MATERNAL AND CHILD HEALTH –
A CHALLENGE OF THE MILLENNIUM DEVELOPMENT GOALS

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ABSTRACT

Since about 1980, the Indian economy has grown, in terms of its gross domestic product (GDP), at over 6 per cent per annum compound, as against an average for the period 1950 to 1980 of around 3 to 3.5 percent. More recently, between 2003-04 and 2007-08, the rate of growth of India’s GDP even breached the 8 per cent barrier, giving rise to breathless celebrations in sections of the media about India being rapidly on its way to being a “superpower” or at the very least an economic powerhouse. While the current global economic crisis has led to some muting of the rhetoric, it is important not to lose sight of some basic and disturbing features of our track record of development even through these years of rapid GDP growth. This paper is an attempt to understand the millennium development goals in a very descriptive and an interesting manner.

INTRODUCTION

The scale of mass deprivation remains immense despite years of high growth and has even worsened in some respects. Perhaps the most disturbing aspect of the nature of India’s development over the past two decades, especially since the start of neoliberal economic reforms in 1991, has been a rise in inequality in all indicators of development and well-being. We shall focus here on one key feature of this record, namely the dismal state of health and nutrition of the mass of Indian population.

Since independence, India has made significant progress in many fields, and these include some of the key indicators of health. Thus, the infant mortality rate (IMR), defined as the number of in facts dying before reaching the age of one year per 1,000 live births, a key and sensitive indicator or the state of health in any society, declined from around 150 at the end of
colonial rule (a grim reminder of how terrible the colonial dispensation was) to 53 for the year 2008. Similarly, the expectation of life at birth was 32 years at the time of India attaining independence, but was close to a little over 63 years for the period 2002-06. 

India has built up, over the decades, a large infrastructure in terms of health facilities in the public sector. Thus, as of March 2008, there were 1,46,036 health subentries (HSCs) and 23,458 primary health centers (PHCs) as against 84,376 and 9,115 respectively at the end of the sixth Five-year Plan in March 1985. Similarly, the number of community health center (CHCs) rose over the same period from 761 to 4,276. There were 1,813 first referral units (FRUs) – district and sub-district hospitals – as of March 2008.

There has also been progress in immunization of children and pregnant mothers and in provision of ante-natal care as compared with the situation at the time of independence through in recent years, under the neoliberal regime, there have been some setbacks. India’s record in areas such as control of malaria has been rather mixed, through, and the recent resurgence of infectious diseases across the developing world has found the country relatively unprepared.

HEALTH CARE AND HEALTH SERVICES

The progress in the public provision of health as well as the health status of the citizens has been extremely modest. On the eve of Independence, the Bhore Committee made a comprehensive set of recommendations for a health policy with a clear focus on public health and rooted in the emphasis on preventive care. Over the years, India has consistently failed to implement those recommendations through official rhetoric continued to pay lip service to the crucial importance of public health and preventive medicine.

Even as late as 1983, the National Health Policy document echoed many of the Bhore Committee recommendations and its rhetoric was consistent with the famous Alma Ata declaration of 1978 of Health for All by 2000. A few years earlier, the Jaisukhalal Hathi Committee had called for a rational drug policy and price control on a large number of drugs and pharmaceuticals to percent profiteering by multinational drug companies and ensures affordable prices of essential drugs for common people. The Indian Patents Act, which was passed in 1970, provided space for the growth of the Indian pharmaceutical industry by ensuring that patenting did not lead to the monopoly of transnational pharmaceutical giants in the market for drugs and chemicals.

