

## CHAPTER-II

### REVIEW OF LITERATURE

The review of literature on the said topic is a very difficult task as the programme itself a new one and it is in its second phase of implementation, There are only few studies have been conducted in India on the overall status of the Reproductive and child Health Programme since its inception. Whatever studies conducted so far are done by Government Departments and very few by Research Scholars and Independent Organizations. The studies considered for the literature review are mostly on the isolated component of the RCH Programme.

As far as Studies on the said programme in Assam particularly in Barak Valley are concerned, there are only one or two can be identified and studies on different components of the programme has been considered

The Census of 2001 had indicated the population of India as 1027 million with 531 million males and 496 million females. In the decade 1991-2001, nearly 181 million persons were added to the population of India. Population increased at an annual exponential growth rate of 1.93 percent in the decade. As per the latest Sample Registration System (SRS) estimates, the annual growth rate of population is 1.74 per cent (1999).

The three most significant factors that can curtail the growth of population are increase in the use of contraceptives, improvement in the mother's health and survival of children. All the programmes of the Department

of Family Welfare are accordingly planned and being implemented for pursuing a combination of these three issues. (Census Report, 2001).

The latest indication of our demographic achievements against different major health indicators shows that except Immunization coverage all other indicators such as IMR, MMR, Crude Birth Rate, Crude Death Rate, Total Fertility Rate, Couple Protection Rate and Life Expectancy at Birth provide picture of our low poor health status in comparison to other developed and developing countries. (Human Development Report, 2002)

In respect of achievement of performance in Family Planning methods and to achieve the long term goals, there is a marginal increase in the case of sterilization i.e. 4.44 millions to 6.67 millions and C.C. users i.e. 17.95 millions to 18.05 millions in the year 2000-2001 from the preceding year., the number of IUD Insertions and O.P. users has decreased i.e. 6.08 millions to 6.03 millions and 7.63 millions to 7.56 millions respectively in the year 2000-2001 in comparison to 1999-2000. This points out that in the case of sterilization, the number of male sterilization is much below the desired level and recommends that the Department should take appropriate steps so that the participation of males is increased in Family Planning methods.( National Family and Health survey,2003)

Community Needs Assessment Approach (CNAA), an action plan is prepared each year at the district level based on the need assessment done by ANMs of Sub-Centre at village level. There is doubt about the implementation of this annual exercise, which is most essential for successful implementation of Family Welfare Programme, specially in the remote and inaccessible areas.

Therefore there is a need of surprise inspections in the performing as well as non-performing districts by Central teams/dedicated NGOs/Social Workers can bring out the ground reality (Negi,2002)

The Rural Family Welfare Centres were set up at all block level PHCs sanctioned upto 1.4.1980 to provide Family Planning and MCH Services in rural areas. There are 5435 such centres functioning in the Country. Besides that, to provide basic health and family welfare services to the rural population 1,37,311 Sub-Centres,21444 Primary Health Centres and 3013 Community Health Centres are functioning in the country and compared to the requirements, there are short fall of 22824 Sub-centres,4463 Primary health centres and 3466 Community Health Centres as per 2002 projected population. Hence, there is a need to open many more Rural Family Welfare Centres, SCs, PHCs and CHCs in the country. The targets for setting up of Sub-Centres, PHCs and CHCs during Ninth Plan seem to have been prescribed for namesake only. The achievement level for the first four years of Ninth Plan 1997-2001 clearly indicates this assessment as only 1053 SCs, 693 PHCs and 410 CHCs were established against the targets of 7686, 1521 and 2903 respectively upto 2000-2001and same can be observed in case of requirement of ANMs and LHVs i.e. there are shortfall of 22746 ANMs and 2987 LHVs in the country. (117th Parliamentary Report, 2003).

