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ROLE OF COMMUNITY PARTICIPATION IN IMPROVING THE RURAL HEALTH CARE SYSTEM: A STUDY WITH SPECIAL REFERENCE TO WEST BENGAL

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Abstract: It is now recognized that improved health outcomes are the prerequisite for developing countries. Good health contributes to development in various ways. In developing countries, Government tries to improve the health sectors but all goes in vein. The failure of government sector leads to the privatization and commercialization of the medical service which in turn makes the healthcare facilities beyond the reach of the rural people. To overcome the situation, World Health Organization emphasized on the importance of community participation in health sector for improvement of public health institutions. The 1987 WHO Harare declaration endorsed direct public involvement in health systems and the reorientation of political and health systems to support participation. Government of India launched the National Rural Health Mission (NRHM) in 2005 .The main objective of NRHM is to make a structural change in rural health care system in such a way that community will participate automatically in this system. This paper tries to find out the role of community involvement in improving the rural health care system.

Key words: community participation, healthcare systems, development, public health sector.

In 1978, Alma Ata declaration (WHO 1978) emphasized on the importance of collaboration between the health sector and other sectors such as agriculture, education, housing and community development. It is commonly stated that people are the centre of health systems and services (WHO 2000). Indeed, communities play many roles in health systems; as producers and consumers of health and health care inputs; as contributors to the financing of health systems; and as citizens in defining and guiding the implementation of the norms, standards and policies that shape health systems. But inequality in health and access to health care globally indicates that many people in fact do not exercise these roles and are excluded from effective forms of participation in health systems. So it is necessary to focus on how people as citizens are playing the role of defining, guiding and monitoring the policies that shape health systems. Community involvement in health (CIH) has been recognized as critical dimension of health systems for many decades. The 1978 WHO Alma Ata declaration recognized participation a central feature of primary health care. The 1987 WHO Harare declaration endorsed direct public involvement in health systems and the reorientation of political and health systems to support participation.

The term participation is often used inappropriately and ambiguously in health systems. Actually the term ‘participation’ may represent different patterns in the distribution of control in decision making and over resources between communities and health services. It also describes a large range of

partnerships, with different degrees of sharing of values, goals, agendas, capacities and resources. Citizens should have more direct influence over policy and spending decisions and health interventions. Various Studies indicates that there is a potential positive impact of participation on the performance of health systems and in health outcomes and that greater degrees of cooperation between communities and health services do enhance these outcomes. In a review of over 60 case studies of community health –service relationships, Goetz and Gaventa (2001) found the same result.

Over the last few years health has received significantly greater attention in discussions of development policies. Now health gets a special place along with other social sectors such as education in international development policies. At present, there is greater degree of international consensus on the importance of improved health in contributing to economic development, i.e. health as a driver of economic performance rather than its beneficiary.

In 2000, the Director –General of the WHO, Gro Harlem Brundtland, set up the commission on Macroeconomics and health, chaired by Jeffery Sachs and report was published in 2001.The purpose of the commission was to access the place of health in global economic development. In addition to re-examining the evidence on the impact of health on economic development, it also addressed how best to improve health through health sector action, including what interventions should be prioritized and how they should be financed. The commission on macroeconomics and health of the world health organization(2001) argues that "health is a creator and pre-requisite of development", with an extension in the coverage of health services and improved health care the key not only to better health outcomes and reductions in poverty, but also increased productivity, and hence growth, in poorer countries. Not only instrumental value of health but also the intrinsic value of health is also very important. To increase the health equity and social justice, it is necessary to accept the policies which focus on universal health coverage and locally responsible service delivery at the primary health care level (The world health report 2008).Rural areas account for the bulk of the population and a higher incidence of poverty, including more extreme maternal and child health conditions, so rural areas should be the top priority in developing countries.

Despite several growths orientated policies adopted by the Government of India, the widening economic, regional and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical manpower and other health resources are concentrated in urban areas where 27% of the populations live. The health status of Indians is not good, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100000 live births). To improve the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in a holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal policies. Shifting from the current 'biomedical model' to a 'socio-cultural model' would bridge the gaps and improve quality of rural life.

The failure and ineffectiveness of the public sector drives the poor people to access the treatment from private sector, which compels them to spend huge money on credit, or they are left to the mercy of quacks. Govt. hardly spends 20-30% of total health spending. About 67% of all hospitals, 63% of all dispensaries and 78% of all doctors in India are in the private/corporate sector.

The growing privatization and commercialization of the medical services makes the healthcare beyond the reach of the rural poor. Poor families spend a higher percentage of their income on health than do the rich, as they are forced to use the services of the private sector because the public sector is ill-equipped and unaccountable. While a number of health insurance schemes are available to the urban sector, the unorganized rural masses that do not have insurance coverage are driven into the arms of the exploitative private sector.

