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Community Participation In Primary Health Care Services In India: A Historical Account

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Abstract

Community participation plays an important role in the area of health since people involvement in making the decisions regarding their health help in planning and executing more effectively all the issues that affect their life. It is making a commitment to the development of the local community, which must include the development of local people's ability to decide and act for themselves. In India concept of community participation in primary health care was laid down by the recommendations of Bhore Committee (1946). Therefore, even before independence there was a focus on community participation in ensuring public health. For this purpose, the government has been appointed various committees of experts from time to time to render advice about different health problems. The reports of these committees have formed an important basis of health planning in India. Inspite of all, there are many challenges ahead to achieve the goal of health for all. There is a need to review the recommendations of health committees in the country to know our strengths and weaknesses to face the challenges in the future. This paper attempts to review the progress of community participation in primary health care services in India, especially in rural areas. It deals with the origin and evolution of health care in India, where it covers the details of the different stages of primary health care in India starting from Bhore committee (1946) to Alma Ata Declaration (1978) to current NRHM (2005-2012).

Keywords: Community Participation, Primary Health Care, National Rural Health Mission and Health Committees

Introduction

Community participation in primary health care is proposed as a strategy to engage community members in developing locally responsive health care for the whole community. It is one of the most important levers to achieve a continuously improving health care system. Community participation in health therefore requires community involvement in assuming responsibilities for achieving the goals and objectives of health programmes. Community participation in health has been the linchpin of primary health care programmes as designed in The Alma Ata Declaration, 1978 in the Republic of Kazakhstan. The importance of community participation in rural health service development is uncontested. The rural health policy framework Healthy Horizons Outlook includes the principle, 'participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programs and services to maintain and improve their health'. The document also states that 'social capability and the physical capacity to plan and implement local programs are required for communities to improve and maintain their health.[1] The origins of the concept of community participation in rural health lie in its application by international organizations, such as the World Health Organization (1991) in developing countries in an attempt to improve health, social and economic conditions.[2]

The broad concept of health has roots in the World Health Organization's 1948 definition of health: *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*[3] It has been well conceptualized that multiple factors e.g. biological, genetic, nutritional, physical, chemical, mechanical, environmental, social, cultural, human behavior, psychological and economic, play a role in the health or disease status of the individuals and

the community. Health and socio-economic progress are very much inter-dependent and health has been accepted as one of the welfare component.[4] Health is not only a basic human right, but it is most desired. In a global survey commissioned for the Millennium Summit of the United Nations by UN Secretary General Kofi Annan (Millennium Poll, United Nations 2000), good health is consistently ranked as the number one desire of men and women around the world. It is also a key precondition to economic development. Health is central to well being and a prerequisite for individual and national progress. Health is significant factor in the development of nation, as high levels of population health go hand in hand with national income. Improvements in health are important in their own right, but better health is also prerequisite and a major contributor to economic growth and social cohesion.[5] Conversely, improvement in people's access to health technology is a good indicator of the success of other development process. It is the availability of the health care services at the accessible distance with effective and complete utilization of the Health Care Services, which plays a significant role as the prominent determinant in achieving the nation's health. India has achieved considerable improvements in human development factors. In India majority of its population lives in rural areas and if basic health care is not to reach the rural areas, then no matter how much progress achieved in the urban and semi-urban areas, as overall growth as a nation will be retarded. India's healthcare system rests on a primary healthcare system that is grossly inadequate and falls woefully short of what it should be to ensure that our people have access to at least basic healthcare. Rural Health Care services in India are mainly based on Primary health care, which envisages attainment of healthy status for all. Also being holistic in nature it aims to provide preventive, promote curative and rehabilitative care services. The different Health Policies and Programmers of the country aim at achieving an acceptable standard of health for the general population of the country. Keeping in line with this broad objective, a comprehensive approach was advocated, which included improvements in individual health care, public health, sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices with the active participation of people itself. Importance was accorded to reduce disparities in health across regions and communities by ensuring access to affordable health, especially to the weaker and underprivileged like women and children, the older persons, disabled and tribal groups.

An assessment of the performance of the country's health related indicators depicts that significant gains have been made in them e.g. life expectancy at birth, child and maternal mortality, morbidity. This paper briefly reviews different committee reports / recommendations, policies and programmes to assure health care facility in India, values and principles adopted in achieving the same like equitable distributions, Universal access to care and coverage on the basis of the need, Community participation and Coordination & convergence with the other health related sectors.

