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Examining Decentralisation of Health Services through Beneficiary and Provider Perspectives in Bilaspur, Chhattisgarh

ORIGINAL ARTICLE


Authors
Manoj Kumar Suryavanshee
Research Scholar

Poonam Verma
Assistant Professor
Department of Sociology & Social Work
Shri Venkateshwara University
Gajraula, Amroha, Uttar Pradesh, INDIA

Abstract

Decentralisation in healthcare has emerged as a corner stone of public health reforms in India, particularly under the National Rural Health Mission (NRHM) framework, now subsumed under the National Health Mission (NHM). It aims to bring governance closer to the people by enhancing efficiency, equity, and participatory decision-making at the grassroots level (Kaur et al., 2012; Bajpai & Goyal, 2004). This review paper critically examines the decentralization of health services in the Bilaspur district of Chhattisgarh, a state characterized by a large tribal population, rugged terrain, and persistent health disparities (Government of Chhattisgarh, 2020). The study adopts a dual-lens approach, capturing beneficiary and provider perspectives while drawing on national health policies, state-level reforms, and field-level innovations. "Empirical and policy-based evidence indicates that decentralized models, such as the Mukhyamantri Haat Bazaar Clinic Yojana and Jan Swasthya Sahyog's integrated rural health interventions, have significantly improved access and acceptability of healthcare services in remote tribal areas" (Jan Swasthya Sahyog, 2024; Government of Chhattisgarh, 2019). "Community-based monitoring (CBM) mechanisms and locally-managed institutions like Village Health Sanitation and Nutrition Committees (VHSNCs) and Rogi Kalyan Samitis (RKS) have further fostered accountability and responsiveness" (World Health Organisation, 2008). "However, the effectiveness of these decentralized frameworks is mediated by constraints such as inadequate human resources, capacity gaps at local levels, and fragmented financing" (Kaur et al., 2012). The findings of this review underscore the need to strengthen institutional capacities, ensure fiscal devolution, and promote genuine community engagement to realize the transformative potential of decentralised health governance in regions like Bilaspur.

Key Words

Decentralisation, Health Governance, NRHM, Community-Based Monitoring, Rural Health.

Introduction

"Decentralisation, a key concept in public administration and development planning, refers to the systematic delegation of authority, resources, and responsibilities from centralized structures to lower tiers of governance" (Rondinelli, 1981). "In the health sector, decentralization has gained global momentum as a reform strategy to improve service efficiency, responsiveness, and equity by bringing decision-making closer to the community" (Bossert & Beauvais, 2002). It includes administrative, fiscal, and political dimensions, each contributing to reshaping health system governance. "By empowering local bodies such as panchayats, municipalities, and community-based institutions, decentralization enables context-specific health interventions and allows greater community participation in planning and monitoring" (Kaur et al., 2012).

India's health governance system has historically been highly centralized, with major decisions taken at the national or state level, leaving limited space for grassroots inputs. "However, this began to shift following the 73rd and 74th Constitutional Amendments in the early 1990s, which recognized Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs) as constitutional entities and envisioned their involvement in social sector governance, including health" (Government of India, 1992). "The decentralization agenda gained further momentum with the launch of the National Rural Health Mission (NRHM) in 2005, which explicitly called for community ownership of health systems, local planning, and flexible financing mechanisms to support need-based interventions" (Ministry of Health and Family Welfare-MoHFW, 2005).

Under the NRHM, various institutional mechanisms were introduced to operationalize decentralization at different administrative levels. These included the establishment of Rogi Kalyan Samitis (RKS) at the facility level, Village "Health Sanitation and Nutrition Committees (VHSNCs) at the village level, and district health societies at the district level. These structures are intended to facilitate participatory planning, monitor service delivery, and manage untied funds for local health needs" (MoHFW, 2005; Bajpai & Goyal, 2004). The mission emphasized capacity building, community-based monitoring, and inter-sectoral convergence to strengthen decentralized governance.

