Role of Women in Health Care Sector of Rural India: A Case Study of National Rural Health Mission, Azamgarh, Uttar Pradesh

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Abstract

This paper will explore the Role of Women in Health Care Sector of Rural India and moreover it will study the impact of National Rural Health Mission (hereafter NRHM) and its participation based programme on rural development, particularly in health sector. World Health Organization defined health as "a state of complete physical mental and social well-being of an individual and not merely an absence of disease or infirmity. Mahatma Gandhi considered health as more valuable than silver and gold. He said, "It is Health that is real Wealth and not pieces of gold and silver"Our ancient society was also very much concerned about health and hygiene. They were depending on Ayurveda and Yoga. Unani and Siddha were added in health care in the Mughal period. The first planning commission of India refers Information, Education and Communication (IEC) to control the communicable diseases and diseases because there are a number of communicable disease and diseases which can be controlled by self-care, as for example – Flu, HIV/AIDS, sexually Transmitted diseases, malaria, diarrhoeal, pneumonia and TB (Public health guide for emergencies).

KEYWORDS: Role of Women, Health Care, NRHM, Rural Development.

Introduction:

As we know that health is a state of complete physical mental and social well-being of an individual. It is not a subject of absence of disease but in a way it can be said that health is not only a part individual but also a part of social development and positive peace. As par Galtung's definition of positive peace, it can be said that health is also a part of positive peace. Galtung refers positive peace as cooperation, development, justice, freedom, etc (Galtung quoted in Vengoechea, 2004: 13). In this way development and peace (positive peace) is very much interconnected and health is a part of these phenomena. People's health is very much depended on their life style, socioeconomic condition and education etc. There are many diseases which are depending on self-care and planning commission was very concerned about it. The first planning commission of India refers Information, Education and Communication (IEC) to control the communicable diseases and diseases because there are a number of communicable disease and diseases which can be controlled by self-care, as for example – Flu, HIV/AIDS, sexually Transmitted diseases, malaria, diarrhoeal, pneumonia and TB (Public health guide for emergencies). These diseases can be controlled by hygiene and self-care. Therefore, people's participation has very important role in disease control.

Our ancient society was also very much concerned about health and hygiene. They were depending on *Ayurveda* and *Yoga*. *Unani*and *Siddha* were added in health care in the *Mughal* period (Banerji, 1975).The major part of current medical system is very much depends on Allopathic, which started in the 16th century. The base of current

health care system is depended on the recommendation of Bhore committee (1946). The Committee recommended the provision of comprehensive health care service and integration with health related department, such as agriculture, irrigation, fisheries, education, communication, etc. Committee recommended three-tier system of health care; Tertiary level (Medical college hospitals), secondary level (District hospital, community health centres *talukas* hospitals), Primary level (Primary health centres, sub centres) (Borkar, 1957). Government of India started the Community Health Workers Scheme in 1979 to fulfil the Alma Ata Declaration of participatory health care delivery (Qadeer, 2011). In addition, Government of India started National Rural Health Mission (hereafter, NRHM) in 2005 five to make it more participatory, to fulfil the aim of Millennium Development Goal, 2000 and to resolve the problems of health care in rural area by their participation.

Role of Women in Health Care

As per definition of WHO, health is a part of development. Development is a basic instinct of human nature. It cannot be achieved suddenly. It is a continuous process. It happens when a member of the society increase his or her quality of life consistent with their own aspiration. The aspiration of a human being is good health care, communication, food, shelter, his community life and economical condition, etc. It means development is a process in which primary focus is given on personal and institutional capacity (Swart, 2006: 105). In this sense, the measurement of development can be seen through the participation of the individual in the planning. Participation is the process, which actively involves individuals, people, groups, communities and organizations in any programme, project and activity. The involvement of local people is beneficial because they know their problems very well. Therefore, the roles of women are important to resolve problems at the local level. The role women are also important in democracy. In Abraham Lincoln's word, "democracy is for the people, of the people and by the people"(Lincoln quoted in Richard & Epstein, 2011: 819).

