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RCH in Meghalaya : Policy Perspectives

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Abstract :

Owing to the increase in the rate of maternal and infant deaths in the last one decade the Government of India has taken sincere efforts in trying to improve the health delivery mechanism to this segment of the population. In 2005 the Government joined hands with the UN for the attainment of the Millennium Development Goals (MDG) where maternal health was one of the primary eight goals and an important part of the Sustainable Development Goals (SDG). This study focusses on the Reproductive and Child Health (RCH) Programme in India with special focus on maternal health in the state of Meghalaya. The RCH Programme was first implemented in the year 1998 which was called RCH Phase I and a revised version called the RCH Phase II Programme was implemented in 2005.

The present study focuses on the performance of the RCH Programme, with an emphasis on maternal health in Meghalaya. Meghalaya is one of the seven sister states in the north east which is characterised by hilly terrain and a rough topography. The importance of this research lies in developing an understanding the challenges of implementing the programme in this geographical set up.

Keywords: Maternal Health, North East India, Meghalaya, Home Deliveries, Institutional Deliveries, Health Outcomes

Introduction and Background

India's burgeoning rate of growth of population accompanied by high death rates in India left no choice for the policy makers and planners but to adopt more strategic family planning programmes in India. The thrust moved from quantity of population to quality of population. The International Conference on Population and Development (ICPD) held at Cairo in 1994 provided a new platform for India to design programmes for better population management. (UNFPA, 1994). The Conference had a plan of action that catered to diverse aspects pertaining to population and health. It looked in to areas like family planning, population and environment, gender equality, empowerment of women, reproductive right and reproductive health, health and mortality and morbidity and a few more.

Responding to the globally evolving health framework around Reproductive health, the Government of India launched the Reproductive and Child Health Programme (RCH) programme I in 1998. Owing to being partially effective in bringing improvements in maternal health outcomes, RCH I was considered as a partially successful initiative. The maternal mortality ratio and the infant death rates continued to remain high. This was a very alarming situation for the country. During 2000, maternal and child health gained a new wave of

significance. There was a shift in the importance of providing good maternal and child health provisions to the people. This change came in when it was acknowledged that health is an important determinant in eliminating the problem of poverty. Subsequently, the Millennium Development Goals (MDG) came into effect in 2000 which was a UN initiative. The major objective of the MDG was to tackle the problem of poverty by bringing an end to the issues which contribute in having an impact on the increasing poverty, maternal and child health being one of them.

Evolution of the Reproductive and Child Health (RCH) Programme

The Reproductive and Child Health (RCH) Programme is a flagship programme under the umbrella of National Rural Health Mission (NRHM). The RCH programme caters to the needs of health for women and children. The Government rolled out the NRHM in 2005 with the objective to revamp the health system in the rural areas and improve financing mechanisms for the same. The reason that triggered the adoption of the NRHM was the poor performance of vital health indicators like Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMF) and Total Fertility Rate (TFR) especially in the rural areas inspite of significant improvements in public health in India over the years. (Family Planning 2016)

The RCH programme has two phases. The first phase of the programme RCH-I was launched in the year 1998 which was not very successful. The RCH-I had brought down the rate of the MMR, however, the progress was negligible. The issue of accessibility, affordability and availability of maternal health care still persisted. (Child Protection and Child Rights , 2003).
The adoption of the Millennium Development Goals and the inclusion of maternal health under Goal No 5 showed concern about bringing improvements in the area of maternal health in a different lens. It had become imperative to improve the condition of health services that was being provided to the pregnant mothers. Therefore in 2005, the Government of India under the NRHM launched a revised version of the RCH programme which was called the RCH Programme II.

The approach under the RCH II to reduce MMR and improve maternal health in general was made more comprehensive and holistic. Maternal health received a new wave of significance with the emergence of the MDGs in the public health domain. Although there was creditable improvement in the performance of maternal health indicators, there was a shortfall of targets towards the end of the MDG framework in 2015. RCH-II laid emphasis on bringing about a substantial change in three critical indicators i.e; total fertility rate, maternal mortality rate and infant mortality rate.

Locating RCH in the north eastern region- A Case of Meghalaya

The NRHM was implemented in the whole country with special focus on 18 states, Meghalaya being one of them. The 18 states were selected on the basis of the criteria of either being one of the poor performing states in terms of health indicators or did not have adequate health infrastructure. Among the many objectives, one of the primary objectives of the NRHM plan was to improve access to improve access to rural people especially poor women and children to equitable, affordable, accountable and effective primary health care.