Chhattisgarh carved out of Madhya Pradesh in 2000, offers a particularly compelling case for examining decentralization in healthcare. "With over 30% of its population comprising Scheduled Tribes and significant portions living in remote and forested areas, the state faces persistent public health challenges including high maternal and infant mortality, poor nutritional outcomes, and shortages of health infrastructure and personnel" (Government of Chhattisgarh, 2020). The state's topography and insurgency in certain districts add another layer of complexity to healthcare delivery. In such a context, decentralization offers both a necessity and an opportunity"necessity because centralized approaches have historically failed to reach the remotest communities effectively, and opportunity because localized interventions may be more sensitive to cultural, social, and logistical realities" (Chhotray & Stoker, 2009).

"Chhattisgarh has adopted several innovative approaches to deepen decentralization in health service delivery. For instance, the Mukhyamantri Haat Bazaar Clinic Yojana, launched in 2018, sends mobile medical teams to weekly village markets, or "haats," in tribal regions, offering on-the-spot outpatient consultations, diagnostic services, and essential medicines" (Government of Chhattisgarh, 2019). This initiative addresses geographical barriers to access and aligns service delivery with traditional social practices. Furthermore, institutions such as Jan Swasthya Sahyog (JSS), a non-Governmental organization based in Bilaspur, have demonstrated successful community-led, low-cost, and comprehensive rural healthcare models. "JSS runs a hospital, community health centers, and daycare centers that serve some of the poorest tribal populations while emphasizing community health workers, health education, and integration with social services" (Jan Swasthya Sahyog, 2024).

From the governance perspective, the operationalization of VHSNCs and RKSs in Bilaspur has gradually shifted local accountability and participatory planning. "These bodies enable community members, elected

representatives, and frontline health workers to jointly identify health priorities, monitor service delivery, and decide on using untied funds. In principle, such participatory platforms should improve the transparency and responsiveness of the health system" (World Health Organization, 2008). "However, their effectiveness varies widely depending on the capacity of local institutions, the awareness levels of beneficiaries, and the support from higher levels of administration" (Kaur et al., 2012).

"Despite these advancements, challenges persist. Local functionaries often lack adequate training in planning and financial management. Structural issues include delays in fund disbursement, limited devolution of decision-making powers, and poor convergence between departments responsible for health, nutrition, and sanitation" (Bajpai & Goyal, 2004). Moreover, tribal communities often face socio-cultural barriers in accessing services, underscoring the need for more culturally appropriate interventions.

This review examines the implementation and impact of decentralised health services in the Bilaspur district using the dual lenses of beneficiaries and service providers. It explores how decentralization has translated into improved healthcare access, quality, and accountability. By integrating policy analysis with field-level experiences and institutional models like JSS and VHSNCs, this paper contributes to understanding how decentralization plays out in complex, resource-constrained settings. The case of Bilaspur offers valuable lessons for scaling decentralized governance mechanisms in other parts of India and globally, especially in marginalized and underserved regions.

Decentralisation in India's Healthcare System

Historical Context

India's decentralization journey in the health sector was shaped by the broader political reforms of the early 1990s, particularly the 73rd and 74th Constitutional Amendments. "These landmark amendments institutionalized Panchayati Raj Institutions (PRIs) in rural areas and Urban Local Bodies (ULBs) in cities as the third tier of governance, empowering them to plan and implement development programs across social sectors, including health" (Government of India, 1992). This constitutional mandate aimed to democratize governance by ensuring participation, accountability, and transparency in service delivery at the grassroots level.

"The turning point for health sector decentralization came with the National Rural Health Mission (NRHM) launch in 2005". This mission aimed to strengthen rural public health systems by improving infrastructure, human resources, and decentralized planning mechanisms. Under the NRHM, community-based institutional structures such as Village Health, Sanitation and Nutrition Committees (VHSNCs), Rogi Kalyan Samitis (RKS), and District Health Societies were introduced to promote participatory governance (Ministry of Health and Family Welfare [MoHFW], 2005). The RKS was tasked with the administration and functioning of public health facilities at the Primary and Community Health Centre levels, while VHSNCs played a crucial role in bottom-up planning and demand generation.

"In addition to these structures, decentralized financial mechanisms were introduced through untied funds allocated to VHSNCs and health facilities. These funds allowed for locally relevant expenditures and encouraged communities to participate in addressing micro-level health challenges" (Kaur et al., 2012). Collectively, these reforms were designed to shift the locus of decision-making from state capitals to the community, fostering a people-centered health system.

