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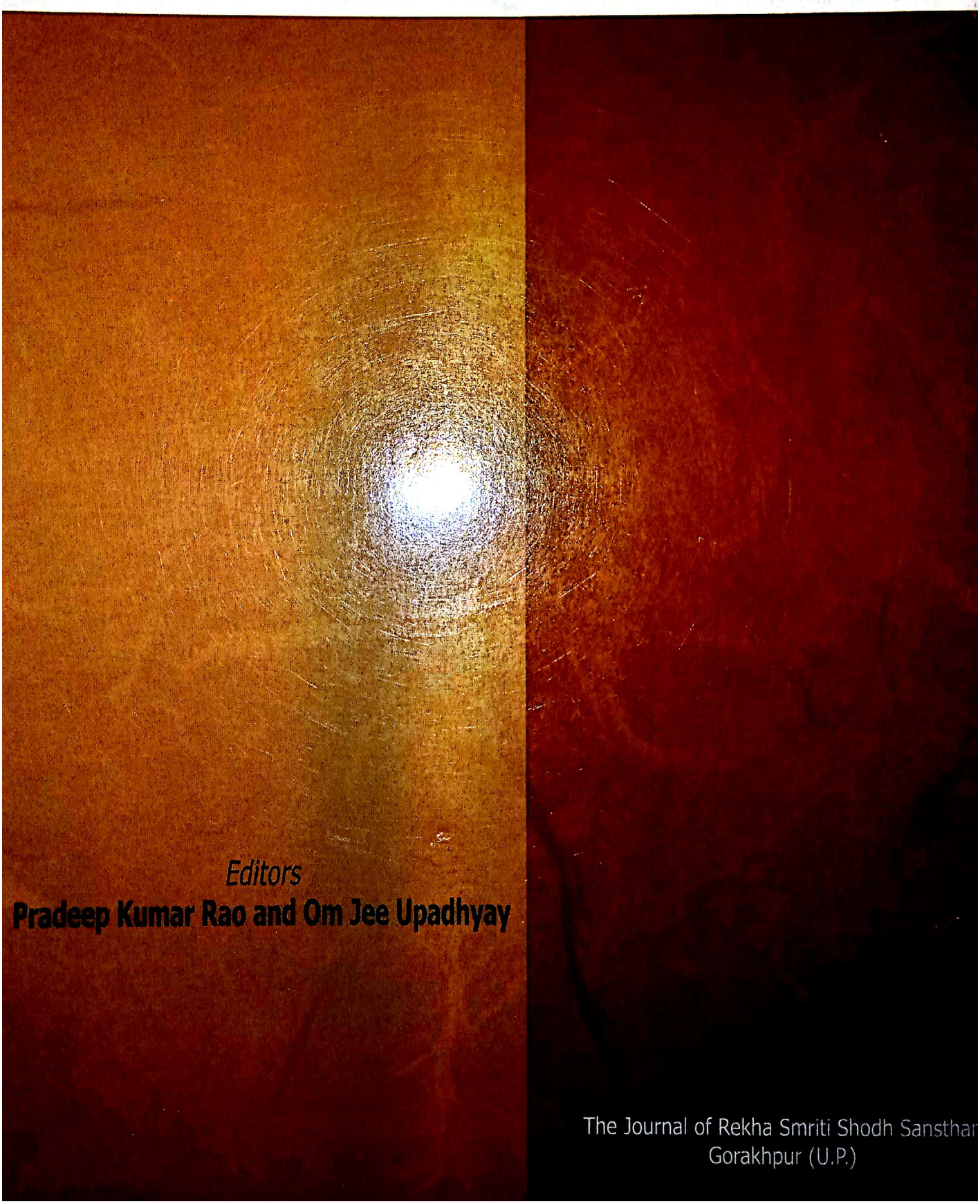

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Role of Panchayati Raj on Health in PESA States

Bijendr Pradhan* & Kiran Dungdung **

The poor health status of PESA states is reflective on their poor environmental circumstances and lack awareness among tribal people, the main reasons behind its the backwardness and detrimental of the states are; poverty, in accessible of trained health professional and believing on traditional healer among the tribal community is possess the poor health-strata than the other general caste people as on National average. The study is based on the existing secondary data, to analyses the role of panchayati raj on health in these scheduled area, whether the tribal people are markedly benefiting from health care programme, which the government is running in scheduled area. The scheduled tribe is the most deprived and vulnerable specially women and children, so government has took initiative to enhancing the health care system among the tribal communities through devolution of power, participatory democracy and local self-governance system. This paper deals with how health care practices are practiced among the tribal communities in PESA states through the PESA Act.

