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LETTER TO EDITOR

Maternal Mortality Ratio and Assam

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Maternal Mortality Ratios (MMR) strongly reflects the overall effectiveness of health systems, which in many low-income developing countries suffer from weak administrative, technical and logistical capacity, inadequate financial investments and a lack of skilled health personnel. The global MMR in 2013 was 210 per lac live births. At the country level, two countries account for a third of global maternal deaths; India at 17% (50,000) and Nigeria 14% (40,000). According to the estimates the MMR in India has reduced from 212 per lac live birth in 2007-09 to 178 per lac live births in 2010-12. Kerala, Tamil Nadu have already achieved the goal of a MMR of 100 per lac live births . Assam and EAG states still fall in the high maternal mortality states categories Assam being at the top position with the score of MMR 328.[1]

As per 2011 Census, the population size of Assam is 3,1205576 ,of which 85.9% live in villages of rural areas.[2] All key indicators of maternal health are poor in Assam and below the national average. In rural areas of Assam, literacy rate for males and females stood at 75.40 % and 60.05 % respectively. Average literacy rate in Assam for rural areas was 69.34 %. Mothers who had ANC in first trimester was 39.4%, who had three ANC was 45.2%, mothers who had at least one dose of TT injection was 69.3%, mothers who consumed 100 IFA tablets was 36.9%, institutional delivery was 35.3%, delivery at home was 63.6%, safe delivery was 40.9%, mother received PNC within two weeks of delivery was 32.2%, 36.2% mothers BP was taken , girls marriage before 18 years was 20.8%. All the above mentioned indicators are very poor in rural areas compared to the urban areas in Assam.[3]

Most of the people in Assam lives in rural areas. There is a rigid hierarchy and class structure moulded by tradition and long-standing customs. The family often a joint family, is a strong binding force. People mainly depends on agriculture and there is lack of alternative employment opportunities. The quality of life is poor because of scarcity of essential goods, facilities and money and not able to pay for medical services. There is isolation caused by distance, poor communication and transport facilities. The environment is unfavourable predisposing to communicable diseases and malnutrition, hook worm infestation, iron deficiency anaemia especially in tea garden communities and these factors are responsible for high MMR in these communities.[4]

Despite of the fact that the state is flooded with many maternal and child health related programmes and schemes which are too far from the poorer section of the people resides in the remote and difficult areas. Low levels of female literacy, ignorance, prejudices inherent in the socio-cultural milieu, low levels of nutrition, poor environmental sanitation , lack of awareness of hygiene are some factors preceding the medical causes and makes

pregnancy and child birth a risky venture. Lack of manpower and adequate infrastructure, delay in recognising early danger signs, delay in transport and referral to the higher facility for emergency obstetric care are associated with high MMR.[5]

Political commitment, economic development, employment opportunity, increased female literacy rate, health education, community participation, availability of adequate infrastructures and manpower with essential drugs , full antenatal, natal and post natal care in stipulated times are the back bone of healthy mothers with healthy deliveries.

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