Role of Women in development is a cost effective method of providing development. Nowadays women's participation has become more popular because of two reasons: firstly, state has been gradually withdrawing from their social responsibility (after globalization) and the second is the process of decentralization.Participation of women at community level leads to be social change and development with the help or involvement of local people in planning, education, health and other indicators of development (Waweru, 2015). Therefore, to improve the health status of the rural community, the Government of India had launched a program on 12th April 2005, named National Rural Health Mission (NRHM). The basic vision of NRHM is to construct the basic infrastructure of development in the health care delivery system. Its vision is also to improve access of rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country. It mainly emphasizes on strengthening the public health system with the focus on primary health care.

Community based monitoring is the key to NRHM to ensure the health services and reach among those people who are living in rural areas, especially the poor, women and children. The role of Panchayati Raj Institutions, Accredited Social Health Activist, Auxiliary Nurse Midwife, and Anganwadi Workers are important in NRHM. ASHAs are called Community Health Workers. Community monitoring is an important aspect of promoting community to take care of their health related

problems, nutrition and sanitation etc. Moreover, decentralised and participatory health care has been continuing since independence but it has made only marginal impact. In addition, NRHM seeks more participatory and more decentralised health care through involvement of PRIs and civil society in health care planning. Involvement of PRIs and civil society seeks community empowerment and they will help health workers. ASHA a community health worker comes from local community and works for health care with the help of AWW, ANM and other members of health department. There is provision of committees under NRHM known as Village Health Sanitation and Nutrition Committee (hereafter, VHNSC), and RogiKalyanSamiti/ Patient Welfare Committee (hereafter, RKS) to fulfil the goal of mission by the help of PRIs and local involvement. ASHA, ANM, AWW and members of PRIs have important role in these committees. Health awareness and monitoring are core work of the stakeholders, committees and stakeholders of the committees (Mission Document, 2005-12).

Formation and Responsibilities of VHNSC

Architectural correction and decentralised health care are the keys to NRHM. Therefore provision of state level, along with planning at district level and *Panchayat* level have recommended by NRHM. VHNSC is a committee to take care of goal of NRHM at *Panchayat level*. The creation of VHNSC; Accredited social health activist (female health activists from local community, NGOs or civil society and PRIs are such as the member of village health and sanitation committees (VHSCs).These people are the means of promoting a true partnership between the local community and peripheral health staff in achieving desired outcomes. They help people in promoting a well-functioning and devolved public health care delivery system. There is the provision of flexible grants to improve health care infrastructure, human resources and capacity through bottom-up institutional framework of governance and accountability. So active participation can take place in shaping the public health system and serve them according to their varied needs (Gill, 2009: 12). ASHA is the major innovations of NRHM to improved hospital care, decentralization of health care from district level to improve intra and inter-sectoral convergence and effective utilization of resources. They go home to home for take care of conceived women. ASHA keep their records and gives valuable suggestion for health care. ASHA comes from local community so she can understand local emotions and local people understand her because they work on a number of 1000 (Kulkarni, Kotwal, Hiremath, Verma, Bhalla, Sigh & 2014).

Selection of Accredited Social Health Activists (ASHA) and Responsibilities

ASHA is a main stakeholder of the NRHM program. She selects form local community and require eighth standard certificate. She gets training to serve maternal women, child and other diseases etc. but did not get fix salary. She gets compensation or incentive in observed Treatments- Short Course (DOTS) for Tuberculosis completion incentive or allowance in Janani Suraksha Yojana etc. She also works for immunization and sanitation.

As per above description it does not mean that ASHA is a foolproof scheme. The selection of ASHA is rigorous and time consuming. She has been given sufficient training to work properly. It takes time, around one year to make her fully trained and in case of selecting another similar functionary when ASHA leaves the system, it is

difficult here new similar functionary. Therefore, it needs special strategies to sustain ASHA scheme. She should be given sufficient facility and resources. Providing sufficient facility and resources to ASHA worker will be good idea to provide health care in decentralized and participatory manner.