Meghalaya is one of the seven sister states in north east India. It is characterised by a hilly terrain and located in the interiors. This makes it even more understanding to understand the availability and accessibility of health services in this kind of a locational set up.

The preliminary analysis based on secondary data gives an inkling about the state of maternal health in Meghalaya. The table mentioned below summarizes the performance of key maternal health indicators in Meghalaya and compares it with India.

Table 1: Comparative Analysis of the Performance of vital Maternal Health Indicators in India and Meghalaya

Maternal Health Indicators	India (2005-2006)	Meghalaya (2005-2006)	India (2015-2016)	Meghalaya (2015-2016)
Mothers who had at least 4 ante natal care visits for their last birth (%)	37	42.8	51.2	50
Mothers who consumed IFA tablets for 100 days or more when they were pregnant with their last birth (%)	15.2	5.9	30.3	36.2
Births assisted by a doctor/ nurse/ LHV/ ANM/ other health personnel (%)	46.6	31.1	81.4	53.8
Institutional births (%)	38.7	29	78.9	51.4
Mothers who received post-natal care from a doctor/ nurse/ LHV/ ANM/ other health personnel within two days of delivery of their last birth (%)	46.6	31.1	81.4	53.8

Source: NFHS 3 and NFHS 4

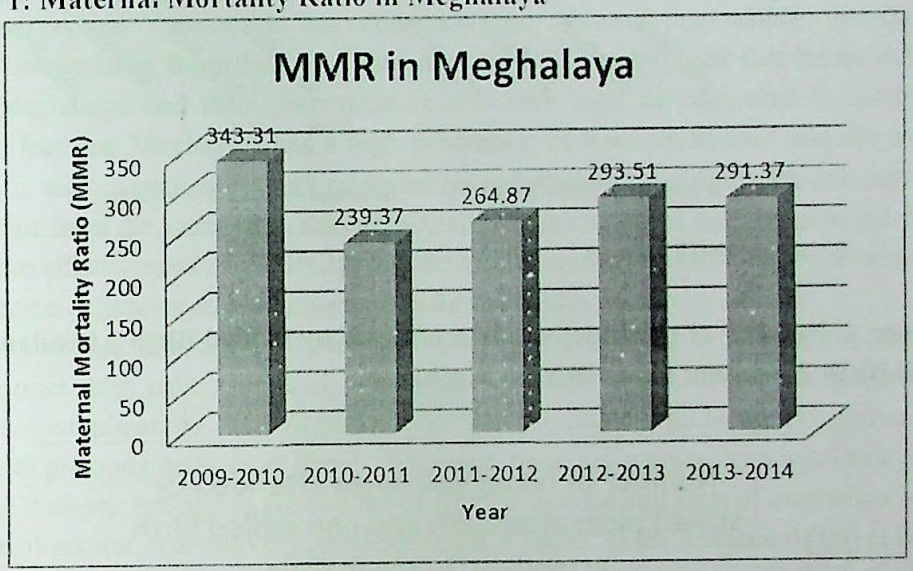
The Table summarizes that the performance of the indicators is relatively poor as compared to the national average. To have a more explicit understanding of the scenario of maternal health in Meghalaya in a broader time frame, trend analysis has been done for four indicators over a period of time. The four indicators are mentioned below:

- Maternal Mortality Ratio- The maternal mortality ratio (MMR) is the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period. A maternal death refers to a female death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy. (Series Metadata Goal 5 , n.d.)
- Number of Pregnant women received 3 ANC check-ups: This implies the percentage of women who use ante natal care provided by skilled health personnel for reasons related to pregnancy at least three times during pregnancy. Ante Natal Care (ANC) third coverage is an indicator of continuity and use of health care during pregnancy and also of access.
- Number of home deliveries and deliveries at public institutions: The number of deliveries that take place in a non-institutional set up is known as home delivery. This is mostly conducted at home. The delivery at home is sometimes conducted by Skilled Birth Attendant (SBA) and sometimes by Non Skilled Birth Attendants (Non SBA). It is important to keep a track of the home deliveries because they are associated with increased risk of obstetrics

emergencies as compared to the deliveries that happen at the institution. Deliveries conducted at Public Institution: This refers to the number of deliveries that take place only in the public health institution. It signifies the preference of the beneficiaries for delivery at the public institution. (Nongkynrih, 2013)