Decentralisation of healthcare in India serves multiple objectives, each aimed at strengthening the health system in unique ways:

- **Enhancing Efficiency:** "By giving autonomy to local institutions, decentralization enables them to tailor health services to community-specific needs. This customization helps improve the allocation and utilization of limited resources, thus reducing wastage and duplication" (Bossert & Beauvais, 2002).

- **Promoting Equity:** A central tenet of decentralization is its potential to ensure inclusive health governance. "By facilitating the participation of marginalized communities especially Scheduled Castes, Scheduled Tribes, women, and the poor local structures can prioritize and address inequalities in health outcomes" (Kumar & Mohanty, 2011).
- **Increasing Accountability:** Decentralisation fosters horizontal and vertical accountability. "Local Governments, being closer to the people, are more responsive and accessible. Structures like RKS and VHSNCs and community-based monitoring initiatives promote oversight and transparency in service provision" (World Health Organisation, 2008).

These objectives align with the broader goals of India's health policy to provide universal access to affordable, quality healthcare services, with a special focus on underserved and remote regions.

Healthcare Landscape in Chhattisgarh

Demographics and Health Indicators

Chhattisgarh, a central Indian state formed in 2000, is marked by considerable geographical, cultural, and social diversity. "Approximately 30.6% of its population is tribal, many of whom reside in forested and hilly terrains that are difficult to access" (Government of Chhattisgarh, 2020). The state also faces security challenges in parts of its southern and central belts due to left-wing extremism, which further hinders healthcare outreach.

Health indicators in Chhattisgarh have historically trailed behind national averages. According to the National Family Health Survey (NFHS-5, 2021), the state's infant mortality rate (41 per 1000 live births) and maternal mortality ratio (173 per 100,000 live births) remain high compared to the national averages. Malnutrition among children and anemia among women are also prevalent. The limited density of doctors and health facilities, particularly in rural and tribal areas, exacerbates the challenge. For instance, some remote villages rely on Sub-Centres located more than 10 kilometres away, significantly impacting access to care.

Decentralisation Initiatives

Recognizing these challenges, Chhattisgarh has implemented several reforms to decentralised health governance. RKS was established at all Primary Health Centres (PHCs) and "Community Health Centres (CHCs) to manage funds, monitor infrastructure, and improve service quality. These samitis are comprised of local elected representatives, healthcare staff, and civil society members responsible for facility-level decision-making" (Kaur et al., 2012).

At the village level, VHSNCs function as community oversight bodies. They were tasked with identifying health priorities, preparing village health plans, and utilizing untied funds for minor but essential expenses like sanitation drives, health education, and emergency transport. However, their performance varies in practice due to a lack of training and administrative support.

One of the state's flagship decentralized initiatives is the Mukhyamantri Haat Bazaar Clinic Yojana, launched in 2019. "This initiative addresses geographic inaccessibility by delivering mobile healthcare services during weekly tribal markets. It has helped bridge the access gap in districts like Bastar, Surguja, and Bilaspur by integrating preventive, promotive, and curative care into existing community practices" (Government of Chhattisgarh, 2019).

Beneficiary Perspectives on Decentralised Health Services

Access and Utilisation

Beneficiary perspectives provide a ground-level view of the effectiveness of decentralised health interventions. In Bilaspur, one of the key districts of Chhattisgarh, residents, especially from tribal hamlets, have reported improved access to healthcare services due to decentralized mechanisms.

First, deploying mobile medical units through the Mukhyamantri Haat Bazaar Clinic Yojana has played a transformative role. "These units, staffed by doctors, auxiliary nurse midwives (ANMs), lab technicians, and pharmacists, provide consultations, medications, and basic diagnostic services directly at weekly market gatherings" (Government of Chhattisgarh, 2019). For tribal populations who previously had to travel 15–20 kilometers on foot to the nearest PHC, this service has significantly reduced the time, cost, and physical effort of seeking care.

Second, untied funds provided to VHSNCs have been used to organize village health camps and facilitate patient transport in emergencies.

"Although there are limitations in fund management and technical training, these small-scale interventions have nonetheless improved local confidence in public health systems" (Kaur et al., 2012).

