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Does Health Policies and Infrastructure Ensure a Better Health Status? A Study on Women's Health of Meghalaya

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Abstract:
Inequalities in the social and economic status of men and women disproportionately deprive women and children of good health. Health is an important factor that contributes to human wellbeing and economic growth. The slogan "Promoting women's health" denotes the significance to fundamental human rights such as the Right to Education, the Right to Employment and Equal pay for work, and the Right to participate in the political life of one's community. The present study was carried out to study the health policies and infrastructure in reference to women health care. The objective of the study was to study the health status of women, to assess the medical infrastructure available in the study areas, and to determine the government aided schemes on rural women health care. The hypothesis considered includes arena of unawareness of the women folk on government aided health schemes and ignorance of the women on their health results in poor health and ultimately lead to poor status of women. The study area was selected from Umsning Block, Jirang Block, and Umling Block of Ri-Bhoi District, Meghalaya. Two villages each from the three blocks were randomly selected. The villages are Myrdon Village, Raitong Village, Old Jirang Village, Paham Village, Hatimara Village and Umlengpur killing Village. Simple Random Sampling method was adopted for the study and the sample size is 100. The findings of the study reveal that there is an acute shortage of medical specialist and paramedical staff in most of the CHCs, PHCs and Sub-Centre's. The study urges the importance of an awareness programmes and seminars on women health issues covering pre-natal and post-natal check-ups in this unexplored district of Meghalaya.

1. Introduction

Women's health in rural areas affects everything in their environment from their families to their economies and vice-versa. Rural Women in India are among the most disadvantaged people in the world in terms of their health status and access to accurate and appropriate health information and comprehensive, adequate and affordable health services. Sexual and reproductive health is a particular concern for rural women, as a host of social, cultural, political, and economic factors increase Indian rural women's vulnerabilities to pregnancy and child birth-related deaths and disabilities, unsafe abortions, HIV/AIDS, and reproductive cancers. Closely related to this, are the personal, relational and institutional barriers, to rural women achieving their fundamental sexual and reproductive rights, their right to exercise control over their bodies and sexual and reproductive lives, which encompasses their right to decide upon such issues as contraception, marriage and abortion. Further, their overall health status is diminished by the lives they are forced to lead – lives that pivot around the harsh realities of malnutrition, illness, injury, and fatigue, frequently the consequence of long hours of demanding physical labor in unhygienic and dangerous conditions; the strains of childbirth and caring for multiple children; and not having enough to eat, which is often the result of more and better food going to male household members.

Indian rural women are especially vulnerable to pregnancy and childbirth-related deaths. With limited access to modern contraception, women are impacted by too early, too frequent, too many, and too late pregnancies. The issue of unsafe abortion, the consequences of which – infection, infertility, disability, and, in certain cases, death are well documented. The twin factors of distance to and cost of adequate care also increase rural women's chances of dying as a result of pregnancy and childbirth complications. Rural women are also less likely to have a skilled birth attendant present at their birth, a critical presence when complications arise.

Another pressing health concern impacting rural women is the alarming spread of HIV/AIDS. The migration of poor, rural people to urban centre's plays a significant role in transmission. Spending time away from home and family, removed from societal norms and lacking in knowledge of and access to measures to prevent infection, many individuals, particularly men, engage sexual encounters and become infected, which often results in their regular female partner becoming infected upon home return. Rural women are also exposed to infection through their involvement with the sex industry, as many women and young girls across India are trafficked from

rural areas to the cities. They are also at an elevated risk of HIV infection due to chronic presence of Reproductive Tract Infections (RTIs).

The Health care scenario of the North Eastern Region, particularly of the rural areas, is not very encouraging. This is primary due to inadequacy in Health Institutions and other Health Infrastructure, lack of Doctors and Health Assistants, shortage of medicines and other essential items. The Geographic condition of the hilly states of this region is also not very congenial for the development of healthcare infrastructure in the rural areas. The healthcare services of North Eastern Region are predominantly urban based. Due to the absence of basic amenities like proper road communication, transportation, housing, accommodation, electricity, water supply, sanitation, social environment, etc. Doctors and Health Workers are reluctant to go to the rural areas. On the other hand, many of the rural people prefer to go for the traditional method of treatment and as such, even when, health centers exist, people do not make full use of these centers. However, there is an overall shortage of modern medical diagnostic and therapeutic aids, super special services, specialized Doctors etc. even in the existing institutions of the urban areas. Moreover, the few laboratories and ancillary diagnostic facilities that exist in some of the North Eastern States are fairly primitive.

