

Re-Examining the Primary Health Care System in Meghalaya

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This paper aims at re-examining the primary health care system in the state of Meghalaya with a focus on the sub centre. The formal health care system was in existence in India since 1946 after the Bhore committee recommended the establishment of health centres for providing integrated curative and preventive services whereas traditional medicine has been practiced since the beginning of settlements as people looked for ways to cure their diseases and depended on traditional healers who still today provide the primary health care to people especially in rural areas. The information and data provided in this paper was collected directly from field interviews with stakeholders such as the Auxiliary Nurse Midwife who is in charge of the sub centre, village leaders and mothers of the reproductive age group across the seven states of Meghalaya.

Introduction:

There are mainly two forms of health care systems in Meghalaya; the formal health care system consisting of the allopathic system of medicine and traditional medicine system. The formal health care system is supported by the State and it has a definite structure of primary, secondary and tertiary health care institutions. The Sub-health Centre (Sub-centre) is the most peripheral and first contact point between the primary health care system and the community and provides interface with the community at the grass root level, providing primary health care services. As per the population norms, one Sub-centre is established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. It is manned by an Auxiliary Nurse Midwife (ANM) and a male health worker commonly known as a Multi-purpose worker. According to the Department of Health and Family Welfare, Government of Meghalaya, the number of functional sub centres in the state is 401. Therefore, on a rough estimation, in Meghalaya one sub centre caters to 15 villages¹. It is important to note that in a hilly terrain and topography like Meghalaya, 15 villages can be sparsely located and the distance to the sub centre can also be very far.

The Primary Health Centre (PHC) is the first contact point between village community and the Medical Officer. The PHCs provide an integrated curative and preventive health care to

¹ Meghalaya Statistical Handbook 2008-2009, the total number of villages in Meghalaya is 6026

the rural population with emphasis on preventive and promotive aspects of health care. The population it covers is 30,000 for plain areas and 20,000 for hilly/tribal/desert areas. The PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. At the next level, there is a 30 bedded hospital or referral unit for 4 PHCs with specialised services known as the Community Health Centre (CHC). It covers 120,000 population for plain areas and 80,000 population for hilly/tribal/desert areas.

On the other hand, traditional medicine system functions simultaneously in the state of Meghalaya. It is community based and widespread (there are one to five traditional healers in 95 percent of the villages)². In Pynursla block (total number of villages is 120) of East Khasi Hills alone, there are 327 traditional healers³. Apart from it being local and accessible by people, traditional medicine also caters to the primary health needs of the people especially in rural areas.

It is essential to note that in this context of the health care systems that function in the state, the health indices of Meghalaya are among the worst in the country. For instance, the health of the children is reflected through the National Family Health Survey (3) 2005-2006 which shows that children under 3 years, 46 percent of children are underweight (too thin for age), 42 percent are stunted (too short for age) and the Infant Mortality Rate (number of infant deaths per 1000 live birth in the last 5 years) is 45. Moreover, the children who are anaemic are 68.7 percent and 33 percent of children are vaccinated. The facts and figures suggest that almost half of the children population of the state is not healthy.

Methodology:

A study was conducted in April 2010 to May, 2010 across the seven districts of Meghalaya. The objective of this study was to obtain a qualitative evaluation of health services (with a focus on sub centre) in the state with respect to accessibility, affordability, adequacy and

² 2010, Study on qualitative evaluation of Primary Health Care in Meghalaya, Martin Luther Christian University

³ 2008, Baseline survey on traditional medicine in Pynursla Block, East Khasi hills, Meghalaya, Martin Luther Christian University

efficiency also to ascertain the needs and expectations of the people with regards to health care. The sample that was taken is given in the Table 1.

Table 1: Sample Size

Particulars	Sample	Total no. of samples
Districts	1 district	7 districts
Blocks	2 blocks per district	13* blocks
Villages: <ul style="list-style-type: none"> • Village Officials (6) • Headman • Village Secretary • Women (2) • Men (2) 	2 villages per block	26 villages
Sub Centres <ul style="list-style-type: none"> • ANM 	2 SCs per block	22** sub centres
Households <ul style="list-style-type: none"> • Household interviews for mothers (15 -45) yrs 	25 households per village	650 households

*In South Garo Hills district, one block was taken as part of the sample.

** 4 sub centres that were part of the sample were not functional

The target areas for the study were rural areas of Meghalaya. The survey was conducted with the help of the Block Development Officers of all the Blocks whereby he/she assisted in the selection of villages for the study. The following are the criteria for selection of the villages: (a) Two villages which are accessible (having an all weather road) (b) Two villages located in remote areas (kuccha roads or no roads at all). The selection of households was based on a random sampling method. The Headmen of all the villages gave the list of all the households of the village where a random sample of 25 households was selected.

As indicated in Table 1, the data collection was conducted through structured interviews with village officials (headman, village secretary, 2 women and 2 men), Auxiliary Nurse Midwife and also household interviews with mothers aged 15 years to 49 years. However, during the interviews, preference was given to the eldest mothers in the household within the age limit. The field visits also included site visits to all the sub centres that were taken as sample. This was to ascertain the functionality of the centres.

Results and Discussion:

In terms of demographic data, the population of villages surveyed for both the surveys ranged from 200 to 2200 population. The main source of income is farming where sixty eight percent of the population are farmers while 23 percent are daily wage earners. The educational status (primary education up to class III) is higher for females with 70 percent and males at 55 percent. In terms of availability of toilet facilities, 60 percent of the population did not have toilets within their compound or homes, 39 percent had toilets within their compound and 1 percent had toilets within the house. In terms of drinking water source & water usage, 34 percent of villages used tap water (only in certain points) while the rest 66 percent depended on natural sources such as spring, well or a river.

Accessibility to Health Care is one of the essential factors that determine whether a person's or a family can avail health care when needed. The aspects that contribute to accessibility are distance of health centre to the village, mode of transport, time taken to reach the health centre and costs. The following table 2 gives the details:

Table 2: Accessibility to Health Centres

Particulars	Sub-Centre	Primary Health Centre	Community Health Centre
Distance	2 km – 12km	7 km – 32 km	12km – 40km
Mode of transport	On foot – Hired Vehicle	On foot - hired vehicle/ bicycle	On foot - hired vehicle
Time	½ hr – 1 hr	1hr – 2 hrs	1 hr – 2 ½ hrs
Costs	Rs. 20.00 – Rs. 600.00	Rs. 30.00 – Rs. 800.00	Rs. 40.00 – Rs. 1200.00

From the data from Table 2, it is evident that even access to the Sub Centre is limited because of the distance and lack of means of transportation to reach the sub centre. Often than not, people have to hire vehicles to take patients to health centres. Access to the other health centres (PHC and CHC) become more inaccessible as people have to spent more in terms of the distance, time and costs because of the distance. Moreover, 60 percent of the respondents

stated that they visited the Sub Centres, while 54 percent visited the PHC and 65 percent visited the CHC.

In terms of affordability, the expenditure of a household per month for allopathic medicine ranged from Rs. 2427.00 to Rs. 3050.00 while the average expenditure of a household for traditional medicine in one month is Rs. 73 to Rs. 115.00. The question that arises is why is there such high costs involved when health care in SC or PHC or CHC are free of costs? The main reasons are because people have to spent huge amounts on transportation, medicines not available in the health centres, food expenses etc... Many times, people have to see private doctors as doctors are not available at the PHC or CHC. The following table 3 gives the details of the expenditure for allopathic medicine per month by one household.

Table 3: Expenditure for allopathic medicine per month per household

Particulars	Expenses (Rs.)
Doctor's Fees	280.00 – 350.00
Medicines	677.00 – 800.00
Food expenses	200.00 – 350.00
Lab tests	770.00 – 850.00
Transport	500.00- 700.00
Total	2427.00 – 3050.00

On the other hand, a household spends a meager amount on traditional medicine per month as traditional healers do not have a fixed price for charging the people as they take what people give them and moreover, the healers are located in the village itself. People do not need to travel to access health care from them. In almost all villages that were taken for the survey the number of traditional healers ranged from 1 to 5. Therefore, the people can access the practitioners anytime. This is evident from the high rates of home delivery of children

assisted by a traditional birth attendant. It was found that 89 percent of all child deliveries took place at home and always assisted by a traditional birth attendant.

