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Decentralised Health Governance in Rural India: A Critical Review of Beneficiary and Provider Experiences in Bilaspur, Chhattisgarh

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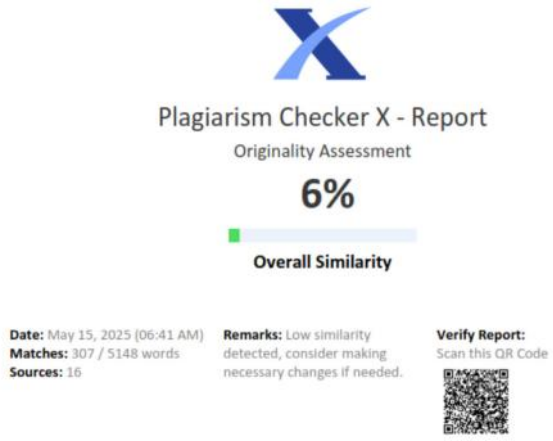

ABSTRACT

This review critically examines the implementation of decentralised health governance in rural India, specifically focusing on the Bilaspur district in Chhattisgarh. The study investigates the roles, responsibilities, and lived experiences of health service beneficiaries and frontline providers within the decentralised framework. Using insights from empirical research, Government policy documents, and scholarly literature, it analyses how local governance mechanisms such as Panchayati Raj Institutions (PRIs), Rogi Kalyan Samitis (RKS), and community health workers particularly ASHAs and ANMs have contributed to or hindered equitable healthcare delivery. The review highlights the achievements of decentralisation in enhancing service outreach and participatory governance while also identifying enduring challenges such as capacity deficits, limited community engagement, weak accountability, and socio-political inequities. The paper analyses the need for robust capacity-building, financial devolution, and inclusive governance to realise the full potential of decentralised health systems in rural India.

KEY WORDS

Decentralisation, Health Governance, Rural Healthcare, Panchayati Raj Institutions, Rogi Kalyan Samiti, ASHA Workers.

INTRODUCTION

Decentralisation has emerged as a central tenet of global public health reforms, particularly in low- and middle-income countries, as a strategy to enhance service efficiency, responsiveness, and community

engagement. In the context of India, decentralisation of health services has been progressively promoted since the 73rd and 74th Constitutional Amendments in the early 1990s, which institutionalised Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs) as vehicles of democratic local governance.

"These amendments paved the way for the devolution of functions, funds, and functionaries to local self-Governments, including responsibilities related to health, sanitation, and nutrition" (Berman, 1998; Government of India-GOI, 1993). As a result, decentralisation became a governance reform and a framework to localise service delivery, enhance accountability mechanisms, and strengthen community participation in health decision-making processes.

"The implementation of the National Rural Health Mission (NRHM) in 2005 further catalysed the decentralisation agenda in India by integrating community-based health planning with local governance. The NRHM recognised that health outcomes could not be improved solely through vertical interventions and therefore prioritised decentralised planning, community participation, and the institutional strengthening of local health systems" (Ministry of Health and Family Welfare-Mohfw, 2005). This policy shift led to the creation and institutionalisation of structures such as Rogi Kalyan Samitis (RKS), Village Health Sanitation and Nutrition Committees (VHSNCs), and the deployment of community health workers such as Accredited Social Health Activists (ASHAs). These interventions were particularly significant for rural and tribal-dominated states such as Chhattisgarh, which historically experienced health service deficits due to geographic isolation, socio-economic deprivation, and poor public infrastructure.

"Chhattisgarh, which was carved out of Madhya Pradesh in 2000, is home to a large tribal population and faces significant health challenges, including high infant and maternal mortality rates, endemic malnutrition, and weak health infrastructure in its rural and forested regions" (Planning Commission, 2011). "In response, the state adopted several decentralisation-oriented innovations in the health sector, including the Mitanin program an early prototype of the national ASHA scheme, which aimed to empower women from local communities to serve as health educators and mobilizers" (Sundararaman, 2007). These reforms were complemented by activating PRIs and RKSs, which were envisioned as participatory platforms to manage health centres, monitor service delivery, and improve local health outcomes through bottom-up governance.

Bilaspur district, located in central Chhattisgarh, provides an illustrative case to study the operational dynamics of decentralised health governance. As a predominantly rural region with pockets of tribal habitation, Bilaspur represents both the opportunities and challenges associated with implementing decentralisation reforms in complex social landscapes.