Since couple of decades, tribal communities have spearheaded the most remarkable struggle for social justice in the country. Predominantly living with India's forest and remote areas, the tribal people faced a steady assault on livelihood, education, Health. On the whole, as per the rough estimates, the prominent tribal areas constitute about 15% of the total geographical area of the country. Scheduled tribes, Schedule castes and *denotified tribes* constitute as a weaker section group on the basis of ecological, economical, education and health angles. The 73rd Amendment of the Indian Constitution in 1992 created an illusion that the Panchayati Raj Institution (PRIs) would be empowered. It inserted part IXth in the Indian Constitution. The Article-243 'G' this part made the provision that states may devolve the powers and authority on these bodies to make them institutions of self-government and to conscientize the poor community.

The 73rd and 74th Constitutional amendments of 1993 followed by this extension to scheduled areas, through the Panchayats (Extension to scheduled Area) PESA Act, 1996, are the Land mark achievements in the process of

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decentralization of powers and authority to Panchayats and Gram Sabah (The Constitution 73rd amendment Act, 1992). However, in these state for the devolution of powers and functions to the panchayats have been given in respect of ownership of sixty-seven forest products, recommendation for grant/renewal of license for manufacture and sale of liquor, preservation of custom and tradition of the people, empowerment of gramsabha to grant certificate of utilization, preparing local plans and to exercise control over the resources of such plans, recommendations of the Zila Parishad before grant of license for minor minerals and consultation with parishad before acquisition of lands for development projects. And this is divided into three-tier Panchayati Raj system means form *Bottom* to *Top* approach system. The areas of the Fifth Schedule, according to the Article-244, cover the Scheduled and Tribal areas other than the areas of the Sixth Schedule like in Assam, Meghalaya, Tripura, Nagaland and Mizoram. The areas of the Fifth Schedule are spread over nine states viz. Andhra Pradesh, Jharkhand, Gujarat, Himachal Pradesh, Maharashtra, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan. The PESA Act, 1996 is regarded as a corrective legal measure to the 73rd amendment in form of extension, of the provisions for the Panchayati Raj to the Scheduled and Tribal areas falling under the Fifth Schedule (The provision of the Panchayat; 'Extension to the Scheduled Areas' Act, 1996 No.40 of 1996, 24th Dec. 1996).

In India, attempts at strengthening local democracy have invariably invoked the traditional self-governing institutions of the village, which have often been romanticised and valorized by a wide variety of observers, from Henry Maine to Mahatma Gandhi. Historically, however, despite their consensual appearance, these institutions were not really democratic as they were concealed forms of social prejudice, oppression and exploitation that were firmly rooted in local power structures. It was in recognition of these that B.R. Ambedkar argued strenuously in the Constituent Assembly against incorporating them into the Document. This is why the impulse for local self-government, embodied in Article-40, was placed in the non-justiciable Directive Principles of State Policy (DPSP). After Independence, the idea of the revival of panchayats was first mooted in the Balwantrai Mehta Committee Report (1957), which saw democratic decentralization as a way of making good the failures of the community development programme. Two decades later, the Ashok Mehta Committee Report on Panchayati Raj Institutions made far-reaching recommendations for the revival of panchayats, which inspired at least a few states – notably, Karnataka, Kerala and West Bengal - to restructure their institutions of local government. At the national level, the initiative to give Constitutional status to Panchayati Raj was attempted by the Rajiv Gandhi government in 1989. Eventually, in 1993, Panchayati Raj was incorporated into the Constitution by the 73rd (for panchayats at the village, block and district levels) and 74th (for municipalities) Constitutional

Amendment Acts.