Aim of the Study

The aim of this research paper is to review briefly different committee reports / recommendations, policies and programmes which assured community participation in rural health, health care facility in India, values and principles adopted in achieving the same like equitable distributions, Universal access to care and coverage on the basis of the need, coordination & convergence with the other health related sectors. An assessment of the performance of the country's health related indicators depicts that significant gains have been made in them e.g. life expectancy at birth, child and maternal mortality, morbidity.

Community Participation in Primary Health Care in India

Community Participation in Primary Health Care is a vital strategy which is a backbone of Health Service delivery for our country. India was one of the first few countries to recognize the importance of Primary Health Care Approach. Primary Health Care was conceptualized in 1946, three decades before the Alma Ata declaration, when Sir Joseph Bhore made recommendations, which laid the basis for organization of basic health services in India.[6] Over the past decades, several Committees and Commissions have been appointed by the Government to examine issues and challenges facing the health sector. The purpose of these committees formed from time to time is to review the current situation regarding health status in the country and suggest further course of action in order to accord the best of healthcare to the people. The committees and commissions have been headed by eminent public health experts, who have studied the issues in an in-depth manner and provided overarching recommendations for various aspects of the health care system in India. The areas covered by them related to organization, integration and development of health care services / delivery system across levels; health policy and planning; national programmers; public health; human resources; indigenous systems of medicine; drugs and pharmaceuticals. An examination of these reports reveals the options, lessons and challenges for strengthening people's participation in India's health system.

Bhore Committee on Health Planning and Development

The Bhore committee report is the first health report, i.e. the Health Planning and Development Committee's Report, 1946. It was a plan equivalent to Britain's National Health Service. The Report was based on a countrywide survey in British India. It is the first organized set of health care data for India.[7] It considered that the health programme in India should be developed on a foundation of preventive health work and proceeds in the closest association with the administration of medical relief. The Committee strongly recommended a health services system based on the needs of the people, the majority of whom were

deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It emphasized the social orientation of the medical practice and high level of public participation. The recommendations of the Bhore Committee report were

1. The integration of preventive and curative services at all administrative levels
2. Short term Primary Health Centre for 40000 population
3. Long term (3 million plan) – Primary Health Centers with 75 beds for each 10000 – 20000 population
4. Formation of Village Health Committee
5. Provision of Social doctor; inter-sectoral approach to health servicers development
6. Three months training in preventive and social medicine to prepare social physicians for better health status of the citizens

Sokhey Committee Report on National Health

The National Planning Committee (NPC) set up by the Indian National Congress in 1948 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report, but endorsed the recommendations of the Bhore Committee Report and commented that it was of the utmost significance.

Community Development Programme

With the beginning of First Five Year Plan (1951 – 55) and Health Planning in India, *Community Development Programme (CDP)* was launched in 1952 for all the development of rural areas in all dimensions, where 80% of the population lived. The Community Development Programme inaugurated on October 2, 1952, was an important landmark in the history of the rural development. Community development was defined as "a process designed to create conditions of economic and social progress for the whole community with active participation and the fullest possible reliance upon the community's initiative". CDP was envisaged as a multipurpose programme covering health and sanitation (Through the establishment of Primary Healthcare Centers and Sub Centers) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) consists of 100 villages with an approximate total population of 100000. For one CDB, one PHC was created.

Mudaliar Committee on Health Survey and Planning

By the close of second Five Year Plan (1956 -61), *"Health Survey and Planning Committee",* headed by Dr. D.L.Mudaliar, was appointed by the Government of India to review the progress made in the health sector after submission of Bhore Committee report. This committee found the conditions in primary health centers to be unsatisfactory and suggested that the primary health care, already established should be strengthened along with the strengthening of sub divisional and district hospital. The major recommendation of this committee report was to limit the population served by primary health centers to 40,000 with the improvement in the quality of health care provided by these centers. Also provision of one basic health worker per 10,000 populations was recommended.