Secondly, ASHA has hardly any freedom for her work. She is dependent on Anganwadi Workers (AWW) and Auxiliary Nurse Midwife (ANM) in every work. However, ASHA gets only incentive while AWW and ANM get fixed salary. Therefore, the work responsibility of ASHA and other workers should be clearer but mutually understanding should be there. The specification of work will helpful to health department for providing good health care in decentralized and participatory manner (Lahariya, Khandekar, Prasuna and Meenakshi, 2006: 1-4).

Selection of Auxiliary Nurse-Midwife ANM and Responsibilities

NRHM has managed an additional 2,500 specialists, 10,000 doctors (including *Ayurveda, Yoga, Unani, Siddha* and Homeopathy (AYUSH) doctors) and over 40,000 ANMs and staff nurses (Sinha, 2009: 74). ANM works at sub-centre (a cluster of 5-10 villages) (Ashtekar, 2008: 24). The idea of posting ANM at sub-centres is to address the basic facilities of health care at village level. NRHM seeks 100% institutional delivery. Institutional delivery can be defined as delivery in either government institutions (sub centres, primary health centres, first referral units, and district hospitals) or private clinics. In this sense, it can be said that delivery should be in assistance of a doctor, a nurse, or an ANM (Pardeshi, G. S., Dalvi, S. S., Pergulwar, C. R., Gite, R. N., Wanje, S. D., 2011: 72).

NRHM is committed to communitisation of itself. It has communitiesed itself under the umbrella of Panchayati Raj Institutions (PRIS) and PRIs have right to form a committee to community's health and also those section which affect health called Village Health Sanitation and Nutrition Committees (VHNSC). This committee get annual fund of 10000 under joint accounts of auxiliary nurse-midwife (ANM) and *Sarpanch*(Sinha, 2009: 72).

Provision of NRHM provides special role to ANMs. Every ANM has to support 4-5 ASHA and the AWWs in discharging her duties and they envisaged special work for the mission to facilitate the people. Therefore, they are expected to devote more time to clinical services. They work for achieving the goals of the mission in the universal access to equitable, affordable and quality health care and accountable, and at the same time, responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance (Malik, 2009).

Responsibilities of Panchayat Raj Institutions

The VHSNC functions under *Panchayati Raj Institutions* (PRI). The Chairperson of the VHSNC will be a woman elected member of the *Gram Panchayat(Panch).* It gives preference to the SC/ST communities from that village. If there is no woman *Panch* from that village, then preference should be given to any *Panch* from the SC/ST. *Panchayat Raj Institution* playing facilitating role in VHSNC with the ANM & ASHA (ER brief VHC 4, 2008).

To fulfill the objectives of decentralization, the involvement of Panchayati Raj Institutions is very important. NRHM seeks an institutional arrangement of constituting Village Health and Sanitation Committees (VHSCs) Now Village Health Sanitation and Nutrition Committee (VHNSC) under the leadership of the head of the Gram Panchayat (hereafter GP). GP members in VHSCs work for monitoring and implementation of health services at the village level. They also work to improve the health facility with the slogan "people health in their hands." Their involvement is good for planning and making health care more essential because they know local problems and resources, and they can mobilize local people easily (Planning Commission of India, 2011: 57).

Responsibilities of Anganwadi Workers

The Integrated Child Development Service Scheme (ICDS) is one of the initiatives taken up by the Central Government. It is one of the largest community based programme in the world. It offers a package of supplementary nutrition, immunization, health check-ups, referral services, and nutrition and health education for mothers /pregnant women, nursing mothers and to adolescent girls (*Kishoris*) through *Anganwadi* workers. It was started from Karnataka as a pilot project on 2nd October 1975 at T. Narasipura in Mysore District with just 100 *Anganwadi* Centres. According to the provision of VHSNC, *Anganwadi Workers* have given such powers- they are the part of the VHNSC. VHNSC get annual fund of 10000 under joint accounts of Auxiliary Nurse-Midwife (ANM) and *Sarpanch* but *Anganwadi* Worker can also be the part of that account (Sandhyarani and Rao, 2013).

