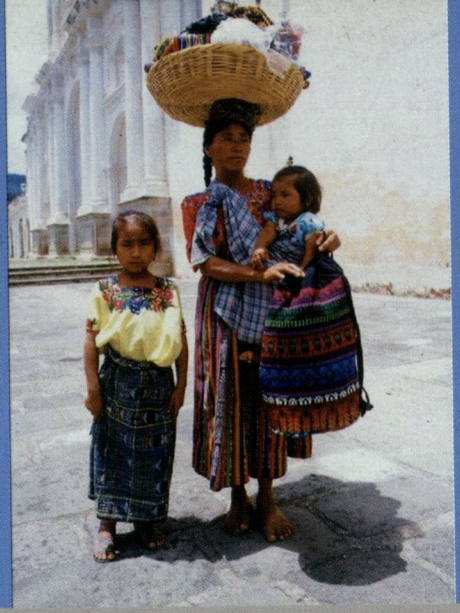

REPRODUCTIVE CHILD HEALTH IN THE NORTH EAST REGION

S.K. Singh
Awadhesh Kumar Singh

North-East India is endowed with resources of land, water, forests, minerals etc. The region is also rich in diverse culture, ethnicity and heritage. The demographic profile of the region is undergoing rapid change. Projections reveal that percentage of population in age group of 0-4 years will decline and the population in the reproductive age group will undergo a massive increase. The demographic transition is both a challenge and an opportunity for the country. The opportunity is that India will have a battery of large productive and reproductive populace. The challenge is to develop synergy between ongoing demographic, educational, economical and technical transitions so that India can hasten population stabilization and rapidly achieve sustainable development. Strategies and programmes followed, till now, have taken a rather narrow perspective on the health of women and children. Women's health programmes have been primarily designed to address issues related to maternal health. Child health interventions have focussed on mortality prevention with insufficient emphasis on developmental issues. Under Reproduction Child Health Programme, government is committed to providing a package of reproductive services such as safe delivery, pre and post notal care, abortion, treatment of reproductive tract infections and sexually transmitted diseases, counselling on sexuality and responsible parenthood, and contraceptive services etc. Against this perspective, the present book highlights the status of Reproductive Child Health in India, particularly in North Eastern Region. It also presents demographic and health profile of north-eastern region as well as assesses the impact of RCH services, community participation and health seeking behaviour of populace. It is hoped that the book will be useful to policy makers, administrators, health workers, representatives and manages of NGO's and other community-based organizations and those who are interested in this field.

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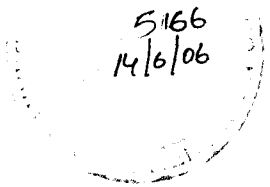

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CONTENTS

1

INTRODUCTION

North–east India, popularly known as the land of seven sisters, is endowed with resources of land, water, forests, minerals etc. The region lies at the confluence of China, and Tibet to the North, Myanmar to the East and Bangladesh to the South. It is connected to the rest of India by a narrow corridor between Nepal and Bangladesh. The indigenous inhabitants of this region, who are mostly tribals, have a bewildering variety of cultures. Out of approximately 31.5 million people, about 8.1 million are tribals. There are about 130 major tribal groups who constitute about one third of the total number of tribes in India. The demographic profile of north east is undergoing rapid change. Projections reveal that percentage of population in the age group of 0 to 4 years will decline and the population in the reproductive age group will under go a massive increase. The demographic transition is both a challenge and an opportunity for India. The opportunity is that country will have a battery of large productive and reproductive populace. The challenge is to develop synergy between ongoing demographic, educational, economical and technological transitions so that India can hasten population stabilization and rapidly achieve sustainable development.

India is expecting to be world's most populated country by 2050 leaving aside China. India is a country with limited resources to feed unlimited population. The decadal growth

of population is more then the population of Brazil. If such trends continue than there will be population explosion. Ironically India was the first country to launch family planning programmes in 1952 and then kept on changing strategies in relation to international conferences like that of Maxico, Cairo. Beijing etc. with limited success. The fact remains that Government alone cannot successfully restrict family size, avail health services and bring development. There is a need of collaboration with voluntary agencies, grass root level leaders and the masses.