Third, institutional deliveries—a key indicator of maternal health have seen marginal improvement due to awareness campaigns conducted at the community level. "Accredited Social Health Activists (ASHAs), who act as the interface between the community and the health system, report that the ability to access support from VHSNCs for delivery-related travel and nutrition kits has led to increased uptake of maternal services" (MoHFW, 2021).

Despite these gains, challenges persist. In remote areas of Bilaspur, seasonal inaccessibility due to rains or forest terrain still affects service outreach. Beneficiaries have reported that mobile units sometimes lack essential drugs or diagnostic equipment. "Furthermore, cultural and language barriers continue to affect health-seeking behavior among tribal communities, particularly in areas where health workers are not familiar with local dialects" (Jan Swasthya Sahyog, 2024).

To address this, some organizations like Jan Swasthya Sahyog (JSS) have introduced community health worker models tailored to tribal contexts. These workers are recruited locally and trained in preventive and curative care, making them more acceptable to the community. "Beneficiaries report that JSS's culturally sensitive, low-cost, and integrated approach to health, especially their doorstep services and health education, has helped bridge the gap between formal health systems and traditional beliefs" (Jan Swasthya Sahyog, 2024).

In summary, decentralized health services in Bilaspur have enhanced physical accessibility and generated a modest increase in utilization. However, structural, financial, and cultural challenges continue to limit the full realization of the benefits. The perspective of beneficiaries underscores the importance of sustained funding, cultural competence, and integrated service delivery in the context of decentralised health governance.

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Provider Perspectives on Decentralised Health Services

Autonomy and Decision-Making

One of the most significant outcomes of decentralization in healthcare, as observed in Bilaspur, Chhattisgarh, is the increased autonomy granted to local health providers. "Frontline workers such as Medical Officers, Auxiliary Nurse Midwives (ANMs), and Accredited Social Health Activists (ASHAs) have reported enhanced flexibility in making operational decisions that respond to localized health issues" (Kaur et al., 2012). For instance, the decentralized framework allows facility in-charges to convene emergency outreach activities or health awareness drives during disease outbreaks without awaiting district-level approvals.

"This autonomy has enabled providers to respond more promptly to emergent community health needs, such as organizing malaria detection camps during monsoon seasons or arranging referral transportation for pregnant women in labor from remote tribal hamlets. By facilitating decision-making at the point of care, decentralization enhances contextual relevance and efficiency in service delivery" (Kaur et al., 2012).

Resource Allocation

Decentralization also facilitates more targeted resource allocation. Through bodies such as Rogi Kalyan Samitis (RKS) and Village Health Sanitation and Nutrition Committees (VHSNCs), healthcare providers have greater input into how health facility funds are spent. "This participatory budgeting allows health facilities to prioritize needs such as drug procurement, equipment maintenance, sanitation improvements, and transportation services" (Bajpai & Goyal, 2004).

However, while the allocation authority has transferred, several challenges persist. "In Bilaspur, providers report delays in the disbursement of untied funds and inconsistencies in fund flow that limit the timely execution of planned activities. Moreover, bureaucratic procedures and the lack of financial autonomy at sub-district

levels often restrict flexibility in spending" (Government of Chhattisgarh, 2020). Additionally, available funds are sometimes insufficient to meet the diverse needs of facilities serving geographically dispersed and underserved populations.

Nonetheless, when resources are effectively allocated, providers can undertake small but impactful interventions such as installing solar lighting in delivery rooms or organizing village-level health fairs, that improve service quality and community satisfaction.

Capacity Building

Effective decentralization hinges not only on delegating authority but also on empowering providers to manage new responsibilities. In this context, capacity building becomes essential. "Training initiatives under the National Rural Health Mission (NRHM) and the National Health Mission (NHM) have sought to equip providers with the skills required for health planning, financial management, community engagement, and patient-centered care" (Kaur et al., 2012).

"In Bilaspur, periodic training sessions have helped frontline workers improve their technical knowledge, recordkeeping practices, and interpersonal communication skills. Health workers have also trained to manage VHSNC activities, prepare village health action plans, and conduct participatory rural appraisals" (Ministry of Health and Family Welfare, 2005).