The Economic Rationale for Investing in the Health of the Poor:

Investment in health is also increasingly recognized as an important – and previously under-estimated – means of economic development. As the Commission on Macroeconomics and Health (CMH) of the World Health Organization (WHO) has shown, substantially improved health outcomes are a prerequisite for developing countries to eradicate poverty. Good health contributes to development through a number of pathways, which partly overlap but in each case add to the total impact as mentioned below:

Improved human capital: Healthy children have better potential. As health improves, rates of absenteeism and early school drop-outs fall. The children learn better which leads to growth in the human capital base.

Higher labour productivity: Healthy workers are more productive, earn higher wages, and miss fewer days of work than those who are ill. This increases output, reduces turnover in the workforce, and increases enterprise profitability and agricultural production.

Higher rates of national savings: Healthy people have more resources to savings, and people who live longer save for retirement. These savings in turn provide funds for capital investment.

Demographic changes: Improvements in both health and education contribute to lower rates of fertility and mortality. After a delay, fertility falls faster than mortality, slowing population growth and reducing the "dependency ratio" (the ratio of active workers to dependants). This "demographic dividend" has been shown to be an important source of growth in per capita income for many low-income countries.

In addition to their beneficial macro-economic impact, health improvements have intergenerational spill-over effects that are clearly shown in micro-economic activities, not least in the household itself. The "demographic dividend" is particularly important for the poor as they tend to have more children, and less to "invest" in the education and health of each child. With the spread of better health care and education, family size declines. Children are more likely to escape the cognitive and physical consequences of childhood diseases and to do better in school. These children are less likely to suffer disability and impairment in later life and so are less likely to face catastrophic medical expenses and more likely to achieve their earning potential. Then, as healthy adults, they have more resources to invest in the care, health and education of their own children.

Public Health Status of West Bengal

Public health status of West Bengal, as judged by various indicators, is presented below

Infant Mortality: The most important indicator of child health is the IMR (Infant Mortality Rate). As per SRS 2009 (Sample Registration System), the IMR of the state was 33 (rural 34 and urban 27) as compared to national average of 50 (rural 55 and urban 34) and was the fourth lowest in the country. Proper antenatal and postnatal check up, improvement of nutrition level of women, delivery at health institution with facilities for newborn care and awareness of mothers to assess severity of the risk of the sick newborn requiring care at hospital as well as arrangement for transporting the sick child with the least delay are some of the solutions for averting deaths of children. Most of those factors are relevant for safety of the mother and avoiding maternal death.

Child Mortality: The CMR (Child Mortality Rate) of the state is also an important indicator of health. The CMR for West Bengal was 40, as per SRS 2009 and the state has already achieved the MDG (Millennium Development Goal) target of 42. However, CMR for Kerala is 14 and that for Tamil Nadu is 33. The corresponding figure of the country was 64. Rank of West Bengal among

different states of the country in respect of CMR is worse than that of IMR deserving more attention to reducing CMR along with reduction of IMR.

Maternal Mortality: Although MMR (Maternal Mortality Rate) of the state is better than most of the states, It is estimated that there are around 2,100 cases of maternal deaths in this state every year. The state is lagging behind in institutional delivery (which has reached nearly 100% in several states compared to around 71% at the end of the year 2010-11 in the state), lack of training of all nurses posted in labour rooms providing them skill for safe delivery, inadequate facilities and not following recommended protocols in the labour rooms, inadequate beds and specialist doctors in government hospital for properly attending all expecting mothers, lack of access to the health centres providing facilities for delivery and having arrangement for blood transfusion and cesarean operation on a 24X7 basis as well as inability of identification and management of pregnancies having risk of delivery through better antenatal checking and appropriate interventions in mitigating the risks etc. Poor status of nutrition, high incidence of anemia and early age at first birth of the child also contribute to higher MMR in this state.

Antenatal & Postnatal Check Ups (ANC & PNC) : Proper antenatal and postnatal check up is very important for reducing morbidity and avoiding mortality of the mother as well as the infant. There should be three ANC during the first three 10 trimesters and preferably a fourth check up (at the residence of the expecting mother) around 36th & 37th week. The expecting mother should register for first ANC within the first trimester of pregnancy.

For the state as a whole total 46% of pregnant women got themselves registered for ANC within first trimester as per HMIS 2009-10 (Health Management Information System). Out of all those registered for ANC only 69% completed three ANCs. Full ANC includes three checkups and consumption of 100 iron tablets, percentage of completing the course is less.