The general health conditions of women in the state of Meghalaya are drastically poor. The common ailments suffered by women are gastroenteritis, tuberculosis, malaria, anemia and general debility. It is common to see many women in the rural areas of the state having 8-10 children. Repeated and frequent pregnancies have been detrimental to the health of women. There is a deep-rooted belief in having large families. The debility due to pregnancies, extreme hard work and low nutritional levels have paved the way for an alarming rise in tuberculosis in women especially in the Garo Hills. A significant portion of women do not receive any antenatal/postnatal care and a large percentage of deliveries are conducted by untrained birth attendants or relatives. The district hospitals are distant and inaccessible to most villagers. When faced with obstetric complications like hemorrhage or obstructed labor, there is considerable delay in reaching these hospitals which results in maternal deaths.

Contraception is generally not popular but there are cases of women using indigenous medicines for the purpose. Women are also more likely to seek help from traditional practitioners for treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) etc. Local health traditions, 'DAWAI KYNBAT' in Khasi Hills and 'ACHIKSAM' in Garo Hills are in fact practiced with a fairly good success all over the State. These practitioners enjoy a high degree of acceptance and respect and they consequently exert considerable influence on health beliefs and practices.

Women's health is devoted to facilitating the preservation of wellness and prevention of illness and includes screening, diagnosis and management of conditions which are unique to women, are more common in women, are more serious in women and have manifestations, risk factors or interventions which are different in women. (National Academy or women's Health Medical Education, 1996)

Women health also recognizes the importance of the study of gender differences, recognizes multidisciplinary team approaches, the values and knowledge of women and their own experience of health and illness; recognizes the diversity of women's health needs over the life cycle and how these needs reflect differences in race, class ethnicity, culture, sexual preference and levels of education and access to medical care; includes the empowerment of women, as for all patients to be informed participants in their own health care. (National Academy or women's Health Medical Education, 1996)

Utilization of maternal and child health services is very poor among the tribes of central India. Clinically acceptable maternal and newborn care practices for delivery, cord cutting and care, bathing of mother and newborn and skin massage are uncommon. Therefore, newborns remain at high risk of hypothermia, sepsis and other infections. Prelacteals, supplementary feeding practices and delay in breastfeeding are very common, although colostrum's is less frequently discard. Malnutrition is a severe problem among tribes and many tribal children and women are severely malnourished as well as anemic. (Ravendra k. et al., 2010)

Maternal survival can be improved by posting of midwives at village level, if they are given proper training, means, supervision, and back-up. The inputs for such a programme to succeed and the constraints of its replication on a large scale should not be underestimated. (Fecuveare V. et al, 1991)

2. Materials and Methods

India is the second most populous country of the world and has changing socio-political-demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growth-orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. About 75% of health infrastructure is concentrated in urban areas where 27% of the population lives. A significant portion of the country's medical needs, in the rural areas have been attended to by the indigenous health systems such as Ayurveda, Homeopathy, *Unani,* Naturopathy, and folk medicine, it has been conveniently neglected by the policy makers, and planners.

The following table is show casing the health facilities of the study area for the year 2009-10.

Sl. No.	Health Facilities	Ri-Bhoi District	Blocks of Ri-bhoi		
			Umsning Block	Umling Block	Jirang Block
1	District Hospital	1	0	1	0
2	Sub-Divisional Hospital	0	0	0	0
3	Community Health Centre's	3	2	0	1
4	Primary Health Centre's	8	4	3	1
5	State Dispensary	2	1	1	0
6	Sub-Centre's	27	17	9	1
7	Urban Health Centres	0	0	0	0

Table 1: Health Facility in Bi-bhoi District 2009-10
Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

The table depicts the health facilities such as District Hospital, Sub-Divisional Hospital, Community Health Centre's, Primary Health Centre's, State Dispensary, Sub-Centre's, Urban Health Centre's has been given according to the blocks.
The data shows that, in the year 2009-10, there were 27 Sub Centre's, 8 PHCs, 3 CHCs, 2 State Dispensary and 1 District Hospital. The highest number of sub- Centre's (17), PHCs (4) and CHCs (2) has been established in the Umsning Block. Not even a single Sub-Divisional Hospital and Urban Health Centre's have been established in Ri-bhoi District.