Nevertheless, gaps remain. Some providers, especially in remote areas, report irregular training schedules and lack follow-up support or refresher courses. Furthermore, the training content sometimes lacks contextual relevance, limiting its practical application. Ensuring regular, hands-on, and context-specific capacity-building initiatives remains vital to sustaining decentralized governance and enhancing service delivery outcomes.

Case Study: Jan Swasthya Sahyog (JSS) in Bilaspur

Jan Swasthya Sahyog (JSS), located in Bilaspur, Chhattisgarh, is a compelling example of decentralized and community-driven healthcare in rural India. A group of dedicated public health professionals founded JSS to provide equitable and quality healthcare to underserved and marginalized communities. "The organization runs a network of healthcare services, including a base hospital in Ganiyari and numerous outreach clinics in remote villages, supported by a cadre of trained community health workers" (Jan Swasthya Sahyog -JSS, 2024). JSS's model is built on integrating clinical care with preventive, promotive, and socio-economic interventions, reflecting a deep understanding of the social determinants of health.

Community Engagement

A defining feature of JSS's decentralized health delivery model is its emphasis on community engagement. "The organization invests significantly in training local community members, especially women, to become health workers or *Swasthya Sakhis*. These workers are the crucial link between the healthcare system and the community, conducting home visits, mobilizing patients, offering health education, and ensuring follow-up care" (JSS, 2024). It not only enhances the cultural relevance and accessibility of healthcare services but also fosters trust, empowerment, and ownership within the community.

Community participation is institutionalized through inclusive health planning processes. "Villagers are encouraged to voice their concerns and participate in decision-making regarding service delivery, disease surveillance, and resource allocation. Such participatory mechanisms have contributed to better health-seeking behavior, early disease detection, and increased utilization of health services" (JSS, 2024). These outcomes demonstrate the transformative power of decentralization when communities are actively involved and empowered.

Integrated Services

JSS operates on the principle that health cannot be addressed in isolation from its social and economic context. The organization integrates health services with nutrition, sanitation, agriculture, and education

interventions. "For instance, JSS runs daycare centres for malnourished children, where children receive nutritious meals, health checkups, and cognitive stimulation. Simultaneously, their families are educated about nutrition, hygiene, and childcare" (JSS, 2024).

Moreover, JSS's agricultural and livelihood initiatives promote food security and income generation among rural households, directly impacting health outcomes. This holistic approach acknowledges the interlinkages between poverty, malnutrition, and disease, demonstrating that decentralized healthcare is most effective when it operates in synergy with broader development goals. Through these integrated efforts, JSS exemplifies how decentralization, when coupled with contextual understanding and inter-sectoral collaboration, can significantly enhance the quality and equity of health outcomes in rural areas.

Challenges in Decentralised Health Services

While the JSS model presents a robust case for decentralized healthcare, it also operates within a broader landscape fraught with challenges. These challenges are particularly acute in rural and resource-constrained settings like Bilaspur, where local health governance structures often struggle with systemic and structural barriers.

Resource Constraints

One of the most persistent challenges in decentralised health systems is the lack of adequate financial, infrastructural, and human resources. "Although decentralization is intended to increase autonomy and responsiveness, many local health institutions are hampered by irregular funding, limited budgetary control, and dependence on higher-level authorities for resource allocation" (Kaur, Prinja, & Kumar, 2012). These constraints can lead to stock-outs of essential medicines, understaffing, and poor maintenance of health facilities.

"In areas like Bilaspur, terrain and remoteness further exacerbate logistical challenges in delivering medical supplies and deploying health personnel. Even with the decentralized planning encouraged under the National Rural Health Mission (NRHM), local bodies frequently lack the financial flexibility and procurement authority needed to respond swiftly to emerging health needs" (Kaur et al., 2012). The result is a gap between policy intent and implementation capacity, undermining the potential benefits of decentralised health governance.

Capacity Issues

Decentralization assumes that local Governments and institutions can effectively plan, implement, and monitor health services. However, many local governing bodies suffer from limited administrative experience and technical expertise.

"Panchayati Raj Institutions (PRIs), which are often entrusted with health-related responsibilities under decentralised governance, face challenges in translating their authority into action due to a lack of training and professional support" (Bajpai & Goyal, 2004).

