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SUSTAINABLE DEVELOPMENT AND PRIMARY HEALTH CARE SERVICES IN MIZORAM, INDIA

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ABSTRACT

Primary Health Care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable(Becker,2007).World Health Organization (WHO) recognizes the central role of primary health care for achieving health and well-being for all, at all ages. Stronger primary health care is essential to achieving the health-related Sustainable Development Goals (SDGs) and universal health coverage. It will contribute to the attainment of other goals beyond the health goal (SDG-3), including those on poverty, hunger, education, gender equality, clean water and sanitation, work and economic growth, reducing inequality and climate action (WHO-1978).The World Health Organization Thirteenth General Programme of Work 2019-2023, has introduced an impact framework to measure country results and progress in achieving the health-related targets of the SDGs. The 2030 agenda for sustainable development outlines a transformative vision with 17 sustainable development goals (SDGs) for economic, social and environmental development. While only SDG-3, to ensure healthy lives and promote well-being for all at all ages, focuses on human health, all goals are interrelated. This issue of the Bulletin of the World Health Organization examines the relationship between health and the SDGs. Universal health coverage could therefore contribute to achieving the SDGs by producing equitable and sustainable health outcomes. Many health disparities between people with different socio-economic status are compounded by gaps in good governance (Acharya, et al, 2018).

KEYWORDS: *Health Care, World Health Organization, healthy lives, Human Rights*

INTRODUCTION

Primary Health Care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable(Becker,2007).World Health Organization (WHO) recognizes the central role of primary health care for achieving health and well-being for all, at all ages. Stronger primary health care is essential to achieving the health-related Sustainable Development Goals (SDGs) and universal health coverage. It will contribute to the attainment of other goals beyond the health goal (SDG-3), including those on poverty, hunger, education, gender equality, clean water and sanitation, work and economic growth, reducing inequality and climate action (WHO-1978).

Primary health care is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the highest attainable standard of health, as echoed in Article 25 of the Universal Declaration on Human Rights: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services"(Buse and Hawkes ,2015).

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OBJECTIVES OF THE STUDY

(i) To study the primary health care services in Mizoram.
(ii) To examine the role of primary health care services for sustainable development in the state

(iii) To analyse the share of public health expenditure in the total state budgetary outlay for the improvement of health facilities in Mizoram.

SOURCES OF DATA AND METHODOLOGY

The study is based on secondary data which are collected from Statistical Abstracts& Handbooks; Government of Mizoram, Economic Surveys, Planning and Programme Implementation; Annual Financial Statements, Demand for Grants-various years, Government of Mizoram; *Official Records, Directorate of Health &Family Welfare, Govt. of Mizoram* Government of Mizoram, Census of India, books , journals, articles etc., related to the study. Simple statistical techniques such as average, percentage etc., are used for the analysis of the data.

SOCIO-ECONOMIC PROFILE OF MIZORAM

Mizoram, situated in the North-Eastern region of India, is a small state with a total area of 21,081 sq. km. It is bounded by Myanmar in the East and South, Bangladesh and Tripura in the West, Assam and Manipur in the North. The state has been divided into 8 Districts, 26 Rural Development Blocks, 23 Sub-Division and 3 Autonomous District Councils. The total population of Mizoram according to 2011 census is 10,91,014(P). Mizos are of Mongoloid stock and the language also belong to the Tibeto–Burman group. In 1952, district council was formed in the area covered by Aizawl and Lunglei Sub-Divisions. A regional Council was started for the region inhabited by the Pawi, the Lakher and the Chakma in 1953. The Lushai Hills District was renamed Mizo District by an Act of Parliament in 1954. Chieftainship was abolished by an Act passed by Assam state assembly in 1954. In 1972, Mizo District was raised into the status of a Union Territory Under North East Areas Reorganizations Act, 1971. The Mizo District Council was dissolved and the Pawi–Lakher Regional Council was divided into three autonomous district councils of Mara, Lai and Chakma. Therefore, Mizoram was conferred statehood in 1987.

PRIMARY HEALTH CARE SERVICES IN MIZORAM

Public health sector had humble beginning, with dynamic and enthusiastic leadership at the state and district levels. Every effort was being made to further increase the number of health facilities so that the community, even in the remotest part of the State could avail health services of trained personnel. The inter-denominational medical institute is under the jurisdiction of the Health and Family Welfare Department, Government of Mizoram. Health Services are provided at primary, secondary and tertiary levels. Primary healthcare is overseen by a sub-centre at village level and a Primary Health Centres (PHC)/Community Health Centre (CHC) at the block/ sub-divisional level. Secondary and tertiary health care are provided by district hospitals and the state hospital/referral hospital.

