CHAPTER - 5

HEALTH INFRASTRUCTURE AND HEALTH CARE FACILITIES IN CACHAR DISTRICT

Cachar district is located in the southernmost part of Assam. Cachar is the sixth largest District in Assam and ranked 324 in India in terms of total area. However, the poor infrastructural facilities, geographical and topographical condition, inadequate facilities of Cachar District are far behind from rest of the country. The present study is confined to rural areas of Cachar district.

This chapter consists with following four sections viz; Profile of Cachar district in section 5.1, health infrastructure of Cachar district in section 5.2, health schemes sponsored under National Rural Health Scheme (NRHM) in section 5.3 and health care facilities available to the respondents in section 5.4.

5.1. Profile of Cachar District

Geographic Profile

Cachar district is bounded by Barail and Jayantia hill ranges in the north, by the State of Mizoram in the south and by a part of neighboring country Bangladesh and the Hailakandi and Karimganj districts of Assam in the west and by the state Manipur in the east. Earlier, British created the district in 1830 after annexation of Kachari Kingdom. The district lies between 92° 24' E and 93° 15' E longitude and 24° 22' N and 25° 8' N latitude. The total geographical area of the district is 3,786 Sq. Km. Barak is the main river of the district and apart from that there are numerous small rivers which flow from Dima Hasao district, Manipur or Mizoram. The district is mostly made up of plains, but

there are a number of hills spread across the district. There is an average annual rainfall of more than 3,000 mm in Cachar district. The climate is Tropical wet with hot and wet summers and cool winters. The climatic condition of this district is significant for humidity and it is extremely beyond the limit.

Demographic Profile

Cachar is densely populated district in Assam. As per the census 2011, there is a population of 1,736,319 in Cachar district. This gives it a 278th ranked in India out of a total 640 districts. The district has a population density of 459 inhabitants per square kilometer which is higher than the state average 397; it is 13th the dense district of the state. Out of the total population, 18.17 per cent lives in urban area and 81.83 per cent population lives in rural areas of the district. Its population growth rate over the decade 2001-2011 was 20.17 per cent with a break up of 81.80 per cent and 18.20 per cent in rural and urban areas of the district respectively. The sex ratio is 958 per 1000 males, and a literacy rate is 80.36 per cent. The district has fourth position in the state in terms of literacy rate. Male literacy is 85.85 per cent, which is higher than the total literacy rate of the district and female literacy is 74.62 per cent, which is lower than the total literacy rate (80.36 per cent) of the district. However, the literacy rate in the district as per the Census, 2011 is higher than the state average. In terms of sex ratio, the district ranked 24th position. As per the Census 2001, the demographic profile of the district shows that 41.39 per cent of the total rural population in the district belongs to the minority community of which Muslims comprise 97.77 per cent. Bengali is the status of Official Language in this district with majority of the people primarily speaking Bengali and Sylheti, a Bengali-dialect.

Economic Profile

Administratively the district is divided into two sub-divisions viz. Silchar (Sadar) and Lakhipur. There are five revenue circles and fifteen community development blocks (CD) in the district. The total number of census villages and towns in the district are 1040 and 19. There are 15 Anchalik Panchayat, 163 Gaon Panchayats, one Zilla Parishad in Cachar district.

In 2006, the Indian government named Cachar one of the country's 250 most backward districts out of 640 districts. It is one of the eleven districts in Assam currently receiving funds from the Backwards Regions Grant Fund Programme (BRGF). There are seven Assembly constituencies in this district, viz. Silchar, Sonai, Dholai, Udharbond, Lakhipur, Barkhola, and Katigorah. Dholai is designated for scheduled castes. Economy of the district is not very encouraging. Geographical remoteness, poor communication and lack of proper infrastructural facilities are some of the main factors behind the low level of economic development of the district.

Health Care Services in Cachar District

Cachar districts are having seven registered health care centers. In this district, the process of assessing the health care requirements and gaps in infrastructure as well as man-power as per National Rural Health Mission (NRHM) is yet to be completed. Cachar has one Civil Hospital, one medical college and one cancer specialist hospital, 32 health centers and 272 sub centre, one community health centers. Due to non-availability of skilled man- power and infrastructure, the purpose of setting up of health care centers was not achieved in the district.