Health workers and program managers at the district and sub-district levels frequently operate without adequate supervision, planning tools, or performance feedback mechanisms. It results in poor planning, inefficient service delivery, and low morale among staff. "Capacity gaps are evident in data management, budgeting, and health information systems, all critical for evidence-based decision-making" (Bajpai & Goyal, 2004). Strengthening the institutional capacities of local bodies through regular training, mentorship, and technical support is essential to realize the full benefits of decentralisation.

Accountability Mechanisms

Another significant challenge in decentralised health systems is ensuring accountability. In centralized systems, hierarchical supervision provides some degree of oversight. However, decentralized structures require new forms of accountability, which are upward (to higher authorities) and downward (to the community). "In

India, several community-based accountability initiatives have emerged, such as community monitoring and social audits, but these remain uneven in coverage and effectiveness" (Kaur et al., 2012).

Community-based monitoring, in particular, has shown promise in enhancing transparency, responsiveness, and trust. It involves regularly collecting and disseminating information on service delivery by community representatives and creating platforms for dialogue between service providers and beneficiaries. "However, the success of such initiatives depends on strong institutional support, political will, and community awareness. Many monitoring processes falter due to weak facilitation, fear of reprisal, or inadequate feedback loops" (Kaur et al., 2012). Without well-designed accountability frameworks and citizen engagement mechanisms, decentralized systems risk becoming fragmented, inefficient, and opaque.

The experience of Jan Swasthya Sahyog in Bilaspur underscores the transformative potential of decentralized, community-led healthcare models. Through integrated service delivery and participatory governance, JSS has demonstrated that it can provide responsive, equitable, and holistic healthcare even in resource-constrained settings. However, the broader implementation of decentralised health systems in India continues to face significant challenges. Resource constraints, limited administrative capacity, and weak accountability mechanisms threaten to undermine the objectives of decentralization.

To strengthen decentralised health governance, there is a need for sustained investment in local capacity-building, improved financial autonomy, and robust monitoring and evaluation systems.

Community engagement must be institutionalized not just as a tokenistic measure but as a core component of health system design. As illustrated by the JSS model, decentralization can become a powerful tool for health equity and social justice when communities are active partners rather than passive recipients.

Recommendations

Strengthen Capacity Building

"A foundational requirement for effective decentralisation of health services is the development of institutional and human resource capacities at the local level. In the case of Bilaspur, despite significant efforts towards devolving power, the lack of adequately trained personnel continues to hinder the full realization of decentralized governance" (Shukla et al., 2018). Health workers, Panchayati Raj Institution (PRI) members, and local health administrators often operate with limited knowledge about health planning, budgeting, and program implementation. Therefore, there is a pressing need to invest in systematic and ongoing training programs that enhance technical and managerial skills at the grassroots level.

"Such training initiatives should focus on equipping Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Community Health Officers (CHOs) with knowledge on primary healthcare delivery, health rights, gender-sensitive care, and data documentation" (Scott & Shanker, 2010). Additionally, PRI members must be sensitized to their planning, decision-making, and community mobilization roles to create accountability mechanisms within local governance structures. "Using digital tools for e-learning and performance tracking may be an effective adjunct to conventional training programs" (Bajpai & Dholakia, 2011).

Ensure Sustainable Funding

One of the principal challenges in Bilaspur's decentralisation process is the irregularity and inadequacy of financial resources at the local level. "The operationalization of decentralized health services demands sustainable and predictable funding to cover infrastructure, human resources, medical supplies, and health outreach programs. Empirical evidence from other Indian states indicates that the lack of dedicated fiscal transfers and delays in fund disbursement significantly hamper decentralized service delivery" (Baru et al., 2010).

A viable strategy to address this concern involves the establishment of a dedicated decentralized health fund with earmarked resources for district and sub-district levels.

"The National Health Mission (NHM) should also streamline fund flow mechanisms and provide financial autonomy to local health bodies to spend according to context-specific needs" (Kumar et al., 2016). Transparent budgetary planning and periodic audits can enhance fiscal discipline and ensure financial decentralization translates into service improvement.