Immunization of Expecting Mother & the Children : Universal immunisation is another very important public health measure for preventing vaccine preventable illnesses. Proper functioning of the Sub-centres, awareness of the mothers and convergence with functioning of the ICDS (Integrated Child Development Services) centres as well as reaching out to the communities through Village Health & Nutrition Day (VHND) is crucial for ensuring 100% immunization. Total number of children aged between 9 and 11 months who have been fully immunised (BCG+DPT123+OPV123+Measles) during the year 2010-11 in West Bengal as per HMIS was 13,51,560 (Male 6,98,964 and female 6,52,596).The average achievement masks the poor performances in many pockets. Poor immunization coverage in such pockets is one of the reasons for delay in eradication of Polio from the state.

Nutrition: Situation of West Bengal is not much different and is just marginally better than that of the country. The newborn is to be breastfed exclusively up to the first six months and the same has to be started within one hour. However, the NFHS-3(National Family Health Survey) in the state found that only around 23.7% of the newborn were being breastfed within the first one hour and only around 13

58.6% of children in age group 0-5 months were being breastfed exclusively. Thus there is need for awareness generation and community mobilization for promotion of breastfeeding as well as other child feeding practices. In fact, apart from poverty, the main causes of malnutrition in the state are deficiencies in child caring and poor feeding practices.

Burden of Communicable Diseases and Non-communicable Diseases: People of the state, particularly the poorer section, face a very high burden of communicable diseases such as diarrhoea, tuberculosis, malaria, HIV and AIDS etc. The entire country as well as the state is facing very fast growing incidences of several non-communicable diseases such as diabetes, hypertension, cancer

and mental illness. Burden can be reduced by improving life style and adopting appropriate food habits etc. The primary health care system is being geared up for early detection of onset of those diseases through more intensive surveillance.

Community Process for Improving Delivery of Public Health Services : Actual delivery of services depends not only on ensuring supply of the same but also on unmediated access and other demand side constraints at the family level. Involving the community for taking care of those issues is very important. Government of India launched the Community Health Guide (CHG) scheme almost three decades ago and the scheme has been withdrawn though some CHGs still exist in the state. The NRHM (The National Rural Health Mission) has introduced the Accredited Social Health Activists or ASHA for working at the community level and maintaining close contact with the families, particularly the mother and the ailing infants. ASHA workers are oriented on different aspects of public health through trainings in different phases. There should be one ASHA worker for every one thousand population and west Bengal requires nearly 60,000 such workers. The BDO (Block Development officer) and the Panchayats have important role in engaging them as well as to see that they are performing their tasks properly. There were 45,157 ASHA workers in the state at the beginning of the year 2011-12. They have completed 17 various phases of training and completion of all the modules of training as well as engagement of the remaining ASHA are important tasks.

Supervision, Monitoring and Convergence of Services at the Gram Panchayet (GP) level :
Supervision of ANM (Auxiliary Nursing Midwifery) and ASHA workers are to be done by the Health Supervisors (HS) and their jurisdiction is coterminous with that of the GP. The office of the HS has been located at the GP office as per joint decision of the Health & FW and the Panchayat & RD Departments. That makes it easier for the coordination with the Gram Panchayat. A formal meeting for such coordination is done in a meeting held on every fourth Saturday where all concerned working at the village level like ICDS Supervisor, representatives of the SHGs (Self Help Groups)and ANMs participate along with the functionaries of the PRI (Panchayet Raj Institution) looking after health. At the Sub Centre (SC) level there is one meeting held on every third Saturday between the ANM and the ICDS workers within its area. Those meetings should identify the problems, interventions required and monitor various services being delivered not only on health and nutrition related services but on incidence of important diseases and progress of development of some of the important health determinants like water supply, sanitation, drainage and solid waste management etc. At the Block level the BMOH meets all the ANMs and the HSs once a month to monitor their works as well as to guide them for the next month. The BMOH is assisted by the BPHN (Block Public Health Nurse) and the PHN (Public Health Nurse) etc in supervision and monitoring of preventive and promotive health care related to mother and child. There is one post of Block Sanitary Inspector, which is generally lying vacant, for assisting the BMOH in monitoring works related to various diseases, particularly those which are communicable.

National Rural Health Mission (NRHM):
As a part of its socially progressive common minimum programme, the UPA govt. launched the National Rural Health Mission (NRHM) in 2005.It aimed to undertake an “architectural correction” of the public health system to enable it to effectively absorb increased expenditure to provide accessible, affordable and accountable primary health care services of rural India. The NRHM, started in 2005, seeks to provide effective health care to rural population throughout the country with special focus on 18 states, which have weak public health indicators and /or weak infrastructure. These 18 states are Arunachal prodesh,assam, bihar, chhatisgarh, himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mijoram, Meghalaya, Madya Pradesh, Nagaland, Orrisa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttarprodesh.