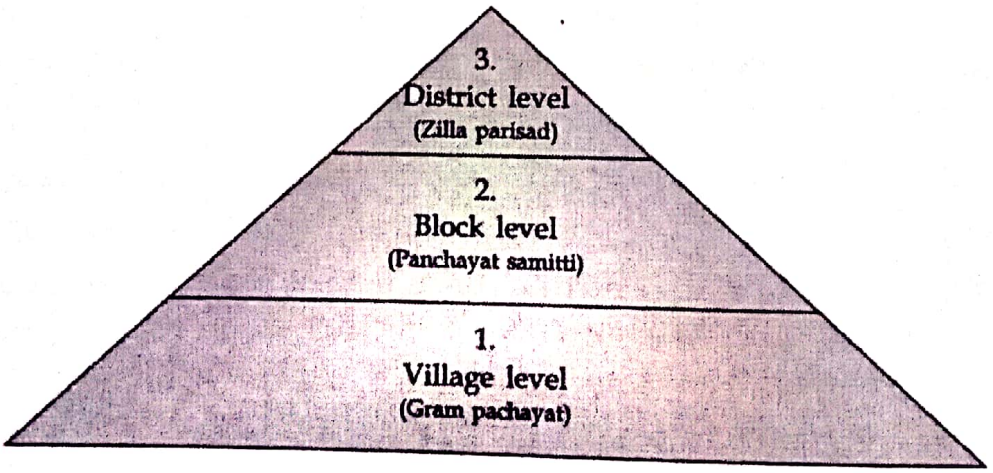
FUNCTION OF PESA (PANCHAYATI RAJ IN EXTENSION TO SCHEDULED AREA) ACT, 1996 IN SCHEDULED AREA :

When we speaks about equal distribution among the *Fresh* and *Raw* in between of poor people, it is must necessary to see their human rights. The PESA act is innovative because it legally recognizes the capacity of tribal communities to strengthen their own systems of self governance or create new legal spaces and institutions that can not only reverse centuries of external cultural and political onslaught but can also create the opportunities to control their own destiny. It also stated that, concept of equity, social justice, community participation and integrated development, embodied within the primary health care concept. Through community-based, people-oriented programmes targeted to the poor, the panchayats were able to demonstrate the feasibility and effectiveness of alternative health care models that were successful in reaching the unreached and serving the unserved. The Gram Sabha of the village becomes the focal institution, endowed with significant powers. For instance, under section 4(d) of PESA; "Every gram sabha shall be competent to safeguard and preserve the traditions and customs of the schedule tribe people, their cultural identity, community resources and the customary mode of dispute resolution (Sujata Ratho, 2007). Also, the *Jal (water), Jungle (forest)* and *Zameen (land)* are the assets of the tribal people because they are totally depended on it. However, the state government has to take appropriate measures to transfer the powers of local Panchayat bodies as per the guideline of the Constitutional amendment to enable the Tribals to have managed theirs own affairs at their level first. But there has been no National Policy, which could have helped translate the constitutional provisions into a reality. There are five principles spelt out in 1952, known as *Nehruvian Panchasheel*, have been guiding the administration of tribal affairs. These are; Tribal people should be allowed to develop according to their own genius, their rights in land and forest should be respected, the teams should be trained to undertake administration and development without too many outsiders being inducted, the development should be undertaken without disturbing tribals social and cultural institutions, the index of tribal development should be the quality of their life and not the money spent.

Realising that the *Nehruvian Panchasheel* was long on generalities and short on specifics, the Government of India formed a Ministry of Tribal Affairs for the first time in October 1999, to accelerate tribal development. The Ministry of Tribal Affairs is now coming out with the draft National Policy on Tribals. The National Policy recognizes that a majority of Scheduled Tribes continue to live below the poverty line, have poor literacy rates, suffer from malnutrition and

disease and are vulnerable to displacement. It also acknowledges that Scheduled Tribes in general are repositories of indigenous knowledge and wisdom in certain aspects. The National Policy aims at addressing each of these problems in a concrete way (Sachchidananda, 1972). It also list-out measures to be taken, to preserve and promote tribal's cultural heritage, ethics, values, norms.

In the first Gram Sabha, in which CARE organization has participated on (October 2002), the team members and staff of partner organizations were considered as more outsiders. By the time, the next Gramsabha come in January 2003 the villagers were discussing issues of health and nutrition. In August-2003 it was seen that nutrition and health issues was an important agenda of the gramsabha and decisions on certain issues taken at the panchayat level and in that gramsabha meeting those who are marginalized section (STs/ SCs) woman, children, physical challenged, Senior citizen to participate more actively, and this is one of the weapon for them to discuss on various social issues (Kar, K. Basanta, 2004-05).



The fundamental spirit of the Panchayat Extension Act for tribal areas under 5th schedule is that it devolves power and authority to Gram Sabha and Panchayats rather than delegation; hence it paves way for participatory democracy. The PESA act is not only think-upon the developments of political empowerment of tribal people but also think-upon a holistic development of these scheduled areas like health, women empowerment, protection against violence (forest, water, land) and education etc.