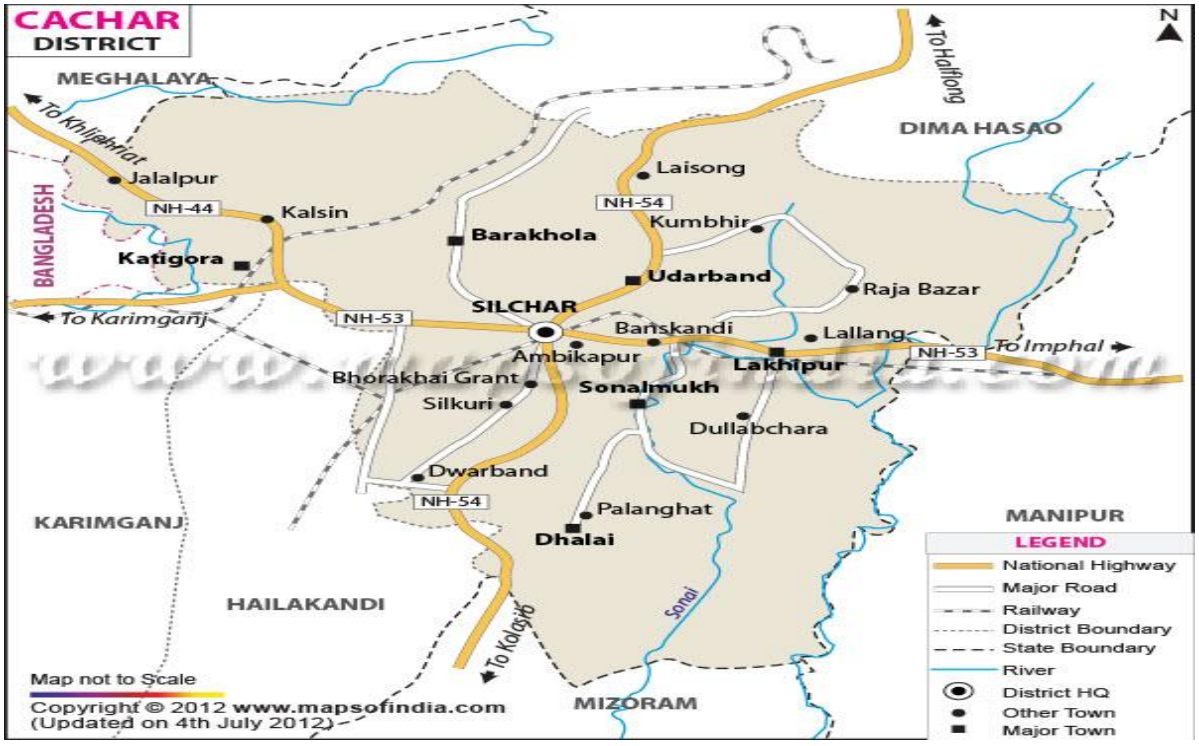
Table 5.1 shows the profile of Cachar district at a glance in comparison to Assam.

Table 5.1: Profile of Cachar District at a Glance in Comparison to Assam

Category	Cachar	Assam
1. Geographica Profile		
i. Latitute	24° 22' N and 25° 8' N	24° 10' N and 27° 58' N
ii. Longitude	92° 24' E and 93° 15' E	89° 49' E and 97° 26' E
iii. Area (in sq km)	3786	78438
2. Administrative Division		
i. Number of sub division	2	56
ii. Number of revenue circle	5	184
iii. Number of CD blocks	15	219
iv. Number of towns	19	214
v. Number of Villages	1040	26395
vi. Number of Gaon Panchayat	163	2202
vii. Number of Anchalik Panchayat	15	
3. Demographic Profile		
i. Total population	1736319	31205576
ii. Male population	886616	15939443
iii. Female population	849703	15266133
iv. Urban population (in per cent)	18.20	14.08
v. Rural population (in per cent)	81.83	85.92
vi. Density of population	459	398
vii. Decadal growth rate	20.17	16.93
viii. Sex Ratio	945	958
4. Literacy Rate		
i. Total population (in per cent)	80.36	72.19
i. Male population (in per cent)	85.85	78.81
ii. Female population (in per cent)	74.62	67.27
iii. Rural population (in per cent)	78.14	85.92
iv. Rural male population (per cent)	83.12	51.12
v. Rural female population (per cent)	70.75	48.88
iv. Urban population (in per cent)	89.77	14.08
v. Urban male population (per cent)	91.95	51.61
vi. Urban female population(per cent)	85.99	48.39

Source: Census of India, 2011

Figure 5.1: Map of Cachar District



5.2 Health Infrastructure of Cachar District

Getting good health care facilities for maintaining their good health is a fundamental human right. It is the responsibility of the government to provide health care to all people in equal proportions. The health status of a country or a state depends largely on the availability of health-related infrastructure. However, health-related infrastructure takes on a wider role than mere physical infrastructure. Apart from the health care centre, dispensaries and hospitals, the manpower required for the smooth functioning of those institutions are also included in health related infrastructure. At the same time to maintain a sound health, access to safe drinking water, toilet and housing is also essential. Thus, health status of a country or a state depends not only on the health

care infrastructures but also on some other basic infrastructure available to the society. Despite a well-developed and extensive network of public health infrastructure; including institutions for training and research, the health outcome is still behind the set goals. Availability of adequate number of health personnel with suitable skills and their appropriate deployment at different levels of health care set-up are essential for providing an effective health care service for the people. Globally, human resources absorb a large part of public expenditure in the health. In low and middle-income countries, cost of human resources for health usually amounts to 60 per cent and 80 per cent of the public expenditure, respectively (Nandan et al; 2007).