Mizoram Government has shown commendable efforts towards the provision of healthcare facilities among the people. Several government medical institutions have been established in different parts of the states especially after 1987 when the Mizoram was elevated to the full fledge state.

In Mizoram, Directorate of Health Services (DHS) is concerned with provision of Community Health services through its network of 12 Community Health Centres, 57 Rural Primary Health Centres, 8 Urban Primary Health Centres,372 Sub-Centres and 166 Sub-Centre clinics.The full spectrum of Promotive, Preventive, Curative, Rahabilative and Pallitive health services are provided to citizens of Mizoram even to the remotest village. Most of the vertical health programmes currently implemented through the National Health Mission (NHM) are through the DHS. Some of the key indicators of family health services in Mizoram are presented in Table-1.

Table-1: KEY INDICATORS OF FAMILY HEALTH SERVICES IN MIZORAM (NFHS-4,2015-16)

Sl. No	Particulars	Urban	Rural	Total
1.	Households with an improved drinking-water supply (%)	94.1	87.8	91.5
2.	Households using improved sanitation facility (%)	90.9	73.1	83.5
3.	Total Fertility Rate	2.0	2.7	2.3
4.	Mothers who had antenatal check-up in the first trimester (%)	77	52.1	65.7
5.	Mothers who had full antenatal care (%)	47.9	27	38.5
6.	Institutional Births (%)	97.2	61	80.1
7.	Children age 12-23 months fully immunized (BCG, measles and 3 doses each of polio and DPT) (%)	49.8	51.3	50.5
8.	Children under 5 years who are stunted	22.7	33.8	28
9.	Children 6-59 months who have anemia(problem)	13.2	22.3	17.7
10.	Women who use any kind of tobacco (%)	59.2	59.3	59.2
11.	Men who use any kind of tobacco (%)	82	77.7	80.4
12.	Women who consume alcohol (%)	6.7	2.2	5
13.	Men who consume alcohol (%)	52.3	44.9	49.6

Source: Records, Directorate of Health &Family Welfare, Govt. of Mizoram

The study reveals that 91.5 per cent of the total numbers of households in the state are having the facilities of improved drinking water supply. Households using the improved sanitation facilities are 83.5 per cent. Regarding mother and child health, the study shows that only 38.5 per cent of mothers had full antenatal care. This further shows the negligence of the mother's health which is an indispensable for the improvement of the general health status in the society. Only 50.5 per cent of children ages 12-23 months were fully immunized with Bacilla Culmate Gaurin (BCG), measles, DPT etc). Among children 6-59 months, 17.7 per cent were suffering from the problem of anemia. This is a great concern where the

society needs to put more efforts. Consumption of tobacco is very common and creates many serious health issues in the mizo society. On an average 80.2 per cent of men and 59.2 per cent of women were intoxicating in such bad habits. It is obvious that the expenditure on the uses of tobacco is high enough out of the family daily expenditure. That unnecessary expenditure should be eliminating and turns them out for the economic returns to the society. Approximately 50 per cent of the total number of male also consumed the alcohol while it was 5 per cent with women. In order to achieve a better standard of health status in the society, individual obligation and pursuance towards the right direction is very important.

INFANT MORTALITY RATE

Another area of research concern is having an in-depth knowledge of the Infant Mortality Rate in the state by comparing the performance of the districts as indicated in Table-2 below.

Table-2:District-wise Infant Mortality Rate (IMR) in Mizoram

Sl.No	District	2015-16	2016-17	2017-18
1.	Mamit	16	19	25
2.	Kolasib	18	20	25
3.	Aizawl	18	22	17
4.	Champhai	25	16	24
5.	Serchhip	28	16	23
6.	Lunglei	29	19	18
7.	Lawngtlai	26	27	27
8.	Siaha	38	28	20
	Mizoram	**22**	**21**	**20**

Source: Planning& Project Section, Hospital & Medical Education, Govt. of Mizoram

The study reveals a high IMR in the two southern most districts (Lawngtlai and Siaha) in Mizoram during 2015-18. This was mainly because of scanty medical facilities in these areas. The number of doctors and other medical personnel also very inadequate subject to the needs of the population in the particular areas. The IMR reduced from 22 per cent to 20 per cent during 2015-18 which was lower than the national Infant Mortality Rate of 33 per cent.

MATERNAL MORTALITY RATE

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. From 2000 to 2017, the global maternal mortality ratio declined by 38 per cent-from 342 deaths to 211 deaths per 100,000 live births, according to UN inter-agency estimates. This translates into an average annual rate of reduction of 2.9 per cent. While substantive, this is less than half the 6.4 per cent annual rate needed to achieve the Sustainable development global goal of 70 maternal deaths per 100,000 live births (WHO, Geneva, 2015-19).As shown in Table-3,the number of maternal mortality was 16 in 2017-18 in the state. The maternal mortality rate was decreased from 88 to 83 during 2015-18 which was lower than 122 of MMR (2015-17) at the national level.

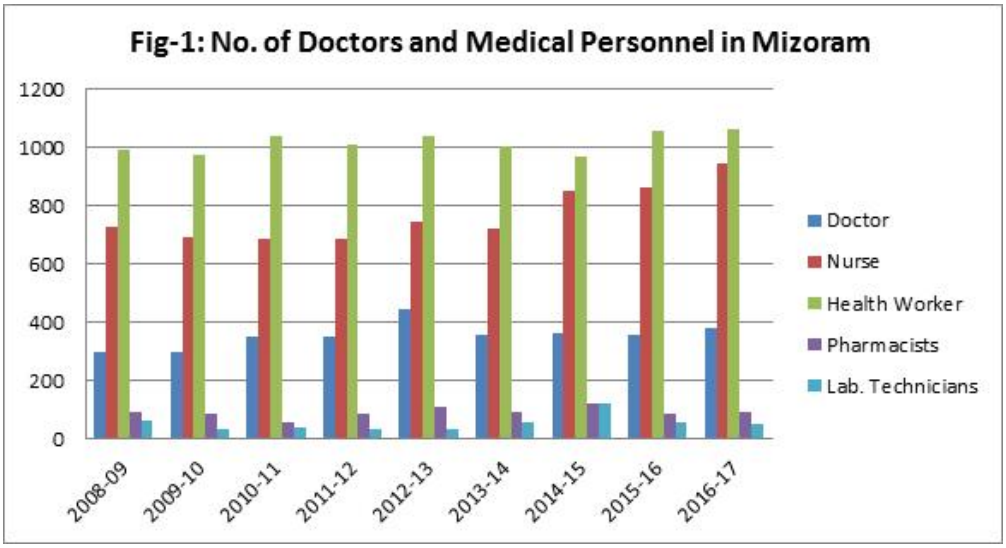
Table-3: District-wise Maternal Mortality Rate (MMR) in Mizoram

Sl.No	District	2015-16		2016-17		2017-18	
		No. of Deaths	MMR	No. of Deaths	MMR	No. of Deaths	MMR
1.	Mamit	2	167	2	180	2	168
2.	Kolasib	2	169	2	167	nil	nil
3.	Aizawl	Nil	Nil	6	130	6	67
4.	Champhai	1	50	1	55	5	278
5.	Serchhip	1	132	Nil	Nil	nil	nil
6.	Lunglei	3	120	2	87	2	80
7.	Lawngtlai	1	69	3	182	nil	nil
8.	Siaha	7	539	4	303	1	81
	Mizoram	**17**	**88**	**20**	**104**	**16**	**83**

Source: Planning& Project Section, Hospital & Medical Education, Govt. of Mizoram

AVAILABILITY OF DOCTORS AND OTHER MEDICAL PERSONNEL

In Mizoram, it is known that there is inequality in respect of availability of health infrastructures, doctors and other medical personnel among the districts which leads to disastrous results in the society. The people especially from the economically backwards group suffered a lot because they cannot support themselves to access better health care facilities.



Even though the central government takes necessary steps by implementing some health policies, the problem is still persistent in the state. Most of the medical personnel are willing to leave the village and remote areas for permanent settlement in the city areas. Meanwhile, the medical facilities in the village hospitals, CHC and PHC are very inadequate even for the basic treatment which leads to serious problems for the people in the effected regions. So the state government needs to take some initiatives to solve the problem.

Data incorporated in Table-4 indicates that 45 per cent out of the total employees are working in the district of the state capital, Aizawl. Meanwhile, the remotest district of the state, Siaha, where people are economically backward, face many health challenges with only 5.2 per cent of the total health employees in the state.