Responsibilities of Non-governmental Organisations (NGOs/Civil Society)

NRHM seeks involvement of PRIs along with local community, community based organisations and NGOs in health care. Involvement of local community, community based organisations and NGOs seeks effective health care. These civil society organisations have three kinds of roles in line, as members of monitoring committees; secondly as resource groups for capacity building and facilitation; and thirdly as agencies helping to carry out independent information collection.

In their first role, social society organisation keeps regular contact with health communities on health related issues. Involvement of civil society in health care seeks rights-based perspective. Involvement of civil society is important in monitoring and they can give valuable suggestions regarding improving public health system function through their experiences. In their second role, NGOs with experience of capacity building could conduct orientation of committee members about the process of Community based monitoring that includes the roles of members. All three types of members comprising Panchayat representatives, civil society organisations and health system functionaries would benefit from such capacity building. In their third role, NGOs and CBOs could also contribute to the collection of information relevant to the monitoring process from the village to state level. In these processes, an element of community mobilisation may also be involved(Government of India, 2013)

These stakeholders have also measure role in a flagship program under NRHM known as *Janani Suraksha Yojana.*

Janani Suraksha Yojana (JSY) is an ambitious scheme. It has been launched under the NRHM. It seeks safe motherhood and reduces maternal and neo-natal mortality by promoting institutional delivery through the help of ASHA. ASHA encourages mothers to go for institutional delivery. JSY provides cash incentive to mothers who deliver their babies in a government health facility. It provides transport and cash incentive to ASHA for encouraging mothers to go for institutional delivery. ASHA works to mobilize community for the institutional delivery and financial management (Janani Suraksha Yojana guidelines for implementation ministry of health & family welfare government of India, 2011).

However, during the literature review and field study it has been NRHM has been observed that brought marginal impact in health care.

Studies of Husain, 2011 and EPW editorial, 2010 say that NRHM has made only marginal impact due to lack of awareness among stakeholders and corruption. The study say that ASHA, ANM and AWW workers are doing their work but many of them did not have sufficient knowledge about their responsibilities. Furthermore, the study found work awareness high among ASHA. The studies say that involvement of Civil Society and PRI seeks implementation of health care program at ground level so people can get benefit and participate in health care planning. However, members of PRI are not so active in their work responsibility. They also found work awareness high among stakeholders in the areas where civil society is active in health care planning.

However, lack of awareness among stakeholders and corruption is found in Muzaffarpur, a district of Bihar during field study. The study has been done in Phulpur, Khetasarai, Deokhari and RajaGanj block and found similar situation in Saraimeer, Khanjahanpur, Kishanpur, Thekmapurblocks. It found minor difference in Bilarmau and Sirjhanapur.

Health workers enrolled one mother (the same person) in three PHCs for delivery. Furthermore, awareness among ASHAs is found high in field study. However, civil society and members of PRIs are not participating actively in the implementation of health care program at ground level so people can get benefit and participate in health care planning.

During the study, it has been found that there is problem in community participation, because stakeholders felt uncomfortable during answering. Many stakeholders do not know about their responsibilities and goal of NRHM. This was found at every level (PHC, CHC, District level and community level). They said work was going on but they did not answer comfortably. During the study, it was felt stakeholders were comfortable in individual interview. They did not call any meeting when asked. Therefore, data have been collected through in-depth interview with stakeholders. Interview was taken at district level, CHC level, PHC level, CHC level, ASHA, ANM, and AWW. Local people were also interviewed to know about the implementation of the policy of NRHM and its community based work.

Findings

NRHM has brought visible impact in the form of revamping infrastructure, quantitative and qualitative improvement in the healthcare infrastructure and

healthcare delivery from the grass root level (Sub-enter level, PHC level, and CHC level to the District Hospital). The availability of special funds at Sub-centre level, PHC level, VHNSC and CHC level to the District Hospital and its hassle-free utilization by local governing bodies has also helped in bringing changes in the system. *Janani Suraksha Yojana* has made an impact in terms of the institutional delivery. The number of institutional deliveries has been increased across the country. ASHA has played an important role in it. The voluntary worker of ASHAs is a hope for meaningful change. They are working with enthusiasm for Reproductive and Child Health (hereafter RCH) program. RCH program seeks mechanisms and provides Mobile health clinics, transportation of pregnant women, and thrust on family welfare activities.