The PHC system is facing shortage of doctors for quite sometime. In Gujarat about 20 per cent of PHC Medical Officers posts are vacant at any time. Study from UP shows that in 1990 40 per cent of PHC medical officers' posts and 42 per cent of specialists posts were vacant<sup>5</sup>. The shortage of doctors is

likely to be more in states where private practice is not allowed in the government system, making government service much less attractive for the doctors. This problem was exacerbated after mid 1980s when the number of PHCs was increased almost three folds by bringing down the norm for PHCs from 1 for 100,000 population to 1 for 30,000 population, with a view to increase access to health services in rural areas.(Dr.D.V.Mavalañkar, 1996)

One of the key factors for success of the family planning programme in Bangladesh has been close contact between the FP worker and the community. Unfortunately in spite of substantial FP and health infrastructure in rural areas regular contact between the worker and the community seems to be low due to lack of adequate micro-level planning, supervision and monitoring as well as due to over emphasis on sterilization and immunization. .(Dr.D.V.Mavalankar, 1996).

Post project studies after the India Population project in UP showed that only 15 per cent of eligible couples were contacted by the health workers. ( Premi, 1995).

Recent survey done in 11 districts of UP have shown that only 7-16 per cent of couples are visited by health workers in last 3 months.( The Population Council, India, 1995)

On the other hand 80 per cent of the households were visited by any health worker in past 3 months as reported in a base line survey in 5 districts of Gujarat.(Operations Research Group, Baroda, 1992).

Most sub-centres do not have a building and sub-centres clinics are not very effective. Data from recent surveys done in UP cited above, show wide

variation in percentage of households reporting visit to a PHC or sub-centre in last 3 months. This figure varies from low of 6 per cent to high of 59 per cent. Attendance at sub-centre clinics is also very low. Only small proportions of deliveries are conducted by the para-medical workers. NFHS data shows that only 12.6 per cent of deliveries are conducted by health workers. Most workers do not have training and required equipments and supplies to properly examine a patient and treat common illnesses. In this situation it is difficult to imagine that the community will readily come forward for RCH treatment from such workers or health centres. The first step will have to be developing close rapport with the community and building up credibility of the workers, and the doctors in the PHC system as source of treatment for common problems. (National Family Health Survey 1992-93).

The PHC infrastructure including buildings, equipment, transport and supplies are generally in a poor shape due to lack of maintenance and timely replacements. This is due to inadequate finances, diversion and wastage of available resources and lack of interest and initiative of the PHC medical officers and their higher level managers. An extensive study of PHCs done by ICMR in 1987-89 has showed that PHCs were deficient in many of the basic requirements. ( Indian Council of Medical Research, New Delhi. 1991).

At various levels in the PHC system the counselling and communication process are quite weak. Situational analysis in two districts of UP referred above indicated that information provision to even acceptors of family planning methods is not adequate. NFHS has shown that even in 1992-3, only

58 to 66 per cent of women in reproductive age knew about various spacing methods. (International Institute of Population Science, Bombay, 1995).

Reproductive and Child Health Programme is the flagship programme of Family Welfare, which combines trinity of objectives viz. reproductive health, Child survival and fertility regulation. The Programme is primarily offered through Primary Health infrastructure. The overall goals of the programme are to reduce maternal and infant mortality and morbidity and unwanted fertility and contribute thereto stabilization of population. Allocation for RCH project in BE 2001-2002 was Rs-1126.95 crores which was reduced to 933.36 crores at the RE stage. Allocation for 2002-2003 has been further reduced to Rs. 800.53 crores. Commenting on the reduced allocation the Department has stated that the outlay for Polio Eradication Programme and vaccines for routine immunization till 2001-2002 used to be routed through RCH Programme. The Planning Commission advised that the Department should club all the immunization related activities under one head. Acting on the advice of the Planning Commission, the allocation for polio activities and vaccines for routine immunization related activities which stands at Rs. 376 crores and Rs. 141 crores respectively have been separated from the RCH Programme which in-turn resulted in decreased allocation for RCH Programme in BE 2002-2003.(National Immunization Booklet,2003)