IMPLICATION OF PESA ACT ON HEALTH CARE IN SCHEDULED STATES :

Discussion on health prospective :

The study emphasizing on, the provision of primary reproductive health services are under the administrative jurisdiction of the local government at the district and sub district levels and the health department exist at each of these levels. In the district panchayat there is a health standing committee, which perform functions related to health services, maintenance of the hospitals, and implementation of family welfare programme. There are various hierarchy is found on health programme from CEO to officer level. (Nijamu Musumbi and Cornwall, 2004) author has focused on the political normative and ethical, It means assisting marginalized people to assert their rights to existing resources. The Human development provides a framework for this formulation. The UNDP (HRD, 1998) includes under the rights-participation, food health, habitant, economy security, education, work rights of children, rights of minorities and indigenous people, right to land, right to equality and right to environmental protection.

When we speaks the role of panchayats in scheduled area, this PRI has playing a crucial role for the upliftment of downtrodden people, to empower them, specially on women health, child nutrition and socio-economic development, because STs/SCs and OBCs are most highly vulnerable in society (Pattnaik, B.K.,2004-05). The 10th five year plan document also reiterated the importance of achieving population stabilization by involving of panchayats and community participation is most essential in planning and monitoring of this programme. The structured family welfare programme must be replaced by decentralized democratic planning through panchayats (M.S. Swaminathan, 2007).

Under the existing National health policy (NHP) of the country, adopted in 1983, the main focus has been the formulation of an integrated and comprehensive approach towards future development of health services. The Eighth Five Year Plan (1992-97), (World Health Organization, 2004) identified human development as its main focus, with health and population control as the top priority objectives. It was emphasized that health facilities must reach the entire population by the end of the Eighth Plan. During this plan, emphasizing on peoples' initiative and participation as a key element. The vertically structured family welfare program needed to be replaced by a more democratic decentralized alternative. In 1996, the government adopted a multidimensional approach towards population stabilization, with a goal of achieving a replacement level of fertility or a total fertility rate (TFR) of 2.1 by the year 2010, but with no targets for specific contraceptive methods use (World Health Organization, 2004).

Research revealed that, among the poor, expenditure incurred to meet the medical needs is the second most important cause of rural indebtedness (D. Banerji, 2003). An Independent Commission on Health in India, which submitted its report to the former Prime Minister (Vajpayee), he pointed out that the health services are in an advanced stage of decay is still poor. Documents from the Planning Commission paint an equally dismal picture (Tenth Five Year Plan, 2004). In 1982 when the Government reformulated National Health Policy and officially adopted the WHO declaration of "Health for All by 2000", it made many significant changes at the policy level (Chatterjee, 1993). It brought forth the role of community and social sciences in promoting public health care. The new policy ignored the earlier health policies objectives of providing primary health care for all, especially to the underprivileged (Quadeer Imran, 2001).

The National Rural Health Mission (NRHM-2005) launched by the Union Government in 2004 aimed to rectify the gross neglect of the health care needs of the rural/poor masses. In addition, ASHA is expected to implement national health program with the support of local panchayats. The Direct democracy has been crux of the India system. Because panchayati raj has been one such rung in this system of democracy based on Mahatma Gandhi's Gram swaraj- means the power should lie by own, with people and they should be capable of self-governing and self-sustaining within their community.

Health Issues and challenges for tribals :

Although tribal people live usually close to nature, a majority of them need health care on account of malnutrition; lack of safe drinking water, poor hygiene and environmental sanitation and above all poverty, lack of awareness and apathy to utilize the available health services also affects their health status. In wake of the opening of tribal areas with high industrialization, and communication facilities, diseases have spread to tribal areas. However, lack of safe drinking water and malnutrition are well-recognized as a major health hazards. Tribals suffer from a deficiency of calcium, vitamin A, vitamin C, riboflavin and animal protein in their diets. Malnutrition and under nutrition are common among Primitive Tribal Groups who largely depend upon food they either gather or raise by using simple methods. The poor nutritional status of tribal women directly influences their reproductive performance and their infants' survival, growth and development (Jennifer Kleinman, 2007). Tribal people, who are self-reliant and self-sufficient, have over the centuries, developed their own medicine system based on herbs and other items collected from the nature and processed locally. They have also their own system of diagnosis and cure of diseases. They believe in taboos, spiritual powers and faith healing. There are wide variations among tribals in their health status and willingness to access and

utilize health services, depending on their culture, level of contact with other cultures and degree of adaptability, so due to that they are still remaining backward and weaker section in a global prospective. Against this background, the National Policy seeks to promote the modern health care system and also a synthesis of the Indian systems of medicine like *Ayurveda* and *Siddha* with the tribal system. So due to this all reasons the health status of these poor states are still lacking behind from other states. So these all cause are motivating to Government for implication of health provision in scheduled area through the panchayats. Like;

