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Identifying The Challenges in Implementation of Health Policies at Primary Health Centre Level

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Abstract

Health is very important part of decision making parameter in the growth and development of any country like India; as is evident from the following, viz. Health care is a basic right and a basic need for all and it is the duty of the state to assure this right and to meet this need. The promotion of health is also an economic investment. Government has done many efforts to get universal access of health care but many past studies shows that child and maternal health services are substantially unequal in access, affordability and accountability across different states in of India. But little discussed about the challenges faced in effective implementation of health policies to remove inequalities in the major health outcomes of child and maternal health on different parameter. The focus of this study is to identifying achievements, challenges in the implementation of health policies related to maternal and child health on selected parameters at primary health centre level in India based on the secondary data. Challenges related to health inequities and access barriers faced by vulnerable groups such as women, socioeconomically disadvantaged populations, rural dwellers and ethnic minorities and other marginalized groups are very important and need great concern. It also tries to make suggestions to accelerate national and regional health strategies and plans to remove disparities in health services. There are vast regional disparities which is major challenge to remove.

Keywords: Primary Health Care, Disparities, Infant Mortality Rate , Maternal Mortality Rate, Antenatal Care, Post Natal Care, Skilled Birth Attendance, Human Resources.

Introduction

From the very beginning, there has been constant evolution and efforts for improvement and betterment in every sphere of the nature by human beings. With the passage of time certain systems and plans have been devised not only at Government and other concerned authorities at mass level but at the local level also. Among all the schemes and planning, education and health have been the main concern from time to time because the planners have always kept in mind that sound mind lives in a sound body. So not only at world level but individual Nations have been paying special attention towards the health because health and growth are closely related. Health is an important component of human capital which, in turn boosts economic growth. Healthy workers are more robust and energetic physically and mentally. They are more productive and earn more. They are also less likely, due to illness, to be absent from work in developing countries where is largest share of workforce is engaged in manual labour than the developed countries.

Illness and disabilities significantly reduce productivity and income. The quality of labour in the form of human capital makes an important contribution to economic growth. The women comprises almost 50% of the labour force, so it cannot be ignored. Health of the future Nations also depend on the health of women because the future nurtured by women in their lap, they take care of their children to make them healthy person to contribute in the economy. That's why the General Assembly of the United Nations in September 2000 adopted Millennium Development Goals(MDG) and gave a special attention to primary health care to reduce child mortality and improve maternal health under goal 4 and 5 respectively to make the earth better in terms of the quality of life followed by the Sustainable Development Goals (2015) by UNDP targeted to attain MDG

4&5 under SDG3 (Ensure healthy lives and promote well-being for all at all ages) by 2030 There is a conceptual intersection between the primary health care/universal health coverage and the Sustainable Development Goal 3. Agenda for Sustainable Development commits countries to achieving universal health coverage by 2030. The primary health care is a vehicle for universal health coverage.

Primary health care is different from the term "primary care", which is the organization of essential health services at the first level of care. Primary care is one important element of primary health care, but primary health care as an overall approach to health.

Aim of the Study

The aim of this study is to identifying achievements, challenges in the implementation of health policies related to maternal and child health on selected parameters at primary health care level and tries to find the reasons responsible for inter- state disparities among rural and urban areas in India. It also tries to make suggestions to accelerate national and regional health strategies and plans to remove disparities in health services.

Methods

This study used the secondary data, from the National Family Health Survey reports, published by Indian Institute for Population Sciences and District Level health survey (DLHS), various publications of the central government, state governments, research institutions, Ministry of Health and Family Welfare Reports, Registrar General of India, Health Information of India, Reports of Planning Commission, Economic Survey (GOI), World Health Reports, SRS Bulletins, Budgetary Documents of the Union and State Governments, Various Studies by Individual Researchers (Published and Unpublished(Sources), etc. is collected and analyzed. .