The percentage of women seeking ante-natal care increased from 61.9 (1992-93) to 65.1 (1998-99). Similarly, the corresponding figures for safe delivery (through trained hands) have risen from 34 to 42 during the said period. Noting the efforts made by the Department, though some progress has

been made in respect of Infant mortality rate, percentage of safe delivery etc., they are still very high in comparison to even a number of developing countries. Some States like Assam, Bihar, M.P., U.P., Orissa and Rajasthan continue to perform much below the National Average. In view of this, the Committee recommends that the Department should make extra efforts to improve the performance in these states. (Sample Registration Survey, 2001).

The special scheme transportation of pregnant women belonging to indigent families to the nearest referral centres is being implemented in 25 per cent Sub-Centres in 'C' category districts in 12 States. The feedback from the States has not been encouraging as the funds released are not being utilized by the Panchayat. Twenty four hours Delivery Services is another initiative to promote institutional deliveries under which additional honorarium is provided to the staff to encourage round the clock delivery services at PHCs and CHCs. It is, however, constrained to note that out of Rs. 1002.35 lakhs released to the States so far, an expenditure of only Rs. 51.26 lakhs has been reported and the Department should approach the concerned States for bringing out the necessary improvements/modifications in the schemes for a better implementation of the same. A scheme for holding RCH Camps at PHCs in remote and under served areas has been initiated during 2000-2001. The Scheme is being implemented in 102 districts in 17 States. While appreciating the Scheme, the findings indicates that only 6 States have intimated that camps are being held in identified districts. (Ministry of Health and Family Welfare and DIFD, 2003)

The detailed state-wise information about the target and achievement in respect of various immunization programmes for the years 1997-98, 1998-99 and 1999-2000 shows that in respect of T.T. (PW) the all India achievement in 1997-98, 1998-99, 1999-2000 and 2000-2001 were 82.6 per cent 83.9 per cent, 81.3 and 83.4 per cent respectively and also indicates that in case of majority of the States, the achievement varies between 70 per cent and 90 per cent. However, in some States, like Assam, Bihar, Arunachal Pradesh, Manipur, Meghalaya and Nagaland the achievement is around 50 per cent.[ National Family Health Survey (NFHS),2002]

Health is an indicator of well-being that has immediate implications for the quality of life as well as for productive capacities and capabilities. Assam has been moving towards the attainment of the goal of 'health for all'. The State Government has emphasized not only the adequate provision of primary health care, but education and awareness of health issues, dissemination of information on prevention, hygiene and healthy practices, food security and nutrition, safe drinking water and good sanitation, maternal and child health and family welfare. An assessment of the health status is possible from key indicators such as infant mortality, crude birth rate, crude death rate, life expectancy and nutritional status.

People in the State now live longer than their parents did, and health profiles have improved. Yet, health indicators in Assam also reveal inequity – between districts, between income and other groupings. There is a rural – urban divide, and a gender gap reflected across almost all indicators. Of concern also is the fact that the commonly used indicators for the measurement of the health



status of a population show that while there has been improvement in the all indicators, Assam's performance in the last decade has been lower than the average for the country. (Sen, 2005)

Life expectancy at birth (LEB) in Assam is below that of the country as a whole, and is one of the lowest amongst major Indian States. In the 1970's men could expect to live longer than women. This has since been reversed; women can now expect to live longer than men. This is a trend that began to take place initially in urban areas, but is now true of rural areas as well. There is still a very significant gap between the LEB for rural and for urban areas. In the period 1992- 96, the LEB in urban areas was 64.6 years. In rural areas it was almost ten years less, at 55.6 years. The percentage of people who are not expected to live beyond 40 years in Assam was also higher than the national average. It was 24.9 percent in 1981 and 21.8 percent in 1991. There is rural – urban gap and a gender gap here too; males have a better chance of surviving beyond forty years of age. (Taleem foundation, 1999).