Since independence, India's various national health schemes and programs have been launched to improve the health status of people of the country, especially for those living in rural areas. The norms for health care infrastructure and manpower were laid down for the first time by the Bhore Committee (1946) and subsequently modified by the Mudaliar Committee (1961) followed by the Bajaj Committee (1987). The Ninth Five-Year Plan had emphasized on health manpower planning taking into consideration, the district specific assessment of available manpower and health care facilities and the demand for health care services. The Central Bureau of Health Intelligence, Ministry of Health and Family Welfare made an effort to obtain reliable and accurate district-wise data on the number of medical, dental, ISM&H professionals and nursing and Para-professionals. Currently, there is a shortage of all key cadre including doctors, nurses and paramedics, particularly in rural areas. Irregular attendance or absenteeism in rural and remote areas, inadequate system of incentives for postings in difficult areas, lack of opportunities for continuing medical education (CME), skill up gradation, lack of

orientation to needs of rural areas, lack of supportive system for career development, non-transparent transfer and posting policy and lack of transparency in career progression are the major issues need policy attention. The current rate of production and severe shortfall in the production of specialists are major issues for achieving the health goals in the country.

The Government of India (GOI) launched the National Rural Health Mission (NRHM) on 12th April 2005. The aim of NRHM is to bring about significant improvement in the health system and the health status of the people. NRHM specially focuses on those states, which have poor health outcomes and inadequate public health infrastructure and workers. The primary focus of the mission is to improve access to health care for the rural people. It seeks to provide equitable, affordable and universal access to rural people, especially women and children. The main goal of NRHM is to reduce infant mortality rate (IMR) and maternal mortality ratio (MMR) by promoting new born care, immunization, antenatal care, institutional delivery and post-partum care. The NRHM foundation is built on community involvement in drawing a village health plan under the auspices of Village Health and Sanitation Committee (VHSC). This would enable rural primary health care services accountable to the community and giving authority to the District Health Mission for implementation of inter-sectoral district health plan including drinking water, sanitation, hygiene and nutrition. The interface between the community and the public health system at the village level is entrusted to a woman. Accredited Social Health Activist (ASHA), a health volunteer organization receiving performance based compensation for promotion of universal immunization, referral and escort services for reproductive and child health (RCH), construction of

household toilets, and other health care delivery programmes. To promote institutional delivery, cash incentive programme under Janani Suraksha Yojana (JSY) is made an integral component of NRHM. Although NRHM aims to cover all the states of the country, special focus is given to 18 states - namely, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The rural and poor people mainly depend on public health services. There are different schemes introduced by the govt. for the women.

This section is again divided into the following three sub-sections for detailed discussion.

5.2.1 Structure of Rural Health Care System

The health care infrastructure in rural areas has been developed as a three-tier system and is based on the following population norms as shown in Table 5.2.

Sub-Centres (SCs) –

The Sub Centre is the most peripheral and first contact point to the members belonging to a community. Sub Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. Each Sub Centre is required to be manned by at least one auxiliary nurse midwife (ANM) / female health worker and one male health worker (Indian Public Health Standards (IPHS)). Under NRHM, there is a provision for one additional second ANM on contract basis. One lady health visitor

(LHV) is entrusted with the task of supervision of six sub-centres. There are 1,53,655 Sub Centres functioning in the country as on 31st March, 2015.

Primary Health Centres (PHCs)

Primary Health Centres **(**PHC) are envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive aspects of health care. There are 25,308 PHCs functioning in the country as on 31st March, 2015. The PHCs are established and maintained by the State governments under the Minimum Needs Programme (MNP) / Basic Minimum Services (BMS) Programme. As per Indian Public Health Standards (IPHS), a PHC is to be manned by a medical officer supported by 14 paramedical and other staffs. Under NRHM, there is a provision for two additional staff nurses at PHCs on contract basis. It acts as a referral unit for six Sub Centres and has 4 - 6 beds for patients. The activities of PHC involve curative, preventive and family welfare services.

Community Health Centres (CHCs)

Community Health Centre **(**CHC) are being established and maintained by the State government under MNP / BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one operation theater, X-ray, labour room and laboratory facilities. It serves as a referral centre for four PHCs and also provides facilities for obstetric care and specialist consultations. As on 31st March 2015, there are 5,396 CHCs functioning in the country.

