Study on Decentralization of Maternal and Child Health Services

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Abstract—*The maternal mortality rate in India is the highest among all the developing countries all over the world. There are many programmes in the country launched by the Government of India in the health sector mainly focusing on maternal and child health. Since the beginning of the Safe Motherhood Initiative, India has accounted for at least a quarter of maternal deaths reported globally. There are variations in maternal mortality rate across the states all over the country. India aims at lowering the maternal mortality rate to 100 per 100,000 live births but that is still far away. This paper analyses the maternal health conditions in Bihar specially focusing on Madhubani district in Bihar. This paper focuses on the changes which have occurred in the health sector in the district in the field of infrastructure, human resource, drugs and medicines, institutional deliveries, the inflow of patients etc. The size of respondents selected for the study was 150 and the study area was in Madhubani district of Bihar. One of the PHC and two APHCs of Madhubani district were visited for the study. It is estimated that the number of institutional deliveries have increased after the launching of NRHM (National Rural Health Mission) in the country and especially after the launching of JSY (Janani Suraksha Yojana). The maternal mortality has also decreased in the district and the number of patients visiting the hospital has also increased. There are so many cases of anaemia in the district. The government hospitals lack the facility of free drug supply and the delivery facilities. There is lack of doctors in the government hospitals. Infrastructure is also a problem in the government hospitals and the place where these hospitals are located is also important.*

1. INTRODUCTION

India with a population of over a billion and decadal growth of 21% estimates its maternal mortality at 301 in 2003 (Family Welfare statistics, India 2006). The MMR (Maternal Mortality Ratio) vary across the states with the largest contribution of north-Indian states. The WHO (World Health Organisation) estimates that, of 536,000 maternal deaths occurring globally each year, 136,000 take place in India (WHO 2007). Bhore Committee report (1946) concluded that MMR in India was around 2000 deaths per 100,000 live births (GOI 1946). In 1959 Mudaliar committee estimated that MMR decreased to 1000 (GOI 1961). A nationwide sample study in 1992 by Indian Institute of Population studies reported the MMR of 437 (IIPS 1992, Iyengar et al).

Maternal and child health are an important aspect for healthy society. The situation of maternal health must be improved for the birth of a healthy baby which would become the future generation of the country and would participate in the nation-making process. Millennium Development Goals (MDG) launched by the UNDP (United Nations Development Programme) focuses on improving the situation of maternal and infant mortality rate through MDG 4 & 5 (Reduce Child Mortality and Improve Maternal Health) by 2015. Despite so many efforts made by different international agencies and local government the progress is not much. There are different reasons for maternal and infant mortality like different diseases of which water borne diseases and HIV/AIDS are the major ones. Apart from the diseases different social factors has also lead to maternal mortality like poverty, poor sanitation facilities, and contaminated water supply, social status of women, lack of education etc. Due to poverty many people face the problem of access to quality health services during the period of pregnancy, which are often costly in private hospitals. Health care services offered in public hospitals lack quality which is most important when it comes to the treatment of pregnant women.

Women in developing countries 100 to 200 times runs the risk of dying in pregnancy and childbirth compared to women in affluent countries due to poor health facilities and lack of knowledge. In a country like India where traditional birth attendants have been in practice the risk multiplies several times, because these attendants are not trained of childbirth and do not understand the problem of severe complications during delivery of pregnancy. Apart from it the lack of transport facilities and proper medical services in the rural areas also creates problem for poor people who have to travel long distance at the time of emergency (Fraser William and Meli Jean 1990). In India Bihar is the most worst performing state in the field of health. The main problems are the marriage of girls at an early age, use of contraceptives measures mainly by women which adversely their health, the problem of illiteracy, male domination in the society etc. the MMR in the state is 531 per 100,000 live births compared to 398 nationally. Pregnancy related care reaches to fewer

women including antenatal, delivery-related and post-partum care (Jejeebhoy J. Shireen 2007).

The decentralization of health services in India started in mid-1990s which focused mainly on the provision of health services in the rural areas. The National Population policy (2000) of India and the Health Policy (2002) mainly focus on decentralization. The launching of the National Reproductive and child Health program after the International Conference on Population Development is a step forward in the decentralization of health services in India. The National Rural Health Mission (NRHM) launched by the government of India in 2005 also focuses on the decentralization of health services in India. Improvement in the maternal health services is the main focus of the NRHM. The reduction in the Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and improvement in other factors affecting the maternal and child health is the main concern of NRHM. The JSY (Janani Suraksha Yojana), the flagship programme under NRHM was launched to increase and promote the institutional deliveries so that both the mother and the child are in safe hands. The opening of the Primary Health Centres (PHCs) at block level and Additional Primary Health Centres (APHCs) at village level depending on the size of population is an effort by the Government of India to decentralize the health system which was earlier operated on centralized basis in each state, state being the main authority.(Kaur Mannet,Prinja Shankar,Singh K Pravin and kumar Rajesh)

This paper addresses the problems and issues related to the decentralized health governance under the genesis of NRHM in India with a focus on Bihar. In particular it focuses on the problems related to the availability of human resources in the health sector, the infrastructural facilities provided in the government hospitals especially in the rural areas, the availability of drug and medicine kits in the hospitals and the number of institutional deliveries taking place in the government hospitals.

2. FIELD SETTING AND INFORMATION

The study was conducted in three villages of Hrlakhi block, Madhubani district of Bihar. The state of Bihar has a total population of 10.41 crores (104,099,425) as per 2011 census. There has been an increase of 25.42% in the population in state compared to the census year 2001. The density of population of the state is 883 persons/sq. km. Bihar has the literacy of 63.67%.

