

MAHARASHTRA AT 7-7-7: IS MAHARASHTRA AN OVERALL HEALTHY STATE?

Rapid urbanization, growing migration and changing tastes and preferences have imparted a strong sociocultural dimension to Maharashtra's health scenario. By 2001, the density of population in Maharashtra doubled as compared to 1960-61.¹ Migration to urban areas from other States and from within Maharashtra has left its impact on fertility, since those from backward regions have also shown a tendency to bring in their social norms with them. According to the Human Development Report on Maharashtra (2002), Maharashtra was expected to benefit "from a combination of industrialisation, higher income levels and history of social reform focused on woman's uplift and empowerment. The hypothesis was that it would leave its distinct positive imprint on population trends that urban values and compulsions would bring about a favourable inclination towards smaller families. Despite 42.4 per cent of the population living in towns and cities, both growing in numbers, size and population densities, *this did not happen.*"² The glaring proof of such a phenomenon is the declining sex ratio in the population. From a figure of 946 (as per the National Census 1991) the sex ratio has dropped down to 922 as reported in the National Census 2001.

Health Budget of Maharashtra

The health budget of Maharashtra was drastically pruned sharply during the decade of the nineties. Health expenditure in Maharashtra fell from 1% of gross state domestic product in the 1980s to 0.52% by the end of 2005-06. As a proportion of total government spending it dropped from 6% during the 1980s to 3.03% by the end of 2005-06. This sudden shrinking has translated into greater costs to be incurred, especially by the poor to take care of their health. No wonder, between 2004 and 2005, the State Administration was able to add only 2 additional primary health care centres (PHC) in the State and the beds per lakh of population in fact reduced from 93 in 2004 to 92 in 2005³.

It is therefore not surprising to hear the complaints from Laxmi and Mahadeo Valavte who reside at Gulavne village located in Chiplun Taluka of district Ratnagiri. The PHC is at a distance of 12 km from village Gulavne. The PHC does not contain medication that is required for ordinary insect bites, and infections. There is no guarantee of the presence of the doctor at the PHC. The PHC charges patients for use of saline water and injections. Due to these inadequacies when Mahadeo Valavte was sick, he preferred going to a private medical facility and spent around Rs. 2000- Rs. 3000.

Manisha and Mahadeo Agre, from village UBhale in Taluka Chiplun submit that the nearest PHC for them is located 10 km away. Until two years ago the doctor in charge of the PHC was a good human being and therefore the PHC was well equipped. But after his departure, the PHC has become only an institution of concrete. Manish Agre feels shy to go the PHC, as there is no lady doctor who she can freely speak to and hence she has to compulsorily go to the Taluka Health Care centre to get treated. For the last one year she has been suffering with healthcare problems, due to which she has become weak. Unfortunately the local PHC is not in a position to support her and therefore she has had to avail the services of the private doctor which has made her incur an expense of Rs. 1500.

Population Policy of Maharashtra and Infant Mortality Rate

In 2001, the Government of Maharashtra announced its 'New Population Policy', very much in tandem with the MDG-4 and 5, with the objective of reducing:

1. Total Fertility Rate from 2.7 in 1997 to 2.1 in 2004 and 1.8 in 2010.

¹ Findings in National Census 2001

² Maharashtra Human Development Report (2002); Pg. 13

³ Maharashtra Economic Survey Data on Health in Statistical Annexes

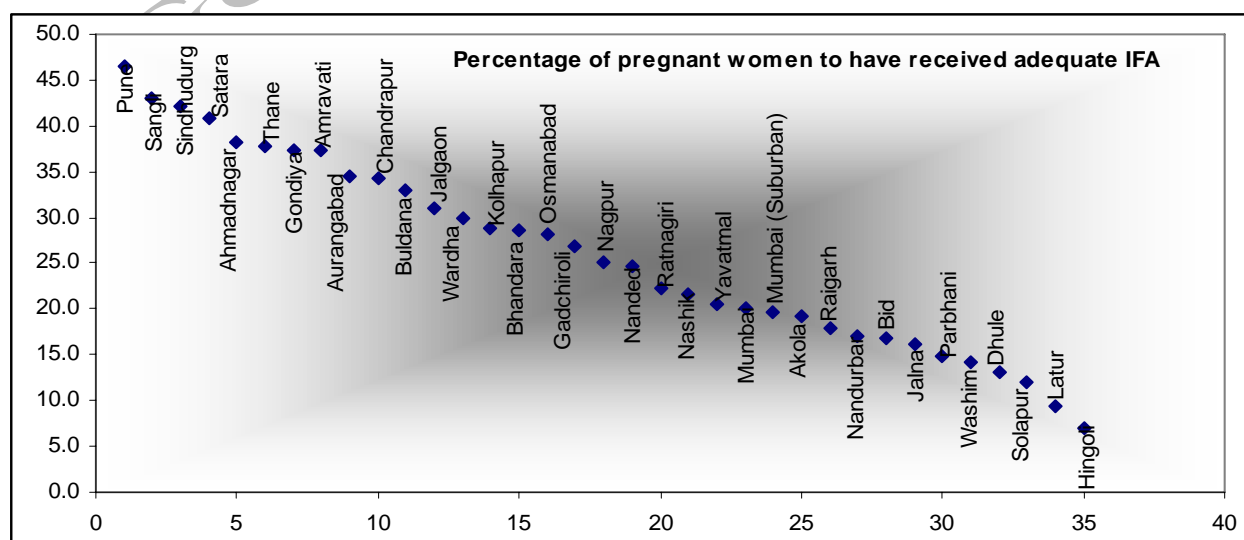
2. Crude Birth Rate from 22.5 in 1998 to 18 in 2004 and 15 in 2010.
3. Crude Death Rate from 7.7 in 1998 to 6.4 in 2004 and 5 in 2010.
4. *Infant Mortality Rate from 49 in 1998 to 25 in 2004 and 15 in 2010.*
5. Neonatal Mortality Rate from 33 in 1996 to 20 in 2004 and 10 in 2010.
6. *Maternal Mortality Rate from 310 in 1998 to 150 in 2004 and below in 2016.*

NFHS fact sheet on Maharashtra ⁴	Total Fertility Rate (children per woman)	Infant Mortality Rate (number of infant deaths per 1000 births in last 5 yrs.)	Fully immunized children in the age group 12 to 23 months (%)
NFHS-I (1992-93)	2.86	51	64.3
NFHS-III (2005-06)	2.11	38	58.8

The table above based on NFHS (2005-06) fact sheet for Maharashtra shows that the State Administration has not been able to achieve the goals that it set for itself in the Population Policy in the context of infant mortality rate. Also distressing to note is that the percentage of fully immunized children as a percentage of living children in the same age group has dropped drastically from 64.3 to 58.8 in spite of the so-called immunization drives being implemented by the State. The survey has also found anemia among children in the age group 6 to 35 months to be remarkably high.

Maternal Health Situation in Maharashtra

The situation of maternal health in Maharashtra seems to have improved according NFHS-III. The percentage of institutional births in the State which were 44.5% during 1992-93 have increased to 66.1% during 2005-06.



⁴ This fact sheet can be downloaded from: <http://www.nfhsindia.org/pdf/MH.pdf>

Be that as it may, the disparities in, antenatal care, immunizations done during and after pregnancy, consumption of iron-tablets/syrups during pregnancy, across the 35 districts of Maharashtra is very alarming. While in Pune, 46.4% of the pregnant women were found to have received adequate IFA tablets/syrup during pregnancy, only 7.1% of pregnant women in Hingoli were found to have received such doses during pregnancy.

Anganwadi and Children in Maharashtra

Anganwadis are considered as the heart of the Integrated Child Development Services (ICDS) programme. The Anganwadi is a child-care centre, located within the village or the slum area itself. It is regarded as a focal point for the delivery of services at the community level, to children below six years of age, pregnant and nursing mothers, and adolescent girls. One Anganwadi worker is expected to serve around 250 families.

Anganwadi centre also serves as the meeting place for women's groups, mothers' clubs and mahila mandals promoting awareness and joint action for child development and women's empowerment. There are more than 60,000 Anganwadis functional under various programmes in Maharashtra.

In spite of the importance of Anganwadis in the growth of a child and in the education of women on nutritional and other aspects of qualitative growth, these Anganwadis are exposed to a number of problems and neglect.

