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Panchayati Raj Institutions (Pris) in Uttar Pradesh: Their Role in Addressing Rural Health Care Services

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Abstract:

The National Rural Health Mission (NRHM) is an ambitious Indian healthcare programme with an agenda to improve the overall health of rural people. The NHM emphasis's the importance of Panchayati Raj Institutions (PRIs), particularly in the timely and effective delivery of a set of rural health care services. Community participation plays a major role in global health policy after the acceptance of primary health care as the policy of WHO, and it is one of the major components of the health system to facilitate health care facilities. The strength and role of PRI are very important when we compare their actual contribution to the quality improvement of the grassroots healthcare system in rural areas. To get the information, an online database search was conducted using PubMed, Science Direct, JSTOR, and the official websites of the Census, Ministry of Health and Family Welfare, and other related government reports and books. The following keywords were used in the search: Panchayati Raj Institutions, Health Care Service, Gram-Panchayat Village NRHM, Primary Health Care, Public Health Care Delivery, Uttar Pradesh. The strength and role of PRI are very important when we compare their actual contribution to the quality improvement of the grassroots healthcare system in rural areas. By organising regular health camps, PRIs can also play an important role in diagnosing health problems at an early stage, avoiding household catastrophic health expenditure. Furthermore, it aims to improve rural people's access to equitable, affordable, accountable, and effective primary healthcare services, particularly for poor women and children.

Keywords: Panchayati Raj Institutions, Health Care Service, Gram Panchayat Village NRHM, Primary health Care, Public health.

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Introduction:

Effective and efficient healthcare services are required by everyone. Providing such services becomes more challenging in India considering the vast population, area and diversity of the country. While dealing with health, it becomes essential to understand it from a holistic perspective, i.e., limiting health not only to biological, medical, environmental, or epidemiological terms. The overall health sector has improved immensely during the past five decades in India. Subsequently, it has reached the majority of the population in most of the areas in the country. However, it is evident from available data that there is still a large chunk of the population that is suffering from illness, poor health, malnutrition, diseases, premature deaths, living in a multifaceted situation of deprivation, particularly in the states like Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh etc. More than two-thirds of the total districts of India lie in these three states only. The human life in these districts is marked by low life expectancy and high morbidity. Importantly, Uttar Pradesh is a state with a high infant mortality rate, under-five mortality rate, high maternal mortality ratio, and undernourishment among males in the 5 to 18 age group and females in the 18-59 brackets compared to the national average for the same. In spite of modern clinical interventions, technologies, and knowledge at hand, large gaps still exist in health outcomes. It is evidently clear that the outreach and strength of the health system is not adequate to bridge these gaps in the present scenario. Additionally, Uttar Pradesh is ranked the second with 19,962 patients per doctor (NHP 2018). This state, according to the Government of India's guidelines mentioned in the Union Health Ministry's Rural Health Statistics report for 2018-19, has a sanctioned strength of 4,509 doctors for all its PHCs. However, there are 1,344 doctors only with 3,165 seats being vacant, exhibiting a deficit of 2,277 doctors. This figure shows that the ground reality is far beyond what is mentioned in official guidelines regarding the health services. Also, the health infrastructure in many places is not up to scratch in accomplishing this mammoth task in rural Uttar Pradesh. Many health centres are languishing due to poor infrastructure and equipment, lack of doctors, healthcare.