But by the mid-1980s, with the promulgation of the New Economic Policy and the New Drug Policy by the Rajiv Gandhi government (along with several other “New” policies announced for education, textiles, and so on), the course of even the rhetoric of policy changed, By 1991, when the economic reform policies of liberalization, privatization and globalization (LPG policies, as they are popularly known) were accelerated under the tutelage of the World Bank and the international Monetary Fund (IMF), the nation was set on a course entirely different from what had originally been envisaged. It would no longer be the case that the government was obliged to ensure the health of the citizens. Instead, health was to become a commodity like any other, and its provision was to be determined increasingly by market forces.
Over the period of reforms, public provision of health care and health services has been undermined both at the level of practice and at the level of ideology and policy. Provision of health through public sector institutions has been imparted negatively by budgetary cuts driven by the presumed need to rein in the fiscal deficit. The State governments, which bear the main burden of public provision, have been hamstrung by a fiscal regime that increasingly deprives them of access to adequate resources. Besides, most of them have also happily gone along with the neoliberal policy regime. The corporate private sector in health care has boomed, even as India is being sold as a favorite destination for “medical tourism”. With increasing commercialization for health care, the access of ordinary people to health care has become more difficult. The weakening of the public health system has left the country very poorly equipped to handle public health emergencies.

LOW PUBLIC SPENDING

It is a well-known scandal that India is practically at the bottom of a list of more than 170 countries in terms of the proportion of total health expenditure that is financed by government. Public spending on health in India was around 1.05 per cent of the GDP during the mid-1980s and is currently at 1.35 to 1.4 per cent of the GDP. The commitment given in the Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) government in 2004 that the total expenditure on health by the Centre and State governments combined would be raised to between 2 and 3 per cent has remained unfulfilled. While there is a substantial rise in the outlay on health and family welfare in the 11th Plan to Rs. 1,40,135 crore from Rs. 58,920 crore in the 10th plan, it still remains way below the levels required to meet the CMP commitment. Now that the second UPA dispensation is not dependent on the support of the Left parties for its survival, the prospect of a rise in government expenditure to the level promised in the CMP in 2004 seems bleak.

While government spending on health remained at about 1 per cent of the GDP in 2001-02, the total of health and health-related expenditures amounted to 5.2 per cent of the GDP at factor cost. The share of the government in total health expenditure has been less than one-fifth. What is worse is that the reform polices have led to greater commercialization of health, and health expenditure has risen at 14 per cent per annum. A conservative estimate of the rise in the poverty ratio on account of rising health expenditure of households, even when calculated using the disputed official methodology, is around 3.6 percentage points for rural areas and 2.9 percentage points in urban areas. It is also known that rising health and education costs have forced poor households to cut back expenditure on food to meet these costs, something that could worsen an already scandalous nutrition situation.

There are of course, large inter-State variations in the public and private provision of health care services and in health care services and in health outcomes. For instance, at one end we have a State like Kerala with an IMR of 12 (urban 10, rural 12) and at the other Madhya Pradesh with an IMR of 70 (urban 48, rural 75). Policy needs to address these disparities, with a far greater focus on the poorly performing States. However, it needs to be emphasized that health and nutrition outcomes across the country have worsened during the reform period. This is shown dramatically by the data on nutritional outcomes from the National Family Health Survey.
s (NFHS). The third of these surveys, relating to 2005-06, after more than a decade of neoliberal reforms, tells us that in urban India between 1998-99 and 2005-06

- The percentage of women with anemia rose from 45.7 per cent to 50.9 per cent.

- The percentage of women with chronic energy deficiency (CED) rose from 22.1 per cent to 25 per cent.

- The percentage of children in the age group of 6 to 36 months who are stunted rose from 35.6 per cent to 39.6 per cent.

The situation in rural area is equally alarming, though it shows some improvement between 1998-99 and 2005-06 in respect of both child stunting and women with CED. The percentage of women with CED declined marginally from 40.6 per cent to 40.7 per cent, but still an unconscionably high level. However, the percentage of women with anemia in rural India actually increased between 1998-99 and 2005-06 from 53.9 per cent.

CAN INDIA PREVENT 200 CHILDREN DYING EVERY HOUR?

It is estimated that India lost 1.8 million children under five in 2008. That is more than 200 child deaths every hour, each day, or more than three deaths every minute. Out of about 25 million babies born every year in India, one million die. Most who survive do not get to grow up and develop well. About 48 per cent are stunted (sub-normal height) and 43 per cent are under-weight. Additionally, about one-third of babies are born with a low birth weight of less than 2,500 gram.