Table 5.2: Rural Health Care System – The Structure and Current Scenario

Centre	Population Norms	
	Plain Area	Hilly/Tribal/Difficult
Sub Centre (SC)	5000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

Source: Adopted from NRHM, 2012 (which is recently known as National Health mission)

5.2.2 Availability of Physical Health Infrastructure in Cachar District

Availability of Physical Health Infrastructure is again decomposed into two parts viz;

- The availability of physical health infrastructure in Cachar district as shown in Table 5.3.
- Comparison of the of these health infrastructure with Indian Public Health Infrastructure (IPHS) norms as shown in Table 5.4**.**

Table 5.3: Availability of Physical Health Infrastructure of Cachar District

Health Institution	Cachar	Assam
Sub Centre (SC)	272	4604
Block Primary Health Centre (BPHC)	8	149
Mini Primary Health Centre (MPHC)	16	380
Community Health Centre (CHC)	1	109
SHC (Subsidiary Health Centre)	2	71
State Dispensary (SD)	2	239
District Hospital (DH)	1	20
SDCH	0	3
Medical College	1	5

Source: National Rural Health Mission, 2012

Comparison of the Health Infrastructure of Cachar District with IPHS Norms:

As mentioned above that NRHM framework envisaged provision of certain guaranteed services at SCs, PHCs and CHCs as per norms of IPHS. NRHM guidelines

provided that one SC is to be set up for a population of 5,000, one PHC for 30,000 and one CHC for 1,20,000 population. For a total rural population of 14.20 lakh in the Cachar District 284 SCs, 47 PHCs and 12 CHCs are required to be set up. However, there are only 272 SCs, 30 PHCs and one CHC in the District as on 2012.

Table 5.4: Availability of Health Infrastructure in Rural Area of Cachar District

Health Infrastructure	Required	In position	Shortage*	Shortage* (per cent)
Sub Centre	284	272	12	4
Primary Health Centre	47	30	17	37
Community Health Centre	12	1	11	92

Source: National Rural Health Mission, 2012

Note: * denotes shortages of required health infrastructure are computed on the basis of population norms.

Table 5.4 depicts that there is a shortfall of 11 CHCs, 17 PHCs and 12 SCs against the requirement. Non-setting up of the required health centre as per population norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas. This also further reveals the heavy dependence either on the district hospitals or on the private sector hospitals. In fact today, due to insufficient health care provisions everyone has to rely on the health care services rendered by the private hospital. Further, the poor rural public health facilities across the district pushed the entire rural health care system to a white elephant making a total failure to attract, retain and ensure regular presence of the specialized medical professionals.

5.2.3: Availability of Human Health Infrastructure in Different Rural Health Institution:

Apart from the health care centres, dispensaries and hospitals, the manpower required for the smooth functioning of those institutions are also included in health

related infrastructure. Table 5.5 depicts the availability of manpower in sub-centres of Cachar district in comparison with the IPHS norms.

Table 5.5: Availability of Manpower in Sub Centres (SCs) of Cachar District

Staff	IPHS norms (per SC)	Present	Required	Shortage*
Auxiliary Nurse Midwife (ANM)	2	505	544	39
Multipurpose Worker (MPW)	1	75	272	197

Source: National Rural Health Mission, 2012-13

Note: * denotes shortages of required is computed from IPHS norms.

Table 5.5 reveals that there is a huge shortage of manpower in SCs of Cachar district. As against the Indian Public Health Standard (IPHS) Cachar district, there is a requirement of 544 Auxiliary Nurse Midwife (ANM) and 272 Multipurpose Worker (MPW). However, there is only 505 ANM and 75 MPW available in these sub-centres. This indicates that there is a shortage of 39 ANM and 197 MPW.

Table 5.6 depicts the availability of manpower in block primary health centres of Cachar district in comparison with the Indian Public Health Standard (IPHS) norms.

Table 5.6: Availability of Manpower in Primary Health Centres of Cachar District

Staff	MO (MBBS)	MO (AYUSH)	Staff Nurse	Lab. Tech.	Pharmacist
IPHS (per PHC)	1	1	3	1	1
Bikrampur	2	1	3	1	2
Borkhola	4	1	5	1	1
Dholai	2	1	6	2	2
Harinagar	1	2	3	2	1
Jalalpur	1	1	3	2	2
Lakhipur	2	1	4	2	2
Sonai	3	0	7	3	2
Udharbond	3	0	4	4	1

Source: National Rural Health Mission, 2012-13

Note: * denotes shortages of required is computed from IPHS norms.

In Cachar district there is eight-block public health centre (BPHC). Table 5.6 reveals that all BPHC in Cachar district fulfils the norms sets by the Indian Public Health Standard (IPHS) and all BPHCs have surplus in respect of human infrastructure. Only Sonai and Udharbond have shortage in medical officer (MO) in AYUSH.

Table 5.7 depicts the availability of manpower in community health centres of Cachar district in comparison with the Indian Public Health Standard (IPHS) norms.

Table 5.7: Availability of Manpower in Community Health Centre (CHC) of Cachar District

Staff	IPHS norms (Per CHC)	Present	Shortage*
MO (MBBS)	2	2	0
Dentist	2	2	0
Anesthetist	1	1	0
Surgeon	1	1	0
Ayush	1	0	1
Obstetrician & gynecologist	1	0	1
Pediatrician	1	0	1
Staff Nurse	10	8	2
Lab. Technician	2	2	0
Pharmacist	2	2	0
Radiographers	1	1	0
Ophthalmic Assistants	1	0	1

Source: National Rural Health Mission, 2012-13

Note: * denotes shortages of required is computed from IPHS norms.