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In this given scenario, it is difficult to improve the basic factors like healthcare professionals, services, facilities, and infrastructures in the near future in the government healthcare sector. This argument compels the existing system to look differently to cater to the health care services in states like Uttar Pradesh. The National Rural Health Mission (NRHM) was introduced in 2005 with the goal of improving the country's overall health system and the health status of its citizens, particularly those who reside in rural regions (NRHM, 2005). Since its inception, the scope of NRHM has been broadened and is now subsumed under the wider umbrella of the National Health Mission (NHM). In order to achieve the goals, set under the National Health Policy and Millennium Development Goals, the mission aims to provide universal access to equitable, affordable, and quality health care services and facilities. These are accountable at the same time for responding to the healthcare and medical needs of the people, reducing child and maternal deaths, as well as population stabilization along with gender and demographic balance. Earlier, the Integrated Child Development Services (ICDS) also strengthened the delivery of rural health care services. In this perspective, health care services include reproductive and child health services, as well as prevention and treatment of different communicable diseases and non-communicable diseases. Reproductive and child health services include the different aspects of child, adolescent and maternal health like nutrition, sanitation and family planning etc. Included among these communicable diseases are malaria, tuberculosis, hepatitis, jaundice, influenza, and diarrhea, etc. The non-communicable diseases include diabetics, cancer and respiratory diseases, etc.

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The rural public health care services in India work through a wide network of Service Centres and Service Providers. The Service Centres include Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs), whereas the Service Providers include medical officers, health educators, Female Health Workers (FHW), Male Health Workers (MHW), Anganwadi Workers (AWW) and Accredited Social Health Activists (ASHA). The ASHAs would act as a bridge between the ANM and the village and be accountable to the Gram Panchayat. At the grassroots level, the service centres are the sub-center and providers are female health workers, male health workers, AWW and ASHA. Besides these, private providers also play an important role in providing health care services, but they are confined mostly to urban areas workers and funds.

Strategies for Addressing Health Issues and Providing Health Care in Rural Areas:

One of the core strategies of NRHM is to enhance the capacity of Panchayat Raj Institutions (PRIs) to own, control, and manage rural health care services. Both the Integrated Child Development Services (ICDS) and the National Health Mission (NHM) highlight the importance of Panchayat Raj Institutions (PRIs) in the delivery of rural health care services. The Population Policy, 2000 also advocates involvement of the elected leaders of the Panchayat Raj Institutions (PRIs) in addressing rural health problems by providing required and available health care services. The Draft of the National Health Policy, 2015 seriously raises the issue of effective implementation of health care services through the members of PRIs. The NITI Aayog, erstwhile the Planning Commission of India, also highlights the role of the members of PRIs in providing

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rural health care services, which has been one of the core strategies of NRHM. The 73rd and 74th Constitutional Amendment Act, 1992 also guaranteed the Gram Panchayats' responsibility for health and family welfare with the help and support of the members of PRIs, who will have adequate power for resource mobilization. The Gram Panchayats have been assigned 29 rural development activities, among which family welfare, health and sanitation are included under Schedule XI and public health under Schedule XII. Thus, the Gram Panchayats will have a significant influence on managing most of the public health issues.

The National Health Mission highlights the importance of Panchayat Raj Institutions (PRIs) in the effective delivery of rural health care services. The National Rural Health Mission (NRHM) called for the constitution of a Village Health and Sanitation Committee (VHSC) to improve the participation of the community at the lowest level. The Village Health and Sanitation Committee (VHSC) and the Swasthya Evam Kalyana Samiti in Uttar Pradesh have effective management structures at the village level, having representatives from related villages. These committees work for the all-around development of the village (s), which reflects the aspirations of the respective local communities. Although the Village Health and Sanitation Committee (VHSC) works under NRHM, it comes under the umbrella of the Panchayat Raj Institutions (PRIs). Ideally, each revenue village in the state should have one such committee. The Committee consists of the village health workers like the Accredited Social Health Activist (ASHA), the Anganwadi Workers (AWW) and the representatives from the Gram Panchayat members of the village. A few selected members of the non-government organisations engaged in development

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activities in the village also should be included in this committee. The marginalised sections of the village society also must be well represented in VHSC. The convener of the committee would be an ASHA worker. Where an ASHA is not in a position to take up the related responsibilities, then it could be an Anganwadi worker from the same village. The committee has some roles and responsibilities, which are performed in the village. It creates public awareness about different aspects of health services like child health, maternal health, adolescent health, and family planning (NRHM, 2005) etc. Such awareness tasks are also focused on hygienic conditions, sanitation and diseases like tuberculosis, malaria, leprosy and blindness etc. The committee discusses with the village community regarding the health situation and develops a suitable village health plan. After analysing the issues and problems related to health and nutrition at the village level, it provides feedback and suggestions to the relevant officials and functionaries of the health department. A routine untied fund of Rs. 10,000 is received to manage the overall expenditure annually for enabling local activities to look after the public health on a priority basis. A Block level committee is also constituted to overview the overall functioning of the village committee and also to solve the grass root issues and challenges in this regard.