"Over the past two decades, the district has witnessed a gradual expansion in health infrastructure, the increased presence of ASHAs and Auxiliary Nurse Midwives (ANMs), and activation of RKSs in primary and community health centres" (State Health Resource Centre -SHRC 2018). However, despite these institutional developments, critical questions remain regarding the effectiveness of decentralisation in improving health service quality, equity, and accountability.

"The literature on decentralisation in India suggests that while institutional structures may be in place, their functional effectiveness often remains limited due to capacity constraints, insufficient financial autonomy, and socio-political hierarchies" (George, 2003; Nambiar et al., 2015). "For instance, studies have shown that RKSs are often dominated by medical officers, with minimal genuine participation from community members or elected representatives" (Dasgupta et al., 2010). "Although ASHAs have become an integral part of rural health service delivery, they frequently face delayed payments, insufficient training, and a lack of institutional support" (Scott & Shanker, 2010; Nair & Panda, 2011). These issues raise concerns about the substantive decentralisation of power and whether local actors have the agency to shape community health services.

In Bilaspur, early field reports and evaluations reveal a mixed picture. "On the one hand, schemes like Janani Suraksha Yojana (JSY) have contributed to increased institutional deliveries, and Mitanins (ASHAs)

have played a significant role in health promotion activities" (Lim et al., 2010). On the other hand, persistent issues such as irregular RKS meetings, inadequate PRI engagement in health matters, "and limited community oversight over service delivery reflect systemic limitations" (Chauhan et al., 2021). While conceptually robust, the decentralization framework often confronts operational hurdles stemming from inadequate devolution of resources, ambiguous role clarity, and weak inter-institutional coordination.

This review paper aims to critically examine the implementation of decentralized health governance in the Bilaspur district, focusing on the dual perspectives of health service beneficiaries and providers. It seeks to understand how decentralized mechanisms are perceived and experienced by local communities and frontline workers and whether they have translated into improved access, quality, and accountability in rural health services. By synthesising insights from empirical studies, policy reports, and theoretical literature, the paper contributes to the broader discourse on governance reforms, health equity, and rural development in India.

The findings from Bilaspur, while context-specific, offer important lessons for other rural and tribal-dominated districts seeking to deepen the practice of decentralised health governance.

Conceptual Framework: Decentralisation in Health Governance

Decentralisation, broadly understood, is the systematic delegation of administrative, fiscal, and political authority from central Governments to subordinate or quasi-independent Government organisations or civil society actors (Bossert & Beauvais, 2002). In the health sector, decentralisation is intended to bring decision-making closer to the point of service delivery, thereby enhancing responsiveness to local needs, improving the efficiency and quality of services, and promoting participatory governance. "The theoretical basis for decentralisation lies in the assumption that local Governments or institutions are better equipped to assess the specific needs of communities, allocate resources efficiently, and ensure greater accountability in public service delivery" (Rondinelli et al., 1983; Brinkerhoff & Azfar, 2006).

Decentralisation is typically classified into four types: political, administrative, fiscal, and market decentralisation. Political decentralisation involves the transfer of decision-making powers to elected local bodies. Administrative decentralization refers to the redistribution of authority, responsibility, and financial resources among different levels of Government. Fiscal decentralization deals with allocating financial resources and revenue-generating powers to lower levels of Government. "Market decentralization refers to the delegation of service delivery responsibilities to private actors or non-Governmental organisations" (Bossert, 1998). A combination of these forms often co-occurs in health systems, aiming to strengthen local health planning, service delivery, and monitoring.

"India's health sector decentralisation gained momentum with the introduction of the National Rural Health Mission (NRHM) in 2005, which emphasised the need for decentralised planning and community participation as essential components of health system reform (Ministry of Health and Family Welfare-MoHFW, 2005). The NRHM advocated for empowering Panchayati Raj Institutions (PRIs) and forming Village Health Sanitation and Nutrition Committees (VHSNCs) to prepare village-level health plans, oversee implementation, and ensure accountability. "The establishment of Rogi Kalyan Samitis (RKS) at the level of health facilities further institutionalised decentralisation by giving these bodies financial and administrative autonomy to manage resources and improve the functioning of public health institutions" (Dasgupta et al., 2010).