Table 5.7 reveals that CHC of Cachar district fulfills all the norms of manpower set by the Indian Public Health Standard (IPHS) except Obstetricians & gynecologist, Pediatricians, Staff Nurse and Ophthalmic Assistants.

Since there are only two State Dispensary (SD) and Subsidiary Health Centre (SHC) prevails in Cachar district. Table 5.8 depicts the availability of Manpower in SD and SHC.

Table 5.8: Availability of Manpower in State Dispensary and Subsidiary Health Centre

Staff	State Dispensary (SD)	SHC
Medical Officer (MBBS)	2	3
Medical Officer (Ayush)	1	1
Lab. Tech.	2	3
Pharmacist	2	2
Staff Nurse	0	6
Anesthetist	0	0
Pediatrician	0	0
ANM	0	2
Radiographer	0	0
MPW	0	0
Ophthalmic Assistants	0	0

Source: National Rural Health Mission, 2012-13

From Table 5.8, it is seen that the condition of State Dispensary and Subsidiary Health Centre is also not satisfactory. In State Dispensary (SD), there is no staff nurse or ANM. However, in two SHCs there are total six staff nurse and two ANM. No radiographer, MPW, Ophthalmic assistant are available in both SD and SHC.

Table 5.9 shows the availability of manpower in various Mini Primary Health Centres (MPHC) in Cachar district. The overall scenario of MPHCs in Cachar district is not satisfactory at all. Out of the 15 MPHCs only ten have Medical Officer (MBBS) doctor and three have Medical Officer (MBBS mandatory one year Rural Posting) doctor. Five MPHCs have no specialist MBBS doctor. Similar is the case for Ayurvedic doctor. Out of these 15 MPHCs, only six have ayurvedic doctor. Total 26 numbers of staff nurse

and 8 numbers of ANMs are prevailing in these MPHCs. However, out of these 15 MPHCs, four have no staff nurse and eight have no ANMs. On the other hand, the situation is good in terms of the availability of laboratory technicians and pharmacists. Except only one MPHC remaining, have laboratory technicians. Similarly, all the MPHCs have pharmacist except only two. However, there are no radiographers, ophthalmic assistants, multipurpose worker (MPW) in these MPHCs. Similarly, no MPHCs have the anesthetist, pediatrician, surgeon, gynecologist, dentist etc.

Therefore, it is concluded that there is huge shortage of both physical and human health infrastructure in the rural area of Cachar district.

5.9: Availability of Manpower in Mini Primary Health Centres (MPHCs) of Cachar District

Name of MPHC	Anesthetists	Pediatricians	Surgeon	MO (MBBS)	MO (MBBS) 1 yr RP	Dentist	MO (Ayu)	Staff Nurse	ANM	Lab. Tech.	Pharmacist	Radiographer	MPW	Oph. Asstt.
Fulbari	0	0	0	2	0	0	1	3	0	1	1	0	0	0
Sibtilla	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Salchapra	0	0	0	2	0	0	0	2	1	2	1	0	0	0
Chibitabichia	0	0	0	1	0	0	1	2	2	1	1	0	0	0
Rajnagar	0	0	0	1	0	0	0	0	0	1	1	0	0	0
Narsingpur	0	0	0	2	0	0	1	3	1	2	1	0	0	0
Borjalenga	0	0	0	2	1	0	0	2	0	2	1	0	0	0
Bidyaratanpur	0	0	0	0	0	0	0	0	1	1	1	0	0	0
Katigorah	0	0	0	2	0	0	0	3	1	1	1	0	0	0
Banskandi	0	0	0	4	0	0	0	6	0	2	1	0	0	0
Chhototamamda	0	0	0	0	0	0	1	1	0	1	1	0	0	0
Jirighat MPHC	0	0	0	0	0	0	1	1	0	1	0	0	0	0
HarinaNPHC	0	0	0	1	0	0	0	0	1	2	1	0	0	0
Digar Kashipur	0	0	0	1	1	0	0	2	0	1	1	0	0	0
Thaligram	0	0	0	0	1	0	1	1	1	2	1	0	0	0
Total	0	0	0	18	3	0	6	26	8	20	13	0	0	0

Source: National Rural Health Mission, 2012-13

5.3 Health Schemes Sponsored under NRHM

Though the health infrastructure in the rural area of Cachar district is not satisfactory but there are some schemes available in Cachar district which are discussed in the following three sub-sections.

5.3.1 Availability of Different Schemes for Maternal and Child Health

(a) Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NRHM being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among poor pregnant women. The scheme provides cash assistance to mothers who have delivered in government health institutions, accredited private hospitals and sub-centres. This scheme gives Rs.1400 to each mother belonging to rural area and Rs.1000 to each mother belonging to urban areas. Table 5.10 depicts the year-wise JSY beneficiaries in Assam and Cachar.