Kalpna Tamboli, at Lonand, of Taluka Khandala in District Satara, spoke to the researchers on her problems while operating a Anganwadi at Saibai Housing Society. Her major problem is that although she is trained to do all the work at the Anganwadi she faces shortage of resources. For example, even if she is in a position to administer doses of basic health care medicines many a times she is constrained as there are none in her Anganwadi. She believes that her Anganwadi can be made more effective, if children here are provided with more amenities and better equipment to play. She is of the opinion that children must have access to natural providers of iron, calcium such as salad and milk respectively.

Vanita Kate is an Anganwadi sevika at Kole in Sangola located in District Solapur. She explained that there are three Anganwadis in the village. She has to persuade a number of parents to send in their children to her Anganwadi. She generally feeds sweet rice, rice gravy and one vegetable to her students.

She complains that her Anganwadi does not have proper toilets. Neither does it have medicines that will help her take care of health care problems such as fever in children or diarrhea. She also does not have displays which she can use to teach basic issues to students. She is upset with the fact that supervisors who come to inspect the Anganwadi only investigate but do not provide them with resources in spite of several complaints. Supervisors are keen that Ms. Kate completes her targets, which has a natural implication on the quality of her output. She feels that the children are being cheated. While they are promised sweets on 15th August and 26th January, they are not provided with any sweets as nothing reaches the Anganwadi. Overall she is extremely disturbed with the direction in which the institution of Anganwadi is moving and she only wants to work as it gives her income support.

Knowledge on AIDS in Maharashtra

The Government of Maharashtra formed Maharashtra State Aids Control (MSACS) in 1998 to control HIV/AIDS pandemic. The funds are utilized to run integrated counseling and testing centres and for the 'Antiretroviral Strategy'. Under the latter, is to suppress viral replication to undetectable levels, thereby converting HIV into a chronic manageable illness.

NFHS-III data shows that knowledge of AIDS amongst women has increased rapidly in the State of Maharashtra. The percentage of ever-married women who have heard of AIDS increased from 61% in 1998-99 to 79% by the end of 2005-06. More than 90% of men in Maharashtra are seen to be aware of AIDS.

Random interviews conducted with AIDS or HIV+ patients (who do not want to disclose their identity) clearly show that the patients are discretely aware of the government programmes. Most of them have praised the approach of the doctors in public hospitals towards them in spite of knowing that they are HIV+ or AIDS patients. Some of them have also been getting their medication free of cost from public hospitals. Interviewees have suggested that the reach-out strategies of the Government need to be bettered with more effective and simple messages.

Malaria Control

In 2006, Maharashtra accounted for 6% of the dengue cases reported in the country (Rajasthan accounted for the highest at 15%)⁵. To intensify malaria-control activities, World Bank assisted Enhanced Malaria Control Project has been started since October 1997. District Malaria Control Societies have been established and registered for 16 tribal Districts in the State. Various activities that will prevent proliferation of Malaria are being carried out through these District Malaria Control Societies. Funds are provided to these District Malaria Control Societies directly by the Centre.

An interesting study conducted by Dhiman, Shahi and others (2005)⁶ shows that tribal beliefs and practices are still becoming major barriers to reducing the spread and intensity of malaria attacks in districts such as Gadchiroli. The paper clearly shows the basic deficiencies in the programmes being implemented in remote areas while controlling malaria, e.g. ashram schools not using mosquito nets.

Conclusions

It is beyond doubt that the State Administration's outlook towards health needs a serious overhaul. Not only is the macroeconomic situation bad, the micro-situation as exhibited through interviews is even worse. The government is clearly becoming an agent of private healthcare practitioners by withdrawing itself from creating medical infrastructure and also by abstaining from providing qualitative basic healthcare services.

Suggestions

1. The government must allocate a minimum of 2% of GSDP towards improving the soft and hard health infrastructure especially at the level of PHCs.
2. Most importantly, a practical incentive based programme must be implemented that will incentivize physicians and experts to spend at least two months in villages that are selected by the Government.

⁵ A detailed paper on this issue can be viewed at: www.nvbdc.gov.in/Doc/DenStatusNote.pdf

⁶ Dhiman, R., Shahi, B. *et al* (2005); "Persistence of malaria transmission in Tribal Area of Maharashtra, India"; *Current Science*, Volume 88; No. 3; February; Pgs. 475-478