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HEALTH INFRASTRUCTURE IN DEVELOPMENT PERSPECTIVE: STATUS OF MORIGAON DISTRICT OF ASSAM

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I. INTRODUCTION

According to the World Health Organization, Health is "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity". Health is a dynamic condition that is influenced by complex interrelationships between individuals and biomedical and behavioural factors, as well as physical and social environments. Interrelationships are reflected in a social view of health that sees health as being created in the settings where people live and work. This social view of health recognizes the need for personal skills development, the importance of empowering communities to take action to promote health, the creation of social and physical environments that are supportive of health, an awareness of the impacts on health of public policies and the need for health services to be oriented towards health promotion and prevention of ill health India is increasingly recognized as a global power in key economic sectors. There have also been positive trends on certain social indicators, particularly those that respond to vertical, campaign-like approaches; the near eradication of polio; a significant increase in literacy rates; and the enrolment of both boys and girls in primary school. However, progress has been slow in areas requiring systemic changes, such as in the provision of good quality services (i.e. primary health care and community-based nutrition services). There has also been limited change in the practice of key behaviours related to child wellbeing, such as hand washing and exclusive breastfeeding. The HIV/AIDS epidemic continues to spread and poses a significant threat. Issues related to child protection, including trafficking and child labour, are becoming more pronounced. Centrally-sponsored schemes have public resources to key sectors, notably the Sarva Shiksha Abhiyan in education (the national policy to universalize primary education),the Reproductive and child Health Programme II, the National Rural Health Mission and the Integrated Child Development Services. The challenge remains to convert these commitments and resources into measurable results for all children, especially to those belonging to socially disadvantaged and marginalized communities.

The Morigaon district of Assam is one of the backward districts of Assam. It is adversely affected by flood almost every year. In this context this paper tries to examine the present status of health infrastructure in the district.

II. OBJECTIVE OF THE STUDY

The main objective of the study is to examine the status of health infrastructure in Morigaon district of Assam.

III. METHODOLOGY

The study is based on secondary data. The secondary data are collected from various sources like Joint Directorate of Health, Morigaon, Economic Survey, Assam, 2018-19. Statistical Hand Book, Assam, 2010, National Rural Health Mission, Assam, Reports of Ministry of Health and Family Welfare, Government of India. The collected data are analysed with basic statistical tools.

IV. STUDY AREA

The area chosen for the study is the Morigaon district of Assam. Morigaon district is situated on the south bank of the Brahmaputrariver in Assam Valley. It was a subdivision of the Nagaon district and was upgraded to a full-fledged district in September 1989. The district has around 9,31,839 population. It has five blocks and five revenue circles.

V. THE STATE OF PUBLIC HEALTH IN INDIA

India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and maternal mortality over the last few decades.In spite of the progress made, a high proportion of the population, especially in rural areas, continues to

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suffer and die from preventable diseases, pregnancy, and childbirth-related problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to the pauperization of poor households due to expensive private-sector health care. India is in the midst of an epidemiological and demographic transition-with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to aging of the population. An estimated 5 million people in the country are living with HIV/AIDS, a threat that has the potential to undermine the health and development gains India has made since its independence. Non-communicable diseases such as cardiovascular diseases, cancer, blindness, mental illness, and tobacco use-related illnesses have imposed the chronic diseases burden on the already over-stretched health care system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor and on women, scheduled castes, and tribes especially those who live in the rural areas of the country. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states.

Public spending on preventive health services has a low priority over curative health in the country as a whole. Indian public spending on health is among the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than 100,000 crores is being spent annually as household expenditure on health, which is more than three times the public expenditure on health. The private sector health care is unregulated pushing the cost of health care up and making it unaffordable for the rural poor. It is clear that maintaining the health system in its present form will become untenable in India. Persistent malnutrition, high levels of anemia amongst child birth, inadequate safe drinking water round the year in many villages, over-crowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Most of these public health determinants are correlated to high levels of poverty and to degradation of the environment in our villages. Thus the country has to deal with multiple health crises, rising costs of health care and mounting expectations of the people. The challenge of quality health service in remote rural regions has to be met with a sense of urgency. Given the scope and magnitude of the problem, it is no longer enough to focus on narrowly defined projects. The urgent need is to transform the public health system into accountable, accessible and affordable system of quality services.

VII. NATIONAL RURAL HEALTH MISSION

In 2005, the government of India took a significant step in the country's health history and created the NRHM with some inputs from Jeffrey Sach and Nirupam Bajpai's research on scaling up health services in India that was conducted at the request of Prime Minister Dr. Manmohan Singh.