Table 5.10: JSY Beneficiaries in Assam and Cachar

Year	Assam	Cachar
2005-06	17523	197
2006-07	182873	3295
2007-08	304741	17148
2008-09	327894	19188
2009-10	366596	23925
2010-11	391675	25176
2011-12	328926	25439
2012-13	437759	27933

Source: Health Management Information System under NRHM, 2012-13

Mamata:

The 'Mamata' scheme seeks to reduce IMR and MMR, by insisting on a post-delivery hospital stay of 48 hours of the mother and the newborn. Any complication that may arise during this period is addressed by skilled doctors available at Govt. health institutions. At the time of discharge from hospital, the mother receives a gift hamper called the 'Mamata' kit. This kit contains essential products for the baby viz. baby powder, baby oil, a mosquito net, a flannel cloth etc. Till date 10,01,923 'Mamata kit' has been distributed since 2010-11 to 2013-14.

Mamoni:

"Mamoni" is a scheme of the Government of Assam that encourages pregnant women to undergo at least three ante-natal checkups which identify danger signs during pregnancy (needing treatment) and offer proper medical care. Under this scheme, at the time of registration, every pregnant woman receives a booklet on tips on safe motherhood and newborn care titled 'Mamoni'. During subsequent ANC check up, the pregnant women are provided with an amount of Rs. 1000 (in two installments, an amount of Rs. 500 is given after second ANC check up and and another Rs. 500 after third ANC check up) for expenses related to nutritional food and supplements. Every Govt. health institution offers these services for the women who have registered at their place. It is under "Assam Bikash Yojana", State Govt. sponsored schemes under Health & Family Welfare Department**.** Till 2013-14, total 36,50,453 number of cheques has been disbursed.

Majoni:

Social assistance to all girl children born in the family up to second order is given

a fixed deposit of Rs. 5,000 for 18 years. On her 18th Birthday, the girl will be able to en-cash the fixed deposit. In case she is married before attaining 18 years of age, the fixed deposit will be forfeited**.** This scheme is applicable to families who are limiting themselves to two children. It is under "Assam Bikash Yojana", State Govt. sponsored schemes under Health & Family Welfare Department. Till 2013-14, total 3,08,109 numbers of Fixed Deposit has been issued.[2]

Morom:

The Morom scheme provides financial support to indoor patients of Government Health Institutions for supplementary nutrition and compensation for wage loss during hospitalization and post hospital expenses. The facility is available for indoor patient admitted in Govt. Hospitals. Indoor patients admitted to a Hospital will receive benefit as follows:

- For Medical College: Rs. 75/- per day for maximum 7 days;
- For District Hospital: Rs. 50/- per day for maximum 5 days
- For SDCH/ CHC/ PHC: Rs. 30/- per day for maximum 5 days.

The scheme has been started from 1st May 2010. It is a Govt. of Assam sponsored scheme. Amount paid under Morom scheme till 2013-14 is Rs. 2061.66 Lakhs.

Janani Sishu Suraksha Karyakram:

Janani Sishu Suraksha Karyakram (JSSK) has been implementing from February, 2012. It is a national initiative to make available better health facilities for women and child. The new initiative of JSSK is to provide free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30

[2] Source: Assam Bikash Yojana (ABY) Report-4 (2013-14).

days after birth) in government health institutions, accredited private hospitals and sub-centre in both rural and urban areas wherein the delivery is conducted. Pregnant women under the schemes are entitled for free and cashless delivery, free caesarean section, free drugs and consumables, free diagnostics tests such as blood test, urine test etc. They are also entitled for free nutritional diet during stay in health institutions (up to 3 days for normal delivery and 7 days for caesarean delivery), free nutritional supplement such as Horlicks to the mothers, free ultra sonography, and free tests required for blood transfusion. They are also getting free conveyance from home to health institution, between health institutions in case of referral and free drop back home after delivery under 'Aadarani Scheme'. They are getting exemption from all kind of user charges, including for seeking hospital care up to six weeks post delivery for post natal complications. In case of new born till 30 days after birth, they are getting free treatment at the public health institutions, drugs and consumables, diagnostics such as blood test, urine examination and other user charges.

The following Table 5.11 depicts the beneficiaries in Cachar district from different scheme of govt.

Table 5.11: Beneficiaries from Different Schemes in Cachar District

Schemes		2009-10	2010-11	2011-12	2012-13 (upto October)
Majoni	Form submit	2410	4459	3251	1962
	Form issued	1883	4717	2945	956
Mamoni	1st installment	6375	27635	18962	15078
	2nd installment	582	18918	13278	11702
Morom		NA	14276	21731	14645
Momota		NA	10764	14168	9518
Institutional delivery		27680	29154	29710	31973
Home delivery		4585	8885	8019	NA

Source: National Rural Health Mission, 2012-13.

Thus, it is observed that the number of institutional deliveries increases from 27680 in 2009-10 to 31973 in 2012-13 due to the different scheme introduced by the government.