Area *&* Variables of The Study

The study is confined to some strategic indicators of Maternal Child Health (MCH) care facilities within the constraint of availability of data for this study: Under-Five Child Mortality Rate(CMR), Infant Mortality Rate, Proportion of one year old children immunised against measles, Maternal Mortality Ratio (MMR), Proportion of births attended by skilled health personnel, Antenatal Care (ANC) coverage (at least one visit), intra natal care(INC), post natal care(PNC) etc.

Various Efforts and Schemes/Policies/ Programmes for Primary Health Care

By recognizing the importance of health in socio-economic development and in improving the quality of life, Ministry of Health and family Welfare, Govt. of India has initiated National Rural Health Mission (NRHM) in 2005 and National Urban Health Mission (NUHM) in 2013 and which is also known as National Health Mission (NHM) to attain MDG. The goal of the programme is to provide accessible, affordable and quality health care to the vulnerable sections of the society. Under NHM a wide array of policies and various schemes has been introduced to improve the maternal and child health care as Janani Shishu Suraksha Karyakram (JSSK) complete elimination of out of pocket expenses to ensure that every pregnant women would reach to government institutional facility, Janani Suraksha Yojna (JSY) schemes for promotion of institutional delivery, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A), Facility Based Newborn Care (FBNC), Reproductive and Child Health (RCH), Essential Newborn Care (ENC), Integrated Child Development Services (ICDS), Navjat Shishu Suraksha Karyakram (NSSK), Essential Obstetric Care, Emergency Obstetric and Newborn Care, Safe Abortion Services ,Indira Gandhi Matritva Sahyog Yojana (IGMSY), National Health Population Policy, National policy on children 2013 , national policy on early childhood care and education, and empowering Frontline health service providers, India newborn Action Plan, home based newborn care scheme, child death review, Rashtriya Bal Swasthya Karyakram, Infant and young feeding nutritional rehabilitation centres, through Janani Suraksha Yojana Janani Shishu Suraksha karyakram, Pradhan Mantri surakshit matritiva Abhiyan, Antenatal intranatal postnatal care ,maternal death review , Pradhan Mantri Matru Vandana Yojana, Pradhan Mantri surakshit matritva Yojana, etc. to achieve desired goals . These policies bridged the infrastructural gaps and helped to create strong health systems which are the prerequisite to achieve the MDGs (Goal4&5) in the Primary health care system.

Achievements

The National Health Mission

It has played a crucial role in reducing inequity in healthcare access. The percentage of utilizing prenatal care among the poorest through public facilities has increased from 19.9 per cent to 24.7 per cent from 2004 to 2018. Similarly, the percentage of accessing institutional delivery among the poorest increased from 18.6 per cent to 23.1 per cent and from 24.7 per cent to 25.4 per cent for post-natal care. The poorest utilising inpatient care and outpatient care has increased from 12.7 per cent to 18.5 per cent and from 15.6 per cent to 18.3 per cent. Therefore in conjunction with Ayushman Bharat, the emphasis on NHM should continue.

Maternal and Child Health Statistics

India has registered significant progress in improving maternal health as well as reducing child mortality rate over the last few decades. India is constantly striving for further improvement and achievement in schemes devised for the welfare of women and child.

Indicator	Year 1990	2015	2016-18	MDG Target by 2015	SDG Target by 2030
Child Mortality rate(CMR) under five deaths per thousand live births	125	43	36	42	25
Infant mortality rate(IMR) deaths per thousand live births in 1990	80	37	32	27	12
Proportion of one year old children immunized against measles	42.2%	81.8%	95%	100%	100%
Maternal mortality rate per one lakh live births	437	122	113	109	70
Proportion of births attended by skilled health personnel	47%	81.4%	81%	100%	100%

Source: NFHS National Family Health Survey - 4 and SRS bulletin 2018, SDG India report

The role of health care, in improving the wealth of a nation and in stimulating economic growth is well established. During the past century and particularly after independence in 1947, several gains have been made in health and health care in India as shown in Table-1. Public Health care programmes richly deserve much of the credit for this.