VIII. THE VISION OF THE NATIONAL RURAL HEALTH MISSION

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9%GDP to 2-3%of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, safe drinking water, gender and social concerns.
- Address inter-State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, accountable and effective primary health care.

VIII. STATUS OF HEALTH CARE PERFORMANCE INASSAM

The status of health care performance in the state has gradually improving over the last few years. The has six (6) medical colleges, twenty four (24) civil hospitals, 12 First Referral Units , 841 primary health centres, 154 state dispensaries, 4690 sub centres,21475 number of beds for patients in the government hospital at the end of 2019. (Economic

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Survey Assam, 2020). The Government of Assam has taken efforts for sustainable health care facilities in the state.

The birth rate is lower than all India level but the death rate of the state is higher than the all India average. Only 17.6 percent deliveries are institutional deliveries.

Health is an important component of Human Development Index (HDI). Human Development of Index is a composite index measuring average achievement in three basic dimensions of human development-a long and healthy life, knowledge and a decent standard of living. Health may be defined as a state of complete physical, mental, social well being and it may be envisaged as a fundamental right.

The life expectancy at birth of Assam is only 58.9 years. The state like Kerela has high life expectancy at birth which is 74 years.

Health Services in Status of Morigaon District

The health services of Morigaon district include hospitals, PHC, dispensaries, rural family welfare planning centre and sub centre. The health services in the district may be conceived from the following tables.

TableV.I.Health services in the Morigaon District

Health Services	**Number**
Blood Bank	1
Special Newborn Care Unit	1
Mobile medical unit	1
Boat Clinic	1
Sub Centres	125
Ambulance (108+102), Adarani	10+14+10=34

Source: Economic Survey Assam, 2019-20

The district has only one civil hospital which is in the Morigaon. It has also one railway hospital and a hospital in PPP mode in Gopal Krishna Tea State.

TableV.II Health infrastructure in the Morigaon District

District Hospital	1
Sub Centre (SC)	123
Community Health Centre (CHC)	6
Primary Health Centre (PHC)	35
State Dispensary	15
Rly. Hospital	1
First Referral unit(FRU)	0
Tea Garden Hospital under PPP	1

Source: Dept of Health, Government of Assam (2019-20)

The total government doctors in the district under study area are 71. Dispensaries are over-crowded with patients. In summer season, some of the dispensaries like Nelie state dispensary have to handle 150 patients a day by a single doctor. The district has more than 70 private practitioners' doctors. Some of the people of the district reported to the present researchers that the government doctors of the district are more interested in private practice rather than attending patience in the dispensaries. The overall result of health services offered in the dispensaries, hospital, PHCs are not satisfactory. There is poor utilization of health resources and the rural health infrastructure. The health facilities offered in the private sector is also not satisfactory. It is reported that the private practitioners prescribe too many medicines. During flood, the death rate among the pregnant women is high owing to road transportation problems, people have to take the patients to the nearest health centres using various inconvenient means like boats, bullock cart etc. There is also shortage of specialists like surgeons, pediatricians, gynecologist etc in the health centres of the district.

The Pradhan Mantri Jan Arogya Yojana is an ambitious health insurance scheme that has been touted as an important tool to achieve universal health coverage. However, there is still no clarity regarding the financial implications of this scheme.

The challenges before the components of Ayushman Bharat, the (ir)rationality behind raising the insurance coverage manifold are highlighted, a political economy narrative of the changing health financing scenario is drawn, and how the design of Ayushman Bharat will feed into executing the proposed public–private partnership model in public facilities and facilitate the strategic purchasing agenda of the National Health Policy is examined.

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Ayushman Bharat is a step towards creating a system that would facilitate in relinquishing public funds and public institutions to already dominant private players, which will have serious implications for the healthcare delivery system in India.

The relevance, provisions and the implications of the National Medical Commission Act, 2019 for the future of medical education and health practice in the country are examined here. This act is a step towards improving governance and introducing reforms with the potential to create an enabling environment, and facilitate standardisation in processes and transparency in the functioning of the health sector.

VI. HEALTH INDICATORS

In this study we have taken five health indicators in the district. These are literacy rate, infant mortality rate, birth rate, death rate and sex ratio.

