CHAPTER-V

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5.1 Introduction

The infant and child mortality in Assam have shown substantial decline in the last few decades. Despite improvements in the general mortality situation and thereby in infant and child mortality, the latter remain markedly high. Though such a reduction appears quite encouraging, there are large differentials in the risks of infant and child deaths among different districts of Assam. The variations in infant and child mortality rates differ among different socio-economic and demographic strata.

The infant mortality in Assam has declined from 139 to 76 from 1971 to 2003, but the rate of decline has been slow as compared to other states of India. There has been fluctuation in declining trend of IMR in Assam, e.g. in the year 1975 the IMR increased to 8 points and became 144, which was 136 in 1974. The exact cause of this sudden increase is not known. Again in 1985, there was a jump of 12 point’s, i.e. in 1984 it was 99, which became 111 in 1985, again in 1991 a 6 point increase is recorded. The lowest infant mortality in Assam was in the year 1996, i.e. 74. In Assam, like other Indian states and developing countries, the IMR is double for the rural areas compared to urban areas. In 1971 the IMR for urban areas was 73 and for rural areas it was 144, which has declined to 37 and 78 in 2001.

At present, Assam’s position is 5th in terms of IMR after Madhya Pradesh, Orissa, Uttar Pradesh, and Rajasthan. In Assam the IMR is 6 point higher than the national average. In 1970, it had IMR of 126, which declined to 103 in 1980, 76 in 1990 and remained in the same position till 2000. The statistics reveal that in the last decade there has been no practical change in the IMR in Assam.
5.2 Comparison of Jorhat and Dhubri:
The primary data shows that in the district of Jorhat, Neonatal mortality (early Neonatal and Late Neonatal) accounted for 85 percent of total infant deaths and in the district of Dhubri, it was 78.3 percent. In the period of one month to one year, only 10 percent in Jorhat and 13.3 percent in Dhubri died. Child mortality in both the districts was low that is 5 percent in Jorhat and 8.3 percent in Dhubri. From this analysis, it became very clear that the most important period of child’s life is the neonatal period. If proper care for this period is taken, than to large extent infant mortality can be reduced, which will increase the overall life expectancy of the population.

A comparative study of the reproductive and child health indicators in the districts of Dhubri and Jorhat also has been done here which includes marriage below 18, birth order 3+, know all family planning methods, antenatal care, full antenatal care, institutional delivery, safe delivery, full vaccination, aware of AIDS (female), Reproductive Track Infection/ Sexually Transmitted Infections (RTI/STI) (female), awareness of AIDS among male, and RTI/STI (male) by taking secondary data. A comparative study of these variables shows that in all terms, Jorhat district is far better of than the Dhubri district.

The primary data shows that in terms of all most all background characteristics Jorhat is far better of than Dhubri. For this study the background characteristics taken are: questions on age, type of place of residence, type of house, highest educational level, ownership of house and ownership of agricultural land provide information on characteristics likely to influence demographic and health behaviour.

The other determinants of infant and child mortality discussed in this thesis for comparing Jorhat and Dhubri are reproductive behaviour and intentions. The analysis covered survival status of all births, quality of care, quality of family planning and health services, antenatal, and delivery care: the questionnaire collects information on whether women received antenatal care place of delivery. Besides, the questioner was framed with the intension of collecting information on whether women received antenatal care and place of delivery, breastfeeding and health, feeding practices, the length of breastfeeding.
and Immunization coverage. The wide gap between these two districts in terms of these variables may be one of the major causes of the high and low infant and child mortality in Dhubri and Jorhat respectively.

**Logistic regression analysis** demonstrates that components of early childhood mortality are place of residence, highest educational level of the mother, assistance during delivery, place of delivery, type of living house, exposure to mass media, antenatal care, family planning, and standard of living.

The binary logistic regression analysis shows that the type of place of residence is strongly linked to ‘child is alive’. Type of House is also very significantly related to child survival. But semi-pucca house is not significantly associated with child survival. Educational level of the mother is very important for child survival. As level of education goes higher, the probability of survival also increases. But primary schooling does not show any correlation with child survival.

This study suggests scope for further research where the inclusion of the biological variables, like birth weight, may be better able to explain the relationship of socio-economic and demographic variables with infant and child mortality.

Differentials in infant and child mortality that were observed between different socio-economic and demographic sub-groups and the factors which were observed to affect child mortality significantly may have important policy implications.

The general life style and living standard of the people by its various dimensions measured at the familial level, and by a variety of environmental and social factors influence the infant mortality in a community. Factors exogenous to life-styles, the availability and utilization of medical health facilities, are also very crucial in this regard. The structural differences in the childbearing population and the pattern of childbearing are very important as immediate determinants of infant mortality. Such factors may be
responsible to a certain extent in creating differentials in infant mortality rates between these two districts.

5.3 Suggestions:
As infant and mortality rate is much higher in Dhubri than Jorhat due to a large number of factors which are discussed in this thesis in detail. Necessary policies and programme interventions have to be developed to tackle these factors. To reduce the infant and child mortality in Dhubri district, following measures can be adopted.

