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Social Exclusion and Rural Health Infrastructure with special reference to Women's Health Care: An Empirical Study on Ri-Bhoi District of Meghalaya

Papiya Dutta[1] & Mhadeno Y Humtsoe[2]

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.

Keywords: *Social exclusion, Health care infrastructure, Women, Ri-Bhoi.*

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,

[1] Assistant Professor, Department of Rural Development, University of Science & Technology, Meghalaya; Email: papiyadtt3@gmail.com.
[2] Research Scholar, The Gandhigram Rural Institute, Gandhigram, Tamil Nadu.

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 centres play 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).

Health Care Services in the North Eastern Region:

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.

Status of Women Health in Meghalaya:

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.

Status of Medical Infrastructure in Ri-Bhoi District, Meghalaya:

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 other forms of locally produced herbal medicine, it has been conveniently neglected by the policy makers, and planners.

The following table 1 is show casing the health facilities of the study area for the year 2009-10 where the health facilities such as District Hospital, Sub-Divisional Hospital, Community Health Centres, Primary Health Centres, State Dispensary, Sub-Centres, Urban Health Centres has been given according to the blocks.

Table 1: Health Facility in Ri-Bhoi District 2009-10

Health Facilities	Ri-Bhoi District	Blocks		
		Umsning	Umling	Jirang
District Hospital	1	0	1	0
Sub-Divisional Hospital	0	0	0	0
Community Health Centres	3	2	0	1
Primary Health Centres	8	4	3	1
State Dispensary	2	1	1	0
Sub-Centres	27	17	9	1
Urban Health Centres	0	0	0	0

Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

The data shows that in the year 2009-10, there were 27 Sub Centres, 8 PHCs, 3 CHCs, 2 State Dispensary and 1 District Hospital. The highest number of sub-Centres (17), PHCs (4) and CHCs (2) has been established in the Umsning Block. Not even a single Sub-Divisional Hospital and Urban Health Centres have been established in Ri-Bhoi District.

Table 2: Coverage and Availability of Infrastructure in Ri-Bhoi District

Particulars	Blocks		
	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

Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

Community Health Centres (CHCs), the secondary level health care designed for health care institutions 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 2 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 in Bhoilymbong and Patharkmah CHCs, which create lots of hurdles during emergency situation.

Table 3: Positions of Medical Staff & Paramedical Staff of CHCs

Particulars	Bhoilymbong CHC	Nongpoh CHC	Patharkmah CHC
Position of Medical Staff			
Physician	0	1	0
Surgeon	0	1	0
Gynecologist	0	1	0
Pediatrician	0	1	0
AYUSH	0	1	0
Anesthetist	0	1	0
General Practitioner	1	1	1
Position of Paramedical and Support Staff			
ANM	1	1	1
Staff Nurse	1	1	1
Ward Boys	1	1	1
HA / LHV (Male)	0	1	0
HA / LHV (Female)	0	1	0
Health Educator	0	1	0
Lab Technician	1	1	0
Radiographer	1	1	0
Driver	1	1	1
Block Programme Manager	1	0	1
Accountant	1	1	1
Doctor Assistant (Compounder)	0	1	1
Cleaning Staff	1	1	0
Administrative & Other Staff	1	1	1

Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

As per the minimum norms, CHCs are required to be manned by four medical specialist i.e., surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. However table 3 shows that in Bhoilymbong and Patharkmah CHCs, there are specialist i.e., surgeon, physician, gynecologist and pediatrician. It also indicates that there is acute shortage of medical specialist and paramedical staff in all the CHCs. It seems that all the CHCs were sanctioned without sanctioning all the post of specialist, which should now be approved.