Health Infrastructure Disparities

Despite overall improvements in health indicators, Inter - state, inter-district and regional disparities continue. As states Nagaland , Madhya Pradesh and Jharkhand etc. continue to lag behind, While states like Kerala, Tamil Nadu, Karnataka and Goa are performing well, particularly at primary health care. recognized gaps need to be understood and addressed. Disparities in Health sector can be determined through proper allocation of available resources and utilization as well as demand for health care needs.

Kerala is the top-performing among States and UTs with SDG index score of 82. Eleven States and two UTs bagged a position in the category of Front Runners (with Index score more than/equal to 65). However, four States fell behind in the Aspirants category (with an Index score of less than 50) and Nagaland stands at the lowest position with score of 29.The seriousness of the problem can be understood from the below data on the different indicators of the health:

Maternal Mortality Ratio

Maternal Mortality Ratio (MMR) is 113 per 1,00,000 live births in India as the SDG target is 70 by 2030. Assam has the highest MMR of 213 on the other hand three states- Kerala, Maharashtra, and Tamil Nadu have achieved this target with MMR of 42, 55, and 63, respectively.

Proportion of births attended by skilled personnel

In India 81% of deliveries attended by skilled personnel who are properly trained and have appropriate equipments and drugs. The states Kerala, Puducherry and Lakshadweep have achieved the target of 100% on the other hand Nagaland has 41.3% coverage.

Institutional Deliveries: Institutional deliveries are

Institutional Deliveries: Institutional deliveries are 54.7% approximately of estimated deliveries happen in a health institution in India. Nagaland is worst performing with 40.6% and Kerala is the best-performing State with 74% institutional deliveries. Among UTs, Chandigarh and Puducherry have achieved the target of 100 per cent.

Under 5 Mortality Rate

36 children die for every thousand live births in India before completing 5 years of age. The UN target is of 25 per 1000 live births by 2030. The Madhya Pradesh is far behind the target with 65 on the other hand Kerala has 07 per 1000 live births already achieved the target.

Infant Mortality Rate

32 children per thousand live births die under one year of age in India.In kerala it is 7 (9 in rural and 5 in urban).on the other hand the Madhya Pradesh has 48(52 in rural and 36 in urban) per 1000 live births.

Proportion of Children Immunised

59.2 per cent of children in India in the age group of 0-5 years are fully immunised (One dose of BCG, 3 doses of DPT and OPV and one dose of measles vaccine). The national target is to increase it to 100 per cent. Nagaland has the minimum coverage rate of 12.8% and Kerala has maximum coverage rate of 72.8%.

Availability of Physicians, Nurses, Midwives

In India the availability of medical staff is 38(2016- 2018) per 10,000 population. On the one hand Kerala has 112 and on the other hand Nagaland has 1 and Jharkhand has medical staff of 4 whereas the SDG target of 45 by 2030.

Challenges

According to the NITI Aayog's State Health Index Report 2019 the overall SDG health index score of India for Goal 3 ranges between 29 and 82 for States and between 50 and 71 for UTs of India. Now the question arises why some states are performing well than other states which are not performing well. To know the answer of this question we must know about the challenges which are faced during implementation of policies for primary health care.

Many of the **key challenges** identified are:

(A) Challenges related to Health System

Availability of Human Resources (HR) For Health

The disparities in distribution of health workers (rural-urban) within country are very significant. According to WHO Review report, inadequate remuneration was reported in Manipur and Meghalaya as an important reason for recruitment among specialists while lack of residential quarters for Medical Officers in Haryana was another. Irrational and uneven distribution of HR is observed in Assam, Haryana, Maharashtra, Nagaland, Karnataka, Punjab, Telangana, Uttarakhand and Uttar Pradesh. Recruitment and retention of specialists and doctors

in remote areas is still a major challenge for many states. While some efforts have been made to address the human resources issue in maternal health services but there remains a dearth of available skilled manpower and mismanagement of available human resources, especially in the rural public-health system.