The present programme structure of the Family Welfare Department of the Ministry of Health and Family Welfare. Government of India, New Delhi, is complex and has been built up overtime. New projects and programmes have been added to the original core of family planning programmes for example MCH, CSSM, RCH etc. In the 7th Plan (1984–89) Maternal and Child Health (MCH) component was added with focus on the health needs of women in reproductive age group and children under five in addition to providing contraceptives and spacing services to the desirous married couples. Similarly, the Child Survival and Safe Motherhood (CSSM) Programme was launched in 1992 with the assistance from the World Bank and UNICEF to strengthen the maternal and child health component of National Family welfare program. The CSSM included components like management of acute respiratory track infections, diarrhea care and emergency obstetric services. It was first serious attempt at integrating issues pertaining to morbidity, mortality and quality of life of pregnant mothers and infants. International conference on Population and Development, 1994 at Cairo recommended that the participating countries should implement unified programme for RCH. The concept was to provide the beneficiaries need based, client centered, demand driven high quality and integrated health services leading to population stabilization. The RCH package of India consists of (i) prevention and management of unwanted fertility, (ii) management of pregnancy and child birth; (iii) prevention and

management of RTI's and STD's; (iv) child survival through immunization, diarrhea and acute respiratory illness control and care to newborn etc. As national population policy, 2000 has assigned important role to community based organizations (Panchayats, NGOs, Youth Clubs, SHGs) for implementation, monitoring and management of the RCH programmes at the grass root level. Village self-help groups are to be utilized to organize and provide basic services for RCH combined with the ongoing Integrated Child Development Scheme. Integrated and coordinated service delivery package for basic health care, family planning and maternal child health related services were provided at village levels by the community and for the community. The NGOs were encouraged to participate in the operation of RCH programmes.

In 1943, the Government of India appointed the historical Bhore Committee to survey the health situation in the country and make recommendations for the future. Remarkably influenced by the considerations of the Beveridge Committee in England, which gave birth to the National Health Service in the country, the Bhore Committee made far reaching recommendations guided by two overriding principles. First, the position of health care services was the responsibility of the state, second, comprehensive health care should be available to people irrespective of their ability to pay. The blueprint for the development of health services that was outlined, both in the short-term and long-term, emphasized preventive services, focusing on rural areas and linking health with overall development. In the First Plan, more than half of the expenditure was allocated for development of hospitals and dispensaries and 40 per cent of the total provision was allocated for medical education and training. Primary health centres were to be developed as part of the Community Development Programme. The First Plan gave birth to the launch of what are called unipropose, vertical programmes for the control of malaria, small pox, filarial, leprosy, cholera and venereal diseases. India was the first country in the world to launch a family planning programme during this period.

While recognizing the importance of maternal and child health, this was to form an integral component of the general health services. In the Second Plan, encouraged by international agencies, the control programmes was converted into the National Malaria Eradication Programme. It was envisaged that malaria would be eradicated by 1966. The operational strategy for the family planning programme over the first two plan periods, again inspired by international agencies, was the clinical approach. The Third Plan witnessed the coming to the fore recommendations of the Health Survey and Planning Committee, known in popular parlance as the Mudaliar Committee. The committee noted that the primary health care system that had evolved so very haltingly, bear no resemblance to that visualized by the Bhore Committee. The committee recommended the upgradation of existing services. In 1962, National Tuberculosis Programme was launched following a series of small pox eradication programme. This finally started paying dividends although when India finally eradicated small pox in 1975, it had not only poured in much more resources than had been anticipated. In the Fourth Plan, the pace of the family planning programme was substantially accelerated, family welfare centres for vasectomy were supplemented by more than 1000 mobile service units. In 1972–73, sterilization reached a peak of 3.1 million. Two thirds of these were performed in camps. The World Bank and the Population Council endorsed developmentalist perspective. The echoes of such shifts reverberated in India as the Fifth Plan codified this changed perspective. It noted that the primary objective is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups. The year 1975 entered the annals of the history of public health in India for two reasons. First India was finally declared small pox free. Second, the year witnessed the declaration of emergency which facilitated the passage of the draconian National Population Policy of April 1976 which called for a direct assault on the population problem. In 1977, the government announced the implementation of the recommendations of the Srivastava