Particulars	Blocks Ri-Bhoi District		
	Umsning Block	Umling Block	Jirang Block
	Bhoilymbong CHC	Nongpoh CHC	Patharkmah CHC
Status of Building			
Own Building	1	1	1
Regular Electricity Supply	1	1	0
Beds	1	1	1
Generator	1	1	0
Telephone	0	1	0
Running Vehicle/ Ambulance	1	1	1
Investigative Facilities			
OPD rooms	1	1	1
Consulting Rooms (AYUSH)	1	1	1
Consulting Rooms (Specialist) CHC	0	1	0
Fully Equipped Labor Room	1	1	1
Minor OT	1	1	0
General OT	1	1	0
Separate wards for male and female	1	1	1
Separate public utilities (toilets) for male & female	0	1	1
Sitting arrangements for patients	1	1	0
Facility for food	0	1	0
Storage of medicine	1	1	1
Linkage with Blood Banks	0	0	0
Waste Disposal System	0	0	0

Table 2: Coverage and Availability of Infrastructure of Ri-Bhoi District
Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

Community Health Centre's (CHCs), the secondary level health care designed for health careinstitutions acts primarily as referral centre (for neighboring PHCs) for the patients requiring specialized health care services accessible to the rural people. However, the above table shows that, the infrastructure availability at the CHCs is fairly good. None of the CHCs has any linkage with blood banks and also none has a proper waste disposal system, in most cases medicines are being burnt or thrown in open space. There are no telephones inBhoilymbong and Patharkmah CHCs, which create lots of hurdles during emergency situation.
The study comprises of primary and secondary data. The primary data was collected through the in-depth interview of the respondent and through spot observation. The secondary data were collected through published works in form of books, articles, journals and internet resources.
The schedules were used as the tool for collecting the data accompanied by spot observation. The research scholars adopted home-visited method and group discussion method.
In this backdrop the research aims to make a study by keeping the following aims and objectives.

- To study the health status of women
- To assess the medical infrastructure available in the study area
- To determine the government aided scheme on rural women health

2.1. Survey Area

- Jirang Block, Ri-Bhoi District, Meghalaya

Old Jirang Village (15 respondents) & Paham Village (15 respondents)

- Umling Block, Ri-Bhoi District, Meghalaya

Hatimara Village (20 respondents) & Umlengpur Kiling Village (20 respondents)

- Umsning Block, Ri-Bhoi District, Meghalaya

Myrdon Village (15 respondents) &Raitong Village (15 respondents)

The research design was carried out in the state of Meghalaya from the District of Ri-bhoi. Simple Random Sampling technique was applied in order to obtain a representative sample. A total number of 100 respondents were randomly selected from six villages of Ri-Bhoi District - Umsning Block, Jirang Block, and Umling Block. Two villages each from the three blocks of Ri-Bhoi District were randomly selected. The villages are Myrdon Village, Raitong Village, Old Jirang Village, Paham Village, Hatimara Village and Umlangpur Village.

3. Results & Discussions

Women health in the study areas is found to be very poor; illiteracy and improper attainment of education has an impact on the health of the women folk. The finding shows that women between the age group of 51 years and above are mostly found to be illiterate and did not acquire any pre-natal and post-natal check-ups.

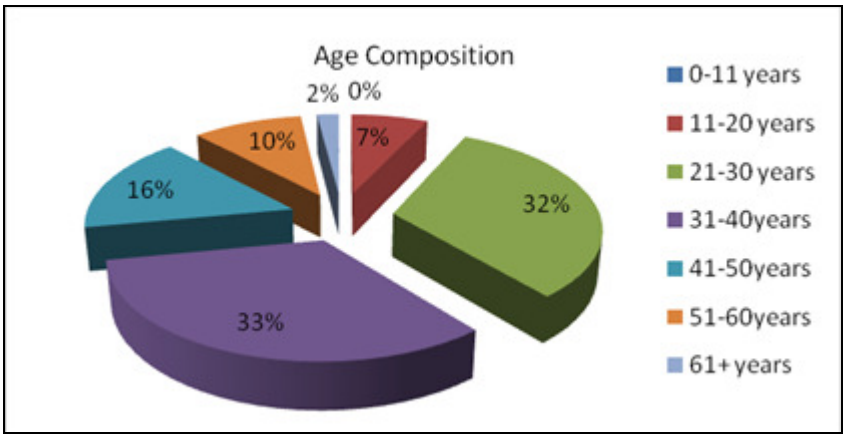

Figure 1: Age composition of the respondents:
Source: Data compiled from the field survey, 2015

The data shows the age composition of the respondents. Most of the respondents were from the age group of between 31- 40 years, which composed of 33% and 32% from the age group of 21- 30 years. The least was from the age group of 61 years and above, which composed of 2%.