Inadequate Human Resources for Health

Health status of any country crucially depends on the availability of health infrastructure in general and human resources for health. Several research studies, using cross-country data, have highlighted a positive causal link between the availability of the health workforce in a healthcare system and health outcomes (Jadhav et al, 2019, Choudhury and Mohanty 2020, Anand and Bärnighausen 2004). Density of doctors and Nurses/Midwives 10(4+6) in Jharkhand and 65(42+23) per 10000 population in kerala in different Indian states. Adequate value is 45 and minimum is 23. Density of doctors, Nurses/Midwives and Allied professionals in Bihar is 13(8+2+1) and in Kerala 74(42+23+9) and in Haryana (8+13+10) per 10000 population in different Indian states.

Infrastructure of Health Centres

Half of the SCs and 30% of the PHCs do not have their own buildings. About a quarter of the FRUs do not have telephones, and 40% do not have a vehicle. Over 70% of the FRUs and CHCs do not have linkages with a district blood-bank. More than half of the CHCs, FRUs, and district hospitals do not have residential quarters for staff. None of the national facility surveys mentions the maternity ward; so, it is not clear how many exist. the dearth of a skilled staff, particularly specialist, for providing EmOC. About 50% of the CHCs and 30% of the FRUs do not have anaesthetists, and an obstetrician.

Poor Quality of Health Services

In spite of achievement of universal and comprehensive coverage , timely access to quality health services is a great challenge. There is a chronic shortages of qualified staff, equipment and supplies, coupled with an absence of basic standards in health care delivery or weak enforcement where such standards exist, which further exacerbate inequity of access to quality health care.

Workforce Management

Due to the absence of adequate department specific policy framework regarding HR, covering issues such as transfers and career promotions , frequent transfers of MOs reported in UP, delayed promotions of Medical Officers in Haryana and forced prolonged postings of HR in difficult areas in Meghalaya. There is no HR policy for contractual staff in many states. General MOs and PG qualified MOs are hired at the same pay scale in many states. Poor coordination of policies across sectors and gaps in certain primary health care-related policies for its implementation and development is a significant challenge.

Training and Capacity Building

Systematic training plans is missing in many states. Training progress is slow in Karnataka, Odisha and Uttarakhand. In Nagaland, no training has been conducted for the last two years. The lack of a proper mechanism for training needs assessment was observed in many states. Skilled Birth Attended trainings have not been planned in Punjab despite the low availability of them in the state.

Affordability and the Cost of Health Care

Private and public hospitals coexist in most places. But the private sector is the dominant healthcare provider in India inspite of costly affair but on the other hand the public sector offers healthcare at low or even no cost but it lacks the confidence of quality and reliability by having drawbacks including a perpetual shortage of funds, equipment and skilled staff, generally is not the first choice. Unregulated private enterprise in an industry marked by high level of market failure - While the share of public institutions has increased both in hospital and outpatient cares, the private sector dominates in total healthcare provision in India. Around 74 per cent of outpatient care and 65 per cent of hospitalisation care is provided through the private sector in urban India2017-2018.

Health Information Systems

The national Health Management Information Systems (HMIS) is a national portal to provide timely reliable health information at each level of management at the right time, in the right form which can help in decision making to the Indian people. HMIS has been implemented in all States and UTs to provide information on the function and service at 2,15,984 health care facilities. However, 2,05,691(95%) facilities are reporting on HMIS portal across India. Various other Information Technology initiatives have been implemented, such as Mother and Child Tracking System(MCTS)/Reproductive and Child Health(MCH) portal, ANMOL, E- raktkosh, E-Aushadi and Mera Aspataal to have the information remotely for transparency and accountability .While health awareness has spread considerably, gaps remain prominent in many areas like child and adolescent health; geriatric morbidity and care; and mental health. There are many reasons responsible for this are lack of focus on preventive care, patient counseling in health delivery system, lower public priority to health concerns. Poor quality, limited availability and underuse of available data is the challenge for evidence-based decision-making .