Enhance Community Participation

"Community engagement is a cornerstone of decentralised governance, ensuring that health services are responsive, culturally appropriate, and aligned with local priorities. In Bilaspur, community participation has been facilitated through Village Health Sanitation and Nutrition Committees (VHSNCs), but the level of involvement remains uneven and often symbolic" (NHSRC, 2011). Many beneficiaries, particularly from marginalized Adivasi and Dalit communities, still experience barriers to meaningful participation, including illiteracy, caste discrimination, and lack of awareness.

"To deepen community engagement, it is imperative to empower local institutions like VHSNCs and Rogi Kalyan Samitis (RKS) by providing capacity-building support and financial autonomy. Community consultations, participatory health planning, and social audits should be institutionalized to create feedback loops and improve service delivery" (George et al., 2015). Moreover, integrating the voices of women, youth, and marginalized populations in planning forums can enhance equity and promote inclusive governance.

"Grassroots innovations, such as the use of community scorecards and health report cards, have shown promising results in increasing accountability and improving service uptake in other Indian contexts" (Garg et al., 2013). These tools can be adapted and scaled in Bilaspur to foster a culture of participatory monitoring and collective action.

Implement Robust Monitoring Systems

Monitoring and evaluation (M&E) mechanisms play a crucial role in assessing the effectiveness of decentralized health systems and guiding policy decisions. "In Bilaspur, M&E frameworks remain fragmented, with poor data quality, irregular reporting, and limited feedback utilization. Strengthening monitoring systems involves the creation of real-time data platforms that can collect, analyze, and visualize performance indicators at the block and village levels" (Patil et al., 2021).

Digital health management information systems (HMIS) must be integrated with ground-level reporting by ASHAs and ANMs to capture timely and disaggregated data on service delivery, health outcomes, and community feedback. Equally important is institutionalizing regular performance reviews, peer assessments, and third-party evaluations to ensure objectivity and accountability.

Furthermore, decentralization requires a bottom-up approach to monitoring, where frontline workers and communities actively contribute to evaluating health programs. "Training community-based organizations (CBOs) and PRI members to use simple monitoring tools can bridge the information gap and promote evidence-based planning" (Sundararaman & Muraleedharan, 2015).

Conclusion

The decentralization of health services in Bilaspur, Chhattisgarh, offers a compelling case for analysing the benefits and limitations of devolved governance in rural healthcare. "Over the past two decades, initiatives under the National Rural Health Mission (NRHM) and later the NHM have significantly expanded access to primary healthcare in tribal and underserved regions like Bilaspur. Innovations such as Health and Wellness Centres (HWCs), strengthened VHSNCs, and increased community outreach have collectively contributed to improvements in maternal health, immunization, and health awareness" (Kumar et al., 2022).

Nevertheless, decentralization in Bilaspur has not been without challenges. The uneven distribution of financial and human resources, coupled with bureaucratic delays and weak local capacities, has hindered the

full realization of its potential." Despite formal devolution, the persistence of top-down decision-making and inadequate training of local stakeholders continues to undermine autonomy and accountability" (Berman et al., 2010).

Provider experiences reflect both opportunities and constraints. While many frontline workers appreciate the localized decision-making and proximity to communities, they frequently cite overburdened workloads, poor infrastructure, and irregular salaries as barriers to effective service delivery. "Similarly, beneficiaries report increased access but remain concerned about the quality of care, availability of medicines, and responsiveness of health workers, especially in remote tribal hamlets" (Shukla et al., 2018).

The case of Bilaspur underscores that decentralization must go beyond structural reforms to incorporate investments in human capacity, participatory governance, and systemic monitoring. The active involvement of communities in planning and oversight ensures that services are contextually relevant and socially just. Strengthening the capacities of PRIs, VHSNCs, and health workers is vital to creating a resilient and responsive rural health system.

Furthermore, lessons from Bilaspur emphasize that decentralization must be backed by adequate funding, transparent governance, and sustained political will. In doing so, it can serve as a transformative approach that bridges equity gaps promotes local ownership, and enhances the overall effectiveness of health interventions in rural India.

As India moves towards achieving Universal Health Coverage (UHC) under the Ayushman Bharat initiative, the experience of districts like Bilaspur provides valuable insights into tailoring health governance to local realities. Integrating decentralized structures with digital innovation, capacity building, and inclusive participation presents a forward-looking pathway to health equity and social justice in rural India.

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