Another significant intervention was the deployment of Accredited Social Health Activists (ASHAs), locally recruited women trained to act as intermediaries between the community and the health system. "The ASHA program was envisioned not only as a means of expanding service outreach but also as a mechanism to foster community participation and empowerment" (Scott & Shanker, 2010). Together, these structures represent an integrated approach to decentralisation, seeking to transform India's historically top-down public health system into one that is community-driven, participatory, and locally accountable.

"However, decentralisation does not automatically guarantee improved outcomes. Its success depends on several enabling factors, including adequate capacity at the local level, effective devolution of financial and decision-making powers, functional accountability mechanisms, and inclusive participation that accounts for gender, caste, and class-based inequalities" (George, 2003; Nambiar et al., 2015). Therefore, while decentralisation is a promising strategy for health system reform, its design and implementation must be context-sensitive and equity-oriented to achieve meaningful transformation.

Methodology

This study adopts a qualitative review methodology to critically examine the implementation and outcomes of decentralised health governance in rural India, with a specific focus on the Bilaspur district in Chhattisgarh. The review synthesises secondary data drawn from a range of sources, including peer-reviewed journal articles, Government evaluation reports, field-based NGO assessments, and grey literature. The objective is to construct a comprehensive understanding of beneficiary and provider experiences within the decentralised health governance framework from 2005, the year of the National Rural Health Mission (NRHM) launch, through 2023.

The selection of literature was guided by thematic relevance and regional specificity. Priority was given to studies that explore the role of key decentralised institutions such as Panchayati Raj Institutions (PRIs), Rogi Kalyan Samitis (RKS), Village Health Sanitation and Nutrition Committees (VHSNCs), and community health workers like Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs). Special emphasis was placed on empirical studies that examined real-world implementation, community perceptions, and institutional challenges within Bilaspur or comparable districts in Chhattisgarh.

A systematic search was conducted using academic databases such as JSTOR, PubMed, Google Scholar, and Scopus, using keywords including "health decentralisation India," "PRIs in health governance," "Bilaspur health services," and "community health workers Chhattisgarh." Additionally, Government documents from the Ministry of Health and Family Welfare (MoHFW), National Health Mission (NHM), State Health Resource Centre (SHRC), Chhattisgarh, and various state-level policy reviews were included to provide policy context and programmatic insights.

The review employs a thematic synthesis approach to organise findings around core dimensions such as service delivery, accountability, community participation, and equity. This methodology allows for integrating diverse perspectives and facilitates a critical analysis of the effectiveness, limitations, and contextual factors influencing decentralised health governance in rural Chhattisgarh.

Decentralised Structures in Bilaspur: An Overview

1. **Panchayati Raj Institutions (PRIs):** Panchayati Raj Institutions (PRIs) play a constitutionally mandated role in decentralised planning and monitoring of public services, including health, at the village (Gram Panchayat), block (Panchayat Samiti), and district (Zila Parishad) levels. In Bilaspur, PRIs have shown partial effectiveness in local-level health governance, particularly in mobilising community health awareness and supporting outreach services. "However, they often lack decision-making authority, adequate financial resources, and technical training. Political interference and hierarchical power structures also limit their capacity to influence health service delivery meaningfully" (Kumar & Sharma, 2016).
2. **Rogi Kalyan Samitis (RKS):** Rogi Kalyan Samitis (RKS) are facility-level management committees composed of medical officers, PRI members, and civil society representatives. In Bilaspur, some RKSs have successfully utilised untied funds for minor facility improvements, transparency in drug procurement, and community outreach. "Nevertheless, their impact is undermined by limited participation from non-medical stakeholders, with decision-making typically dominated by medical professionals" (Dasgupta et al., 2010).

3. **Community Health Workers: ASHAs and ANMs:** Community health workers, especially "Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) form the backbone of rural health outreach. In Bilaspur, ASHAs have significantly improved immunisation coverage and maternal health indicators. However, they face challenges such as delayed remuneration, lack of institutional support, and inadequate refresher training" (Scott & Shanker, 2010). ANMs also struggle with excessive workloads, infrastructure shortages, and logistical delays in supplies.