- Strengthen the allopathy system of medicine in tribal areas with the extension of the three-tier system of village health workers, auxiliary nurse midwife and primary health centre.
- Expand the number of hospitals in tune with tribal population.
- Validate identified tribal remedies (folk claims) used in different tribal areas.
- Encourage, document and patent tribals' traditional medicines.
- Promote cultivation of medicinal plants related value addition strategies through imparting training to youth.
- Encourage qualified doctors from tribal communities to serve tribal areas.
- Promote the formation of a strong force of tribal village health guides through regular training-cum-orientation courses.
- Formulate area-specific strategies to improve access to and utilization of health services.
- Strengthen research into diseases affecting tribals and initiate action program.
- Eradicate endemic diseases on a war footing.

COMPARATIVE STUDY ON HEALTH STATUS OF SCHEDULED TRIBES AMONG PESA STATES :

The health outcomes among the scheduled tribes are very poor, even as and compared to the scheduled castes and other general society. Among the scheduled tribes or *Adivasis* of India, mortality, morbidity and malnutrition rates remain particularly high when compared to the Indian population at large. Remoteness of villagers, uncooperative attitudes among medical personnel, limited manpower and a lack of awareness within tribal communities- all pose difficulties in achieving adequate health care delivery system.

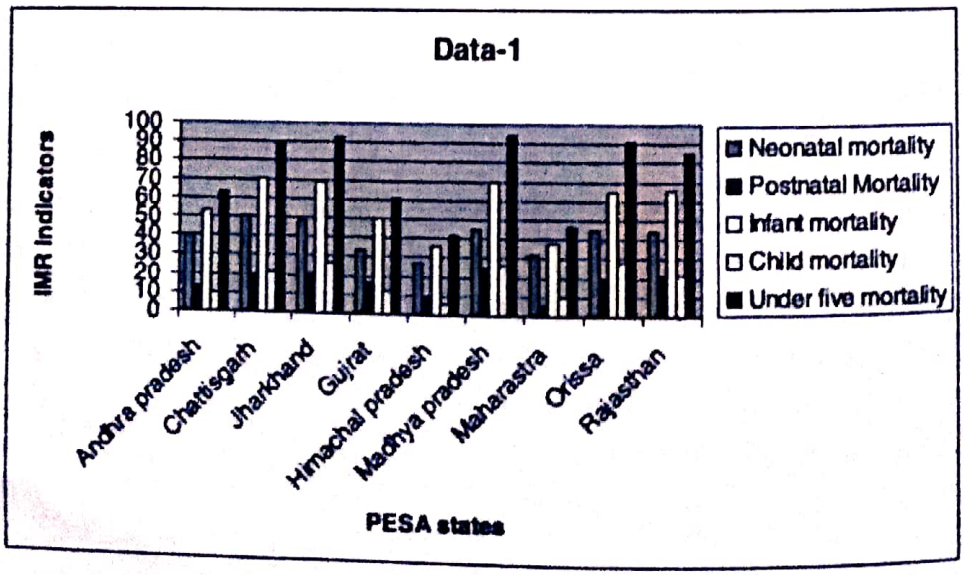
A. Early childhood mortality rates in PESA states :

The PESA state is representing the data of scheduled tribe children those who are coming under 0-5 years old. The neonatal, post neonatal, infant mortality and child under-five mortality rates for the five-year period preceding the survey by NFHS-3 is very poor and found a critical situation among the schedule tribe.

Table 1: Child mortality rates among Scheduled Tribes in PESA state:

Name of the state	Neonatal Mortality (NN)	Postnatal Mortality (PNN)	Infant Mortality (1qo)	Child Mortality (4q1)	Under-five Mortality (5q0)
Andhra Pradesh	40.3	13.2	53.5	10.2	63.2
Chattishgarh	51.1	19.7	70.8	21.0	90.3
Jharkhand	48.6	20.2	68.7	26.1	93.0
Gujarat	33.5	16.2	49.7	11.9	60.9
Himachal Pradesh	27.3	8.9	36.1	5.6	41.5
Madhya Pradesh	44.9	24.7	69.5	26.5	94.2
Maharastra	31.8	5.7	37.5	9.5	46.7
Orissa	45.4	19.36	64.7	27.6	90.6
Rajasthan	43.9	21.4	65.3	21.3	85.4