Illiterate	Primary	High School	Secondary	Higher Studies
39%	50%	5%	6%	0%

Table 3: Education Status of the Respondents:
Source: Data compiled from the field survey, 2015

The table shows that 61% of the respondents were literate, whereas 39% of the total respondents were found to be illiterate. Of which 50% of the respondents were seen to have acquired primary school and 5% of the respondents have acquired high school. 6% of the respondents were found to have acquired secondary and none have acquired higher studies. This indicates that, most of the respondents of the study areas have acquired formal education. However, it has been observed that they are not in a state to understand the importance of acquiring a proper pre-natal and post-natal health care, vaccination, intake of nutritious food, regular check-up of their health, their children's health etc.

0-2 children	3-5 children	6-8 children	More than 9 children
37%	39%	20%	4%

Table 4: Total Number of Children:
Source: Data compiled from the field survey, 2015

The table shows that 39% of the respondents have 3-5 children's and 37% of the respondents have 1-2 children's. whereas 20% of the respondents have 6-8 children's and 4% of the respondents have more than 9 children's. In comparison to the educational status, it has been observed that those women who have attended formal education and few of the illiterate women have less than 5 children. Whereas most of those women who did not acquire formal education and few of those women who had acquire formal education were seen to have more than 6 children. Most women who have more than 6 children responded that they take more children as they like to have big families, while some responded that they take more children as they need more manpower in their dairy farms.

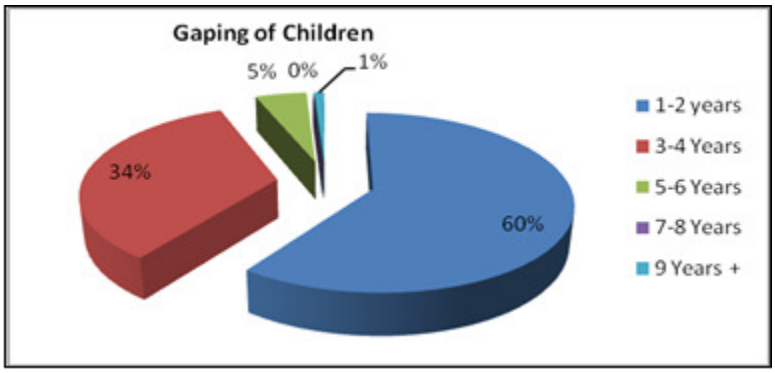

Figure 2: Pie-chart showing the Gaping of Children
Source: Data compiled from the field survey, 2015

The above pie shows the gaping of the children's; it is shown that 60% of women took a gap of 1-2 years. 34% of the women took a gap of 3-4 years, and 1% of women took a gap of 9 years. Repeated and frequent pregnancies results in detrimental to the health of women, however most of the women being ignorant and unaware of this fact gets pregnant frequently with the mindset that complications will arise.

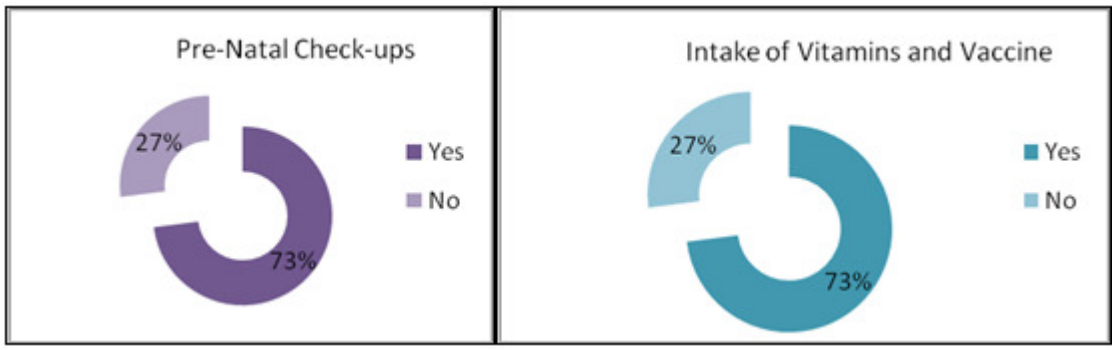

Figure 3: Showing the pre-natal check-up and intake of vitamins and vaccine
Source: Data compiled from the field survey, 2015

The above pie shows that 73% of the women had an access to pre-natal check-ups during their pregnancy and they also had an access to intake of vitamins and tetanus vaccine during their pregnancy. Whereas 27% of the respondents mostly between the age group of 51 years and above were found that they did not had an access to pre-natal check-ups nor had an access to intake of vitamins and vaccine. This is so because of their ignorance of the importance of pre-natal check-ups and intake of vitamins and vaccine.