Committee as a scheme for strengthening rural health care services. In this year, Community Health Volunteers Scheme was inaugurated as a step towards repositioning people's hands on a war footing. In 1980, 'Health for all', An Alternative Strategy was adopted. This strategy routed in the community, provided adequate, efficient and equitable referral services, integrated and promoted preventive and curative aspects and combined the valuable elements in our culture and tradition with the best elements of the Western System. The Sixth Plan adopted a long–term demographical goal of reducing the net reproduction rate of one by all the states of the country by 2001. Towards this end, it recognized the need for poverty eradication, improvements in infant and child survival, female interary and nutrition. Thus, in the plan period, there was an increasing emphasis on the sterilization of women, often at laparoscopic camps. Health programmes that were included in the 20 Point Programme, viz., tuberculosis, leprosy, and UIP were now assigned targets to be achieved while the CHV scheme was unceremoniously buried. The Seventh Plan noted the inability to meet the targets set out both for rural infrastructure development and control of communicable diseases in the Sixth, it sets no contradiction in the commending the development of specialties and super specialties to grapple with the major health problem of non–communicable diseases. During this, natural AIDS control programme commenced with a soft loan of US $ 84 million from World Bank and technical assistance from WHO. A separate organization, the NACO, was consequently set up. The Eighth Plan document again note the depressingly familiar inability to meet the goals of the previous plan in control of communicable diseases, in achieving the family planning goals. During this period, AIDS control began to assume increasing importance, not so much because it was assessed as a major public health problem epidemiologically, but because funds began flowing from international agencies. The Ninth Plan stated that reduction in the population growth rate has been recognized as one of the priority objectives during the Plan period. The priorities

in the Plan were started to meet the felt needs for contraception, and to reduce the infant and maternal morbidity and mortality so that there was a reduction in the desired level of fertility. During this period, two important policy documents were announced, first the National Population Policy, significantly announced before, the second i.e. the National Health Policy.

International consensus has emerged to reduce indices/ deaths arising out of communicable and preventable diseases, as indicated by three of the eight Millennium Development Goals directly identified with health. Keeping 1990s as the benchmark, the three goals and targets therein that have to be achieved by 2015 are (i) to reduce under five (infant/ child) mortality by two thirds, (ii) to reduce maternal mortality rate by three fourths; and (iii) to combat human immunodeficiency virus/ acquired immune deficiency syndrome (HIV/ AIDS), malaria, tuberculosis (TB) and other diseases by not only halting their rising incidences but also by reversing their spread. India Vision 2020 envisages increasing access to health care for women and children, eliminating childhood deaths from diarrhea by 2010, effective targeting of undernourished children, restructuring malaria workforce to reduce incidence by 50 per cent and improving diagnosis and treatment of TB. It also seeks to address the state of under equipped, under staffed and under financed health care infrastructure and suggests increasing public spending from 0.8 per cent to 3.4 per cent of gross domestic product.

Effective public health measures need to address issues of food hygiene, availability of clean air and water and proper sanitation. Designing of public policy should factor in local specifications, with decentralization and devolution of power, the local bodies will have a greater role. Addressing state, district or block specific public policy does not mean doing away with the role of the Central Government. It requires the Centre to be more proactive in addressing inequalities across states and to ensure appropriate regulatory and monitory mechanisms. The presence of NGOs and CBOs is lower in poorer regions. There is need to increase the number of care

providers and create suitable working conditions to ensure their availability in remote areas.

The Ministry of Health & Family Welfare (MOHFW), Government of India is implementing a Reproductive Child Health (RCH) Programme in the country. For this purpose, it is absolutely essential to obtain knowledge of the existing situation at different levels of health facilities in the country. A facility survey at district level will help in assessing the availability of trained staff, equipment and supplies and their utilization at Primary Health Centres (PHCs), Community Health Centres (CHCs), First Referral Units (FRUs) and District Hospitals. The major findings emanating from the Facility Survey Phase–I are given below:

Status of Infrastructure in PHCs (in Numbers)

	Number of PHCs Surveyed	*7654*
Infrastructure	Water	4765 (62.3)
	Electricity	6222 (81.3)
	Labour Room	3627 (47.4)
	Laboratory	3474 (45.4)
	Telephone	1453 (19.0)
	Vehicle Working	2141 (28.0)
Staff	MO	6762 (88.3)
	All HA (F)	4023 (52.6)
	All HA (M)	2506 (32.7)
	Lab Technicians	2775 (36.3)
	Deep Freezers	4941 (64.6)
Equipment	Vaccine Carrier	6529 (85.3)
	B.P. Instrument	5787 (75.6)
	Auto–clave/ Sterilization	4514 (59.0)
	MTP Suction Asp.	1190 (15.5)
	Labour Room Equipment	3999 (52.2)
Supplies	Kit 'G' IUD Inser.	3637 (47.5)
	Kit I, Normal Delivery	3449 (45.1)
	EMOC Drug	1517 (19.8)
	Mounted Lamp	285 (3.7)
	Oral Pills	4537 (59.3)
	Measles Vaccine	4644 (60.7)
	IFA Tablets	2414 (31.5)
	ORS Packets	4924 (64.3)