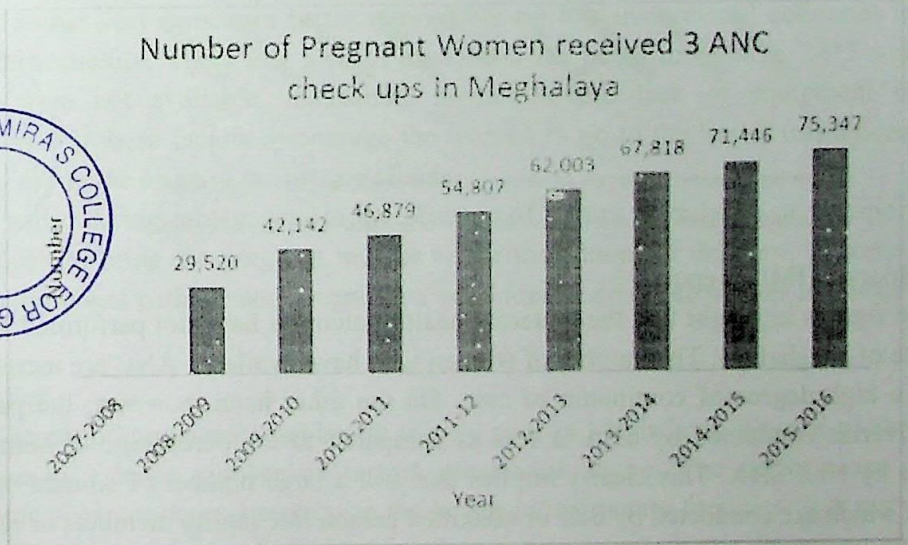
- Number of home deliveries attended by SBA Trained (Doctor, Nurse, ANM): Home deliveries conducted by a professional who has been given some knowledge and training for conducting deliveries are known as Skilled Birth Attendants (SBA). It comprises of doctors, nurses and Auxiliary Nurse Midwife (ANM). The risk of maternal mortality is less in home deliveries conducted by SBA. (Sanku Dey 2014)

Figure 1: Maternal Mortality Ratio in Meghalaya



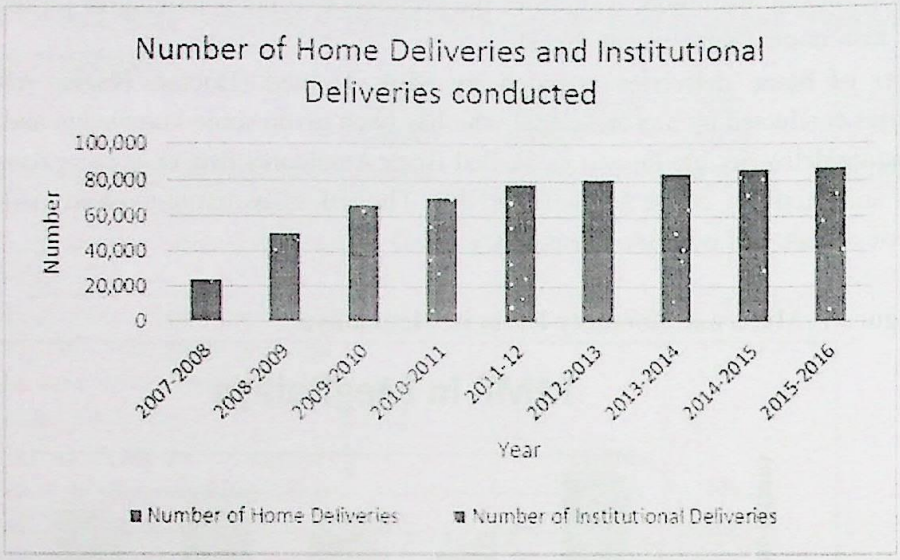
Source: HMIS (Health Management Information System) Report

Figure 2: Number of pregnant women who received 3 ANC check-up in Meghalaya from 2007-2016