Source: NFHS-3, Volume-1, 2005-06



This data represented in these scheduled area, how the inter-variation and inter-correlationship are found as an causes and effect relationship in the health status of children. Because the Infant mortality, Neonatal mortality, Postnatal mortality, Child mortality and under five mortality rate are very high among the scheduled area, due to lack of infrastructure, lack of communication, illiteracy of mother, untrained handling of delivery cases and unsafe drinking water (Basu and Kshatriya 1992). It is found that, the highest Neonatal Natal mortality found in Chattisgarh (51.1) and lowest one is Himachal Pradesh (27.3) according to NFHS-3. The same condition prevails in Chattisgarh, Jharkhand, Orissa and Rajasthan as they could not have access a good health due to poor literacy among the tribal, poor economic condition, poor communication and transportation facilities.

While child mortality has declined, significant regional and inter-state differentials persist. Among these states, it is observed that, the highest postnatal mortality (PNM) ratio is in Madhya Pradesh (24.7) and lowest is in Maharashtra (5.7). When we compare the under-mortality rate among the scheduled area then highest ratio is in Madhya Pradesh (94.2) and lowest is in Himachal Pradesh (41.3). Besides these all in a specific way, when we see the comparison among these states in child mortality ratio, then it is seems that, highest is in Orissa (27.6) and the lowest one is in Himachal Pradesh (5.6) according to NFHS-3. That means, the main reasons behind the problem is the backwardness of the state, poverty, in accessible of trained health professional and believing on traditional healer among the tribal community is possess the poor health-strata than the other general caste people as on National average.

B. Maternal Health Care among the scheduled tribe :

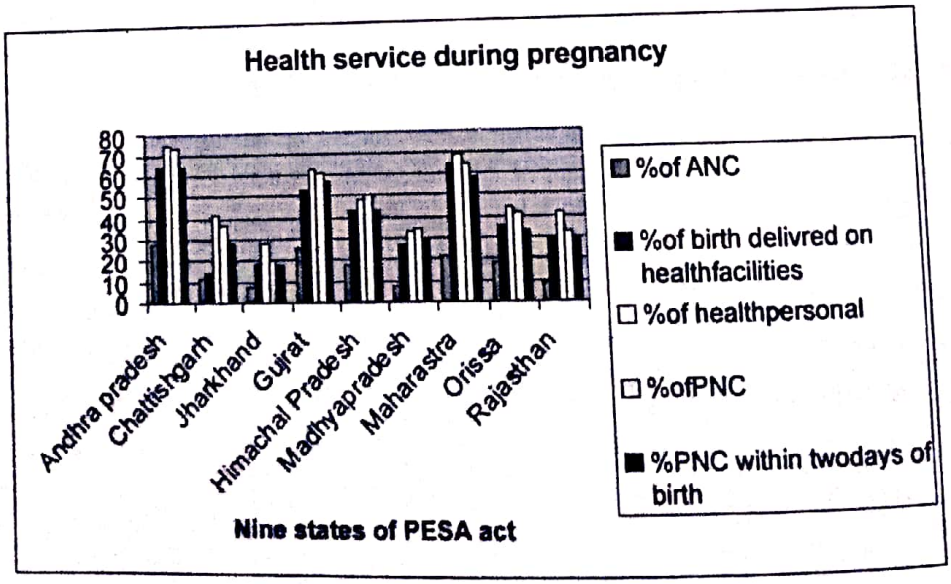
Maternal and child health has remained an integral part of the family welfare program of India, since the time of the first and second five-year plans (1951-56 and 1956-61) when the Government of India took steps to strengthen maternal and child health services. As part of the minimum needs program initiated during the fifth five-year plan (1974-79), maternal health, child health and nutrition services were integrated with the family planning service.