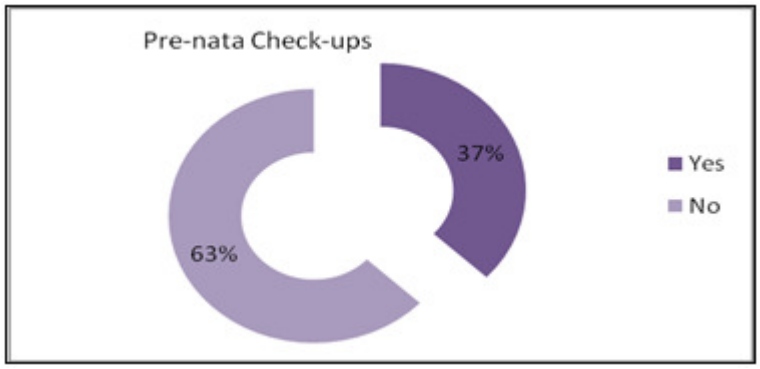

Figure 4: Doughnut Chart Showing the Post-Natal Check-up:

Source: Data compiled from the field survey, 2015

The pie 1.4 shows that only 37% of the women had an access to post-natal check-ups. This comprises of those women who gave birth in the hospitals and those who had complications in their pregnancy and had a caesarian. It is found that 60% of the women did not have an access to post-natal check-ups after their delivery. It is because most of the women gave birth from home and they are ignorant of the importance of post-natal check-ups. The other reason behind is the distance of the health care centre's from their villages, improper equipments, poor facilities and absence of gynecology specialist in the nearby health centre's.

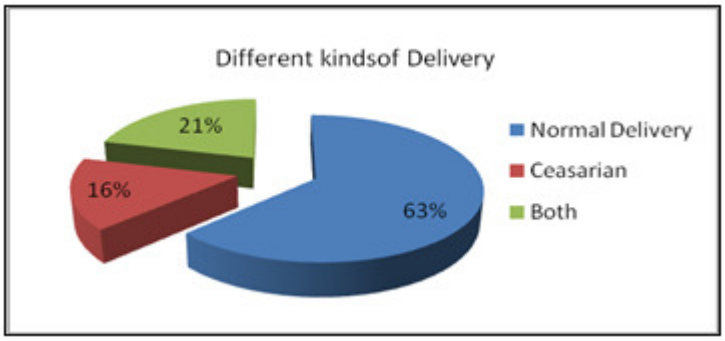

Figure 5: Pie chart showing the different kinds of delivery method
Source: Data compiled from the field survey, 2015

The data shows that during the delivery gestation 63% of the women had a normal delivery, whereas 16% of the women had a caesarian because of some complications. 21% of the women had a normal delivery as well as caesarian.

Home Delivery	Hospital Delivery
62%	42%

Table 5: Preference of Delivery method:
Source: Data compiled from the field survey, 2015

The table shows that 62% of the women delivered from home as they feel safer and secure, while some responded that due to financial problems, poor transportation facility, and poor medical facility in the near health centre's or distance of health centre's (in some village), they prefer to deliver from home with the help of elder women who knows how to deliver (untrained). Whereas 42% of the women responded that, they prefer to deliver from the hospitals in the cities (Guwahati & Shillong), as there is no trained midwifery or nurse in their village. As in the hospitals gynecology specialist doctors are available and they receive a proper care and treatment.