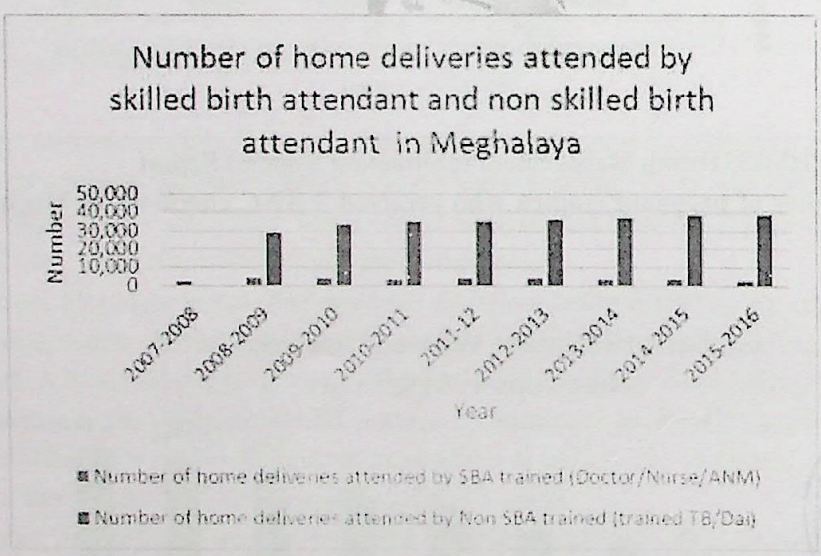
Source: HMIS Report

Figure 3: Number of home deliveries and institutional deliveries conducted in Meghalaya from 2007-2016



Source: HMIS Report

Figure 4: Number of home deliveries conducted by Skilled Birth Attendant (SBA) and Non Skill Birth Attendant (Non SBA) in Meghalaya



Source: HMIS Report

The above figures highlight that the maternal health outcomes have not performed satisfactorily in the state of Meghalaya. The number of women who have availed 3 ANC are increasing which indicates a high degree of continuum of care. On the other hand, however, the percentage of home deliveries conducted by SBA is less as compared to the percentage of home deliveries conducted by Non SBA. This clearly implies that still a large number of women opt for home deliveries which are conducted by dais or unskilled person like family members or relatives. The graphical representation No 4 gives brings to light that although the proportion of institutional

deliveries have increased over time, home deliveries still constitutes a significant proportion of total deliveries which is close to institutional deliveries.

Understanding performance of RCH in Meghalaya- Initial ideas

To have an in-depth understanding of the factors that led to the poor performance of institutional deliveries and the home deliveries conducted by SBA, a pilot study was conducted in select districts of Meghalaya. The sampling of villages was done on the basis of purposeful stratified sampling and about 8 poor performing districts were identified. The methods used involved focus group discussion and interview. The focus group discussion was conducted with the villagers and the interview was conducted with important key stakeholders involved in the implementation of the programme. The tools like interviews and focus group discussions helped to create a conceptual framework to understand the reasons responsible for the poor performance. The findings from the interviews and the FGD highlighted that home deliveries still exist in Meghalaya and their proportion is still very high as compared to institutional deliveries. The fact that Meghalaya has a high proportion of home deliveries and the maternal mortality ratio is also considerably high provides an opportunity to explore the reasons for the same. The output from the interviews also suggested that institutional delivery is a good proxy for analysing the effectiveness of the RCH programme. Therefore a need was felt to understand the factors of home deliveries and its impact on maternal health outcomes.

It was observed that most women are still very comfortable with home deliveries especially the ones who have delivered in the past at home and had an experience of safe delivery with no complications. The women do not feel the need to go to the institution if they are satisfied with previous delivery at home. However, there are women who would have opted for institutional delivery but due to constraints of limited income and lack of awareness towards the importance of institutional delivery, they delivered at home. If the distance of travel between the home and the health institution is more and there was no ambulance service they would have to spend their own money on conveyance. The local conveyance is expensive and owing to low income the villagers would prefer to deliver at home. Some women are compelled to deliver at home so that they could easily take care of the elder siblings as there was no one at home.

Another very important factor responsible for low institutional deliveries has been poor health infrastructure. There is a lack of doctors in the heath institution, 24*7 round the clock services were not available, inadequate medicines and lack of equipment in the health institutions. All these factors discourage the women to go to the health institutions and so they prefer to stay home or go to the private clinics.

Lastly, during labour pain in the absence of proper ambulance or transport facilities, it was difficult to bring the pregnant mother to the institution for delivery. In some villages, the road condition was pathetic and it was not a good idea to drive the mother in labour pain on such roads.

Conclusion

The condition of maternal health is very poor in Meghalaya. Women prefer to deliver at home due to a large number of factors mentioned above. The performance of the RCH programme does not depend merely on the health infrastructure facilities. It is not only an issue of demand supply mismatch in the health infrastructure domain but is dependent on a number of

other factors like poverty, education of women and the family, awareness, mind set and religious beliefs.

The performance of the maternal health outcomes can be improved if attention is paid to these other factors as well. In short, it is imperative to improve the condition of other socio-economic factors like poverty and education in order to better maternal health outcomes. The MDG has provided a platform for this and it is recommended that the Government policy should work on similar lines to improve maternal health. The RCH programme needs to be more integrated with other programmes and cannot work effectively to improve maternal health in isolation.

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