Structural Procedural and Technological Constraints

Facility wise reporting on Health, lack of infrastructural facilities for storage and maintenance of records, incomplete information, unreliable and intentionally managed information, inappropriate forms/cards and reports absence of feedback and monitoring, manual paper-based system (Formats) and lack of internet connectivity are the major challenges in implementation step.

Healthcare Financing

Many states have successfully implemented Public Financial Management System (PFMS) under National Health Mission. However, the progress of its implementation in different states is at varied stages. States such as Odisha and Punjab have completed 100% agency registration followed by Jharkhand with

95%, on the other hand implementation of PFMS in West Bengal is reported to be unsatisfactory, as only 68% agencies have been registered under the PFMS. Household Out of Pocket Expenditures (OOPE) still remains a major concern. Delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem for most states . Delays of 20-21 days minimum in Odisha, and maximum 256 days in Maharashtra were noted. Uttarakhand has reported the lowest utilization of funds whereas States such as Bihar, Chhattisgarh, Meghalaya and Telangana were found to have allocated additional funds (at least 30% per capita).

Low Budget Allocations for Healthcare

Health being a state subject causes conflict between the centre and the states in India, spending on heath by states matters the most. According to National Health Accounts (2017), spending on healthcare is done by the states is 66 per cent. India ranks 179th out of 189 countries in prioritization assigned to health in its government budgets. The state expenditure on healthcare is highly variable across states and is not the function of the income level of the state. The reduction of public health budgets or inefficient funding allocations negatively affects the Primary health care of vulnerable groups and will increase in out-of-pocket expenditures.

(B) Challenges related to Socio-Economic Conditions

Low Literacy Rate

The literacy level of women in the reproductive age group (15–49 years) in India is just 55%. Illiteracy in mothers makes the IMR double. There is a high degree positive relationship between education level and rate of antenatal care(ANC) , institutional delivery or skilled birth attended(SBA) and post natal care visits(PNC) can be seen from below table:

Utilization of Maternal Health Care Services (in percentage)

Women Education Level (2015-2016)	More than 4 ANC	SBA	PNC Visits
Illiterate	29.23	66	51
Primary	43.5	74.1	59.4
Secondary	59.6	92.3	73.5
Higher	72.7	94.9	77.6

Source: National Family Health Survey - 4.

Poverty

Poor pregnant women are less likely to receive proper nutrition and maternal care. There is a high degree positive relationship between income level of the family and utilisation of maternal health services as shown in below table:

Utilization of Maternal Health Care Services (in percentage)

Income Level of Family (2015-2016)	More than 4 ANC	SBA	PNC Visits
Poorest	28.8	64	47.9
Middle	47	87	69.4
Richest	79.9	96	79.5

Source: National Family Health Survey - 4

Poor Social Status of Women

India is a male dominated society in which any decision regarding health care taken by the husband or his family during pregnancy and not the pregnant woman. Women did not get any antenatal care because their husband/her family thinks that it was not important to access antenatal care.

Age of Marriage and Nutritional Status of Women

Early marriage is an age-old tradition in India. Pregnancy in teenage girls is twice as common in rural as in urban areas in India. Poor nutritional status of women leads to increased maternal mortality. The percentage of women with anaemia is 55.6%. After hemorrhage being a major maternal killer in India, anemia, especially iron-deficiency anemia, was the main medical condition leading to maternal death. is highly prevalent among the Indian population

Lack of Timely Availability of Help

Delay in reaching the health centres due to non availability of timly transport leads to emergency situations. Even if transport is available no cash is available to pay for transport and this worsens the situation. After reaching on the desired health centre, overcrowding, lack of equipment and other medical supports coupled with a chronically understaffed environment, delays emergency management, lack of management capacity in the health system has led to poor quality services and slow progress.