Through the 1990s there was a secular decline in the Infant Mortality Rate in Assam, from 81 per 1000 live births (1991) to 76 per 1000 live births by the end of the decade (1999). This is a positive development, but the IMR in Assam is higher than the national average. Across districts there are major differences; the data shows that while some districts have IMR rates comparable or lower than the national average and are therefore performing very well, there are others with high IMR rates. The rural-urban gap is extremely high. Urban IMRs were less than half the rural IMRs, in the entire period. The rural-urban divide is also apparent in the data on under-5 mortality, which measures the probability of dying before the fifth birthday. Under-5 mortality is substantially higher in rural

areas. Not surprisingly there were other significant correlations, most tending to confirm the view that children of disadvantaged parents were most at risk. Such disadvantaged groupings, for example, included illiterate mothers and low-income households. (Assam Human Development Report 2003)

The Crude Birth Rate (CBR) has declined significantly in Assam, over the last few decades, but it continues to be higher than the national average. In Assam, as in the rest of the country, the CBR is much higher in rural areas as compared to that in urban areas. (Prasad, 2000)

The Total Fertility Rate (TFR) was 3.3 children per woman in 1995-97, a substantial decline from 1980-81, when it was as high as 4.1 children. The TFR for all India was 3.4 in the 1995-97 period. There is a substantial rural-urban gap in fertility rates as well. (Mallik, 2002)

The Crude Death Rate (CDR) is another indicator of the health status of a population. The death rate in Assam declined quite substantially in the early nineties, but in the mid nineties, the decline came to a virtual standstill and the rate even showed a marginal increase. As in the case of the CBR, the CDR in rural Assam is substantially higher than that in urban Assam, and the same is true for rural and urban India. (NHDR Assam, 2003)

An analysis of the health status must go beyond indicators, and take into account the trends in critical areas. Nutrition is increasingly recognized as a crucial determinant of health. An analysis of the nutritional intake of children shows both chronic and acute malnutrition among children. The proportion of children under three years of age, who are underweight, decreased from 49 percent in 1992-93 to 36 percent in 1997-98. The proportion of severely underweight children also decreased from 18 percent to 13 percent. Under-

nourishment is substantially higher in rural areas than in urban areas. (Boruah, 2004)

Morbidity is being increasingly used as an indicator of the well-being of people. Both rural and urban Assam had a high proportion reporting ailments. Among the most common illnesses, asthma was fairly prevalent, followed by malaria, jaundice and tuberculosis. Water-borne diseases are also common, and show a steep rise during periods of flood, in itself a frequent occurrence. (The Assam Tribune, 2004)

*Maternal and Child Health form an integral part of the Family Welfare Programme in Assam. Only about 60 percent of expectant mothers received any kind of ante-natal care (ANC), and 17.6 percent of the deliveries took place in health facilities or institutions. The proportion of births that took place in health facilities or institutions is four times higher in urban areas than in rural areas. Reproductive health care area has certainly improved, but the gains have been very limited. Since the percentage of institutional deliveries is low and those by untrained hands are high, it is not surprising that maternal mortality is still high, at 401 per 100,000 live births, compared to an all India figure of 408 per 100,000 live births, in 1997. (Ministry of Health & family Welfare, 1998)*

The continuing prevalence of diseases reflects shortcomings that should be addressed by the health care system. An effective system of vaccination can contribute to the health and longevity of children. Despite the fact of expanding coverage and administrative effort, there are gaps in the extent, periodicity and coverage. These gaps are more marked for vulnerable and relatively disadvantaged communities and groups. The Universal Immunization Programme initiated in 1985 sought to cover 85 percent of all infants against the

six vaccine preventable diseases by 1990. The six diseases are polio, tetanus, whooping cough, diphtheria, childhood TB and measles. After an initial spurt in immunization in the early nineties, the immunization coverage for children declined during 1996- 99. (Jain.2003)