NRHM is the largest primary health care programme being run in any single country. Major objectives of NRHM include the following to raise spending on health (from 0.9% of GDP to 2.3% of GDP), with improvements in community financing and risk pooling; to provide access to primary health care services for the rural poor, with universal access for women and children, to see a concomitant reduction in IMR/MMR/TFR, to prevent and control communicable and non-communicable diseases and to revitalize local health traditions. In essence these do not differ from health plan goals adopted by India over last sixty years. The mission's uniqueness lies primarily in the institutional instruments used to achieve those goals, foremost amongst which are attempts at structurally reconfiguring the public health system to facilitate decentralization and communitisation, widely accepted as beneficial trends in the development sphere today.

The 'architectural correction' which is an important objective of NRHM includes the provision of a fund to be flexible in nature so that it can be utilized properly in need. Not only at state level but also at district level planning can be adopted. In addition, to make a correlation between community and peripheral health staff, female health activists (ASHA) and village health and sanitation committees (VHSC s) have been created. The main objective of NRHM is to develop a efficient public delivery system through the provision of flexible grants to improve infrastructure, human resources and capacity. Furthermore, to make a structural change in rural health care system in such a way that community will participate automatically in this system.

NRHM Goals

- Reduction in IMR and MMR
- Universal access to public health services such as women's health child, child health, water, sanitation and hygiene, immunization and nutrition
- Prevention and control of communicable and non communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care
- Population stabilization, gender and demographic balance
- Revitalize local health traditions and mainstream AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy)
- Promotion of healthy life styles.

Monitoring and Evaluation system:

The information system to measure the process and impact of the NRHM including Family welfare programme is as below;

a) Service statistics through Health Management Information System (HMIS) and Routine Monitoring
b) Sample Registration System and population census, Office of Register General India
c) Large scale surveys-National Family Health Surveys, District Level Household and Facility surveys. Annual Health survey
d) Area specific surveys by Population Research Centre
e) Other specific surveys by national and international agencies
f) Field evaluation through Regional evaluation teams

Community participation :"community participation is an educational and empowering process in which the people, in partnership with those who are able to assist them , identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage , control and asses the collective actions that are proved necessary"

Ideally, true or active participation means that the people should be knowledgeable about their own health problems and they should identify the needs for their solution or reduction, draw out plans of actions according to the priority and the resources available, organize and implement the programmes and monitor and control their progress; periodically evaluable for getting the feedback, and do the reprogramming. However, under poor social and economic conditions, it may be hard to expect spontaneous participation from the people. People have to be mobilized and encouraged to take greater interest and responsibilities for the maintenance of their own health. Initially the involvement may be passive, and this has to be gradually and progressively made more active participation.

Dimensions of community participation:

From the available experiences it is observed that community may be involved in a variety of wages as noted below;

- The services may be organized on a community basis with wide and easy access of the people to the services provided.
- The community may contribute to the operation and maintenance of services.
- The community may participate in planning and managing the services.
- The community may make inputs into overall policies, strategies, and work plan of the programme.
- The community may help in overcoming factionalism and interest conflicts in the community and promote emergence of a cohesive group capable of engaging in cooperative efforts for the benefit of all.

Conclusion:

Participation has a variety of purposes and occurs in a diverse range of contents. Measuring the success of participation need to take these factors into account. A participation indicator should measure activity that reflects meaningful progress towards this goal. Performance indicators can measure many activities and have to monitor the different dimensions such as Inputs (efforts), Outputs (efforts or results), Changes and Processes (how and why a result was achieved), Successes or achievements of programs or organizations. Indicators allow comparisons between services, against standards, or within the same agency over time. When developing and selecting indicators, the following criteria from the national health performance should be considered. The indicator should be:

a) worth measuring

b) measurable for diverse populations

c) understood by people who need to act

d) relevant to policy and practice

f) reflected in results of actions when measured over time

Community participation builds public support for policies and programmes, generates compliance with regulations and keeps alter public health behaviors. One of the major strategic interventions under NRHM is the system of ensuring accountability and transparency through people's participation- the Rogi kalyan Samitis. The ministry of health needs to define a clear policy on social participation and operational methods in facilitating community health projects. Potential areas of community participation could be in life style modification in chronic diseases through physical

activity and diet modification and primary prevention of alcohol dependence through active community based activities like awareness creation and behavioral interventions.

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