Lack of Reliable Estimates of Maternal Mortality

Information related to causes, and patterns of maternal mortality in India are incomplete and unsatisfactory compared to infant mortality for which estimates are available from the Registrar General of India. The negligence to this issue is indicative of the position accorded to women in India.

Absence of independent advocates for maternal health in civil society

Maternal death has not been the important issue of sociopolitical or legal debate in India. Political parties and leaders, International agencies, Consumer groups, the judiciary, and members of legislative assemblies even the mass media hardly pay any attention to the massive tragedy of maternal mortality.

Political will and Good Governance

Ministry officials, politicians and other leading figures who are able to advocate, pass legislation and implement health reforms and support primary health care, oversee it and it is beyond their electoral cycles.

Practical Issues

According to some observations, In states where private practice is allowed to government doctors, there could be a financial self-interest of doctors in the form of private practice may lead to- low standards of performance in the government facility.

The ANM plays dual role as family planning and MCH care provider but they concentrate on family-planning indicators on institutional deliveries, due to no incentives for this.

That the compensation package and promotional opportunities typically do not depend on performance of staff are further factors that impact motivation of workers. An extreme example is the ANM or doctor, and provides 24-hour services,The

medical staff who lives in a remote village gets the same salary and benefits as who lives in a city.

The government health staff wants to work in larger cities for the comfort of their families and for educational and other opportunities;. As posting in remote places may be a punishment for poor-performing.

Lessons from high-performing states

Kerala and Tamil Nadu have consistently reported low maternal and child mortality. The key factors for success in Kerala have been high political commitment for social sectors, high level of awareness in the community (e.g. the majority of women have a higher education), primarily an urban population, and good infrastructure (roads) leading to high access to public-health services. The government and private health infrastructure (health centres and hospitals) are much better in terms of numbers, density, and, perhaps, accountability. This combined with high awareness in the community has led to high use and better health outcomes in Kerala.

The key lesson from success in Tamil Nadu is a long-term focus on maternal mortality through pilot-testing of evidence-based interventions on a smaller scale and then up scaling successful ones, with focus on the systematic implementation of interventions suited to local conditions to provide consistent higher-quality services in rural areas. In addition, monitoring and reviewing maternal and child deaths, analyzing medical and social causes, and taking actions to improve the system are the reasons for success. largely possible because of consistent and highly-committed leadership provided by technical officers in the health department over the years.

Measures to overcome Challenges to Primary Health Care

From the analysis of above data we can say that the government policy played the significant role for primary health care by addressing the three aspects namely; a) Access, b) Affordability and c) Accountability. There is a need of developing more accountable health systems that can only improve access and health indicators.

The challenges discussed above can be overcome by developing an exclusive model for implementing, monitoring, measuring and reporting SDG related course of action. Though India has well established organizations such as the CSO to provide statistical data many times they are general and do not match specific requirements. Even in case of MDGs, India was not able to measure its achievement accurately because of lack of data. Therefore developing suitable indicators to assess the progress of SDGs and also simultaneously developing a system that can support this exercise by supplying the required data is of paramount importance.

Human Resources for Health

There is a critical need to fill vacancies against sanctioned posts by adopting Competency based skill tests to ensure high quality recruitments. A health department specific HR policy should be developed to address departmental issues of arbitrary postings and delayed promotions. In order to streamline management and utilization of HR information, a HRMIS needs establishment/ strengthening. In states where these are already established, it should be linked with the Training Management Information System (TMIS) - and capacity building. In order to increase retention of doctors in states such as Assam, Chhattisgarh, Karnataka, Odisha, Nagaland and Uttarakhand many incentives may be offered as educational incentives in terms of additional weightage - proportional to their service duration in rural areas, Performance appraisal mechanism, award of annual increments etc. ASHAs as a key member, providing a package of services to the primary health care, closer to the community, it is essential that the challenges related to quality of training, delays in payments, stock out of drug and equipment kits need an urgent action for solution.