Three -tier structure of the PRIs in rural areas of Uttar Pradesh.

ZILA PANCHAYAT (District Level) MPs/MLAs

↑

KSHETRRA PANCHYAT (Block Level) Head-Block Pramukh

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GRAM PANCHYAT (Village Level) Head-Pradhan

Review of Literature:

Community participation is considered as one of the most appropriate and effective approaches which are being used to address the health and family welfare needs of the poor and rural people. So far, provisions for quality health care have not been within the purview of the health department alone, even though it has a leading role in this regard. PRIs provide required and suitable platforms for convergence and coordination with the agencies providing health and nutritional services, water supply, sanitation, education, poverty alleviation and empowerment schemes at the grass root level.

There have been a number of research studies and research conducted in this area in order to evaluate the overall performance and effectiveness of the health care programmes and services. Few of these have come out with relevant findings and viable suggestions, which could be useful to improvise the functioning and implementation of the health care services. Both the National Health Policy (2002) and the National Population Policy of the Government of India (2000) highlighted the role of PRIs in the rural health care system. Even western health experts have recognised the critical role to be played by the PRIs in planning, implementation, and monitoring of the NRHM's successes. The PRIs' success depends on how health functionaries are accountable to the PRIs. Today, panchayats could control the lower level of health staff. Since the doctors are

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highly skilled and well trained, they don't like to come under the obligation of the panchayath system, Poornima, Vijayalakshmi et al. (2011).

Abad-Franch et al. (2011) found that there is a strong relationship between community participation and improvements in health outcomes. Effective community participation helped in the control of diseases in Chagas, but further evidence is necessary in this regard to accept it as an applicable finding. Effective involvement of all the stakeholders in such programmes would only foster true empowerment and lead to improved health and living standards. In 2011, Atkinson et al. (2011) observed that community participation has been playing a key role in addressing communicable diseases like malaria in many low-and middle-income countries.

Rifkin and Pridmore (2001) and Prost et al. (2013) highlighted that the roles of the women's groups had been the most cost-effective and a realistic way to minimise maternal deaths and improve birth outcomes rapidly. Marston et al. (2013) found that community participation as an intervention gets people to think, talk, and act on their health problems and the health services required and offered in this context. On the contrary, Preston et al. (2010) found that there is little evidence of a link between community participation and improvements in rural health outcomes. However, lack of evidence never means lack of effects. They highlighted that community participation should be understood in terms of the expectations of time, resources, tools to measure and overall health development. Mubyazi and Hutton (2012) highlighted the importance of the role of community participation in the context of health planning, resource allocation and delivery of the related health services. The contribution of community participation to improving overall or

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specific health conditions also depends on a variety of factors, including system and socio-cultural factors.

Molyneux et al. (2012) observed that the accountability of the community depends on the village health committees, ward committees, health centers, and women's groups in low-income and middle-income countries. The success of the committees' performance depends upon the selection process, relationships among the respective committee members, different groups, health workers, managers and support of resources by local and national governments.

Rifkin (2014) suggested that community participation should be used in the process of implementation of health programmes for sustaining outcomes rather than as an intervention to improve health outcomes. Despite several obstacles, community engagement, according to Rifkin (2009), has led to an overall improvement of health conditions at the local level, particularly in underprivileged populations. Rifkin (1996) identified a few important reasons behind the failure of community participation in health care facilities. The main reason for the failure, as per his findings, is that community participation was taken to be a magic bullet to solve problems rooted both in the health sector and in the political power structure. He suggested the use of different paradigms where community participation should take a more eclectic approach as an iterative learning process might be a vital thing in this regard. Treating community participation this way will enable more realistic expectations.