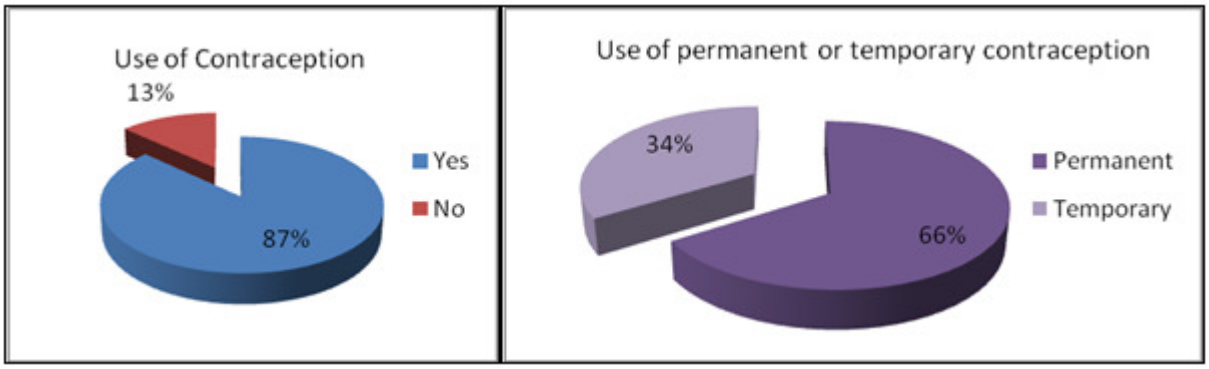

Figure 6: Pie-chart showing the use of contraception
Source: Data compiled from the field survey, 2015

The pie-chart shows that 87% of the women use contraception, of which 66% of them use permanent contraception like, surgical sterilization and 34% of the women use temporary contraception as like, Intra Uterine Device (IUD), pills as prescribed by doctors, pharmacist, condoms etc. Whereas 13% of the women responded that they do not use any contraception and they adopt traditional method of period abstinence.

Yes	No
36%	64%

Table 6: Awareness of HIV/AIDS
Source: Data compiled from the field survey, 2015

The table shows that 36% of the women are aware of the HIV/AIDS disease. It was found that in all the six villages of the study area, awareness or seminar programs on HIV/AIDS have not been organized. Those women who are aware of it came to know through doctors during their pre-natal check-ups, televisions, relatives and friends. Whereas 64% of the women are found to be unaware of the HIV/AIDS disease, and because of this ignorance the percentage of persons infected with this disease is increasing rampantly.

Headache	Gastric	Body ache	Cold flu	Back ache
33%	23%	17%	21%	6%

Table 7: Respondents Prone to:
Source: Data compiled from the field survey, 2015

The table shows that 33% of the women are mostly prone to headache and 23% of the women suffer from gastric. Whereas 21% of them are prone to cold flu frequently and 17% used to suffer from body ache. 6% of the women are prone to back pain. In times of all this sickness some women prefer to take tablets as it reliefs them quickly; while most of them responded that they prefer traditional practice like massage (head ache, back ache, body ache), herbs like tulsi, aloe vera and other local medicinal plants (gastric and cold flu). However, it was found that, in all the six villages there was not even a single professional traditional healer who has been practicing for a long period of time or someone whom all the people prefer to go to. Hence, the people practice in their own according to the knowledge they have about indigenous herbs and medicines.

Community Health Centre's (CHCs), Primary Health Centre's (PHC), and Sub-Centre's institutions acts primarily as referral centre for the rural population. Thus an adequate health care service is essential to establish in the rural areas. The following table highlights the scenario of medical infrastructure available in the villages of Ri-bhoi District.

Old Jirang Village	0
Paham Village	0
Myrdong Village	0
Ritong Village	0
Hatimara Village	0
Umlengpur Kiling Village	0

Table 8: Total Number of Midwifery:
Source: Data compiled from the field survey, 2015

The finding shows that 62% of the women preferred to give birth from home but in all the six villages not even a single midwifery that has been trained or supervised was found. During home delivery women are helped by elder women, mother or relative who knows to deliver through experience. The ignorance of the importance and necessity to have a skilled birth attendant present at their birth, results to a critical presence or maternity death when complications arise.

	Old Jirang	Paham	Myrdon	Raitong	Hatimara	Umlangpur Kiling
PHC	1 km	3 kms	4 kms	3 kms	12 kms	12 kms
CHC	8 kms	10 kms	10 kms	3 kms	40-45 kms	40-45 kms
Hospital	15-20 kms approx.	15-20 kms approx.	45 kms approx.	30 kms approx.	8-10 kms approx.	8-10 kms approx.
Pharmacy	1 km approx.	3 kms approx.	10 kms approx.	3 kms approx.	2 kms approx.	2 kms approx.

Table 9: Distance of Health Care:
Source: Data compiled from the field survey, 2015

The table shows that in all the villages the PHCs, CHCs, pharmacy and hospitals are distant and inaccessible to most women. When faced with obstetric complications like hemorrhage or obstructed labor, there is considerable delay in reaching the health centre's and hospitals which results in maternal deaths. The twin factors of distance to and cost of adequate care also increase rural women's chances of dying as a result of pregnancy and childbirth complications.

The government of India has implemented various programmes and schemes on Women Health Care in order to improve the health status of the rural women. Of which only two schemes – NHM (earlier NRHM) and ICDS have been introduced in the study areas.

1) National Health Mission (NHM):

The National Health Mission (NHM) was implemented in the all six villages in the late 2000, with an aim to improve the health status of the people with special reference to women and child health care. In all the six villages of the study area, there is only one ASHA worker, an initiative under NHM which seek to enhance the health status of the women. The ASHA worker helps in taking the pregnant women to the hospital for check-ups and delivery. However, ASHA workers are found to be inactive in all the six villages. None of the respondents have received any help from the ASHA workers. This could be the reason of ignorance of the ASHA worker or the mindset of the women folk of not wanting to approach to seek help from ASHA, as they are of the view that all the expenses are not free of cost and they have to pay by themselves even if the ASHA worker accompanies them.

2) Integrated Child Development Scheme (ICDS)

The Integrated Child Development Scheme (ICDS) was implemented in all the six villages in the mid-2000, with an aim to improve the health status of women and children by providing nutritious food through Angawadi. In all the villages there are one or two workers and they distribute the food to the pregnant women and children between the age group of 0-6 years. The food items distributed are rice, flour, sugar, suji, milk powder, snacks and pulses. The beneficiaries receive subsidies once in three months.

4. Conclusion

61% of the respondents in the study areas were found to have acquired formal education. However, it has been observed that they lack in understanding the importance of acquiring an adequate pre-natal and post-natal check-up, vaccination, intake of nutritious food, regular check-up of their health, their children's health etc.34% of the respondents have an access to BPL card, whereas, 66% of the respondents are deprived from acquiring BPL card and they are considered as APL. The reason among some of the respondents is because they are non-ST.55% of the respondents are housewives. Whereas 45% of the respondents are found to be employed; as wage earners, vegetable vendors, business women (grocery shop etc.), dairy farmers, teaching staff and non-teaching staff.13% of the women responded that they do not use any contraception and they adopt traditional method of period abstinence.64% of the women are found to be unaware of the HIV/AIDS disease, and because of this ignorance the percentage of persons infected with this disease is increasing rampantly. In all the villages the PHCs, CHCs, pharmacy and hospitals are distant and inaccessible to most women. When faced with obstetric complications like hemorrhage or obstructed labor, there is considerable delay in reaching the health centre's and hospitals which results in maternal deaths. There is also an acute shortage of medical specialist and paramedical staff in all the PHCs, CHCs and sub-centre's. The ASHA workers are found to be inactive in all the villages.

An effort towards organizing an adequate awareness and seminar programs on women health care with special reference to pre-natal and post-natal check-ups and the importance of a skilled attendant during delivery is required.

An awareness and seminar programs on the use of modern contraception and its impact of preventing HIV/AIDS, Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) are the need of the hour.

In all PHCs, CHCs and Sub-Centre's in the nearby villages or within the villages are required to be manned by four medical specialists i.e., surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff, in order to enable the villagers to have an adequate access to health facilities.

There is a need to organize an awareness program or seminar on HIV/AIDS as majority of the women folk in the rural villages are unaware of it. The ASHA workers are also required to be trained adequately and to be more active in the society.

The finding depicts that all the villages of Ri-bhoi District – Myrdon Village, Raitong Village (Umsning Block), Old Jirang Village, Paham Village (Jirang Block), and Hatimara Village and Umlengpur Kiling Village (Umling Block) are at the initial stage of development so there is not much progress in the health sector and the people are deprived of adequate health facilities. Thus there is a need to impart an awareness programme on various aspects of women health and the importance of acquiring adequate health facilities rather than indigenous practices. Limited access to education and employment are making health improvements more difficult. Further, there is a need for the parents to understand the importance of providing proper and higher education to their daughters, as educated girls can brighten the future of their country by the good upbringing of their children. The progress of a country depends on girls' education. So girls' education should be encouraged.

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