MDG TARGET

In South-East Asia, the Maldives, Sri Lanka and Thailand have reduced newborn and childhood mortality significantly. India has also demonstrated steady progress. Under-five mortality decreased from about 150 per 1,000 live births in 2005-06. But at this rate of decline, India will not be able to achieve the Millennium Development Goal 4 (MDG) target of 50 under-five deaths per 1,000 live births by 2015. Moreover, progress has been uneven in various States in the country.

CAUSES

The causes of death among children are well understood in India. Newborn mortality (death within the first 28 days of life) contributes to more than half of under-five mortality. In newborns they are asphyxia (inability to breathe at the time of delivery), infections and prematurity. After 28 days of life, they are the result of acute respiratory infections (pneumonia) and diarrhea. Undernutrition contributes to 35 per cent of deaths. In addition to these, immediate causes of childhood deaths, there are several socio-cultural factors including poverty, poor water and sanitation facilities, illiteracy (especially among women), the inferior status of women in society and pregnancy during adolescence (that can be attributed to early marriage).
Child mortality rates are also higher among rural populations when compared to their urban counterparts.

We know what needs to be done to save these precious lives. Newborn deaths can be prevented by ensuring nutrition of adolescent girls, denying pregnancy beyond 20 years of age and ensuring a gap of three-five years of age and ensuring a gap of three-five years between pregnancies, skilled care during pregnancy, childbirth and post-natal are, and improved newborn care practices that include early and exclusive breastfeeding, preventing low body temperature and infections, and early detection of sickness and prompt treatment. Childhood deaths can be prevented by exclusive breastfeeding for six months and complementary feeding from six months of age with continued breastfeeding from six months to two years, immunization, an dearly treatment of pneumonia, diarrhea and malaria. In addition, it is important for the mother and other caretakers at home to invest in appropriate child caring practices, right from birth to support early childhood development and lay a foundation to maximize human potential.

India needs to provide these live saving interventions to most, if not all, newborn and children who need them. However, their (interventions) coverage has been quite low. For example, in 2005-06 (the national family health Survey- NFHS 3 report), the rate of initiation of breastfeeding within an hour of birth was only 26 per cent and exclusive breastfeeding at six months was just 46 per cent. Yet these two interventions have the potential to prevent 19 per cent of deaths. The use of oral dehydration salts in cases of diarrhea, the most recommended treatment, was just 43 per cent and only 13 per cent cases of suspected pneumonia received antibiotics. Immunization coverage has been relatively better, suggesting that high coverage is achievable.

INTERVENTION

The main causes of poor coverage of interventions include ineffective planning and implementation, mainly due to weaken the health system. To address the systemic challenges, India launched a flagship programme, the National Rural Health Mission in 2005-06 to strengthen the health system in rural areas. Commendable initiatives have been put in place such as training about 8,00,000 village level health volunteers (Accredited Social Health Activist, or ASHA), hiring additional staff, strengthening the infrastructure of health facilities, augmenting programme management capacity at State and district levels, and enhancing community participation. However, much more needs to be done to minimize health inequities that exist among different subpopulations in the country.

Public health expenditure in India has remained at a low – about one per cent of GDP – for quite some time. This needs to be scaled up. Considering that about 70 per cent of health care is accessed from the private sector in the county, better regulation and participation of private health service providers must be ensured. Synergy between the health and nutrition sectors must be fostered through better coordination between the Ministry of Health and the ministry of women and Child development, which are responsible for the ICDS (Integrated Child Development Services) programme.
To reach undetached newborns and children, there is a strong case for providing home-based management of non-severe pneumonia and diarrhea in children by trained ASHAs and other community health workers. This initiative needs to be supported by provision of incentives, necessary drug supplies, close supervision and appropriate referral linkages. At the same time, the quality of health services at first-level health facilities and referral hospitals must continue to be strengthened.