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Farmer and Nimegeer (2014) observed that though community participation can be used in designing rural primary healthcare services, the outcome depends upon the community's receptiveness and varies from innovative models to passive protest. Designing acceptable local services depends on how the community members are engaged in this regard. Bath and Wakerman (2013) found small but substantial evidence of an association between community participation and improved health outcomes in Australia. They suggested to policymakers that they ought to strengthen policies and funding support for participatory mechanisms in primary health care.

Pachauri (2009) noted that civil society organisations and community-based institutions such as Gram Panchayats and Self-Help Groups (SHGs) should work creatively and effectively to mobilise concerned communities and also to generate demand for contraception and other reproductive health services. Mohapatra (2010) suggested that Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) and Self-Help Groups (SHGs) should be more active at the grassroot level and identify the groups with need and give them proper information and services related to health and family welfare in India.

The aforementioned research works, as well as their major findings, highlight the importance of elected PRI leaders in expanding rural health care services to meet existing health problems and challenges in this area. Participation gained momentum in the global health policy arena as the member countries of WHO accepted primary health care as their official policy in the Alma Ata Declaration in 1978. According to the declaration, "health is a human right, and inequalities in current health status are politically, socially, and economically unacceptable."

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It also stated that, (WHO,1978) "the essential health care must be made 'accessible to individuals and families in the community through their full participation". This declaration started to give importance to social justice and linked it to equity and participation as the principles of primary health care. With this spirit, many countries created respective cadres of community health workers (CHW) to serve the poor and vulnerable rural people where the majority of the world's population lives in response to the call for community participation in this declaration.

Material and Methodology:

The method that was used to gather the evidence for this paper is a literature review and a scan of government reports. This review study was carried out in the year 2020. To get the information, an online database search was conducted using PubMed, Science Direct, JSTOR, and the official websites of the Census, Ministry of Health and Family Welfare, and other related government reports and books. The following keywords were used in the search: Panchayati Raj Institutions, Health Care Service, Gram Panchayat Village NRHM, Primary Health Care, Public Health Care Delivery, and the term Uttar Pradesh. The pertinent literature is compiled from published, media and already documented sources for getting insights on the topic of the research. Studies were included if they addressed predefined aspects of primary health care and the primary health care system, and the published international peer-reviewed health-related journals, official reports, and books were taken into account.

