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RESEARCH ARTICLE

REDUCING INFANT MORTALITY RATE (IMR) IN JAMMU & KASHMIR-TRUTH OR MYTH

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ABSTRACT

This article is in response to the claims of Government of Jammu & Kashmir where they have congratulated and felicitated the State health machinery for leading in reducing the IMR from 34 to 26 per 1000 live births in a single year and registering decline of 8 points in IMR which has been highlighted as the highest among all the states of the country. We are extremely happy for this historic achievement but have some reservations.

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INTRODUCTION

This article is in response to the claims of Government of Jammu & Kashmir where they have congratulated and felicitated the State health machinery for leading in reducing the IMR from 34 to 26 per 1000 live births in a single year and registering decline of 8 points in IMR which has been highlighted as the highest among all the states of the country. We are extremely happy for this historic achievement but have some reservations. To elaborate this truth or myth on IMR, Let us first explain what is IMR and how it is estimated. Infant mortality rate (IMR) is the ratio of deaths under 1year of age in a given year in a particular geographical area to the total number of live births in the same year in the same geographical area; usually expressed as a rate per 1000 live births. It is one of the most universally accepted indicators of health status not only of infants, but also of whole population and of the socioeconomic conditions under which they live. In addition, the IMR is a sensitive indicator of the availability, utilization and effectiveness of health care, particularly perinatal care (from 20th week of pregnancy to 1st week of life of New born). Demographers opine that in most developed countries, where IMR rate is already below 10 per 1000 live births, further decline in IMRs would be difficult to achieve without some revolutionary advances in perinatology.

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The decline in IMR has been attributed to: 1) improved obstetric and perinatal care, e.g., availability of oxygen, fetal monitoring during labour. 2) Improvement in the quality of life, that is, economic and social progress.3) better control of communicable diseases, e.g., immunization and oral rehydration. 4) Advances in antibiotics, insecticides and chemotherapy. 5) Better nutrition, e.g., emphasis on exclusive and early initiation of breast feeding up to 6 months of age. 6) Adopting family planning methods, e.g., birth spacing and small sized family and 7) Improved level of health education of general public. No doubt our strategies have changed in this part of the World in the management of childhood illnesses including the capacity building trainings for both doctors and paramedical staff, infrastructure up-gradation and establishment of SPECIAL NEW BORN CARE UNITS in District Hospitals, NEW-BORN STABILIZATION UNITS in Community Health Centers, and BABY CARE CORNERS in different hospitals across state which has helped in making infants stable just after birth and improving the IMR. Also an increase in the manpower in the form of doctors, Specialists like Pediatricians, Gynecologists and Anesthetists available in the hospitals have helped us in reducing the IMR every year, BUT to have a drop of 8 points in a single year is more than the expectations.

The Sample Registration System (SRS) is a large-scale demographic survey for providing reliable annual estimates of birth rate, death rate and other fertility & mortality indicators like IMR at the national and sub-national levels. Initiated on a pilot basis by the OFFICE OF THE REGISTRAR GENERAL,

INDIA in a few selected states in 1964-65, it became fully operational during 1969- 70 with about 3700 sample units. The field investigation consists of continuous enumeration of births and deaths in selected sample units by resident part time enumerators, generally anganwadi workers & teachers, and an independent survey every six months by SRS supervisors. The data obtained by these two independent functionaries are matched. The events where there is not agreement among the two independent sources are re-verified in the field by a common visit by both the concerned enumerators and thereafter a valid information about the exact count of births and deaths is obtained. The sampling unit in rural areas is a village or a segment of it, if the village population is 2000 or more. In urban areas, the sampling unit is a census enumeration block with population ranging from 750 to 1000. At present, SRS is operational in 7,597 sample units (4,433 rural and 3,164 urban) spread across all States and Union territories and covers about 1.5 million households and 7.52 million population..

Towns and cities within a state were first stratified according to 1961 census population as: (a) Stratum I: towns with a population of 100,000 and over; (b) Stratum II: towns with a population of 50,000- 99,999; (c) Stratum Ill: towns with a population of 20,000- 49,999; (d) Stratum IV: towns with a population under 20,000. Sample units are allocated over the four strata in proportion to their population. All cities in stratum I were included. The other towns and the blocks were selected on a simple random-sampling basis. In allocating the number of sample blocks to these cities and towns, it was ensured that each area should have at least two blocks. In the states, the system is under the control of one of three agencies-the Director of Census Operations, the Bureau of Economics and Statistics or the Directorate of Health Services-depending upon the availability of suitable field personnel at the time the scheme is initiated in a state. A nucleus staff is provided at the state headquarters for overall direction and administration of the project. In addition to the information of age, sex and marital status as collected in the household schedule, data on births and deaths are also recorded.

The Sample Registration System is subject to three types/sources of errors: (a) sampling errors; (b) non-sampling errors; (c) matching errors.

In any survey, non-sampling errors require attention. Such errors are of particular importance in the Sample Registration System because of the variety of hierarchies involved and the repetitive nature of the survey. Among the causes contributing to non-sampling errors in this system are the fact that some of the sampling units are not easily accessible due to the hilly and far-flung location, due to weather and road conditions and sometimes due to political or communal disturbances. Also the lack of a constant and efficient supervision and less frequent trainings can also lead to non-sampling errors. The non-sampling errors do have an effect on the quality and, consequently, on the results of the survey.

This is exactly what has happened to our State in the conduct of the survey. The State of Jammu and Kashmir has been divided into four divisions for SRS. One of the four divisions is JEHLUM VALLEY NATURAL DIVISION which starts from South Kashmir in the Qazigund area to the North Kashmir upto Uri area where the bulk of the population lives on the banks of river JEHLUM. This division which contributes around 25% of the sample has been left out of the survey in the recent survey (WHICH IS CLEARLY MENTIONED IN THE SRS REPORT) mostly because of the unrest (political/law and order) in this part of the valley. It is quite clear that leaving one of the four divisions in the survey will give less accurate and biased results. Also the precision of the results will be affected because of a reduced sample size which is evident from the long confidence interval of 20 to 33.The people living in these areas are not socially and economically well off and their health indicators might be poorer as compared to the overall indicators of the state. Hence skipping them in the overall estimation of IMR can falsely give an overall lower IMR than the real IMR.

There are two ways to clear this situation. Firstly we have to do the survey in the left-out region of Jehlum Valley according to the original protocol and incorporate the results into the final outcome, thus the issue will be cleared and we will get a more accurate and more precise estimation of IMR. Secondly we have to wait for the next SRS bulletin which will be conducted as per the protocol and if that IMR is less than 26 we can celebrate it that time.

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