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MANAGEMENT OF RURAL HEALTH SERVICES BY PANCHAYATI RAJ INSTITUTIONS

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In spite of efforts to promote community participation in primary health care, there remains a high degree of polarization between the "consumers" and "providers" of health services. Active participation by rural communities may become a reality if financial and administrative control of the rural health facilities is delegated to village panchayats. Only then villagers may actively identify their health needs and strive to improve the quantity and quality of health services they may need.

SINCE the pre-historic times, human beings sharing common interests have always lived together in groups, which later on became organized. Thus, the concept of the community is an ancient one. A group of people living in a geographical area, sharing common interests, when identify their common problems and try to solve them through co-operative efforts using locally available resources, this may be called community participation. The central concept of primary health care is that communities take major responsibility for their own health. Health professionals are only to assist and support the process, instead of being *providers* of health care. The most important aspect of primary health care is that the health needs must be identified by the communities themselves and not by the urban-based authorities. Improvement in health status requires actions in allied sectors like sanitation and female literacy. Intersectoral collaboration, an important goal of primary health care, needs to be strengthened at the field level today.

Among the rural folk, it is the illiterate poor sections who should be encouraged to participate in their own interest. Rural communities are sub-divided into groups based on sociocultural and political lines and these compete for scarce resources and facilities. Well-to-do groups corner positions of power and it is not uncommon to see prominent persons accompanying patients to health centres and demanding preferential treatment from doctors. In the present situation, a few poor villagers can talk of getting good treatment without paying for it.

Identifying health needs

India has the adequate technology to provide health care for all her citizens and has allocated sufficient funds for public health expenditure during 1985-90(1). Despite vast inputs, rural communities are known to prefer private practitioners because of their personal approach and their convenient clinic timings.

While working in a sub urban slum area in Bombay (India), we found that though potable water

supply was adequate and basic sanitation was available, public taps installed by the municipal authorities were carelessly left open and the doors of many toilet blocks were stolen. Parents allowed children to defecate just outside the functioning toilet blocks. Many inhabitants did not feel the need for basic sanitation and thought that the authorities had provided the facilities with some ulterior motives. The situation was the same in rural areas where scarce drinking water was allowed to run waste because of leaky taps. Many times users did not bother to shut off the taps after use. However, in villages where hand-pumps were the only source of potable water, no such waste was observed probably because physical effort is required to draw water.

Socio-political Will

Economic prosperity does not necessarily lead to better health. Kerala, though much poorer than many Indian states, has the lowest morbidity and mortality. This is because the socio-political will to bring about improvements in health care came from the community itself mainly due to high literacy leading to awareness of basic human rights. Poor utilization or misuse of public facilities is due to a low literacy rate. The transmission of major communicable and waterborne disease ceased in European countries much before the advent of antibiotics and preventive vaccines because of better sanitation and public awareness that resulted from mass education. Thus India needs to educate her millions of illiterate citizens before any improvement can be expected in the health profile.

Voluntary organizations provide cost-effective health services of a high quality at convenient timings, but these organizations cannot be expected to provide health care in all the Indian villages. Management of rural health facilities by panchayats will free the villagers from the throttling grasp of bureaucratic controls and make the rural communities self-reliant. However, many officials, including doctors may feel that health care is too complicated an issue to be left to illiterate rural people and may oppose the idea of communities becoming self-reliant. We feel that if the same illiterate villagers can decide India's destiny during elections, there is no reason why they cannot take decisions regarding their own health. It must be remembered that till Oral Rehydration Therapy demystified the treatment of diarrhoea, many doctors considered management of diarrhoea too complex an issue. Persons with mild attacks were hospitalized and given expensive intravenous fluids.

Active participation

Active community participation will be a reality if financial and administrative powers are delegated to a governing body in the village panchayats. Such a system will introduce genuine democracy in the field of public health. The Medical officer at the primary health centre should be a member of all the governing bodies in the villages allotted to the PHC and should have adequate powers to decide on health matters. All subgroups in the rural communities should be made to actively participate in identifying their health related needs. The role of the Government should be restricted to provision of financial inputs and technical guidance, leaving day-to-day administrative and financial decisions to the panchayats. Health education should be tailored to suit local needs so that the citizens know how to manage ailments in their homes and when to ask for professional care. This shall be a rural people's movement for health and would require less Government funding. The villagers may feel that the health programmes are their own and not the ones imposed by the Government. It is difficult to convince illiterate persons to attend health centres for preventive services like child immunization because they do not feel the need for such services. While working in rural areas, we learnt that a domiciliary approach enhances coverage because the daily routine of the villagers remained undisturbed. Curative services may remain clinic-based, but their timings should suit the *consumers* and not the *providers* of curative services. Our experience is that poor utilization of curative services is mainly because of unsuitable clinic timings. Many farm labourer cannot attend health centres for fear of losing daily wages.

Even if the community strive actively to improve the quality and quantity of health care they may need, there should be a periodic evaluation by an independent professional body. The mass media can create consumer awareness so that our illiterate villagers know that they can demand basic health care as their basic right and not as a favour.

REFERENCES

1. HEALTH STATUS OF THE INDIAN PEOPLE
   Foundation for Research in Community Health, Bombay, 1987.

2. Kartikeyan S., Chaturvedi, R.M., Deo, M.G.,
   THE SOCIOCULTURAL DIMENSION IN LEPROSY VACCINE TRIALS
   Leprosy Review (In Press)

3. Kartikeyan, S. and Bhalerao, V. R.
   STUDY OF COMPLIANCE OF PATIENTS IN LEPROSY CONTROL PROGRAMME IN AN URBAN SLUM.
   J. Postgrad. Med. 32(3): 127-130, 1986.

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