Beneficiary Experiences: Accessibility, Quality, and Trust

A mixture of positive and negative outcomes characterises beneficiaries' experiences with decentralised health services in Bilaspur. "On the one hand, health initiatives like the Janani Suraksha Yojana (JSY) have contributed to a significant improvement in institutional deliveries, which is a key indicator of maternal health care" (Lim et al., 2010). The JSY scheme, which incentivises institutional births by providing financial assistance to pregnant women, has been particularly successful in enhancing access to safe deliveries in rural and marginalised communities. As a result, maternal mortality rates have declined, and more women are choosing institutional deliveries over home births, thus reducing the risk of complications during childbirth.

"However, despite the positive outcomes of some interventions, disparities in access to quality healthcare remain a persistent challenge in rural and tribal areas of Bilaspur. Healthcare access is still uneven, especially in remote tribal belts, where geography, infrastructure, and socio-economic barriers hinder timely access to essential health services" (Baru et al., 2010). In these areas, beneficiaries often report poor healthcare infrastructure, including lacking basic facilities like clean drinking water, sanitation, and proper medical equipment. Additionally, the scarcity of trained healthcare personnel in these regions exacerbates the challenges faced by vulnerable populations, particularly in remote, interior villages.

One of the most pressing concerns among health service beneficiaries is absenteeism among health workers. Studies have consistently pointed out that health workers, especially Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), are often absent due to various factors, including insufficient motivation, lack of transportation, and personal or family commitments.

"As a result, when patients seek care, they often encounter vacant or understaffed health centres, leading to delays in treatment and missed healthcare opportunities" (Chauhan et al., 2021). In some cases, villagers report that even when health workers are present, the quality of care is compromised due to inadequate training and a heavy workload, which reduces their capacity to provide optimal care.

Furthermore, informal payments for services that are supposed to be free remain a significant barrier to accessing healthcare, especially for the economically disadvantaged. Beneficiaries often report being asked to pay informal fees for medical consultations, tests, and medicines, which the Government does not officially charge. "These under-the-table payments are particularly burdensome for low-income households, exacerbating inequities in access to care" (Baru et al., 2010). This situation undermines the goal of providing universal health coverage and erodes public trust in the healthcare system.

Another factor contributing to the mixed experiences of beneficiaries is socio-economic hierarchy. Even though there is growing awareness of Government health schemes, many individuals, particularly those from marginalised social groups, feel disempowered and unable to access the full benefits of these schemes. "A study by Chauhan et al. (2021) found that, despite a general awareness of Government health programs, villagers often feel powerless due to entrenched caste, gender, and economic inequalities". For instance, low-caste individuals, women, and tribal populations face significant social barriers in accessing services, which prevent them from fully benefiting from decentralised health governance structures. The power dynamics and social stratification in rural areas contribute to the marginalisation of vulnerable groups, limiting their ability to voice grievances or demand better healthcare services.

Moreover, there is a lack of effective grievance redressal mechanisms at the grassroots level. "Beneficiaries report that when they do encounter issues such as absenteeism, poor service delivery, or informal payments, there are few accessible channels to lodge complaints or seek redress. Community members often feel discouraged from raising complaints due to fear of retribution or social exclusion" (Chauhan et al., 2021). This lack of accountability further exacerbates the feeling of powerlessness among villagers and reduces trust in the healthcare system.

In summary, while decentralised health services in Bilaspur have led to improvements in specific health outcomes, such as increased institutional deliveries through programs like JSY, significant gaps remain in accessibility, service quality, and beneficiary trust.

Addressing these issues requires systemic reforms that tackle absenteeism, improve infrastructure, ensure equitable distribution of resources, and establish effective grievance redressal mechanisms to restore public confidence in decentralised health governance.

Provider Experiences: Constraints and Opportunities

Despite the decentralisation of health services, healthcare providers in Bilaspur face numerous challenges that hinder their ability to deliver quality care. One of the most significant challenges is the lack of human and material resources. Health facilities in rural Bilaspur are often underfunded, with inadequate infrastructure, limited medical supplies, and insufficient staff. These issues are exacerbated by the high turnover rate among healthcare personnel, particularly Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), who are often overburdened with tasks that exceed their capacity. "According to Nair and Panda (2011), healthcare providers frequently report being unable to perform their duties effectively due to the lack of necessary equipment and inadequate staff support, which negatively impacts service delivery".

