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Research Article

FERTILITY PREFERENCES AND ANTENATAL CHECK-UPS AMONG THE RURAL KHASI WOMEN OF RI BHOI DISTRICT, MEGHALAYA (INDIA)

Pushpita Purkayastha and Kh. Narendra Singh

Department of Anthropology, Assam University: Diphu Campus, Diphu – 782 462, Assam

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ABSTRACT

This paper attempts to study the maternal health status of the rural Khasis of Ri Bhoi district, Meghalaya. The study was conducted in Ri Bhoi District of Meghalaya (India). A total of 225 Khasi women respondents from five selected villages of Umling block in Ri Bhoi District (Meghalaya) were interviewed for the study. Secondary data were also considered for comparison. The findings of the present study revealed that high incidence of home deliveries and poor antenatal check-ups were observed among the studied population. Among the Khasi women of Meghalaya, the health indicators reflecting the condition of women has not been encouraging as revealed from various secondary data considered in the present study. Various measures including, health awareness, health education, and maternal healthcare facilities with adequate health staff etc. are to be taken into account to improve the overall health status of the community especially the maternal health.

INTRODUCTION

The development of any society can be measured by the quality of health care delivery services in general and maternal and child health care in particular. Maternal and child health (MCH) are natural corollaries of each other, which refer to the health of women during pregnancy, childbirth, postpartum care, etc., care of relatively more vulnerable newborns and children from malnutrition, infectious disease, etc., and socio–economic conditions greatly affect the health status, either negatively or positively. It is therefore, important to consider the role of social, cultural, health system and economic factors that impact on maternal and child health, and ultimately mortality. Because women are a particularly vulnerable segment of a society and suffer from social, economic and nutritional deprivation to a far greater extent than men (Amin 1995). Several studies have revealed that economic factors, such as household income and occupation are negatively associated with a fertility rate in developing countries (Kost and Amin, 1992; Bicego and Boerma, 1993; Adhikari, 2010). In general, when the care of a child's mother suffers, the childcare suffers as well (UNICEF 1996; Engle *et al*. 1999). The health and nutritional status of mothers and poor nutrition in early childhood contributes to low birth weight, to delay in cognitive development and resultantly, to lower educational achievements and lower incomes (Barber 1998, Politt 2000). Srinivasan K and Dhandapani C (2012) in their study pointed out women's health in India and key challenges in health sector. According to them, biological and social factor affect women's health. Women's health is also affected by fertility, education, utilization of health care services, cultural factors and working status of women. A woman's decision to seek health care could be affected by the influence of her partner or other family members; social norms; her education; her status in society; the distance she lives from the clinic; how sick she is; her previous experiences with the health system and how she expects to be treated by health care providers; her level of decision-making power in the household; and her access to credit, land and income (Lule: 2005). The National Rural Health Mission (NRHM) has listed Meghalaya as one of the 18 High Focus State. This was done on the basis of the prevalence of weak health indicators and infrastructure in the state (NRHM: 2012). As per the 2002 survey conducted by the Department of Community and Rural Development, Government of Meghalaya, 48.70 percent of the population in the state has been categorized as falling under the Below Poverty Level (BPL). With a huge population of the state categorized as BPL it becomes an important task for the government to see to it that affordable and accessible health care facilities are provided to the people especially to those belonging to the marginalized community. Five districts of the state have been categorized as High Focus District where special attention has been given. The status of the health of women and children is an important factor indicating the well

Corresponding author:* **Pushpita Purkayastha
Department of Anthropology, Assam University: Diphu Campus, Diphu – 782 462, Assam

being of a state. A closer look at the health indicators of the state will show that in terms of the health of women and children, the state has not been able to perform well. Primary Health Care is the key to attaining this target, which includes education concerning prevailing health problem, prevention and control of disease, promotion of food supply and proper nutrition, supply of safe water and basic sanitation, maternal and child health care including family planning, immunization and provision of essential drugs (International Conference on Primary Health Care, Alma-Ata, USSR, 1978).

The tribal populations are recognized as socially and economically vulnerable. Despite the fact that the tribes of Meghalaya are largely matrilineal, the health indicators reflecting the condition of women has not been too encouraging either. The health indicator of women in the state reflects the poor state of affairs. Meghalaya has a high maternal mortality rate (MMR) which stands at 264.87 well above the national average of 212 (SRS: 2011). Various studies have shown that there are direct and indirect impacts of socio economic factors on the maternal health which in turn affect the child health. Among the various socio economic factors that have bearing on the health of the mother, some of the important factors are education of parents especially of mother, occupation, income of the family. It has been seen that these factors directly or indirectly affect the status of the community with regard to different aspects of life such as housing condition, awareness of health care (e.g. Family planning, ANC, Immunization etc.), expenditure on medication and health care and other basis amenities of livelihood. Govindan S and Dhandapani C (2012) examined the health care system and health status among tribal community in India. The study reveals that lack of personnel hygiene, poor sanitation, poor mother-child health service, absence of health education, lack of national preventive programmes and lack of health services are responsible for the poor health of the tribals. Maternal malnutrition which was quite common among the tribal women was also a serious health problem especially for those having numerous pregnancies too closely spaced and it reflected the complex socio-economic factors that affected their overall condition. The poor state of affair of the maternal health of the Rural Khasi of Meghalaya is evident from the secondary data from different sources. The present paper focuses on fertility preferences and antenatal checkups among the Khasi mothers living in villages of Umling block, Ri Bhoi District, Meghalaya.

METHODOLOGY

The present study is conducted on the basis of both primary and secondary data. Data on age at marriage, fertility preferences and antenatal checkups along with the socio economic condition were collected using interview schedule. For primary data collection, extensive fieldwork was carried out in five villages viz., Diwon, Khasi Killing, Mawsmai, Nongkylla Khasi and Umling selecting 45 women respondents from each village of Ri Bhoi District, