

Current Status of Service Delivery in the Health and Family Welfare Sector in Kerala: with Particular Reference to Reproductive and Child Health Program

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EXECUTIVE SUMMARY

Kerala state of India is quoted as a model for the developing country because of its high achievements in the field of health and family welfare at a low cost. Kerala's infant mortality rate of 10/1000 live births and life expectancy of 76 years for women and 70 years for men are close to that of developed countries. Over 97% of institutional deliveries, high coverage of immunizations, access to universal health care etc are some of the highlights of the Kerala model of health care. Some of the recent studies reported that the cost of health care has been increasing in the state and the quality and quantity of health care provided through the public sector were decreasing. As a consequence to the liberalization policies of the Indian government, budget allocations to public sector specifically for education and health care has been decreasing since 1991. This affected the State of Kerala also and we wanted to study the current status of service delivery in the health and family welfare sector in Kerala with particular reference to reproductive and child health.

We selected five districts from the state, two from the north, two from the south and one from the central region. We conducted household survey to find out from the people the services that they received from various health care institutions. A total of 5000 households (3500 rural and 1500 urban) were selected by a multistage random sampling and trained investigators collected information from all the households using a pre-tested structured interview schedule. We collected information on antenatal care, delivery practices including medical termination of pregnancy, immunization coverage and source of immunization, low birth weight, awareness on sexually transmitted infections and reproductive tract infections, utilization of health services from the health care institutions and the quality of health care. We collected information from selected 65 sub centres, 19 mini primary health centres, 10 block primary health centres, 4 community health centres and 5 first referral units from the five districts. The information collected from the institutions included infrastructure facilities, drugs and supplies, staff strength, bed strength if any, and services provided from those institutions. We also conducted focus group discussions (FGD) in one of the northern districts and one southern district. Separate FGDs were conducted for junior public health nurses, junior health inspectors and selected women in the age group of 15-50 years. We also interviewed key stake holders like Senior Medical Officers at state, district and

PHC level and elected representatives of local bodies. Data entry and analysis were done using Excel and SPSS software.

The average number of antenatal visits was found to be 8 in the total sample. There was not much difference between the five districts or between the urban and rural areas. The cost of an antenatal visit was reported to be around rupees 200. There is a need to reduce the number of antenatal visits. Recent studies have shown that without any problems to the mother and baby the number of antenatal visits can be reduced to 4 or 5. This would reduce the cost of care for pregnancy and delivery and overcrowding at maternity hospitals in the state. Tetanus toxoid coverage was found to be nearly 93 per cent with comparatively lower proportion in rural area. The district wise difference shows much difference with the highest coverage in Kollam and Alappuzha (99%) and the lowest in Ernakulam district (76%).

Institutional delivery was found to be 98.2% for the entire sample. Only Malappuram district reported home deliveries. All the other four districts had 100 per cent institutional deliveries. Female obstetricians conducted 85.9% of deliveries in our sample. In a poor state like Kerala over dependence on specialists is a concern because it raises the cost of health care. Nearly 98% of women preferred to have their deliveries conducted by a female provider. Majority of deliveries (52%) were conducted in private hospitals. Since over two third of hospital beds in Kerala is in the private sector this is not high as one would expect. Barring Malappuram district home deliveries are becoming extremely rare in Kerala. Sub centres and primary health centres are also not conducting deliveries particularly in southern districts. This is the reason for the overcrowding of tertiary level maternity hospitals in government sector. In spite of having a high proportion of institutional deliveries the state does not have reliable data on maternal mortality ratio. This could be collected from hospitals easily, provided the private hospitals would also report maternal mortality to the state health authorities.

Low birth weight was found to be 13.3 %. This figure was one of the lowest in recent studies in Kerala. Immunization coverage of children between 12 to 23 months was found to be low in Malappuram district. In all the other districts, coverage of DPT 3 and OPV 3 was over 90%. However in Malappuram district both DPT 3 and OPV 3 coverage was less than 50%. This is surprising since the TT coverage for pregnant women in Malappuram was over 90%. After a period of 'no polio' case in the state for more than three years one case of polio was reported in Malappuram district. Therefore there is an urgent need to improve immunization coverage in Malappuram district and areas of low coverage in other districts. The demand for including Hepatitis –B vaccine and MMR in the immunization schedule was raised in the FGDs.

Thirty nine per cent of households reported that someone from the health centre visited their house in the last one month. This is a remarkable increase from the 17% reported in 1987 and 25% reported in 1996. The decentralization process that started in the state in 1996 could be one of the reasons for this increase in house visit, because of supervision by elected representatives.

Medical termination of pregnancy was reported to be very expensive in both government and private sector. Awareness on STI and RTI was reported to be high but the knowledge on the source of treatment for it was poor. This was evident from the large number of reported cases of RTI and STI from many institutions.

Infrastructure facilities in many institutions were reported to be inadequate. Many sub centres did not have minimum facilities to accommodate the junior public health nurse. This might be one of the reasons for the low proportion of house visits. The maternal mortality and infant mortality captured by the health workers was found to be only around 25% of the actual mortality. There is a need to improve the routine surveillance system by which we would be able capture this vital information. The mini primary health centres were found to be functioning as outpatient clinics only. Inpatient facilities were not provided. Unless inpatient facilities are provided in primary health centre, the only government institution in a Panchayat with a Medical Officer, people will be pushed to private sector hospitals. If this is going to be difficult in the near future inpatient facilities need to be provided at least in the block PHC level. The entire block PHCs could be converted to community health centres in a phased manner and it should provide specialists care also.

The occupancy rate of block PHCs and CHCs was less than 50%. This could be improved by providing more manpower and infrastructure facilities like blood transfusion in CHCs. In block primary health centres the average number of doctors was found to be three and two thirds of them were specialists. However in the CHCs only 50% were specialists. With the current number of doctors sanctioned for CHCs (around 4) it would be difficult to provide 24 hour services in these centres. In most CHCs the required specialists were not available. A redistribution of specialists working in the block PHCs to community health centres and raising the average number of doctors in the CHC to at least 7 would improve the current situation in CHCs.

In the FRUs that we studied an average of 340 deliveries was taking place in the month preceding the survey. One of the concerns here was the proportion of cesarean section (CS). Average proportion of CS in the five FRUs was 39%, which was slightly more than that reported by NFHS 2 for urban Kerala (38%). In two of the FRUs the proportion of CS was more than 50% which is unacceptably high.

Since subcentres and primary health centres did not perform delivery and related services their role needs to be redefined. Non-communicable diseases like cardiovascular diseases, diabetes, chronic obstructive pulmonary diseases, cancer and mental illness are increasing in the state. In addition road traffic accident is also increasing. Therefore in the changing scenario the role of grass root level organizations and manpower in the health sector needs to be redefined so that health services will become more efficient.