Fortunately, there is renewed commitment at the global and national levels towards achievement of MDG 4. To save newborns and children, national governments, development agencies, civil society and other stakeholders must work in close collaboration.

India’s cricket World Cup victory followed by Anna Hazare’s indefinite fast on the Lokpal bill virtually knocked out of the news arenas some really bad news. Just days before all these media-grabbing events, the Census office released preliminary figures for 2011. The most shocking of them is that in the 0-6 year age group, the number of girls to every 1,000 boys is just 914, even lower than the 927 of the 2001 census.

How has this happened even as the adult sex ratio has gradually crept up from 933 women to 1000 men in 2001 to 940 women to 1000 men today? Why has this happened even as women’s literacy rate has gone up and the gap between male and female literacy rates has shrunk? Why has this happened even when there are laws in place to ensure that sex-selection does not lead to the elimination of girls?

Perhaps a coincidence, but just a few days after the disturbing census results were made public, a group of activities met in Mumbai to mark 25 years since they launched a campaign against the use of medical technology for sex detection and selection. Their campaign had culminated in the first law against sex-selective abortions being passed by the Maharashtra government on January 1, 1987.

MISUSE OF TECHNOLOGY

In those days, the popular method of sex detection was amniocentesis. It was an invasive procedure involving amniotic fluid being extracted from the womb for testing. The technology had been devised to detect fetal abnormality. Instead, in India it bean to be used to detect the sex of the fetus. Women risked an abortion if they got to know at a later stage of pregnancy.

In the absence of a law or any restraining regulation, those conducting these tests were openly advertising them. Advertisements like “Better 500 now then 50,000 letter” were common, suggesting that Rs. 500 on a test to confirm the fetus today was better then spending many times more for a dowry later.

There are several aspects of how this first legislation came about that are pertinent in the context of the recently-concluded agitation by Anna Harare and his supporters for a Jan Lokpal Bill to check corruption. The Maharashtra law banning sex selection came about through a push from below by the activists and a response from above. The activities tried to gather together as much evidence and data that they could about something that was just below the surface. It was
not virtually impossible to prove as the mother, nor the doctor, would admit that test had been used for such a purpose. Ironically, they had stumbled upon this issue when a multinational company, concerned about the mounting medical claims from its women employees who had sought abortion, asked women activists to speak to them.

Through a verity of techniques, including sending in decoys to doctors suspected of conducting such tests, the activists assembled some proof. They were lucky to find at least one sympathetic senior bureaucrat, the Maharashtra Health Sectary. Without any dharma or fasts and little media coverage – there were no private TV channels those days – the government and activists spoke to each other, argued over the provisions in the bill and ensured that it was finally passed. That law was the precursor to the central law banning sex-determination tests passed in 1994 and amended in 2003 – the Preconception and Pre-natal diagnostic Techniques (Prohibition of Sex-selection) Act2003.

**LOOPHOLES**

Even after the 1994 Central Act was passed, the activists were not happy. They pointed out that not a single doctor had been convicted under the Act. Also the law made women who undertook the test culpable for the crime. Furthermore, sex reselection techniques did not come under the ambit of the Act. After advocacy and dialogue had failed to get the law amended, the activist turned to the courts and presented their case. It was at the interventions of the Supreme Court that the government was compelled to amend the law to make it more watertight.

But given the latest Census figures, it is evident that the law even today is not strong enough. So the question that must be asked is whether making it any stronger ill make a difference if the mindset of families remains firmly set against girls. Can laws really deal with what is essentially a social problem in India? The other question that needs to be raised and discussed is whether high economic growth and women’s status in society are necessarily linked. As India becomes economically stronger, will the value and worth of its women also become higher? In 2001, this was disproved as the lowest sex ratio existed in districts that were the most prosperous.