Status of Infrastructure in CHCs (in Numbers)

	Number of PHCs Surveyed	*851*
Infrastructure	Water	606 (71.2)
	Electricity	786 (92.4)
	Operation Theatre	734 (86.3)
	Labour Room	229 (26.9)
	Laboratory	508 (59.7)
	Generator	438 (51.5)
	Telephone	521 (61.2)
	Vehicle Working	514 (60.4)
Staff	OBGYN Specialist	250 (29.4)
	Anaestnesist	80 (9.4)
	Lab Technicians	622 (73.1)
Equipment	Boiler Apparatus	290 (34.1)
	Oxygen Cylinder	412 (48.4)
	Shadow-less Lamp	549 (64.5)
Supplies	Tubal Ring	49 (5.8)
	Std. Surgical Kit (6)	240 (28.2)
	EMOC Drug Kit	122 (14.3)
	RTI/ STI Lab. Kit	35 (4.1)
	New Borne Care Kit	10 (15.3)
	LabourRoom Kit	410 (48.2)

Status of Infrastructure in FRUs (in Numbers)

	Number of FRUs Surveyed	*698*
Infrastructure	Water	574 (82.2)
	Electricity	667 (95.6)
	Operation Theatre	670 (96.0)
	Labour Room	255 (36.5)
	Laboratory	508 (72.8)
	Generator	504 (72.2)
	Telephone	552 (79.1)
	Vehicle Working	502 (71.9)
Staff	OBGYN Specialist	327 (46.8)
	Anaestnesist	145 (20.8)
	Lab Technicians	594 (85.1)
Equipment	Boiler Apparatus	397 (56.9)
	Oxygen Cylinder	445 (63.8)
	Shadow-less Lamp	601 (86.1)
Supplies	Tubal Ring	62 (8.9)
	Std. Surgical Kit (6)	444 (63.6)

Number of FRUs Surveyed	*698*
EMOC Drug Kit	199 (28.5)
RTI/ STI Lab. Kit	77 (11.0)
New Borne Care Kit	254 (36.4)
LabourRoom Kit	486 (69.6)

Though RCH programme has been implemented in India with vigour and spirit, however, there is paucity of literature on RCH programme and particularly community participation in it. Against this backdrop, present study has been conducted in north-eastern region, covering Mizoram and Tripura states. The study purports to review the health status and health seeking behaviour and to assess the role of community in RCH services delivery.

Objectives of the Study

The study had the following main objectives:

1. To identify the level of utilization of the services relating reproductive and child health care and family planning against the background of the socio-economic characteristics, demographic attitudes and fertility behaviour of the couples.
2. To examine the socio-economic features, educational status, demographic attitudes and fertility behaviour of the members of community based organizations;
3. To assess the awareness of the members of CBO's regarding prescribed roles and duties about population control, raising family planning acceptance, promoting reproductive and child health care and improving the quality of services.
4. To identify major activities being performed by the members of CBO's in implementation, monitoring and management of the RCH programme at the grass root level.
5. To understand the major problems faced by the CBO's in popularizing family planning and implementing RCH programmes.

6. To assess the performance of ANMs and other health personnel of the PHCs and sub centers in delivering the RHC services. An attempt has been made to study their interaction and coordination with the CBO's.
7. To examine the role of the workers of Integrated Child Development Scheme (ICDS), NGOs and Self-Help groups in promoting the RCH services and supporting the PRIs.
8. To assess the needs of training for the members of CBO's for efficient Monitoring and Management of the RCH programmes. An attempt has been made to develop suitable informative and educational material to meet the training needs of the Panchayat members.
9. To examine the adequacy of the existing financial resources of the CBO's to perform RCH and other activities relating to population control and to suggest the measures to raise the funds.

Hypothesis

The following hypotheses have been empirically tested:

1. the village level leadership lacks initiative and motivation for a social cause like family limitation and acceptance of family planning due to opposition by certain religious groups and people with traditional thinking pattern.
2. With the reservation of women in PRIs, most of the elected females are illiterate or less educated and in many cases, are not aware about their roles and duties. They generally function under the guidance of their husband or close relatives who have their vested interests.
3. Members of CBO whether male or female lack expertise to understand different aspects of population problem and RCH programme.
4. Level of interaction between CBOs, PHCs and sub–centres is very low.
5. Inter–departmental coordination and their cooperation with PRIs is inadequate.