Mukherji Committee Reports on Basic Health Services

The Mukherji Committee headed by the then Secretary of Health Shri Mukherji, was appointed to review the performance in the area of family planning. The committee observed that the multiple activities of the mass programmes like family planning, small pox, leprosy, trachoma, National Malaria Eradication Programme (maintenance Phase) were making it difficult for the states to undertake these effectively because of the shortage of funds and recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff. The committee however, does visualize that at later stage not long from how, there can and should be a much greater integration between the Family Planning and Maternity and Child Health Programme and the basic health services. The committee also worked out the composition and organization of basic health services, which should be provided at the Block level. Also strongly it recommended that Importance must be given to due strengthening of the supervisory levels to correspond to the strengthening of the base organization. This is particularly necessary for the basic health services since the quality of the performance of the functionaries at the base level, who have to be comparatively more numerous but cannot be so well paid nor of very high caliber nor technically so well equipped, will determine greatly the quality of the whole service and the benefits derived there from by the rural people. Supervision of their work has, therefore, to be particularly strong and continues. This supervision must be both administrative and technical must be adequate both in degree and quality and must not be confined only to exercise of control but must extend also to providing help and guidance.

Jungalwalla Committee on Integration of Health Services

The Jungalwalla committee on Integration of Health Services was set up in 1964 under the chairmanship of Dr. N Jungalwalla, the then Director of National Institute of Health Administration and Education (currently National Institute of Health and Family Welfare). It was asked to look into various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of doctors. The committee defined "integrated health services" as "a service with a unified approach for all problems instead of a segmented approach for different problems". The committee recommended integration from the highest to lowest level in the services, organization and personnel. That is Medical Care and Public Health Programmes should be put under charge of a single administrator at all levels of

hierarchy by adopting - The Unified Cadre, Common Seniority, Recognition of extra qualifications, equal pay for equal work, special pay for special work, abolition of private practice by government doctors, improvement in their service conditions.

Kartar Singh Committee on Multipurpose Workers

The Kartar Singh Committee, 1973 headed by the Additional Secretary of Health named "committee on multipurpose workers" to laid down the norms about health workers to form a framework for integration of health and medical services at peripheral and supervisory levels. For ensuring proper coverage the committee recommended the amalgamation of peripheral workers into a single cadre of multipurpose workers. Also it recommended the organizational change of with respect to primary health centres and SCs - one PHC to be established for every 50,000 population. Each Primary Health Centre to be divided into 16 Sub-Centres each for a population of 3000 – 3500. Each Sub-Centres to be staffed by a team of one male and one female health worker. The work of 3-4 health workers to be supervised by one Health Assistant.

Shrivastav Committee on Medical Education and Support Manpower

The Shrivastav Committee was set up in 1974 as "Group on Medical Education and Support Manpower" to determine the steps needed to (i) reorient medical education in accordance with the national needs and priorities and (ii) develop a curriculum for health assistants who were to function as a link between medical officers and MPWs. The committee recommended

1. Creation of bands of paraprofessional and semi-professional health workers from within the community (like school teachers, post masters etc) itself.
2. The establishment of 3 cadres of health workers between the community level workers and doctors at PHC.
3. The development of "Referral Service Complex" by establishing linkages between the primary health centre and higher level referral and service centers viz taluka, district, and regional and medical college hospitals.
4. Establishment of a medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission.

Rural Health Scheme: Community Health Volunteer Scheme - Village Health Guides

Acceptance of the recommendations of the Shrivastav Committee report led to the launching of Rural Health Scheme in 1977, wherein training of community health workers, reorientation training of multipurpose workers and linking medical colleges to rural health was initiated. Also to initiate community participation, the Community Health Volunteer – Village Health Guide (VHG) scheme was launched on 2nd October 1977. According to the VHG Scheme the village community selects a volunteer was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work. VHG acts as a link between the community and the Government Health System. He / She mainly provide health education and create awareness of Maternal and Child Health and Family Welfare Services. He / She have to keep a track of communicable and treat minor ailments and provide first aid to the patients.

Alma Ata Declaration- Health for All by 2000

The Alma Ata declaration of 1978 launched the concept of 'Health For All' by year 2000. It was signed by 134 governments (including India) and 67 other agencies. The Alma Ata Declaration in 1978 gave an insight into the understanding of primary health care. It viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue to achieve the goals of development. The Declaration recommended that primary health care should include at least: education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong secondary- and tertiary-level care linked to it. It called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people, and this was to be guided by the principles of universality, comprehensiveness and equity. In one sense, primary health care reasserted the role and responsibilities of the State, and recognized that health is influenced by a multitude of factors and not just the health services. At the same time, the Declaration emphasized on complete and organized community participation, and ultimate self-reliance with individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youth and women's groups, consumer groups, other non-governmental organizations, etc. The Declaration affirmed the need for a balanced distribution of available resources.[8] The declaration asserted "Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation at every stage of their development in the spirit of self-reliance and self-determination."