5.3.2 Health Outcomes of Cachar District in Relation to Assam

Table 5.12 reflects health attainment of the district especially in the rural areas with respect to six variables viz; Infant Mortality Rate (IMR), Under Five Mortality Rate (UMR-5), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), Crude Birth Rate (CBR) and Crude Death Rate (CDR).

Table 5.12: Health Outcome of Cachar District in Comparison to Assam

Health Indicator	IMR			UMR-5			MMR	TFR	CBR			CDR		
	T	R	U	T	R	U	T	T	T	R	U	T	R	U
Cachar	53	56	37	69	74	44	288	2.9	25.3	26.2	21.6	7.3	7.4	6.5
Assam	55	59	31	71	77	36	347	2.4	21.2	22.2	16.4	7	7.4	5.3

Source: Annual Health Survey, 2010-11.
Note: T denotes Total, R denotes Rural and U denotes Urban area.

From Table 5.12, it is observed that the Infant Mortality Rate (IMR) in Cachar district is lower than the state average. Moreover, a large gap between rural (59) and urban (31) in IMR is also observed. Similarly, looking at the UMR-5 indicator, it is observed that the situation of Cachar district is better than the state average. However, the situation is worse in rural areas of Cachar district compared to its urban areas. The situation is same for the Maternal Mortality Rate (MMR). In comparison to the state average, the MMR is low in Cachar district. While regarding the Total Fertility Rate (TFR), the district reflects a relatively worse situation compare to the state. Similarly, while studying about the Crude Birth Rate (CBR), we have noticed that the birth rate is

quite high in the district than the state. The gap in the birth rate is also observed between the rural and the urban areas. The similar is the case for the Crude Death Rate (CDR).

Thus, it can be argued that the health status of the state as a whole is not satisfactory; and in Cachar district again there is inequality in the achievements regarding the health. Though the situation of the district for some indicators (IMR, UMR-5, MMR) are better than the state average but still the health status of Cachar district is not satisfactory. It is thus, clear that the health status of the rural areas is poorer than the urban areas.

5.3.3 Accessibility of the Maternal Health Care Facilities of Cachar District in Comparison to Assam:

In this sub-section, an attempt has been made to analyze the accessibility of the maternal health care facilities of Cachar district in comparison to Assam with respect to following six indicators:

- Percentage of mother's who received any form of ante natal care,
- Mother's who received full ante natal care,
- Mother's who received ante natal acre from the government source,
- Institutional delivery,
- Delivery at government hospital and
- Safe delivery

Table 5.13 reflects about the accessibility of the maternal health care facilities of Cachar district with special reference to the rural areas of the district. It appears from the table that with regard to the indicator mother's who received any Ante natal Check-up

(ANC) is satisfactory for the district. However, when it is about the mother who relieved full ANC, then it is a matter of great concern. Again, if the same is compared with the state then it is found that only 17.8 per cent of the total mother received full ANC in the district; while the figure is 16.7 and 24.0 per cent for the rural and urban areas respectfully. This factor may be responsible for higher rate of maternal mortality rate (MMR) in the state. On the other hand, institutional delivery rate both in Assam and Cachar district is not satisfactory. The rate is lower in Cachar district compared to the state. Further, a huge gap in case of institutional delivery between rural and urban area is observed which reflects the actual status of rural health scenario of Assam and Cachar district. For example, in the district the institutional delivery rate for the rural area is only 61.5 per cent as compared to the 82.4 per cent for the urban areas. Similarly, the gap in case of the state is also remarkable with 62.9 per cent for the rural areas and 84.9 per cent for the urban areas. Thus, it is observed that the institutional delivery rate in rural area is lower than urban area and the gap is quite unacceptable. The case is similar for the safe delivery. The per cent of safe delivery in the rural areas is lower than urban the areas. At the same time, for comparing of two important parameters relating to the reproductive health care facilities, viz., mothers who received ANC from government source and delivery at government hospitals, it is observed that the rural people take more ANC from the government sector. It is also observed that in the district, there is a very large gap between mothers receiving any ANC and ANC received at government source, which implies that for receiving ANC, people of the districts are largely depending on the private sector.

Table 5.13: Accessibility to the Reproductive Health Care Facilities

Health care facilities		Cachar (in per cent)	Assam (in per cent)
Mothers who received Ante Natal Care (in per cent)	Total	95.6	94.8
	Rural	95.2	94.2
	Urban	97.7	98
Mothers who received full Ante Natal Care (in per cent)	Total	17.8	18.4
	Rural	16.7	17
	Urban	24	27.3
Mothers who received Ante Natal Care from Govt. source (in per cent)	Total	50.3	71.8
	Rural	52.3	73.3
	Urban	39.8	62.5
Institutional delivery (in per cent)	Total	64.8	65.9
	Rural	61.5	62.9
	Urban	82.4	84.5
Delivery at Govt. hospital (in per cent)	Total	54.1	54.6
	Rural	53.6	54.6
	Urban	57.1	54.6
Safe delivery (in per cent)	Total	69.4	71.6
	Rural	66.6	68.9
	Urban	84.3	87.9

Source: Annual Health Survey, 2012-13, Assam.