VI.I Literacy Rate

Literacy rate is one of the most important indicators of human resource development. In Cencus 2001, literacy rate is defined as 'a person aged 7 and above who can both read and write with understanding in any language is to be taken as literate. A person who can only read but cannot write is not literate. As per 2001 cencus the literacy rate of the Morigaon district was 58.83 percent- the male 64.15 percent and female 51.15 percent. The rural literacy rate was 57.01 percent and urban literacy rate was 84.21 percent. It is observed that when literacy rate increases the health status of the people also improves.

Table VI.I

Indicators from Annual Health Survey 2010-11

(Reference period of estimates: 2007-2009)

Sr. No.	State / District	CBR	CDR	IMR	Neo- natal Mortality Rate	Under Five Mortality Rate	MMR	Sex Ratio at Birth (SRB)	Sex Ratio (0-4 Years)	Sex Ratio (Total)
ASSAM		21.9	7.2	60	39	78	381	925	956	953
1.	Barpeta	20.8	6.7	48	33	65	366	887	941	936
2.	Bongaigaon	19.7	6.2	53	31	68	366	931	984	948
3.	Cachar	26.5	7.5	57	36	79	342	929	953	974
4.	Darrang	20.8	8.3	69	39	90	366	953	918	954
5.	Dhemaji	23.0	4.5	44	27	52	367	950	972	949
6.	Dhubri	22.1	7.1	72	50	91	366	893	960	930
7.	Dibrugarh	20.1	7.5	55	37	71	430	912	950	953
8.	Goalpara	22.5	6.9	56	39	74	366	878	957	946
9.	Golaghat	21.9	8.0	62	47	82	430	923	955	959
10.	Hailakandi	32.1	7.0	55	36	91	342	810	874	942
11.	Jorhat	20.0	8.2	57	43	71	430	962	983	975
12.	Kamrup	18.7	5.9	46	30	57	366	947	960	909
13.	Karbi Anglong	21.2	6.9	59	36	77	342	930	926	946
14.	Karimganj	25.8	6.6	69	46	83	342	913	933	964
15.	Kokrajhar	23.1	7.7	76	41	103	366	892	1017	953

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16.	Lakhimpur	24.4	6.9	56	41	68	367	984	1010	950
17.	**Marigaon**	**23.5**	**8.5**	**72**	**44**	**93**	**367**	**920**	**944**	**956**
18.	Nagaon	24.6	8.1	66	41	86	367	943	952	964
19.	Nalbari	18.8	7.4	64	48	88	366	937	987	1039
20.	North Cachar Hills	18.6	5.5	58	35	78	342	884	940	935
21.	Sibsagar	19.7	8.1	58	37	79	430	926	952	959
22.	Sonitpur	19.8	6.5	68	46	80	367	949	977	968
23.	Tinsukia	21.1	7.5	55	39	74	430	942	956	962

Source: Annual Health Survey (2010), Govt of India

VI.II Infant Mortality Rate

The infant mortality rate refers to the death rate of newly born babies in a particular region during a particular period of time. The infant mortality rate serves as the most sensitive indexes of health conditions of the general population because the risk of death is always greater during first year of life than in later years of life. The infant mortality rate of assam was 61 in 2009 whereas it was 50 for all india level. The infant mortality in Morigaon district is 72 in 2009 as shown in the above table VI.I. The high infant mortality rate in Morigaon district reflects poor public health service, negligence in the pregnancy period and also poor natal care. To improve the situation, it is prerequisite to provide clean and safe drinking water clean and safe drinking water, provision of better sanitation facilities, 100 percent immunization and attendance of trained personal during deliveries.

VI.III Birth Rate

The birth rate depends on marriageable age, fertility period, and family formation period. The birth rate in Assam was 23.6 in 2009 whereas in 22.5 for all India level.The birth rate in Morigaon district was 27 in 2001 census. Low rate of family planning, increase in mean age of marriage, the fertility of the population are the major factors responsible for high birth rate in the district.

VI.IV Death Rate

The death rate in Assam was 8.4 in 2009 whereas it was 7.3 for all India level. The death rate In the Morigaon district was 8 in 2001 census. The high death rate in the district is recorded due to poor diet, unsafe drinking water, .and poor health facilities.

VI.V Sex Ratio

The sex ratio means number of female per thousand male population. The sex ratio Assam was 935 in 2001. The sex ratio depends on a number of parameters like poverty level, high infant mortality rate, provision of poor medical facilities and absence of pre natal and post natal care along with the literacy rate.