The adequacy of health centres is another important factor for people to gain access to adequate health care. Adequacy was measured in terms of infrastructure, availability of required equipments and availability of staff. In this study, the focus was on the sub centre. It was found that the villages covered by one sub centre ranged from 2 to 24 and a population ranged from 2000 to 7000. The staff present at the sub centres was an ANM and a Chowkidar. There was no Male Multipurpose Worker present in either of the Sub Centres. In 50 percent of the sub centres, the ANM stayed at the sub centre. In terms of basic infrastructure, following are the details that will indicate the adequacy of the sub centre:

Table 4: Status of Infrastructure of the Sub Centres

Status of Infrastructure	15-Govt
House building	83 % Government owned
Travel of ANM to other villages	On foot/Hired vehicle
No Toilet facilities in the SC	68%
No Water supply in the SC	59%
No Generator	95%
Telephone	Nil

Patient and Child Care Facilities at the Sub Centre:

In terms of patient and child care facilities at the sub centre, there are glaring deficiencies that resulted in under utilization of the capacity of the sub centre. In 22 percent of the SCs only, examination room was present, 5 percent of SCs only has labour rooms and there were no deliveries conducted at the SC due to lack of facilities. Following is the picture of a sub centre at Wahkhen village in Pynursla Block, East Khasi Hills district. Adjacent to the picture are the details pertaining to the sub centre.

Demographic relating to the Sub Centre:

- Population: 2153
- Villages covered: 5
- Staff Structure: 1 ANM & 1 chowkidar
- Rented house

Issues:

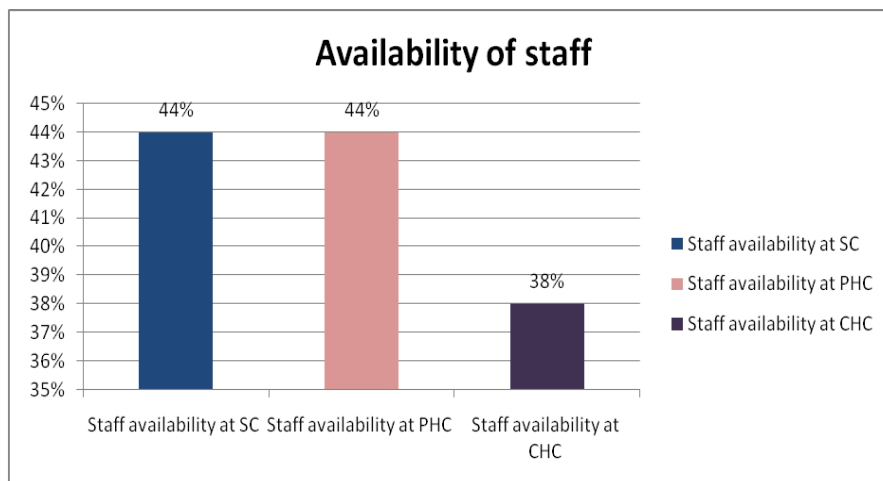
- No residential staff
- Limited rooms
- No toilet facilities available
- No water supply
- No telephone
- No cold chain equipment available
- No separate clinic room
- No examination room
- No labour room
- Lack of supply of basic medicines for health care



**Figure 1: Wahkhen Sub Centre
Pynursla Block, East Khasi Hills**

From Table 4 and the case of the Wahkhen Sub Centre, it is evident that the sub-centres are inadequate in their infrastructure resulting in inadequate health care services to people. Therefore efficiency of the health centres is also in question. The efficiency in terms of availability of staff in the three different health centres (SC, PHC and CHC) is shown in the Graph 1:

Graph 1: Availability of Staff

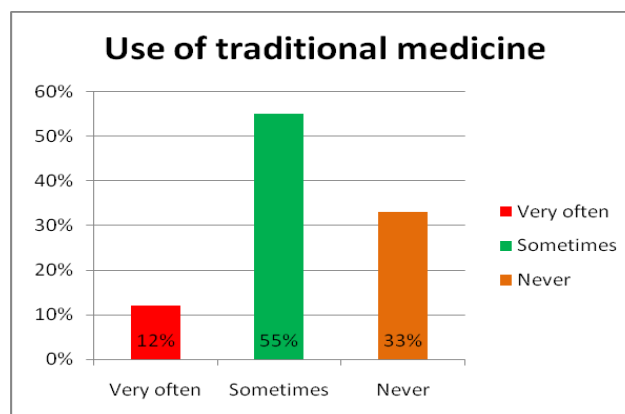


In all the health centres, people expressed that 44 percent of the time, staffs are available at the SC and PHC while it was 38 percent in the CHC. Although at the sub centre level, there is only an ANM, yet the people access it first before they go to the PHC or CHC. However, there are many reasons for non availability of ANMs; they have to go to different villages for giving immunizations and to perform her other duties.