Today, there is an additional and more worrying phenomenon. Like a virus, the declining child sex ratio is spreading to districts that till now had not been affected. More research will reveal why this had happened but could this be one of the negative fallouts of economic growth? For, has increased prosperity actually resulted in easier access to technology that assists sex selection? Sonography, the technology currently most popular in sex selection does not come free although it is for cheaper today than when first introduced. Portable sonography machines can be loaded in the back of a car and taken to even smaller towns or large villages. But even this would not have made difference had there been no demand for the technology. That a growing demand exists is evident from the census figures.
GETTING MORE CONSERVATIVE

Also, is the availability of more money actually having the opposite effect? Is it reinforcing regressive attitudes? instead of bringing in more enlightened and liberal attitudes, is it making people more conservative, getting them to hold on to beliefs that should find no place in a modern India? How else can one explain the story of India’s disappearing girls?

Apart from the law, a great deal of work has been done to create awareness about the value of the girl child. There have been campaigns, state governments offer incentives for girls’ education, and even the media and the advertising fraternity has been sensitized to the issue. But all this seems to be of no avail. So while India shines on the cricket field and in other arenas, the darker, uglier side of our society continues to stare us in the face. Dealing with this is at least as challenging as rooting out corruption. But will people come out and demonstrate for what someone called this “invisible constituency”? Going by the trend that has come to the fore with the release of latest Census data, Oriya youths may find it difficult to get bride for them 20 years from now. The fear stems from the fact that the child sex ratio has fallen by 19 points from 953 girls per 1,000 boys in 2001 to 934 girls per 1, 000 boys in 2011.

According to provisional figure of census 2011, total population of children in the age group 0 to 6 is 50,35,650. Of this 26,03,208 are boys and 24,32,442 are girls. The total child population is 12 per cent of the State’s total population. In 2001, the total child population in Orissa was 53, 58,810 with composition of 27, 44,552 boys and 26, 14,258 girls.

There has been a fall of 32, 3,000 children in the age group of 0 to 6 in 2011 compared to 2001. However, the difference between number of boys and girls in 2011 has widened to 1, 70,766 in 2001. The State has 11th lowest child population among different states.

“The drop in child sex ratio is a very disturbing trend. Downward trend in child sex ratio indicates that problem lies in feeder source. Female foeticide could be one of the major reasons behind falling number of girl child,” said S. B. Agnihotri, Orissa-cadre IAS officer and a renowned researchers on child sex ratio.

Mr. Agnihotri said in 2001 in some parts of Nayagarh the child sex ratio had even gone down below 900. In many developed regions of Orissa, the in child sex ratio was cause of concern, he said.

CHILD SEX RATIO OF ORISSA (DISTRICT WISE FIGURE)

<table>
<thead>
<tr>
<th>Districts having alarming situation</th>
<th>2001</th>
<th>Districts of Orissa Census</th>
<th>2011</th>
<th>Districts of Alarming situation</th>
<th>2011 Child sex ratio</th>
</tr>
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<tbody>
<tr>
<td>Nabrangapur</td>
<td>988</td>
<td>Kalahandi</td>
<td>947</td>
<td>Cuttack</td>
<td>913</td>
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<tr>
<td>Malakangiri</td>
<td>979</td>
<td>Subarnapur</td>
<td>947</td>
<td>Khurda</td>
<td>910</td>
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The planning Commission has constituted a high level expert group to develop a framework to provide universal health coverage to the people in the 12th Five Year Plan. Constituted two months ago, the group has already held two constitutions – one each at Nagpur and Delhi – and is expected to submit its interim report in January next year, which should set the ambitious plan in motion.

“I expect to see Universal Health Coverage (UHC) featuring prominently in public debate and policymaking in 2011,” believes Dr. Srinath Reddy, president of the Public Health Foundation of India, which has been entrusted with the work of developing a broad framework for the exercise.

“Political alignment around UHC will increase as leaders recognize that responding to the moral imperative of providing financial protection against catastrophic health expenditure and reducing out-of-pocket spending by citizens also has an electoral appeal.”