Table 4: Coverage and Availability of Infrastructure of PHCs

Particulars	Blocks			
	Umling Block	Umsning Block		Jirang Block
	Byrnihat PHC	Umtrai PHC	Mawhati PHC	Warmawsaw PHC
Status of Building				
Own Government Building	1	1	1	1
Rented Premises	0	0	0	0
Other Rent-free Building	0	0	0	0
Regular Electricity Supply	1	1	0	0
Beds	1	1	1	1
Generator	0	0	0	1
Telephone	0	0	0	1
Running Vehicle/ Ambulance	0	0	1	1
Investigative Facilities				
OPD rooms	1	1	1	1
Consulting Rooms (AYUSH)	0	1	0	1
Consulting Rooms (Specialist) CHC	0	0	0	0
Fully Equipped Labor Room	1	1	1	1
Minor OT	0	1	1	1
General OT	0	1	1	1
Separate wards for male & female	1	1	1	1
Separate public utilities (toilets) for male & female	1	1	1	1
Sitting arrangements for patients	0	1	1	0
Facility for food	0	0	0	1
Medicine shop	0	1	0	1

Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

Primary Health Centre (PHC) is the corner stone of rural health care. PHC are supposed to meet the health care needs of rural population. However, table 4 shows that most of the PHCs do not have generators, telephone, general OT, facility for food for in patients, medicine shops, etc. In Meghalaya most of the PHCs are not functioning in an effective manner due to shortage of specialized manpower.

Table 5: Positions of Medical Staff & Paramedical Staff of PHCs

Particulars	Blocks of Ri-Bhoi District			
	Umling Block	Umsning Block		Jirang Block
	Byrnihat PHC	Umtrai PHC	Mawhati PHC	Warmawsaw PHC
Position of Medical Staff				
Physician	0	0	0	0
Surgeon	0	0	0	0
Gynecologist	0	0	0	0
Pediatrician	0	0	0	0
AYUSH	0	1	0	1
Anesthetist	0	0	0	0
General Practitioner	1	1	1	1
Position of Paramedical and Support Staff				
ANM	1	1	1	1
Staff Nurse	1	1	0	0
Ward Boys	0	1	1	1
HA / LHV (Male)	0	0	0	0
HA / LHV (Female)	0	0	0	0
Health Educator	0	0	1	0
Lab Technician	1	1	1	0
Radiographer	0	0	1	0
Driver	0	0	1	1
Block Program Manager	0	1	1	1
Accountant	1	1	1	1
Doctor Assistant (Compounder)	0	0	0	1
Cleaning Staff	1	1	1	1
Administrative & Other Staff	1	1	0	1

Source: NRHM Meghalaya (negpied.gov.in/…/evaluation_NRHM.pd…)

The above table 5 shows that none of the PHCs had medical specialist i.e., surgeon, physician, gynecologist and pediatrician. It also indicates that there was an acute shortage of medical specialist and paramedical staff in all the PHCs. Because of the poor medical infrastructure, the needy are not being able to get adequate health facilities, which results in poor health status of the people.

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 of 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 colostrums 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).

The strategies to increase the accessibility and availability of health care services are important particularly for communities in rural areas. Financial support that enables mothers from poor households to use health services will be beneficial. Health promotion programs targeting mothers with low educator are vital to increase their awareness about the importance of antenatal care services. (Christina R Titaley, Michael T Dibley, Christine L Roberts, 2010).

Materials and Methods:

Based on the issue of health infrastructure and social exclusion, this paper aimed to make a study on it with special reference to Ri-bhoi district of Meghalaya. The specific aims and objectives of this paper were:

i) To study the health status of women,

ii) To assess the medical infrastructure available in the study area, and

iii) To determine the government aided scheme on rural women health

The study comprised 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.

Method of data collection:

The questionnaires were used as the tool for collecting the data accompanied by spot observation. The researchers adopted home-visit method and group discussion method.

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).

Sampling Design:

The research design was carried out in the state of Meghalaya from the District of Ri-bhoi. Simple Random Sampling technique was used 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.

The Ri-Bhoi District of Meghalaya was formed on 14th June 1992 with Nongpoh as the headquarters of the District with a total geographical area of 2,378 sq. km. The total population was 258,380 (census, 2011) with a literacy rate of 77.22%. The main language spoken in Ri-Bhoi is Karew which its native spoken language, also known as the Bhoi language. In 2006, the Ministry of Panchayati Raj named Ri-Bhoi as one of the most backward districts (out of 640). It is one of the three districts in Meghalaya, currently receiving funds from the Backward Regions Grant Fund Programme (BRGF).

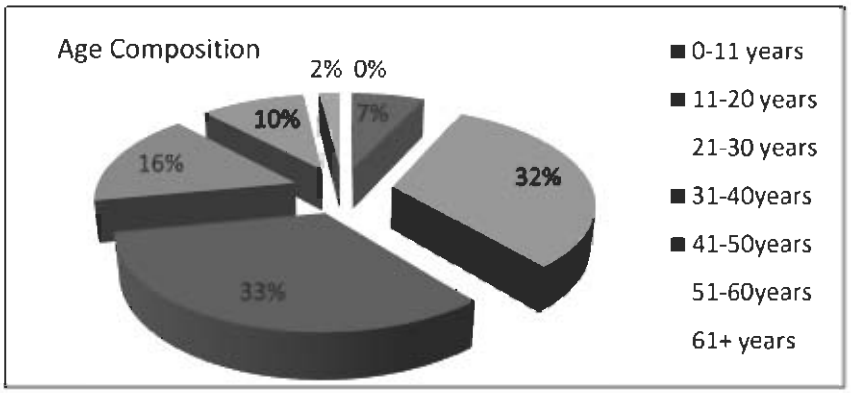
Data Analysis:

The figure 1 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 were from the age group of 61 years and above, which composed of 2%.

The data from the field shows that 61% of the respondents were literates, where as 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.

Fig 1: Age composition of the respondents



Source: Data compiled from the field survey, 2015

Field level data further shows that 39% of the respondents have 3-5 children and 37% of the respondents have 1-2 children, whereas 20% of the respondents have 6-8 children and 4% of the respondents have more than 9 children. 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 acquired formal education and few of those women who had acquired formal education were seen to have more than 6 children. Most women who have more than 6 children responded that they preferred more children as they like to have big families, while some responded that they preferred more children as they need more manpower in their dairy farms.

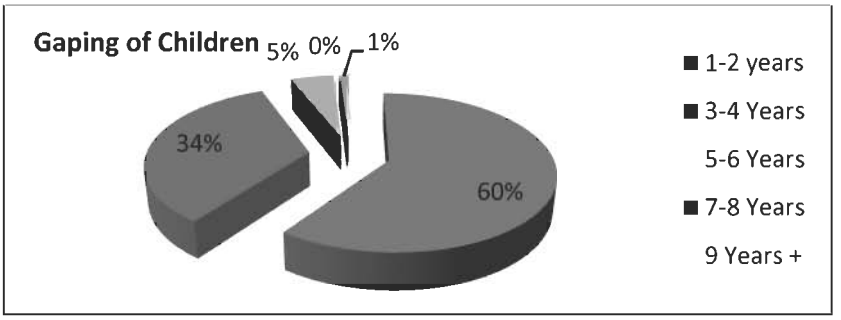
1. Women's Health Status:

Women's 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 acquired any pre-natal and post-natal check-ups.

The pie chart (figure 2) shows the gaping of the children. 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 is 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.

Fig 2: Pie-chart showing the Gaping of Children

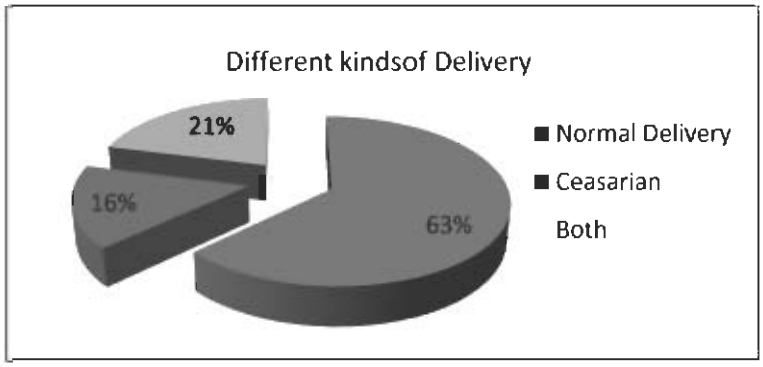


Source: Data compiled from the field survey, 2015

Field data reveals 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.