ICSSR and ICMR Reports on "Health for All - an Alternate Strategy"

The report of Study Group on "Health for All – an alternate Strategy" commissioned by ICSSR and ICMR (1980) under the chairmanship of Dr. V. Ramalingaswami indicated that most of the health

problems of a majority of India's population were amenable to being solved at the primary health care level through community participation and ownership. The report of ICSSR / ICMR report "Health for All: An Alternative Strategy" offered a viable alternative strategy to reach most of the Indians who are in need of such services. The report recommended an alternative health care system that was accessible, culturally acceptable and cost effective for all citizens accountable to the people it served. It advocated –

1. Encouraging people to utilize their age-old health culture and practices together with the best of all available systems provided in a simple and effective manner.
2. With the support of the community, this decentralized system could devise a graded training and referral system from the village to community's own hospital and training complex.

This would meet almost 95 percent of all requirements of preliminary health and medical care. Broad-based medical and surgical specialty level within a 30000 population level would be serviced by the government Primary health Center. The report was set in the context the failures of the imported, top heavy, centralized, elite-oriented model of health care delivery that characterized the first 30 years of Indian independence.

Mehta Committee on Medical Education Review, 1983

The Mehta committee mainly reviewed the medical education in all its aspects and specifically discussed about lack of availability of Health manpower data in India. Also committee recommended establishing Universities of Medical Sciences and Medical and Health Education Commission; method for updating the manpower data and projections for doctors, nurses and pharmacists.

First National Health Policy, 1983

The responsibility of the state to provide comprehensive primary health care to its people as envisioned by the Alma Ata declaration led to the formulation of India's First National health Policy (NHP) in 1983. The major goal of policy was to provide of universal, comprehensive primary health services. The policy emphasized the role that could be played by private and voluntary organizations working in the country to support government for integration of health services. It stressed the creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities like nutrition, drinking water supply and sanitation; the active involvement and participation of voluntary organizations; the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people.

Bajaj Committee on Health Manpower Planning, Production and Management, 1987

An "Expert Committee for Health Manpower Planning, Production and Management" was constituted in 1985 under Dr. J.S. Bajaj, then professor at AIIMS. The committee discussed in details the different components of primary health care, manpower requirement at different levels and catering the demand by vocational training and managing the manpower. The major recommendations are

1. Formulation of National Medical and Health Education Policy.
2. Formulation of National Health Manpower Policy.
3. Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC.
4. Establishment of Health Science Universities in various states and union territories.
5. Establishment of Health manpower cells at centre and in all states.
6. Vacationalisation of education at 10 +2 levels as regards health related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers.
7. Carrying out a realistic health manpower survey.

Bajaj Committee on Public Health System, 1996

The Ministry of Health and Family Welfare, constituted an Expert Committee on Public Health Systems under the chairmanship of Dr. J.S. Bajaj, to comprehensively review the public health system in the country and to offer appropriate recommendations. After the detailed deliberations the committee exhaustively reviewed the current status of public health system, epidemiological surveillance system, status of control strategies for epidemic diseases, existing health schemes, environmental health and sanitation, role of state and local health authorities in epidemic remedial measures, health manpower planning and health management information system. A series of short term and long term recommendations along with action plan are proposed to impart a greater degree of responsiveness in the public health system. Key recommendations are Policy initiatives with respect to review National Health Policy, Establishment of health impact assessment cell, surveillance of critically polluted areas, search for alternative strategy / strengthening of health services / system research, uniform adoption of public health Act by the local health authorities, establishing National Notification System / National Health Regulations, Joint Council of Health, Family Welfare and ISM and Homeopathy, Establishing an Apex Technical Advisory Body, Constitution of Indian Medical and Health Services, Administrative restructuring of department of Health and Family welfare and DGHS, strong Health Manpower Planning division under DGHS, opening of Regional Schools of Public Health along with the emphasis on implementation of recommendation of committee recommendations of manpower planning, production and management of 1987.