Universal health coverage will also require investment in health intrastate, especially a massive scale-up of public sector services at all level’s a vast expansion of the health workforce, safeguarding of India’s generic drug industry to ensure availability of inexpensive drugs, empowerment of communities through health promotion and action on determinants of health like water, sanitation, nutrition and environment.
Another important positive trend will be the transformational impact of the national Rural Health mission that could be extended to the urban poor is extended to the urban poor through the National Urban Heath Mission. This has been in the pipeline for a while now.

HELPING HAND

The public health foundation of India will contribute to these efforts by initiating debates on UHC; assist in strengthen the health system through its health systems Support Unit and Training Division; promoting health literacy; and creating a large pool of public health professional s who will contribute to policy development as well as programme design, delivery and evaluation.

The four diploma programmes, which are presently delivered from its campuses in Delhi, Hyderabad, Gandhi Nagar and Bhubaneswar, will be complemented in 2011 by distance education diploma courses in Public Health nutrition, Epidemiology, Health Promotion and Maternal and Child Health. To address the acute shortage of healthcare workers in the country, the Ministry of Health and Family Welfare will finalize the modalities for introducing a three- and-a-half year course in Bachelor in Rural Health Care in consultation with the Medical Council of India.

Reiterating its commitment to provide healthcare facilities to the people, the Ministry of Health and Family Welfare will go a head with its proposal to upgrade the national Centre for Disease Control (NCDC) at Delhi at an estimated cost of Rs. 382.41 crore to be completed by April, 2013. This includes improvement of infantries, installation of state-of-art equipment, creation of new divisions and up scaling existing ones. The NCDC will, thus, be a much better position to investigate disease out-breaks and respond adequately to public health emergencies of international concern.

LIVING WITH HIV AIDS

Accessing care, support and treatment will also be easier for HIV/AIDS patients as the national AIDS Control organization (NACO) will implement its decentralization policy. Anti Retroviral. (ART) centers with high patient load and requisite infrastructure are being upgraded as ART Plus centers. Second line and alternative line ART is now being made available at 7 ART Plus Centers.

The scheme of Link ART Centers (LAC) initiated in 2008 for distribution of Anti Retro Viral drugs and monitoring of drug adherence in stabilized patients will also handle the enrolment of People Living with HIV/AIDS into HIV care, sample collection for CD4 count, refer eligible patients to nodal centers for art initiation, follow up of pre-ART patients, screening of HIV-TV co-infection, and treatment of minors. This has been done considering the gap between case detected at integrated Counseling and Testing Center and those registered at ART centers. The NACO has taken a giant step forward in the area of HIV diagnosis for infants and children by formulating technical and operational guidelines on “Care of HIV exposed infants and children below 18 months of age”. The EID programme is being rolled-out in a phased manner through 767 ICTCS and 179 ART cents in the country.
CONCLUSION

The dismal health and nutrition situation, implying a poor state of food and nutrition security in both rural and urban India, needs to be addressed on a war footing. But one finds little sense of urgency on the part of a government firmly anchored in a neoliberal mindset to address India’s permanent state of nutritional emergency even after more than two decades of a compound annual growth rate of GDP exceeding 6 per cent. Instead, a completely unregulated, commercial private sector in health is allowed to run riot, even hijacking medical education in the process and playing with the lives of millions of poor people.

The slogan of “public-private partnership”, in most instances a euphemism for “partnership for private profit”, has become the mantra of the government to implement all programs. The enormous mess in urban health, on top of a dismal rural health care situation, cries for urgent attention, but unless health is seen and provided as a basic human right little will change. That does not seem to be on the agenda of the government, now or in the foreseeable future.

While it is true that the issue is not merely one of enhancing outlays but also one of improving health delivery systems to obtain desired health outcomes, outlays constitute the basic prerequisite. A government that is able to provide largesse of nearly Rs. 5 lakh crore per annum over the past two years to the corporate sector in the name of fiscal stimulus has no excuse for not raising health funding to the levels required to address the country’s health crisis. Where there is a will, there is a way.

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