Table 1: Key Health Indicators in Bihar and India

Indicators	Bihar 2005	India 2005	Bihar 2010	India 2010
IMR	61	58	48	47
MMR	312	254	261	212
TFR	3.9	2.7	3.7	2.5
NMR	32	37	31	33
CBR	30.4	23.8	28.1	22.3
CDR	8.1	7.6	6.8	7.1

Source: SRS, Registrar General of India, GoI

Table 2: Health Indicators of Bihar

Indicators	Status (in Fig.)
Under 5 mortality rate	72
Underweight % children (0-3 yrs)	55%
3+ ANC visits by mothers	34%
Skilled attendance at Birth	53.2%
Institutional deliveries pvt	12.9%
Institutional Deliveries govt	48%
Anaemic women in reproductive age group (15-49 yrs)	68.2%
Contraceptive prevalence rate	28.4%
Mean age at marriage	17.6

Source: NFHS 3 (2005-06), SRS 2006, 2007 and 2009, CES 2009 and FRDS 2010

3. METHODOLOGY

The methods used for doing the research include Interview, Questionnaire, FGD and purposive sampling. Different stakeholders like ASHA workers, ANMs, MAMTA, doctors in PHCs have been interviewed. Beneficiaries have also been interviewed. Data collected from the field has been analysed to see the changes that have occurred over the time period in the field of maternal healthcare.

One PHC in the block (Primary Health Centre) and two APHCs in the village (Additional Primary Health Centre) were visited to collect data.

There were altogether 150 respondents out of which 30 were functionaries and 120 were women of reproductive age group and pregnant women who were admitted in the hospital. The respondents were asked questions related to the level of education, habitation, level of awareness related to different factors affecting maternal health and the problems faced by them at the time of pregnancy and during work.

4. FINDINGS

There are various socio-economic determinants of maternal health as being prescribed by WHO 2010. These include institutional deliveries, MMR, infrastructure, health services and human resources which include the community health service providers ASHA, ANMs etc. for this study following determinants were taken to analyse the situation of health services: Human resource; infrastructure; drug procurement; institutional deliveries.

There were altogether 50 respondents including both the ANC patients and PNC patients. Out of these 33% women were Muslim, 67% were Hindu (66% High caste, 34% low caste). 45% of them were living in semi-pacca house (out of which 37% had their house near drainage), 35% were living in kachha houses and only 20% of them were living in the pacca houses (out of which 8% were near the dumping yard). The level of awareness about hygiene was good among women most of them were aware of the hygiene practices like they should wash hands by using soap, the place where they are

cooking should be clean, food should kept in proper condition, water should be kept in a pot which has lid etc. 78% of the women were aware about the hygiene practices while 22% of them were not properly aware of the hygiene practices. 87% of the women were using proper toilet (35% flushed,52% pit) while 13% of them were using open space(field etc.) and were not having toilet facility in their house. 78% of them used hand-pump as a source of drinking water while 22% of them used tapped water. 45% of the women used unboiled water for drinking while 55% used boiled water for drinking.

The level of education was satisfactory among women. 45% of them were intermediate educated, 32% were metric educated and 23% were less than metric educated. The women who were more educated were having more awareness related to pregnancy and child health. This shows that the level of education is related to the health of mother and child. 75% of the women were not going for proper medical check-up during pregnancy like ultrasound, B.P., weight etc. 88% of them had their first ultrasound in their ninth month of pregnancy, while the ultrasound should done three times, once in each trimester. 91% women were having anaemia, out of which only 40% used Iron tablets or syrups.

33% of the women were giving birth to their first child, 41% were giving birth to their second child and 26% were giving birth to their third child. 67% of them had not registered their pregnancy in the govt. hospital which is necessary to get all the facilities provided by the government to pregnant women and lactating mother. Only 38% had met ASHA, ANM or Anganwadi worker and that too in the eighth month of their pregnancy. Most of the women were not aware of many of the government programs like THR (Take Home Ration facility) through Anganwadi centres, incentive given under JSY (Janani Suraksha Yojana) etc. However positive attitude of patients was seen for vaccination. Most of the patients had taken vaccination at time.92% of women had taken proper vaccine at time given by the ASHA and ANM in the field. Most of the women were aware about the proper nutrition during pregnancy, the importance of breast feeding and its importance in the development of child and proper child development techniques (with the help of adds on TV& Radio).

5. CONCLUSION

Human resource: There is lack of human resource in the health sector. The number of doctors available in the hospitals is lacking in numbers. In each of the hospital the doctors available are not able to give the patients proper time which they should give to each patient. This often results in the frustration of doctors and both the patients. Although after the implementation of the NRHM and the placement of doctors in large numbers the situation is worse in the rural areas. Doctors also face the problem of accommodation in the rural areas due to which they do not want to work in the rural areas.

Infrastructure: The infrastructure of the government hospitals is also not satisfactory. The hospitals lack the infrastructural facilities like the proper place for sitting patients, lack of beds for the patients, and improper building for the hospital facilities to be available to the patients. The number of rooms in the hospital is also not proper.

Availability of drugs: The availability of drugs in the hospitals is not proper. Patients are not able to get the medicines at time. Sometimes there is also a chance that the patients would get expired medicines. Although the government focuses on the availability of free medicine for the patients it is not available to them all the time. There is lack of supply of Iron tablets and syrups for the pregnant women. The community health workers are not getting the medicine kit they have to be given by the government.

From the above points it is clear that the decentralization of health services has not improved the health system much. The patients still face problem in concerning the doctors and they still face the problem of availability of good government hospitals in the rural areas. The problem of emergency treatment of the severe patients still remains the same. Apart from the decentralization of the health services which focused mainly on improving the health services in the rural areas the problem in the areas which are located interior remains the same. Situations have changed from the earlier times but still some changes needs to be done on ground level so that the poor people do not face the problem of the receiving proper treatment in the rural areas.

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