However, it inefficiency in work was found at every level.

Findings from local people

During the field study it was found that local people have less knowledge about committees and works of committees. They know about ASHA, ANM and AWW. They do not know about the role of PRIs. They participate in some of meetings but do not know the actual reasons of their participation. Some of people said that they participate in meetings whenever ASHA, ANM and AWW call them because ASHA, ANM and AWW are working for them.

Findings from stakeholders of committees and health workers

This was found in local survey. Lack of awareness regarding health care delivery and community-based program has been found among health workers also because of attendance in the meeting is not compulsion of meeting. ASHA, ANM and AWW are doing their work but they are not aware of community participation and their responsibilities regarding VHNSCs. Therefore, there is no fixed day for VHND (a program under VHNSC to resolve the problem of malnutrition) at local level. ASHAs, AWWs, ANMs and PRIs are not aware of this. Thus, individual works of ASHA, ANM and AWW for health care is meritorious.

During the study, it was found that village health committee was not working properly. There was no any working committee at any level due to the absence of regular training program and lack of awareness of PRI members. Moreover, it was found that AWW and ASHA were working well. AWW works for malnutrition, sanitation, immunization and mother and neonatal care. She organizes an open meeting on the third Friday of every month. This date can change according to the need. Their effort has made positive change in bringing down the malnutrition. ASHA helps AWW and working for hundred percent institutional deliveries. ANMs also support them.

However, local people face many problems due to lack of support from PRIs and community. They do not get resources in time. They get less support from health department except ANM. Therefore, they demand immunization centre at every AWC, reduction of register maintaining or paperwork because it takes time. They also demanded of proper training and public support from mothers to maintain the sanitation programme due to less support from people, health department and PRIs, and lack of proper training, stakeholders of committees and local people are facing

many problems. They are not aware about many of programmes. For example, they do not know about village committee, PHC, CHC and district health society and their works. They do not know about VHND and how to organize the public meeting. Moreover, some differences have been found during the study at Saraimeerand Bilarmaublocks.

During the study at Khanjahanpurblock, it was found that health workers get support from civil society (MuzaffarpaurVikasMandal). This society helps them in sanitation work and awareness program but this society does not have adequate information about role of civil society in NRHM program.

During the study at Sirjahanpuri block, it was found that stakeholders of health committee were doing some additional work. They get support from AYUSH department. AYUSH department helps them organizing camp to take care of child who comes to AWC. They run *RashtriyeBalSwasthykaryakram* (hereafter RBS). RBS stand for 4 D weight, height, nutrition, health. ASHA involves in it.

However, health workers (ASHA, ANM and AWW) of Khanjahanpur and Phulpur block demand support and active participation from local people, PRIs, support from health department. They also demand, resources, immunization centre at every AWC, reduce resister because it takes time, proper training and public support basically from mothers to maintain the sanitation program.

In addition, it was found that Sub-Centre, PHC, CHC and district health society help stakeholders but did not organize monthly meeting of committee. They keep monitoring the stakeholders. PRI helps them in monitoring. PRI also monitor PHC, CHC, works of ASHA, ANM, and AWW but during the study corruption case was found in the work of ASHAs. ASHA works for hundred percent institutional deliveries. However, it was found that one pregnant woman appears in three PHCs for delivery and same situation in immunization.

Finding at Sub-centre level

The Sub-Centre is the first contact point between the primary health services and the community. Auxiliary Nurse Midwife (ANM) and one Male Health Worker are basic requirements for every Sub-Centre. They have all management responsibility of centre. One Lady Health Worker (LHV) is endowed with the assignment of supervision of six Sub-Centres. Sub-Centres works for interpersonal communication in order to bring about behavioural change in community and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centres are given basic medications to minor illnesses required for dealing with key wellbeing needs of men, women and youngsters. The Ministry of Health and Family Welfare is giving 100% Central help to all the Sub-Centres(Rural health care system in India, n.d.).

