Rural community should be satisfied and receives the best health care.

Therefore the argument by Sthiapragyan Ray fits best into the current scenario that '*There is no shortcut for to successful decentralization initiatives particularly when it comes to health care services delivery in Rural communities. Successful and sustainable decentralization initiatives involves a political process, which ironically has to be initiated and if necessary sustained from the above.*'-S.Ray (2007) PP: 88

7. Conclusion

Linking the health sector with the panchayat system is a complex chain process Involving several actors. The role of Panchayat in health care services delivery is very essential because it is bridge between the local rural community and the state government when it comes to access of various schemes of health for Rural areas. The important part in the health of Rural community is the access to high quality health care services. In many areas accessibility is diminished by lack of all - weather roads, lack of basic infrastructure, geographical location of the villages etc.

In the findings of the study it was evident that both the village (Nanishiholi and Acharasan) are having the same problems which are discussed above like lack of basic infrastructure, shortage of paramedical and medical staff etc, and as a result the health care service delivery of both the panchayat was not satisfactory. Rural healthcare in India is characterized by a huge gap between supply and demand. In order to meet the growing demand of Rural health care it is important that the Village Panchayat should particularly focus more on a) formulation of local health plans based on community needs and assessment, b) mobilization and management of resources(financial, Human, material), c) communication and awareness generation and implementation of various health programs. If this aspects are taken care off

we can except the better delivery of Health care especially in Rural Areas.

There should not be a gap between the decentralize approach to health care delivery services on paper and in form it has taken on ground. However more important than all this, the study calls attention to the need for high degree of commitment of panchayat and Sarpanch towards the health care delivery to the village, awareness in the Rural communities for health care needs, Health education should be also given with the health care services to the Rural community so that there is some sort of sensitization towards the basic health care needs among the Rural community, etc. for improving the Health services provided by the Panchayat and also to enhance the role of panchayat overall development of the village. Further studies might attempt to understand better mechanism for successful implementation of decentralized health care initiatives in Rural Gujarat.

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