Diarrhoea is a common cause of mortality among children. Acute Respiratory Infection (ARI), primarily pneumonia, is another cause of illness and child mortality. Assam has the highest incidence of anaemia in the country. About 70 percent of women in Assam have some degree of anaemia. The prevalence of anaemia is higher for rural women than for urban women. Among children too the prevalence of anaemia is high. Cancer, cardio-vascular diseases, diabetes and stroke are important non-communicable diseases affecting the older population, the proportion of which is increasing with longer life expectancy. Lifestyle changes are however even more significant causal factors. ( Rapid House Hold Survey, 1999)

The availability of medical facilities is comparable to the national average. There are imbalances though, between rural and urban areas, and the efficacy of infrastructure in rural, especially remote areas is less than required. (Population Commission, 2001).

While access to health facilities has improved considerably, there are remote, riverine and hilly areas that continue to face problems of accessibility. For riverine chars, the State Government has initiated a scheme of boat clinics. Similarly, mobile clinics have been started in hill areas. The Government of Assam has taken several initiatives to promote health care. These include legislation to provide an adequate regulatory environment for the construction of clinics and nursing homes, centralized procurement of drugs, and innovative

schemes such as the boat clinics. New management techniques like the formation of Hospital Management Societies are being introduced in hospitals, so that resources are used judiciously and efficiently. (Sharma, 2000)

The expenditure on health as a proportion of total public expenditure was 5.23 percent in 1980-81. It remained more or less constant in 1990-91- at 5.04 percent but declined in 1998-99 to 4.65 percent. The expenditure on the health sector as a proportion of Gross State Domestic product has also been quite small compared to education, for example. (Department of women and Child welfare Report, 2000)

There is a need to improve the quality of data, the periodicity of its collection and the extent of its coverage. While the collection of data especially disaggregated data is important, its analysis is even more consequential. Resource and infrastructure constraints make it even more imperative to analyze information and to target those areas and diseases that impact more significantly on the overall health status of the State and its people. The rural-urban gap is significant, and in some cases, widening. Given the fact of relatively low urbanization, it is clear that the overall health profile and status can only be improved with vastly more attention to the rural sector. Within this framework, the emphasis needs to be on those districts which are most inadequately served, and within districts on those blocks that have less than adequate access to health services. There are also population groups that have health indicators that are substantially lower than the State average. Another gap is the gender gap, apparent in life expectancy and maternal mortality rates. Infrastructural constraints, such as poor transportation, prevent the

proper utilization of existing services, particularly in rural areas and are perhaps more important than constructing health care centres. (Srinivasan, Gulati, (et al), 1998)

The private sector is expanding rapidly and in the absence of any controls/ regulations the health care that is provided is often substandard. The Government has enacted the Health Establishment Act to control the unplanned proliferation of private hospitals in the State but the rules under the Act are yet to be framed. (Ahluwalia, 2003)

The State needs to find the resources that will enable the expansion of the health care system and allow for its efficient functioning. Since the State continues to be under fiscal stress, especially in the short term, resources will need to be generated. Given the fact that private health care systems are expanding, and these provide services at fees much higher than in the public domain, revenue can be generated from the health services, at least from people who can afford to pay. (Ahluwalia, 2003)

### **Women: Striving in an Unequal World**

Through the ages women have played an extremely important role in Assamese society. Contributing at work and at home, women hold the key to the advancement of the State, its people and the economy. However, even today, asymmetry and inequity are unfortunately a fact of life for women. The position of women in Assam is not different from that of women in other regions of the country. In fact in some respects, women in Assam are more disadvantaged.