Table 2: Health care services during pregnancy:

Name of the state	Percentage who received all recommended types of antenatal care	Percentage of births delivered in a health facilities	Percentage of deliveries assisted by health personnel	Percentage of deliveries with a postnatal check-up	Percentage of deliveries with a post-natal check-up within two days of birth
A. P.	28.2	64.4	74.9	73.3	64.1
Chattishgarh	11.3	14.3	41.6	36.5	28.4
Jharkhand	7.5	18.3	27.8	19.6	17.0
Gujarat	25.6	52.7	63.0	61.4	56.5
H. P.	17.4	43.0	47.8	50.6	43.2
M. P.	7.2	26.2	32.7	33.8	28.5
Maharastra	21.6	64.6	68.7	64.0	58.7
Orissa	18.4	35.6	44.0	40.9	33.3
Rajasthan	8.6	29.6	41.0	31.8	28.9

Sources: NFHS-3, Vol-1, 2005-06

(II) DLHS-2



This table clearly shows that, still today the poor tribal communities have failed to achieve the minimum standards of health care facilities among women and children. Because, inaccessibility of modern health facilities, poor economic status, traditional health care practices and ignorance of diseases. In terms of Antenatal care facilities Andhra Pradesh (28.2%) is much better than Jharkhand

(7.5%), Madhya Pradesh (7.2%) and Rajasthan (8.6%). As it is observed that, the Post-natal check-up Andhra Pradesh (73.3%) is much better of when compared to Rajasthan (31.8%) and Madhya Pradesh (33.8%). In a same condition the Andhra Pradesh and Maharastra is having a good birth delivery health facilities (64.6) than the Chattishgarh (14.3%) and Jharkhand (18.3%). The Maternal mortality ratio in India is estimated at 301 per 100,000 live births, which puts the risk of a woman dying each time she becomes pregnant at 1 in 330. This in turn means that if a woman gets pregnant three times in her life, the chance of her dying is 1 in 110 (Radkar and Parasuraman, 2007). Not surprisingly, higher rates of maternal mortality are more in rural and backward caste women especially on scheduled tribe than of urban and forward caste women. This is also a pointing towards the poor accessing on health care in general and maternity facilities in particular, in the rural scheduled area is high in India. Again the data stating that, the women are most venerable than the men because they are doing hard works (like: collection of minor forest products, involve on NREGS works) during the pregnancy time, and they don't know how to deal the situation so they their life is found critical (Basu, 2004).

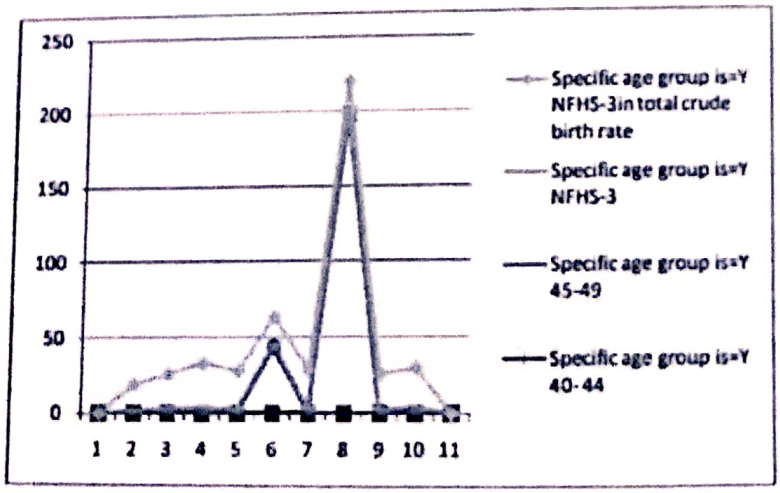
D. Total Fertility pattern among scheduled tribe:

The results of National Family health Survey (NFHS.2) India, Rajasthan indicates the issues of fertility pattern of tribes. A tribal woman produced (4.31) children during her reproductive life but they want only (2.7) children. Tribals' considered on average (2.9) children as ideal in their family. The tribal maintain sufficient space between births of two children. Median month's interval since previous birth was (29.5) months. It shows that tribals' are aware about adverse implications of rapid growth of population. Preference for son is strongly reported among tribes, 97 percent of tribes want at last one son.

Table 3: General Fertility pattern among woman and man

Age-specific and total fertility rates (TFR) and crude birth rates for NFHS-3 and TFRs for the one year period preceding the survey, according to residence and state, India 2005-06.