Further, it is now a fact that a great majority of people preferred health care services from the private sector. They are reluctant to take the health care services from the private sector with an expectation of getting better quality services.

Thus, the reproductive health care services of the district are also not satisfactory and a visible inequality between rural and urban areas is observed with an inclination towards the private sector.

5.4 Health Care Facilities Available to the Rural People

The rural people mainly depend on public health care facilities. The govt. has

introduced various health schemes but due to their ignorance and awareness problem, negligence behavior of the health providers the services are not properly utilized. 65 per cent respondents respond that they are satisfied with the services provided by the SCs, 52 per cent respondents have reported that they are satisfied with the services provided by the PHCs and 45 per cent respondents have reported that they are satisfied with the services provided by the CHC. It is also observed that 62 per cent of respondents have reported that ANMs are available in the sub centre. However, 36 per cent of the respondents have reported that they are not getting free medicines from these sub-centres. In relation to the primary health centre, 54 per cent of the respondents respond that though doctors are available in these health centre but they are not getting proper service in time from health centres. The average waiting time for getting treatment is approximately 1.10 hours. The situation is similar for community health centre. 47 per cent respondents have reported that though doctors are available in this health centre but the situation is not improving because still they wait a longer time for getting the treatment from community health centre. The average waiting time for getting treatment is approximately 1.30 hours. Moreover, 52 per cent and 57 per cent respondents have responded that they are not getting free medicines all the times from primary health centre and community health centre respectively.

Though govt. has introduced many health schemes especially for reproductive women but still only 42 per cent respondents have argued that they are benefitted from these schemes. Moreover, 23 per cent women have responded that they are not getting full amount of JSY and Majoni schemes. 58 per cent women have reported that they are aware about these schemes. However, 72 per cent of respondent respond that Accredited

Social Health Activist (ASHA) are doing a great job for pregnant women and at present 642 ASHAs are prevailing in the district.

Table 5.14: Health Infrastructure in Terms of Respondents View

Indicators	Number (in per cent)
Satisfied with SC	65
Satisfied with PHC	52
Satisfied with CHC	45
Mean waiting time (SC) (in minute)	45
Mean waiting time (PHC) (in minute)	80
Mean waiting time (CHC) (in minute)	90
ANM available in SC	62
Not getting service from PHC in time	54
Not getting service from CHC in time	47
Not getting free medicines from SC	36
Not getting free medicines from PHC	52
Not getting free medicines from CHC	57
Benefitted from different schemes	42
Satisfied with the service of ASHA	72

Source: Field Survey, January 2013- December 2014.

Therefore, from the above analysis of health infrastructure in Cachar district it can be argued that the health infrastructure of Cachar district in not satisfactory. There is a huge shortage of both physical and human health infrastructures in Cachar district. The condition of Block Primary Health Centre (BPHCs) is relatively better in comparison to Sub Centre (SCs) and Community Health Centre (CHCs). However, the situation of Mini Primary Health Centre (MPHCs), State Dispensary (SDs) and Subsidiary Health Centre (SHCs) is very miserable. Non-setting up of the required health centre as per population

norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas. Most of the MPHCs are running by a nurse or pharmacists and as a result, patients are not getting proper treatment. Though some doctors are present in these PHCs, but specialist doctors are still not present in these health centers. For the treatment of women related diseases viz; menstrual problem, white discharge, sexual problem, gynecological problem etc. female doctor are not available in these health centres which affect the rural women specially Muslim women because they are conservative as well as shy to discuss these problems with male doctor. It is also observed that there is huge shortage of male workers in the sub centre even though the post of health workers at various levels are sanctioned, many of them lying vacant. Therefore, the existing facilities are underutilized. The doctors do not want to continue their service in rural areas due to poor infrastructural facilities. Thus in these areas there is a huge demand of doctors and other staffs. Taking care of too many people by limited doctors may sometimes hamper the patients' health.

Though govt. has introduced many schemes especially for reproductive women, but no special attention has been given for the improvement of old aged women. Govt. has appointed Accredited Social Health Activist (ASHA) to maintain a link between the pregnant women and the facilities, which are provided by the govt. According to the facility survey (2011), there are 642 ASHAs are working in the district. Poor economic condition, poor educational attainment, and deep-rooted non-scientific belief along with poor implementation of govt. health service causes health hazard or problems.

Therefore, the health infrastructure of the Cachar district is not sufficient compare to the need of the women and the health care facilities of the existing health centres are

not up to the mark. As a result of this health status of most of the women are found ill and they are facing different types of diseases which is already discussed in the Chapter 4. They are using some traditional preventive measures to get a relief from these health problems even they are also ready to pay as per their ability to express their demand for health care which is explained in detail in the following chapter.