National Population Policy, 2000:

The National Population Policy was announced in the year 2000, the overarching policy framework for family planning and maternal and child health goals, objectives and strategies. The immediate objective of National Population Policy

was to address the unmet needs of contraception, health care infrastructure and health personnel and to provide integrated delivery for basic reproductive and child care services. It envisaged development of one-stop integrated and coordinated service delivery at the village level for basic reproductive and child health services through a partnership of the government with voluntary and non-governmental organizations.

Second National Health Policy, 2002

Nearly twenty years after the first health policy, the Second National Health Policy, 2002 was presented. The NHP 2002 recognized as the noteworthy successes in health since the implementation of the First National Health Policy 1983. These successes included the eradication of small pox and guinea worm, the near eradication of polio and the progress towards the elimination of leprosy and neonatal tetanus. The National Health Policy sets out a new policy framework to achieve public health goals in the socio-economic circumstances currently prevailing in the country. The approach aims at increasing access to the decentralized public health systems by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions. It sets out an increased sectoral share of allocation out of total health spending to primary health care.

National Rural Health Mission (NRHM, 2005-2012)

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission (NRHM) in April 2005 to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The mission envisages a primary health care approach for decentralized health planning and implementation at the village and district level. The mission was made operational from April 2005 throughout the country with special focus on 18 states having weak demographic indicators and infrastructure. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.[9] The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. The key core strategies under NRHM are :

1. Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services.
2. Promote access to improved health care at household level through the village level worker , ASHA
3. Health plan for each village through Village Health Committee of the Panchayat.
4. Strengthening sub centers through better human resource development, clear quality standards, better community standards, better community support and an untied fund to enable local planning and action and more multipurpose workers.
5. Strengthening existing Primary Health Centers through better staffing and human resource development policy, clear quality standards, better community support and an untied fund enable the local management committee to achieve these standards.
6. Provision of 30 – 50 bedded CHC per lakh population for improved curative care to a normative standard. (Indian Public Health Standards defining personnel, equipment and management standards)
7. Preparation and implementation of an inter-sector district plan prepared by district health mission, including drinking water supply, sanitation, hygiene and nutrition.
8. Integrating vertical health and family welfare programmes at national, state district and block levels.
9. Technical support to national, state and district health mission for public health management.
10. Strengthening capacities for data collection, assessment and review for evidence base planning, monitoring and supervision.

Supplementary Strategies under Mission

1. Regulation for private sector including the informal Rural Medical Practitioners (RMPs) to ensure availability of quality service to citizens at reasonable cost.
2. Promotion of Public Private Parternership for achieving public health goals.
3. Mainstreaming the Indian System of medicine (AYUSH) revitalizing local health traditions.
4. Reorienting medical education to support rural health issues including regulation of medical care to medical ethics.

Conclusion

India faces the daunting challenge of meeting health care needs of its vast population and ensuring accessibility, efficiency, equity and quality of healthcare and thereby achieving the objective of growth with equality and social justice. It calls for sustained efforts and planning, as well as coordinated action from public and private players and community involvement. About a sixth of the world‘s population lives in India and thus, the progress on priority health outcomes in the country as well as in the world depend to a large extent on the progress of health standards at the state and district levels in India. The government has begun taking steps to improve rural healthcare. It is the

availability of the health care services at the accessible distance with effective and complete utilization of the health care services, which plays a significant role as the prominent determinant in achieving the nation‘s health. Access is important but people‘s experiences of what the facility has to offer in terms of medical care and whether it is worth their while to use it are equally important in utilizing healthcare facilities. The primary health care approach lays emphasis on health care provision by the people. It centers on people’s participation in their own activities. Community involvement in health programmes has been tried through various approaches in India. Health care delivery in the country has utilized community volunteers from time to time in different forms to link the community with the health care system. The healthcare in a country as a whole is facing many challenges. India desperately requires tremendous magnitude of India's healthcare needs and the immense investments required to improve the health status of people from all parts of India and across all strata of society. In addition, there is also an urgent need to raise the availability of qualified doctors, nurses and paramedical staff and to create an infrastructure and a participatory system with the help of people to work in rural areas. Further, general lack of awareness on healthcare issues and the low public consciousness of hygiene and sanitation norms will need to be addressed as a starting point and with it the lack of accessibility to healthcare services. India needs to focus on preventable rather than curative.

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