Name of the state	15-19 year	20-24 year	25-29 year	30-34 year	35-39 year	40-44 year	45-49 year	NFHS-3 (TFR)	NFHS-3 crude birth rate
A. P.	0.098	0.168	0.058	0.021	0.009	0.003	0.000	1.82	16.8
Chattishgarh	0.092	0.197	0.137	0.059	0.025	0.010	0.004	2.62	22.7
Jharkhand	0.122	0.222	0.165	0.084	0.040	0.012	0.017	3.69	28.8
Gujarat	0.084	0.242	0.157	0.059	0.015	0.003	0.000	2.80	24.3
H. P.	0.072	0.186	0.124	0043	0.008	0.001	0.000	1.94	18.3
M. P.	0.096	0.248	0.154	0.074	0.035	0.008	0.009	3.12	24.9
Maharastra	0.084	0198	0.100	0.032	0.006	0.001	0.001	2.31	19.3
Orissa	0.073	0.190	0.129	0.057	0.017	0.006	0.002	2.48	23.0
Rajasthan	0.098	0.245	0.171	0.085	0.026	0.012	0.004	3.21	25.7



Source: NFHS-3, Volume-1, 2005-06

This graph is shows, the Total Fertility Ratio (TFR) in these PESA states, the lowest TFR is Andhra Pradesh (1.82) and Highest TFR is having Jharkhand (3.69) and the other state are in medium. The reason behind the highest TFR is due to ignorance and did not using modern means of technology and medicine, unaware about use of contraceptive means and mostly it is found due to communication problem for which they could not able to avail the medicine. So these are the reason behind to found high TFR. A rich amount of data on issues ranging from fertility and age of marriage to spousal violence and health care has very recently become available, following a 9-state survey conducted in 2005-06. The National Family Health Survey (NFHS-3) shows a reassuring decline

in the rates of fertility, birth and infant mortality. However, anemia, wasting and malnutrition continue to be on the rise among both children and adult women. Between the last such survey (NFHS-2), conducted in 1998-99 and the present one, anemia in married women has gone up from 52 to 56 percent, and in pregnant women, from 50 to 58 percent. Anemia among men, by contrast, is 24 percent (IIPS, 2007:310).

E. Various types of Diseases among scheduled tribe:

Number of women and men age 15-49 per 100,000 who reported that they have diabetes, asthma or goiter or any other thyroid disorders by state, India, NFHS- 2005-06

Table 4 : Types of diseases in general;

(a) Number of women per 100,000 (b) Number of men per 100,000

Name of the state	Diabetes	Asthma	Goiter or other thyroid disorder	Diabetes	Asthma	Goiter or other thyroid disorder
A. P.	838	2151	1155	2116	2189	829
Chattishgarh	659	746	563	932	858	358
Jharkhand	652	1291	858	629	407	74
Gujarat	968	1530	484	524	1844	72
H. P.	1048	384	648	344	527	304
M. P.	558	1283	599	555	1102	424
Maharastra	479	1714	590	906	1855	201
Orissa	556	2533	362	1179	1592	122
Rajasthan	282	1565	376	362	1739	246
India	881	1696	949	1051	1627	383

Sources: NFHS-3, 2005-2006.

The table markedly emphasizing upon the women health condition, because women are involving both formal and informal house work activities more than men and in a result they are facing a lots of problem as physically and mental depression. When we analyses the status of women health regarding on Diabetes, Asthma and Goiter or other thyroid disorder in compared to men than, the

women are highly vulnerable group.

FINDINGS AND SUGGESTION :

Women and children are the vital infrastructure and investing in women capabilities is the surest way to achieve overall development of the nation. Through involvement of PRI in a PESA state should be adopting for the following measures, which are drawn from the present study, could enhance especially the capabilities of tribal women.

- To expanding the access to primary and secondary education to Tribal adult girl children could help in delaying at marriage, child bearing, better dietary practices and utilization of health care services.
- The personal hygiene and environmental education could be extended to the scheduled areas and particularly the value of different local foods available with their nutritional could be taught to tribal women for preparing inexpensive balanced diets out of the food sources available in their villages.
- To empower the women, men, youths and school going children to take participation on panchayati raj and to discuss their existing problems, social issues and challenges and its outcomes before all, through the devolution of power and a participatory democracy.

CONCLUSION :

Obviously, the PRI's has playing a crucial role for the empowerment of poor and backward masses but still the ST's people are could not access it due to their pro-poorness. They have to rights how to incorporate the things but these people are still remaining far-away from Government provisions. The findings come into concluding that, the health status of schedule tribe is still remaining poor because they believe on traditional health care practices than the other caste people and they are still-today giving more preference on Ayurvedic medicine and could not prefer the institutional/modern health care practices. So due to this reason the health status of scheduled tribe people is found so poor and condition is worst. The ultimately this article has stating that how to bring-out within one umbrella through PRI and integrating upon the various programmes and facilities which are in the hands of PRI's, with a democratic and participatory approach for the holistic development of scheduled area.

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