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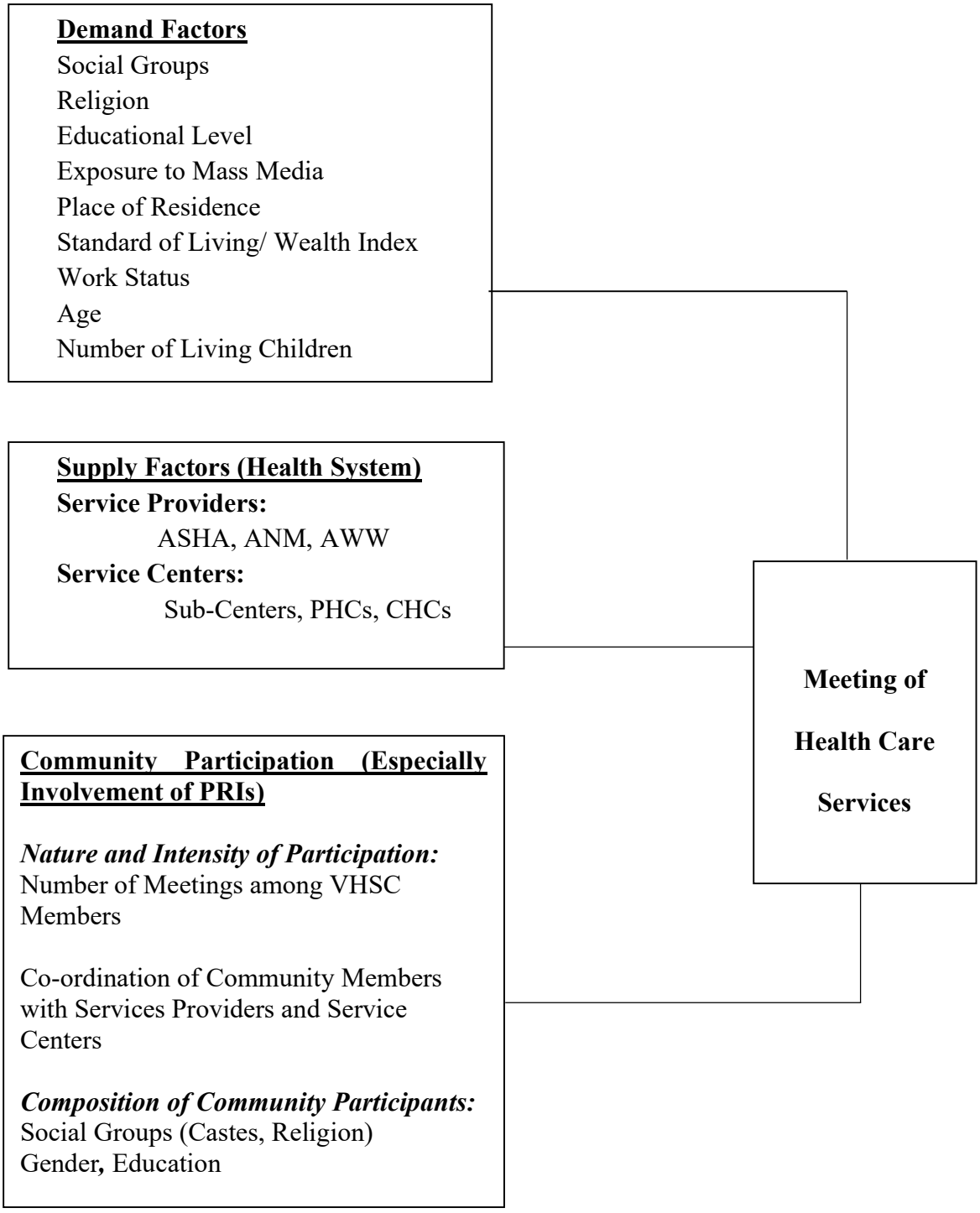
Conceptual Framework:



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Concluding Remarks:

The National Rural Health Mission (NRHM) aims to improve access to affordable, accountable, and effective primary healthcare services, particularly for poor women and children. It also aims to effectively integrate health concerns with other health determinants such as sanitation and hygiene, nutrition, and safe drinking water through a district health plan. The main objective has been to enable the health system and programmes to effectively handle increased allocations and promote policies that strengthen public health management and service delivery mechanism. The strength and role of PRIs are very important when we compare their actual contribution to the quality improvement of the grassroots healthcare system in rural areas. By organising regular health camps, PRIs can also play an important role in diagnosing health problems at an early stage, avoiding household catastrophic health expenditure.

Policy implications:

- A mechanism should also be developed to involve VHSNCs/GKSs for awareness.
- The guidelines should be reframed with clarity and give more power to the committee.
- Continuation of funds and, most importantly, an increase in the amount of funds is a timely requirement.
- Inclusion of all ward members and health workers in the village or extension of the committee from village to ward level will be more effective in community mobilization.

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- The MDD programme should start at the beginning of June (June-September) and coverage of the programme should be extended from a particular ward to the entire village.
- An independent agency should monitor the programme to know the gap and actual utilisation of services.
- Redistribution of LLIN is essential where it is used for more than a year or torn.
- The fund for toilet construction should be increased to increase the space of both the toilet and the tank.
- A surveillance mechanism should be developed for inter-state migrant labourers to reduce the incidence of malaria**.**

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