Timely Release of Funds

States should ensure timely release of funds for effective utilization of funds. Similarly, the State Health Society should also release funds to District Health Societies (DHS) timely. States need to ensure the flexibility (need-based expenditure) in the diversion of funds for better planning and use of resources.. In order to address high Out Of Pocket Expenses, States should strengthen the implementation of programs such as free Drugs, free ambulance services, free blood services, free diet and Diagnostic Schemes and the JSSK scheme.

Primary Health Care Promotes Efficient Use of Financial Resources for Health

The gate keeping function role of primary care in primary health care depends on the quality and training of primary health care staff, well-tailored policies, regulatory frameworks and functional referral systems, which are essential to reduce health costs for health systems. Enhancing accountability and transparency in the use of funds is important for Member States, as is predictable and sufficient funding for primary health care. Health insurance schemes and innovative public-private partnerships can also lead to improvements in health outcomes.

A Sufficiently Large and Well-Qualified Health Workforce Is Needed For Successful Primary Health Care Implementation

An effective primary health care system needs a skilled health workforce and interdisciplinary teams. Generating a health workforce that is adequate in terms of size and qualifications depends on the quality of health education and training, salary levels and regulatory frameworks. Equity of access and care depends on a sufficiently large health workforce that is sufficiently incentivized (financially or otherwise) to work in more remote or underserved populations.

Community Participation and Engaged Users Improve Access and Quality of Care

Inclusive participation is essential to ensure that health systems remain people-centred and health solutions are tailored to meet community needs. Engaging users of primary health care services with local policy-makers is important for a successful primary health care system. It is also important to ensure adequate regulatory frameworks and accountability mechanisms in health systems.

Evidence-based actions require improvements in collection and use of data

In the desk review, data- and evidence-driven approaches were noted as key to effective and efficient primary health care implementation. For governments and other health sector staff to make well-informed decisions, the generation and use of data and evidence are crucial. However, government capacity to collect, analyze and use data is often subject to significant capacity constraints. India needs to develop and strengthen a system of reporting maternal deaths , and each maternal death should be audited to improve maternal health services.

Increasing access to essential programmatic initiatives

As maternal and child care nutrition, immunization, care and treatment of communicable and noncommunicable diseases and other essential elements of primary health care systems.

Empowering Individuals and Communities

Through increased education, health promotion and communication, individuals, families and communities learn to take responsibility for their own health. Many countries now allow patients to choose their family doctor. Providing services to specific population groups such as refugees, elderly people or people with disabilities facilitates health access and improves health equity.

Promotion of health reforms

Reforms to reorient primary health care system take time and often incremental changes occur over decades. Health system includes various aspects such as universal health coverage-related legislation, increased financing and financial risk pooling, equity-promoting initiatives, health information systems and other uses of technology.

Innovations to Improve Primary Health Care Performance and Service Delivery

Initiatives such as public health insurance schemes and other financing mechanisms addressed socioeconomic disparities and made health care more accessible. Other innovations, such as performance-based payment schemes, improved primary health care in some countries, while the use of e-health systems improved networking and information sharing between medical disciplines and enhanced the quality of health care.

Advances in Information and Communications Technology

This area included advances in telecommunications, the Internet, use of electronic medical records and development of e-health applications (tele-health, applications for mobile devices, e-referrals). Mobile applications and telemedicine have made working in remote areas, where many vulnerable, poor people live, more attractive for the health workforce in many locations. Technological resources have been used to augment the role of the health workforce and to provide training and education to develop a health workforce with the necessary knowledge and skills to effectively manage current and future health challenges

Political will, Good Governance and Leadership

The translation of political will into action is a prerequisite for achieving the principles and objectives of primary health care. Consistent and highly-committed leadership through financial commitment are needed for primary health care to succeed. Good governance, coherent policies and strategies are cited as being the foundation for achievement of primary health care goals, in a people-centred manner.