Data 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.

Fig 3: Pie chart showing the different kinds of delivery method



Source: Data compiled from the field survey, 2015

The figure 3 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 both normal delivery as well as caesarian.

The data 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 centres or distance of health centre's (in some village), they preferred to deliver from home with the help of elderly women who knows how to deliver (untrained). Whereas 42% of the women responded that, they preferred to deliver from the hospitals in the cities (Guwahati & Shillong), as there was no trained midwifery or nurse in their village. As in the hospitals gynecology specialist doctors were available and they received a proper care and treatment.

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

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

The data shows that 33% of the women were mostly prone to headache and 23% of the women suffered from gastric. Whereas 21% of them were prone to cold flu

frequently and 17% used to suffer from body ache and 6% of the women were prone to back pain. In times of all this sickness some women preferred to take tablets as it relieved them quickly; while most of them responded that they preferred 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 were practicing for a long period of time or someone whom all the people preferred to go. Hence, the people preferred to practice according to the knowledge they had about indigenous herbs and medicines.

2. Medical Infrastructure:

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

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 was found to be trained or supervised. During home delivery women were helped by elderly women, mother or relatives who knew how to deliver through their experiences. 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.

Table 6: Distance of Health Care

	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.

Source: Data compiled from the field survey, 2015

The table 6 shows that in all the villages the PHCs, CHCs, pharmacy and hospitals were distant and inaccessible to most of the women. When faced with obstetric complications like hemorrhage or obstructed labour, there were

considerable delays in reaching the health centres and hospitals, which usually encourage in maternal deaths. The twin factors of distance and cost of adequate care also increase rural women's chances of dying as a result of pregnancy and childbirth complications.

3. Health Policies:

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 – NRHM and ICDS were implemented in the study area.

a) National Rural Health Mission (NRHM):

The National Rural Health Mission (NRHM) was implemented in the all six villages in the late 2000s, 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 was only one ASHA worker, an initiative taken under NRHM 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 were found to be inactive in all the six villages. None of the respondents received any help from the ASHA workers. This could be the reason of ignorance about the ASHA workers or the mindset of the women folk of not wanting to approach to seek help from ASHA workers, as they were of the view that all the expenses were not free of cost and they have to pay by themselves even if the ASHA worker accompanies them.

b) Integrated Child Development Scheme (ICDS)

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

Major Findings:

1. 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-ups, vaccination, intake of nutritious food, regular check-up of their health, their children's health, etc.

2. 34% of the respondents have an access to BPL card, whereas, 66% of the respondents were deprived from acquiring BPL card and they are considered as APL. The reason among some of the respondents is because they are non-ST.
3. 55% of the respondents were housewives, whereas, 45% of the respondents were found to be employed as wage earners, vegetable vendors, business women (e.g. grocery shop), dairy farmers, teaching staff and non-teaching staff.
4. 13% of the women responded that they did not use any contraception and they adopted traditional method of period abstinence.
5. 64% of the women were 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.
6. In all the villages the PHCs, CHCs, pharmacy and hospitals were distant and inaccessible to most of women. When faced with obstetric complications like hemorrhage or obstructed labour, there was considerable delay in reaching the health centres and hospitals which sometimes results in maternal deaths. There was also an acute shortage of medical specialist and paramedical staff in all the PHCs, CHCs and Sub-Centres.
7. The ASHA workers were found to be inactive in all the villages.

Recommendations:

- An effort towards organizing an adequate awareness and seminar programmes on women's 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 programmes 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-Centres 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 staffs, in order to enable the villagers to have an adequate access to health facilities.
- There is a need to organise an awareness programme 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.

Conclusion:

The finding depicts that all the villages of the study area in Ri-Bhoi District - Myrdon Village, Raitong Village (Umsning Block), Old Jirang Village, Paham Village (Jirang Block), 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 awareness programmes 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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