Additionally, poor working conditions further complicate the situation. "Health workers in Bilaspur often work in remote areas with limited access to transportation, making it difficult for them to reach health facilities or attend to patients promptly. Many healthcare centres are in dilapidated buildings, and the lack of proper sanitation facilities, electricity, and clean water adds to the challenges faced by healthcare providers" (Nair & Panda, 2011). This discourages health workers from staying in these areas, leading to absenteeism and low morale, affecting the quality of care provided to beneficiaries.

Despite these challenges, healthcare providers in Bilaspur also acknowledge the potential of decentralized governance structures, particularly in fostering better coordination and improving healthcare outcomes. However, providers feel that these structures, such as Rogi Kalyan Samitis (RKS) and Panchayati Raj Institutions (PRIs), often fall short of their potential due to weak administrative support and inconsistent implementation. "RKS meetings, which are designed to be a platform for local health management and decision-making, are often irregular or symbolic, lacking the genuine engagement of all stakeholders, including healthcare providers, community members, and PRI representatives" (Nair & Panda, 2011). In many cases, these meetings are not seen as forums for meaningful dialogue or decision-making, which reduces their effectiveness in addressing local health issues.

Another significant challenge healthcare providers report is the lack of empowerment and autonomy at the local level. While decentralised health governance aims to give more decision-making power to local authorities and communities, healthcare providers often find themselves constrained by bureaucratic red tape and centralisation in certain aspects of health policy. "This limits their ability to make timely decisions about resource allocation, staff management, and service delivery improvements. As a result, healthcare providers often feel disempowered and frustrated, as they are unable to respond to the needs of their communities flexibly and efficiently" (Dasgupta et al., 2010).

However, providers also recognise the opportunities for improvement that decentralisation could bring if the right support systems are implemented. Many healthcare providers in Bilaspur believe that local governance

can improve coordination, resource allocation, and responsiveness to community needs. "They argue that decentralisation could facilitate better integration of health services with other sectors such as education, sanitation, and nutrition, leading to more comprehensive community development" (Nair & Panda, 2011). If RKS and PRIs were better empowered to make decisions and the administrative support was more substantial, providers believe they could deliver more effective and efficient healthcare services. Moreover, local-level planning could ensure that health services are more closely aligned with the population's specific needs, particularly in rural and tribal areas.

In conclusion, while healthcare providers in Bilaspur face significant challenges related to inadequate resources, poor working conditions, and weak administrative support, they also see the potential of decentralised health governance to improve healthcare delivery if better empowered and supported. Strengthening the role of local governance structures, ensuring regular and meaningful participation in RKS meetings, and improving working conditions could lead to more effective healthcare provision in rural areas.

Challenges in Decentralised Health Governance

Despite the potential of decentralised health governance to improve healthcare delivery, numerous challenges persist in its implementation, especially in rural areas like Bilaspur. These challenges arise from capacity deficits, limited community participation, and the intersection of gender and caste dynamics, which continue to undermine the efficacy and inclusiveness of decentralised healthcare systems.

1. **Capacity Deficits:** "A significant challenge in the decentralised health governance system is the capacity deficit among key stakeholders, particularly within the Panchayati Raj Institutions (PRIs) and Rogi Kalyan Samitis (RKS). Many members of PRIs and RKS representatives lack the essential skills and training required for effective health planning, management, and oversight of healthcare resources" (Sundararaman, 2007). Health planning involves understanding community health needs, allocating resources effectively, and monitoring health outcomes, all of which require expertise in public health management and financial oversight. However, due to insufficient capacity-building initiatives, many PRI members are ill-equipped to handle the complex nature of health governance. In many instances, the lack of financial management skills in these local bodies results in inefficient use of funds and delays in the implementation of health projects, undermining the goals of decentralisation.

   "Moreover, the devolution of financial powers to local bodies often leads to the poor utilisation of resources as local representatives are not sufficiently trained to create effective budgeting strategies, allocate funds based on local health priorities, or ensure financial accountability" (Sundararaman, 2007). As a result, the expected benefits of decentralisation, such as improved service delivery and accountability, are often diluted, leaving rural communities with inadequate healthcare resources.

2. **Limited Community Participation:** Another significant challenge is the limited community participation in decision-making processes. "Although decentralisation aims to bring governance closer to the people and encourage active participation, tokenistic inclusion of community members in decision-making bodies often undermines the democratic potential of these processes" (Mohan & Banerji, 2015). In many cases, local governance structures, such as PRIs and RKS, are designed to be inclusive, but in practice, they often fall short of engaging community members meaningfully. The limited involvement of communities, particularly marginalised groups, in health planning and policy implementation hinders the ability of decentralised governance to reflect local needs and priorities.