The life expectancy at birth in Assam is only 58.9 which is one of the lowest among the states as shown in the following fig (VI.I)

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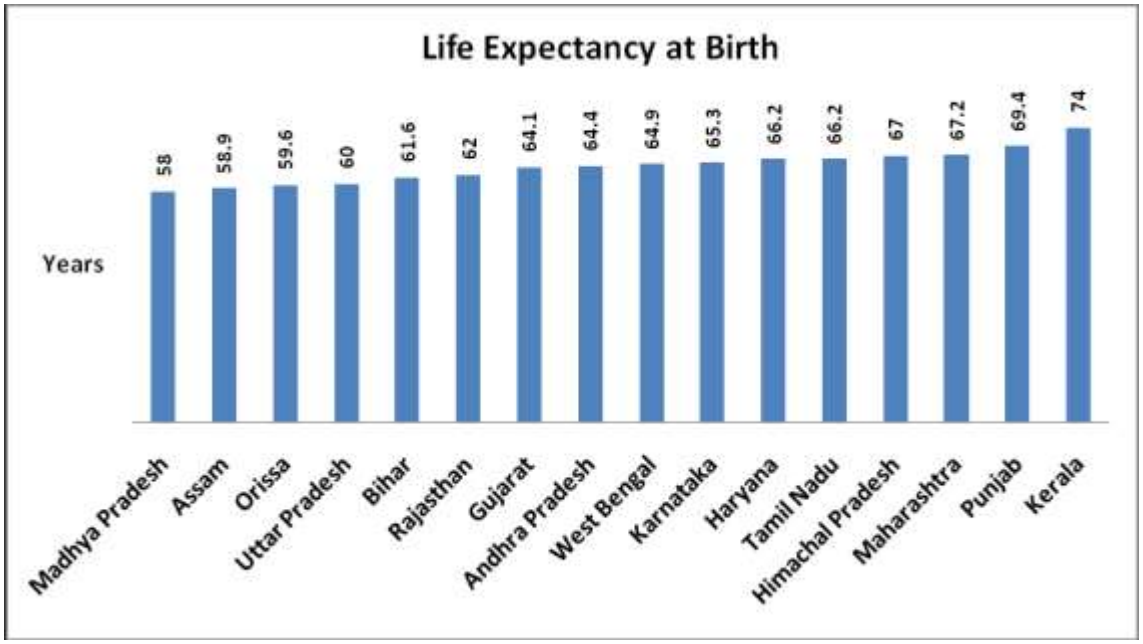
Fig V.I



Source: Ministry of Health and Family Welfare (2011)

Table3.1: Health Indicators of Assam

Particulars		**Assam**	**India**
Birth Rate (2012-16)		23	24.1
Death Rate		8.8	7.5
IMR(2004)		66	58
MMR(1998)		409	407
Life Expectancy at Birth (1998-02)	Male	57.7 years	61.6 years
	Female	58.1 years	years 63.3
Of Institutional Deliveries		17.6	33.6
Percentage of children Fully Immunized		77	42

Source: Ministry of Health and Family Welfare (2011)

VII. MORIGAON AS A MODEL DISTRICT

On September 27, 2010 the Model Districts Health Project launched in its first "model district" in Morigaon, Assam, which will serve as a pilot for India's Northeast states. The Columbia Global Center, South Asia, in conjunction with The Earth Institute at Columbia University and India's Ministry of Health & Family Welfare, will be creating five Model Districts in total across the country to improve maternal and infant healthcare in rural India. India has the highest number of maternal deaths in the world as well as staggering rates of infant and child mortality. One of every 15 children in India dies before they reach their fifth birthday. In addition, India is home to 46% of the world's underweight children. Despite these challenges, the WHO ranks India 171st out of 175 countries for public health spending. The Model Districts seek to implement targeted improvements to the National Rural Health Mission, in an effort to demonstrate to state and national government officials how current public health operations and spending can be improved upon to accelerate national progress towards the United Nations' Millennium Development Goals on maternal health, child health, and nutrition. The Model Districts' team of public health researchers is based out of the Columbia Global Center, South Asia, and will be providing technical advising, policy recommendations, and monitoring and evaluation for all five sites. As a first step in Assam's Model District, the project has created a multi-sectoral team of health, nutrition, water, and education officials to focus activities on maternal and child health. The project will also focus on improved training for Accredited Social Health Activists (ASHAs), the critical community based health workers that mobilize women and children for health services within the villages. The project will also focus on training nurses in better antenatal care delivery, which is vital for lowering the risk of maternal death,

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and will introduce mobile phone technologies so that data can be collected—and mothers and babies tracked— throughout rural areas that are difficult to access.

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