In terms of doctors availability at the PHC and CHC, 54 percent of the time doctors were available at the PHC and 58 percent of the time, doctors were available at the CHC. The people expressed that 51 percent of the time, they got prompt services from the SC and 48 percent from PHC. In terms of satisfaction with the services of the health centres, 33 percent of the population said they were satisfied with the services of the SC and 54 percent with the services of the PHC. It is evident that the people have not been able to gain access to health care services as there is un-availability of doctors for almost half of the time.

On the other hand, as mentioned earlier, traditional medicine is accessible and affordable by people since healers are present in the village. Moreover there is a wide use of traditional medicine. The following graph clearly shows that people do use traditional medicine.

Graph 2: Use of traditional medicine



In terms of efficiency, 23 percent of the population said that traditional medicine is very useful while 54 percent said that it is useful to treat diseases. There are many common diseases which can be cured by traditional medicine like cough, cold, fever, diarrhea, dysentery, jaundice, bone fractures, body pain, anaemia and so on but the most common is '*Niangsohpet*' (an infantile disease which affects the navel) which is mostly common in the Khasi, Jaintia and Ribhoi areas.

Recommendations:

The findings relating to the sub centres' inaccessibility is due to distance of the village to the health centre and lack of transportation facilities. It is inadequate in terms of basic infrastructure and also of staffs, unaffordable because of the huge amount of out of pocket expenses that people have to incur and inefficient has clearly showed the under capacity of the centres resulting in inadequate health care services to people at large. However, the traditional medicine system has been accessible, affordable by the people and also its services have been adequate and efficient. From the study, it is clear that people access the sub centre first before accessing any other health care centre. Thus the sub centre needs to be strengthened and its role and function to be reexamined. It is therefore important to restructure the system in the following aspects:

1. Enhancing the staff structure at the sub centre level:

Apart from the existing ANM, additional staff can be included such as:

- Community Health Practitioner (Degree in BSc in Community Health Practice). The CHPs can complement the role of the ANM. These are front-line health workers in the community who are not doctors, but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care. Thus the CHPs can diagnose and treat most common illnesses, all-in-one consultation cum dispensing, provide first aid in emergencies, make timely referrals to the right sources, understands local language and culture and affordable as they are not doctors.
- Traditional Healer: The traditional healers of the area can come to the sub centre on a rotation basis e.g. one healer can come to the sub centre once a week. They can cater to the health needs of the people like they used to and also be taught simple techniques to detect emergency situations and refer to the PHC. The traditional healers can also be key informants in their communities about various diseases such as mental health disorders, malaria, tuberculosis, HIV/AIDS etc...

Thus in the sub centre, there will at least 3 health personnel, an ANM, a Community Health Practitioner and a Traditional Healer

2. Infrastructure and equipments:

- The number of Sub centres in Meghalaya needs to be relooked. Calculations of the number of SCs should be done taking into account the topography of the state.
- The infrastructure in terms of number of rooms for various functions needs to be increased. Separate quarters for the ANM needs to be constructed so that she is available for most of the time.
- Equipments: Basic equipments such as cold storage for medicines, immunizations, simple equipments for measuring blood sugar levels etc... can be kept at the sub centre. The trained Community Health Practitioner can handle simple diagnostic processes.

Closing Remarks:

Though health care is a basic need and right of the people yet people of the state of Meghalaya do not receive adequate health care. The formal health care in Meghalaya has not reached every household. As discussed earlier, there are many factors that results in such a situation. Thus it is essential to reexamine the primary health care system in its context. Such changes need to start at the policy level; there also needs to be an integration of traditional medicine into the formal health care system. To reiterate the point of this study, the sub centre's role should be enhanced and strengthened so that the people can gain access to adequate, affordable and efficient health care. This will in turn improve the health of the people including children and reverse the figures that were reflected in the NFHS (3). It is in innovations that revolutions are made and societies evolved.

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