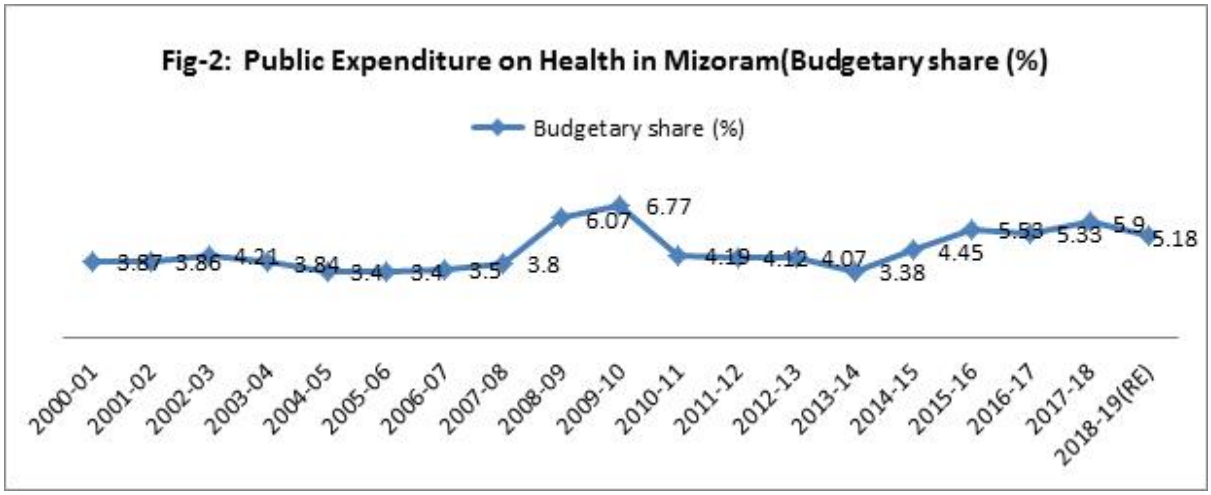
Table-4: District-Wise, No. of Doctors & Medical Personnel in Mizoram (2016-17)

District	Doctors	Nurse	Health Worker	Lab.Technician	Pharmacists	% out of the Total Employees
Mamit	16	45	85	3	4	6%
Kolasib	26	64	62	3	9	6.5%
Aizawl	202 (53%)	455 (48%)	405 (38%)	27 (52%)	52 (57%)	45%
Champhai	31	88	129	6	5	10.2%
Serchhip	21	73	64	5	7	6.7%
Lunglei	48	128	179	7	11	14.7%
Lawngtlai	20	43	78	Nil	2	5.6%
Siaha	18	49	63	1	1	5.2%
Mizoram	**382**	**945**	**1065**	**52**	**91**	-

Statistical Abstracts,2017, Directorate of Economics& Statistics, Govt. of Mizoram

PUBLIC EXPENDITURE ON HEALTH

Another area of interest for the researcher is to analyze the public expenditure on the health services in the state. The study shows that the budgetary share of health expenditure ranging 3-7 % during 2000-19.The highest budgetary share was witnessed in 2009-10. This was mainly due to the implementation of major centrally sponsored scheme like National Rural Health Mission and National Health Mission in the state. It is found that there was almost stagnating share of the expenditures in terms of its percentage share in the total budget of the state government. So, the state government needs to scale up the budgetary expenditure on the health services in order to attain sustainable development in the state.



FINDINGS AND SUGGESTIONS

- The study reveals that 91.5 per cent of the total numbers of households in the state are having the facilities of improved drinking water supply.
- Households using the improved sanitation facilities are 83.5 per cent.
- Regarding mother and child health, the study shows that only 38.5 per cent of mothers had full antenatal care. This further shows the negligence of the mother's health which is an indispensable for the improvement of the general health status in the society.
- Only 50.5 per cent of children ages 12-23 months were fully immunized with Bacilla Culmate Gaurin (BCG), measles, DPT etc).
- Among children 6-59 months, 17.7 per cent were suffering from the problem of anemia. This is a great concern where the society needs to put more efforts.
- Consumption of tobacco is very common and creates many serious health issues in the mizo society. On an average 80.2 per cent of men and 59.2 per cent of women were intoxicating in such bad habits.
- It is obvious that the expenditure on the uses of tobacco is high enough out of the family daily expenditure. That unnecessary expenditure should be eliminating and turns them out for the economic returns to the society. Approximately 50 per cent of the total number of male also consumed the alcohol while it was 5 per cent with women
- The study reveals a high IMR in the two southern most districts (Lawngtlai and Siaha) in Mizoram during 2015-18. This was mainly because of scanty medical facilities in these areas. The number of doctors and other medical personnel also very inadequate subject to the needs of the population in the particular areas. The IMR reduced from 22 per cent to 20 per cent during 2015-18 which was lower than the national Infant Mortality Rate of 33 per cent.
- The number of maternal mortality was 16 in 2017-18 in the state. The maternal mortality rate was decreased from 88 to 83 during 2015-18 which was lower than 122 of MMR (2015-17) at the national level.
- With regard to availability of Doctors and other medical personnel, the Public health services is not sufficient to achieve quality health standard of living in the state. The Problems of Shortages of medical staffs everywhere. Equal distribution of doctors and other medical personnel to cover all the districts is an important work to access better health facilities in the remote areas.
- It is revealed that there is unequal distribution of government registered medical personnel (doctors and other staffs) in the state. Aizawl District benefitted the most with 45% of the total employees, while Siaha with only 5.2%
- The study shows that the budgetary share of health expenditure ranging 3-7 % during 2000-19.The highest budgetary share was witnessed in 2009-10. This was mainly due to the implementation of major centrally sponsored scheme like National Rural Health Mission and National Health Mission in the state. Almost stagnating share of the expenditures in terms of its percentage share in the total budget of the state government. Considering its ramification on the quality of life of the people, it is necessary that budgetary allocation is increased according to the pace of economic development as well as budget size.