Interministerial and Intergovernmental Collaboration and Coordination

There should be horizontal and vertical collaborations among various ministries of health, education and agriculture and between different levels of government (local, state and federal, for instance for food and nutrition programmes to ensure primary health care programmes. Inter sectoral collaboration, a core component of primary health care implementation, requires collective effort. Successful primary health care implementation calls for broad-based partnership. Top politicians, such as health ministers and Chief Minister at the state level and Prime Minister at the national level, Women's NGOs should periodically review MMR and maternal health services to take up the issue of high maternal and child mortality.

Aligning Local Development Plans With Targets

There should be collaboration and coordination between the public and private sectors and within the health sector to encourage integrated care for the needs of local communities. All critical inputs, such as staff, drugs, blood, and equipment should be coordinated, monitored and provided timely at selected locations for achieving the objectives. Regulation of the private sector and implementation of protocols across the board will help to improve accessibility and quality of care provided by both private and public sectors.

Preparing Vision Documents and Action Plans To Guide Their Efforts on The Primary Health Care

Preparing Vision Documents and action plans to guide their efforts on the primary health care to postulate strategies or action plans to realise their vision in a time-bound manner. The articulation of vision has led to convergence of complementary programme components in light of the interconnectedness of health targets. Annual implementation plans and monitoring progress must be made and recorded.

Identifying the State-specific Indicators for Monitoring of the SDGs Goal 3

A substantial amount of data is needed to be produced and analysed on the SDG While data-driven decision making has become the norm, Development of State-specific and District-specific indicators based on the NIF bridges this gap substantially. However, more work is required to collect data that is disaggregated and is available at a higher frequency.

Leave No One Behind

A number of States and UTs have taken initiatives to conduct vulnerability mapping and reinforce people's participation in various development programmes to make them truly

inclusive. Special initiatives have been taken to address the needs of the vulnerable population groups such as women, persons with disabilities, Scheduled Castes and Scheduled Tribes, etc.

Various Aspects of Primary Health Care Implementation Can Be Incentivized

Various aspects of primary health care implementation can be incentivized by the use of salary incentives to attract and retain the health workforce, financial incentives to reward achievement of desired outcomes in medical practices and incentives to foster innovation.

To Develop and Sustain Primary Health Care Systems In The Future, Continued Innovation Will Be Crucial

The innovations may help to seize on opportunities and tackle challenges in primary health care implementation as technology, entail creative solutions to refine processes, reconfigure health finance approaches, restructure public administration and reform entire health systems to make them more people-centred, cost-efficient and equitable.

Conclusion

India has progressed rapidly on the socioeconomic front but progress in some states it is very low. The recent COVID-19 pandemic has highlighted the importance of healthcare, by showing how a healthcare crisis can be transformed into an economic and social crisis. Considering the same and in striving to achieve the SDG target of Universal Healthcare Coverage, India must take steps to improve healthcare accessibility and affordability in the country. Therefore, India's healthcare policy must continue focusing on its long-term healthcare priorities. High political commitment, high level of awareness, strong education system, high level of income, good infrastructure (roads) leading to high access to public-health services, the government and private health infrastructure (health centres and hospitals) are much better in terms of numbers, density, and, perhaps, accountability for women and children health may lead to high use and better health outcomes in India.

In light of the above discussed challenges to primary health care implementation, there is a need for innovative problem-solving techniques may be strengthen, or continue to strengthen, based on what has attained and what has not. It should be possible only by translating this commitment into concrete actions. Broad overview of the challenges, achievements and factors a number of areas for future action can be identified which can help to maximize success in primary health care implementation.

Limitations

The analytical approach is not comprehensive because it is restricted to the only selected indicators and the study covers only two MDG goals i.e**.** MDG 4 i.e. Reduce Child Mortality; and MDG 5i.e. Improve Maternal Health. The results of the study are based on secondary data which have their own limitations.

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