   The participation of community members in decision-making bodies is often symbolic, with consultative processes serving as a formality rather than a genuine attempt to empower local populations (Mohan & Banerji, 2015).

   This minimum effort can be attributed to several factors, such as a lack of awareness, insufficient mobilisation of community groups, and political dynamics prioritising elite voices over marginalised

populations. The failure to ensure that local communities have a real stake in health governance limits the ability of decentralised systems to address the unique challenges faced by rural and tribal populations effectively.

3. **Gender and Caste Dynamics:** The dynamics of gender and caste also pose significant challenges to decentralised health governance. Despite the recognition that women, Dalits, and Adivasis are key beneficiaries of public health programs, they are often underrepresented in decision-making processes within PRIs and RKS" (Rao, 2005). This underrepresentation stems from structural inequalities that persist in rural India, where gender and caste hierarchies continue to shape who has access to power and decision-making opportunities.

   "Women, in particular, face multiple barriers to participation in health governance due to patriarchal norms that restrict their mobility and influence in public spaces. Dalit and Adivasi communities, on the other hand, often face social exclusion and discrimination, which marginalise their voices in local governance structures" (Rao, 2005). As a result, health policies and services may not adequately address the specific needs of these vulnerable groups, perpetuating inequalities in health outcomes.

   "The absence of women and marginalised groups in leadership roles within health governance bodies means that the gendered and caste-based needs of the population are often overlooked in health planning and resource allocation. For instance, the unique health needs of Dalit and Adivasi women, such as maternal health issues, are not sufficiently addressed when these communities are excluded from decision-making" (Rao, 2005). Furthermore, women's lack of representation in leadership roles reduces the likelihood of achieving gender-sensitive healthcare reforms.

Recommendations

Several key recommendations can be made to address the challenges of decentralised health governance in Bilaspur and other rural regions of India. These recommendations focus on enhancing capacity, improving community involvement, ensuring financial flexibility, promoting equity, and supporting healthcare workers to improve the overall effectiveness of the decentralised health system.

1. **Capacity Building: Continuous Training for PRI Members, RKS Committees, and ASHAs:** One of the primary challenges in decentralised health governance is the lack of capacity among local representatives and healthcare workers. Panchayati Raj Institutions (PRIs) and Rogi Kalyan Samitis (RKS) members often lack the necessary training in health planning, financial management, and governance. To address this, it is essential to implement continuous capacity-building programs for PRI members, RKS representatives, and Accredited Social Health Activists (ASHAs) (Sundararaman, 2007). These training programs should equip local health leaders with the skills required for effective health system governance, including budgeting, resource allocation, community mobilisation, and monitoring health outcomes. Additionally, ASHAs should receive training in community health education and referral systems, as their role is crucial in bridging the gap between the community and the formal health system (Scott & Shanker, 2010). Ongoing capacity building will ensure that local bodies can fulfil their responsibilities and better serve the health needs of rural communities.

2. **Strengthening Community Monitoring: Revitalizing Village Health Sanitation and Nutrition Committees (VHSNCs):** The community's involvement in monitoring health services is essential for ensuring transparency and accountability. One way to strengthen community participation is by revitalising Village Health Sanitation and Nutrition Committees (VHSNCs). These committees are intended to monitor and promote health services at the village level. However, their effectiveness has often been limited in practice due to a lack of empowerment and infrequent meetings. To make VHSNCs more effective, they should be given clear roles and responsibilities and adequate training in health monitoring, data collection, and reporting (Mohan & Banerji, 2015). These committees should also be supported with regular funding to carry out their activities and ensure their reports feed into the broader health

governance framework. Empowering local communities to monitor health services will improve service accountability and ensure that health policies reflect local needs.

3. **Ensuring Financial Devolution: Timely Release and Flexibility in Utilising United Funds:** Financial devolution is a critical element of decentralisation, but it often fails in practice due to delayed fund transfers and restrictive usage guidelines.

   "For decentralised health systems to work effectively, local governance bodies must have timely access to funds and the flexibility to utilise them in response to local needs" (Sundararaman, 2007). The untied funds meant for local health services should be released on time, and local bodies should have the autonomy to use these funds for the specific needs of their communities. It includes investing in infrastructure, improving healthcare worker training, and procuring medical supplies. Reducing bureaucratic red tape and providing local institutions greater financial autonomy will enhance their ability to respond swiftly to emerging health needs, improving overall healthcare delivery.