CONCLUSION

Primary health care has been proven to be a highly effective and efficient way to address the main causes and risks of poor health and well -being today, as well as handling the emerging challenges that threaten health and well-being tomorrow. Meanwhile, sustainability is the capacity to improve the quality of human life while living within the carrying capacity of the Earth's supporting eco-systems. As a matter of fact, health is crucial for sustainable human development, both as an inalienable human right and an essential contributor to the economic growth of society. It is also a good summative measure of the progress of nations in achieving sustainable development. It contributes to national development through productive employment, reduced expenditure on illness care and greater social cohesion. A healthy population is essential for economic development.

REFERENCES

1. *Becker,G.S (2007), " Health as human capital: Synthesis and extensions", Oxford Economic Papers,59,379-410.*
2. *Chakraborty,S.(2004), " Endogenous lifetime and economic growth". Journal of Economic Theory, 116,119-137.*
3. *David Roger Walugemble, Shannon Sibbald, Marlene Janzen Le Ber and Anita Kothari (2019), "Health Research Policy and Systems " or http:// doi.org/ 10.1186/s12961-018-0405-y*
4. *Field, E., Robles, O.,& Torero, M.(2009), " Iodine deficiency and schooling attainment in Tanzania", American Economic Journal: applied Economics, 1,140-169.*
5. *Gibbons, D.C, Bindman, A.B, Soljak, M.A , Millett C and Majeed A (2012), "Defining Primary Care Sensitive Conditions: A necessity for effective primary care delivery?", JR Soc Med.2012.105:522-428.*
6. *Kent Buse and Sarah Hawkes (2015) "Health in the Sustainable Development Goals: Ready for a paradigm shift,/ Globalization and Health-March 2015, DOI:10.1186/s12992-015-0098-8?".*
7. *Luca, D.L., Iversen, J.H., Lubet, A.S., Mitgang, E.,Onarheim, K.H, Prettner, K., and Bloom, D.E (2018), " Benefits and Costs of the Women's Health Targets for the Post-2015 Development agenda, In Prioritizing Development : A Cost Benefit Analysis of the United Nations' Sustainable Development Goals", Edited by Bjorn Lomborg, Cambridge University Press,244-254.*
8. *Shambhu Acharya, Vivian Lin & Natasha Dhingra (2018), "The role of health in achieving the sustainable development goals". Bulletin World Health Organization,96:591-591A,DOI:http:// dx.doi.org/10.247/1/blt.18.221432,http:// www.who.int/bulletin/volumes/96/9/18-221432.*
9. *Sustainable Development Solutions Network,2015 – www.publichealthnetwork.cymru*
10. *World Health Organization(2015-19), " UNICEF, United Nations Population Fund and the World Bank, Trends in Maternal Mortality: 1990 to 2015, 2000 to 2017", Geneva,2015-2019,https:// data.unicef.org*
11. *World Bank, (1993), "Investing in Health: World Development Report 1993 ", New York: The World Bank & Oxford University Press.*
12. *World Health Organization (1978),"Declaration of Alma Ata, Adopted at the International Conference on Primary Health Care,", Geneva and Alma Ata Declaration, USSR,6-12, September,1978.*
13. *http://www.statista.com*
14. *http://www.researchgate.net/publication*
15. *http://www.healthaffairs.org*
16. *https://journals.plos.org*
17. *http://oecdobserver.org*
18. *http://documents.worldbank*
19. *http://www.who.int/news*
20. *http://www.thelancet.com*