6. Lack of initiative and expertise among NGOs, Self-help groups and ICDS workers to perform roles relating to RCH programme and non-availability of their help to CBOs.
7. Inadequacy of financial resources with the CBOs.
8. PRIs have been overloaded with many responsibilities (29 subjects as contained in Panchayat Raj Act) reelating to preparation and implementation of different plans for socio-economic development.

Methodology

Present study is empirical in nature and based on mainly primary data collected through field survey. The field survey has been conducted in two states of north-eastern region viz. Mizoram and Tripura. Both rural and urban areas of the selected states have been surveyed.

Coverage of the Study

State	*District*	*Block*	*Villages*
Mizoram	Aizwal	Tlangnuam Block	Comprised of all the localities within Aizawl city, including the surrounding villages, viz. Sairang, Tuiraial, Nisapui and Lungdai.
		Phullen Block	Suang Puilawn, Van Bawng, Phuai Buang, Khanwalian
		Darlawn Block	Khawruhlian, East-Phaileng, Pehlawn, Sakawardai
		Aibawk	Hualngohmun, Kelsih, Sialsuk, Falkawn
		Jireania Block	Mohanpur, Kalkapur, Mandai, West Noabadi, North Noabadi, Champak Nagar
		Sidai Mohanopur Block	Mohanpur, Lembuchora, Netun Nagar, Hejamara, Simra
		Vishalgarh Block	Barabari, Gulagati, Gokulnagar, Modhupur, Debipur, Puratol
		Melagart Block	

Contd....

State	*District*	*Block*	*Villages*
Tripura	West Tripura	Duglai Block	Naya Gram, Surja mani (Babul Chow),Hati Leta, Narayan Kamar, Hapania, Amtuli, Ballabpur, Raier Mora, Gabtuli, Madhavpur, Ishan Chandra Nagar
	North Tripura	Jampui Hill	Kanchanpur, Kumarghat, Langzari, Jampui Hill, BhangbunVanghmun

Beside survey of selected 400 households, 150 community based organizations such as NGOs, Panchayats, SHGs, Youth Clubs, Voluntary Organizations, Mahila Swasthya Sanghs, School teachers, religion groups, and health workers were randomly selected for interview. It is to be noted that Panchayats are functional in Tripura only, though there is Tribal Autonomous Development Council in its jurisdiction, panchayats are not functional. However, Panchayats in the state are very vibrant and taking active role in development, governance and people's empowerment.

Household survey has been conducted in Mizoram and Tripura. Overall 400 households were randomly selected for field survey. The field survey has been conducted with the help of structured interview schedule. It included the relevant questions, research points, and scales of view perceptions, related to general information, family information, marriage pattern, morbidity and mortality, awareness of RCH services, fertility preferences, maternal health, prenatal and post-natal care, vaccinization of pregnant women, safe delivery, assistance during delivery of pregnancy, breast feeding and nutrition, immunization and vaccination of children, awareness, use and knowledge of contraceptives and family planning measures, etc.

The interview schedule for community leaders had relevant questions, research points and scales view perception related to personal information, availability of health infrastructure, quality of services available at health centres, community participation in RCH services, health seeking behaviour etc.

Besides collection of primary data by field survey, secondary data and pertinent literature has been scanned from published and documented sources. Such sources included National Family Health Survey – II, National Sample Survey Reports, Reports of Planning Commission, Government of India, reports of North–Eastern Regional Development Council, Meghalaya, reports of Department of Family Welfare and Health, Government of Tripura, and Government of Mizoram. The annual reports, perspective plan and Economic Review achievement for last 4 years reports available from government etc. were reviewed to get insight and relevant statistics.

The filled in interview schedules were thoroughly checked, edited and processed in computer, using statistical packages. The data has been tabulated interpreted, discussed and analyzed. The policy recommendations are based on analysis of research findings and critical appreciation of pertinent literature.

Scope of Study

The study has its own limitations. The study is confined to north–eastern region and particularly, Mizoram and Tripura. Study is empirical and analytical while statistical analysis of data could not be ensured due to its limitations. Moreover, in absence of exhastive data, reports and literature on Mizoram, thorough review of progress pertaining to the health status, RCH services and health seeking behaviour could not be ensured. The insurgency like situations also affected the field survey in North–Tripura. However, government officials were very cooperative, enthusiastic and they extended their full support.