Finding at PHC level

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health

care. PHC is manned with a Medical Officer supported by 14 paramedical and other staff. There is provision of PHC committee for health care and awareness programme by the help of active participation of local people, PRIs, ANM, ASHA and AWW .

However, during the study of PHC committee at Mushahari Block, it has been found that 'Care India' (an NGO) helps them in their works / health care delivery. ANM and ASHA have got training called *Anamat(*training of ANM and ASHA for child-mother care andmeeting). It has also been found that health workers and other health related departments meet on the last Saturday of every month (it can change according to need). ANM, *VikasMitra*, ASHA, AWW, PRI are involved in this meeting. However, involvement of ANM, *VikasMitra*, ASHA, AWW, and PRI is not compulsory. It has made impact on health care delivery and people's behaviour have changed. However, the goal of hundred percent institutional deliveries has not been achieved until now. Moreover, problems of sanitation, malnutrition and awareness among people for health care etc. Have not been achieved until now due to the absence of proper participation of health workers and other health related departments and local people.

Conclusion

The present study shows that the notion of community participation in development planning has been evolving since the early post-independence days. It has become more popular in post globalization period. It involves local people/community in the projects to solve their own problems. Community participation in development planning increase programme acceptance, ownership, ensures that programmes meet local needs, may reduce costs using local resources and it can help to make programme more efficient, and reach to common people.

During the study it was found that community based programme under NRHM has brought many changes. It has increased institutional delivery, reduced malnutrition and reduced mortality rate. It has changed people's mentality when ASHA workers started work for health care they did not get respect and people ignored their advices but now they get respect from society. Mothers have become more aware.

However, NRHM has made only marginal impact in several states and mission has still a long way to go. It requires more innovations to meet the challenges because during the field study it has been found that NRHM is still facing many problems.

References

Ashtekar Shyam. (2008). The National Rural Health mission: A Stocktaking. *Economic and political weekly,* 43(37), 23-26.

Borkar, G. (1957). *Health in independent India: a decade of progress*. India: Ministry of health Government of India.

Chauhan M. (n.d). *Gandhian views on health.*Dept. of Sociology, MNW College.

Husain, Zakir. (2011). Health of national rural health mission.*Economic and political weekly,* 46(4), 5360.

Janani Suraksha Yojana guidelines for implementation ministry of health & family welfare government of India. (2011). Retrieved from:

http://www.ilo.org/dyn/travail/docs/683/JananiSurakshaYojanaGuidelines/MinistryofHealthandFamilyWelfare.pdf: Accessed on 27.08.2015.

Kulkarni, A., Kotwal, A., Hiremath, Ravishekar N., Verma, A K., Bhalla, S., Sigh, H. (2014). Role of government in public health issues.*Journal of scientific and innovative research*, 3 (2), 244-250.

Lahariya, C., Khandekar, H., Prasuna, J., Meenakshi. (2006). A critical review of National Rural Health Mission in India.*The Internet Journal of Health*, 6(1), 1-4.

Malik, G. (2009). Role of Auxiliary Nurse Midwives in National Rural Health Mission. The nursing journal of India, 3, Retrieved from: http://www.tnaionline.org/april-09/8.htm: Accessed on 03/12/2015:11am.

Planning Commission Government of India. (2011). Retrieved from: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf. Accessed on: 20.12.2016.

Prasad, A. (2011). Analyzing strategies for community participation in National Rural Health Mission: A documentation of action research in four states.*A Project Report Submitted to the Indian Council of Social Science Research, 13-49.*

Qadeer, I. (2011). The challenge of building rural health services. *The Indian journal of medical research, 134*(5), 591-593.

Rural health care system in India. Retrieved from: http://www.nrhmassam.in/pdf/guideline2/bulletin/Rural%20Health%20Care%20System%20in%20India.pdf: Accessed on 20.4.2016.

Sandhyarani, M. C., & Rao, C. U. (2013).Role and responsibilities of Anganwadi Workers, with special reference to Mysore district. *International Journal of Science, Environment and Technology*, *2*(6), 1277-1296.

Sinha, A. (2009). In defiance of the national rural health mission.*Economic and political weekly*, 45(14), 72-75.