Health education programmes should be designed for the families who have experienced infant and child deaths so that the further risk of death may be substantially reduced. The effect of birth order and younger maternal age is mediated through short birth interval. Young mothers at high parity, those children bearing at short birth intervals, and mothers who had suffered child loss before are the vulnerable to excessive infant and child mortality. Policies should be formulated with keeping in mind the factors like, age at marriage, timing of child bearing, delaying the first pregnancy, spacing, education and infrastructural facilities.

There is no doubt that perinatal and neonatal mortality will decline substantially with the institution of a package of basic perinatal care in the community. The problem lies in developing adequate infrastructure, ensuring reasonable quality of expertise among the health care functionaries and improving the penetration of the services into the community within the existing constraints of resources in a cost-effective manner.

Community-based health workers in the Dhubri district should take extra precaution in counseling the mothers on essential newborn care (e.g., birth preparedness, breastfeeding, clean delivery, cord care, and hypothermia prevention). Community-based health workers performance need to be improved and maintained through follow-up after training and periodic supervision in proper counseling, identification, and treatment and/or referral by health workers of newborn problems.

An improvement in the socio-economic status, education and health awareness would
concomitantly lead to a fall in the infant and child mortality in Dhubri district. The health of a newborn is dependent upon the health of the mother. Women must be accorded due status, recognition and attention if we wish to improve our progeny. There should be no discrimination against female children. There is a need to provide them good nutrition throughout childhood but most crucially during adolescence and pregnancy. Girls should be provided with formal and non-formal health education especially in the art of mother craft and child care.

The government should assign top priority to tackling rural poverty in Dhubri district. It should aim at reducing the incidence of poverty in rural areas by strengthening the capabilities of the poor and vulnerable groups to earn income through better education and health facilities. The existence of several anti-poverty programs such as the food subsidy program through the Public Distribution System (PDS), the employment generation program, Jawahar Rozgar Yojana (JRY) and the subsidized credit program for self-employment (IRDP) has made much impact on poverty in Jorhat, but not made much impact on poverty in Dhubri district.

The delivery of immunization and maternal care services needs to be given top priority in Dhubri district in order to improve the condition of infant and child. Maternal, infant and child mortality is influenced by a whole range of socio-economic factors, the status of women, which includes low level of education, economic dependency and lack of access to services. Jorhat district, which has relatively better socio-economic and education status, have lower infant and child mortality than the Dhubri district. Thus, besides improving the maternal health care services, it is necessary to improve the social status of women, including the education standard, to reduce the current level of infant and child mortality.

It was clear from the interview of the mothers in the Dhubri district that the existing health system in Dhubri has major problems of absence of links between communities, sub-centres and referral facilities; shortages of equipment and trained staff at referral
facility; and a lack of emergency transport to adequately meet the needs of pregnant women particularly for the complications of pregnancy and obstetrical emergencies.

Further the issues related to women's health could be supported through action (operational) research. This includes a variety of formal and informal research projects that can be used to introduce, test or modify programme strategies and activities and measure their impact and cost-efficiency. High-quality services will generate their own demand in the long run. But, in our commitment to a safe mother and child, concerted and consistent efforts are required because every mother and child counts.

The rural population in Dhubri district, has a very low purchasing power, relies heavily on the public health system where the services are supposedly free of cost. However, the public health care facilities have poor accessibility and suffer from lack of quality and accountability among the providers. Thus in spite of the huge investment & infrastructure in the public health care system, the poor do not have access to a good quality healthcare. This is more true in case of Dhubri than Jorhat.

5.4 Conclusion:
To conclude infant and child mortality rate in Dhubri is at high level, necessary policies and programme interventions have to be developed to tackle the factors, which are responsible for high infant and child mortality in Assam. Most of the families where infant and child deaths have been occurred are illiterate or educated up to primary level. They were not aware about the existing health facilities in their locality. Health education programmes should be designed for the families who have experienced infant and child deaths so that the further risk of death may be substantially reduced. The effect of birth-order and younger maternal age is mediated through short birth interval. Young mothers at high parity, those bearing children at short birth intervals, and mothers who had suffered child loss before are vulnerable to further infant and child mortality. This may be used for future planning and policy decisions aimed at reducing infant and child mortality as a formula. Policies should be formulated keeping in mind the factors like, age at
marriage, timing of child bearing, delaying the first pregnancy, spacing, education and infrastructure facilities.

At the same time, governments, nongovernmental organizations and donors that are concerned about the level of infant and child mortality also need to pay attention to issues like poverty alleviation and improvements in health infrastructure, women's education and overall status. These improvements are also essential to increase survival rates among the new borns. The chances of significant gains in infant survival are greatly enhanced when broad-based strategies are combined with expanded access to family planning services.

Improving the health status of the community is desirable not only because health itself is an objective worth striving for, but also for economic and social reasons. A healthy population is not only a happy and contented population with a good quality of life, but it is a more productive population. Keeping people healthy also is cost effective as sickness is very expensive not only in terms of direct costs but also in terms of loss of productivity. Therefore the state needs to take preventive measures to improve the reproductive and child health facilities to provide quality health and thereby reduce the incidence of maternal, infant and child mortality.