The sex ratio (SR) in Assam is adverse, and has been for many decades, certainly throughout the 20th century. Encouragingly, in the last decade of the century (1991 – 2001), the SR has improved. There continues to be a significant gap between the ratios for urban and for rural areas, urban SRs being more adverse than rural SRs. The SR in Assam according to the 2001 Census is 932 females per 1000 males, just below the national SR of 933 females per 1000 males. Encouragingly, sex ratios have been rising in all districts since 1971 when more than half of the districts had SRs below 900. (Jain, 2003)

Life Expectancy at Birth (LEB) for women has improved significantly in Assam in recent decades, but continues to be below the average for the country. Women in Assam can expect to live 5.2 years less than their counterparts in the rest of the country. Both men and women in rural Assam can however expect to live almost 10 years less than their urban counterparts. (NFHS-2, 2001)

The Crude Birth Rate (CBR) has been declining since 1971. In 2001, it continued to be higher than the national average. Fertility rates are also high, and should be lower. A comparison of male and female death rates shows that the Infant Mortality Rate (IMR) in the age group 0-4 is higher for males than females. From age 5 onwards the trend is reversed with much higher mortality rates for females. This is true till the age of 50 years or so, when the trend again reverses with male death rates becoming higher. (Mishra, 2003)

In Assam, as in the rest of India, literacy rates for both males and females have shown a rising trend in the last three decades. There continues to be a gap, which is closing slowly. Rural literacy rates are 25 percent lower than urban literacy rates and in case of females, the gap between urban and rural areas is as much as 30 percent. There are continuing and wide differences

between districts with respect to female literacy and this remain one of causal factor of low health status of women in Assam.(Nair,2005)

To achieve gender equity, it is imperative that the gender dimensions of development and societal advancement be adequately addressed. The participation of women in political processes is also important. A sensitive, forward looking and dynamic gender policy that addresses the prevailing inequity, and seeks to create a positive framework for change is required. Advocacy and social change must necessarily be a part of this initiative. Women need to be seen as active partners in the development process. Capacity building, skill formation and improvement in health status must be an integral part of any programme which is to have meaningful results. In Assam with its strong traditions of women's involvement in agriculture and production, gender development is vital to economic growth and human development.

Before going to measure the impact of the RCH Programme in Barak Valley, Assam, we must have a comparative view of achievement on major indicators of Mother and Child Health. Between This comparison is between the MCH status before and after the implementation of the Reproductive and Child Health Programme in the year 1997. The said comparison is presented below in the form of a table.

Indicators	Past Status	Current Status
Crude Birth Rate (per thousand population)	40.8 (1951)	26.1(1999)
Crude Death Rate (per thousand population)	25.1 (1951)	8.7 (1999)
Infant Mortality Rate (per thousand live birth)	146 (1951-61)	70 (1999)
Maternal Mortality Ratio (per 100,000 live births)	800 (1951)	407 (1998)
Total Fertility Rate (per woman)	6.0 (1951)	3.2 (1998)



Couple Protection Rate ( per cent)		10.4 (1970-71)	48.6 (1999)	
Life Expectancy at Birth (in years)		1951:	1996-2001:	
Male		37.1	62.30	
Female		36.1	65.27	
Immunization Status ( per cent coverage)-For pregnant women		1985-86	1999-2000	
TT		40	79.0	
For Infants				
BCG		29	99.1	
MEASLES		44	87.0	
DPT		41	92.8	
POLIO		36	93.4	
FAMILY PLANING				
Year	Sterilization	IUD Insertions	C.C. Users	O.P. Users
1986	2.87	3.68	11.21	2.25
2000-2001	4.67	6.03	18.05	7.56

Source: 117<sup>th</sup> Parliamentary Report 2003

The above table shows the comparison of all India level and in the following chapters, we will see the achievements in Barak Valley of Assam.

The available literature reviewed so far for the study has the gap of not having enough studies and research work on all aspects of RCH rather, these studied mostly focused on the various components of RCH in isolation. These literature also lacking the comparative studies or research on the present RCH status with the goals of RCH Programme and National Health Policy.