4. **Promoting Equity: Special Focus on Marginalised Communities in Planning and Monitoring:** Decentralisation must be inclusive to be genuinely effective. Marginalised communities, such as women, Dalits, and Adivasis, are often underrepresented in decision-making bodies and face specific health challenges that are overlooked in mainstream health policies. To ensure that decentralisation benefits all members of society, a special focus must be placed on ensuring the representation and participation of these communities in health planning and monitoring processes (Rao, 2005). Health policies should be gender-sensitive and culturally appropriate, addressing the unique health needs of these marginalised groups, particularly women and Adivasi populations, who often face higher rates of maternal and infant mortality. Incorporating equity-focused indicators in local health plans will ensure that the needs of marginalised communities are prioritised and that their voices are heard in health governance processes.

5. **Supporting Health Workers: Regular Payments, Career Progression, and Supportive Supervision:** "One of the biggest challenges facing healthcare providers in decentralised systems is the lack of support and motivation due to irregular payments, poor career progression opportunities, and inadequate supervision. Healthcare workers, including ASHAs and Auxiliary Nurse Midwives (ANMs), should receive regular and timely payments to maintain morale and ensure their commitment to the community" (Scott & Shanker, 2010). Additionally, providing clear career progression paths and continuous professional development opportunities will help retain skilled health workers in rural areas. "Supportive supervision, including regular feedback and mentorship, is crucial to improving job satisfaction and performance" (Chauhan et al., 2021). This support system will empower health workers to deliver high-quality services, thereby improving health outcomes in rural and underserved areas.

CONCLUSION

The experience of the Bilaspur district in Chhattisgarh serves as a microcosm of the broader dynamics of decentralised health governance in rural India. "On the one hand, decentralisation has made strides in increasing the visibility of health services at the local level and has contributed to improved accountability in some areas, particularly with the introduction of Rogi Kalyan Samitis (RKS) and the deployment of Accredited Social Health Activists (ASHAs)" (Scott & Shanker, 2010). These initiatives have allowed for better local representation and decision-making, creating a sense of ownership and participation among rural communities. "As evidenced by the introduction of Janani Suraksha Yojana (JSY), institutional deliveries have improved, demonstrating the potential of decentralised programs to enhance healthcare access in rural areas" (Lim et al., 2010).

"However, the transformative potential of decentralisation in improving health service delivery in rural areas like Bilaspur remains largely underutilised. Several challenges persist, particularly weak institutional capacities, including insufficient training and lack of effective monitoring mechanisms" (Sundararaman, 2007).

"Panchayati Raj Institutions (PRIs) and RKS often face challenges in performing their roles effectively due to a lack of financial autonomy, inadequate training, and political interference" (Mohan & Banerji, 2015). "These constraints undermine the ability of local bodies to adequately plan, allocate resources, and address health needs in a timely and efficient manner. The fragmented nature of health planning, which often involves multiple actors with competing priorities, exacerbates this issue" (Rao, 2005).

Additionally, entrenched social inequalities, particularly along the lines of caste, gender, and tribal status, further hinder the equity of decentralised health systems. "Women, Dalits, and Adivasis continue to face significant barriers in accessing healthcare and participating meaningfully in decision-making processes" (Rao, 2005). Without targeted interventions to ensure the inclusion of marginalised communities in health governance, decentralisation risks perpetuating existing inequalities rather than addressing them.

For decentralisation to truly meet the health needs of rural communities, it must be restructured to be more participatory, equitable, and well-resourced. It requires a concerted effort to build local capacities, ensure financial flexibility, and foster genuine community participation in all aspects of health governance.

"The active involvement of marginalised communities, alongside enhanced training for health workers and local governance bodies, will ensure that decentralisation is not merely a top-down policy but a truly inclusive and empowered process" (Mohan & Banerji, 2015).

Ultimately, the success of decentralisation hinges on its ability to adapt to local contexts, empower local actors, and address the specific needs of rural populations. If these factors are adequately addressed, decentralisation can transform health systems, improve accessibility, and enhance the quality of healthcare for millions of people in rural India, as demonstrated in Bilaspur.

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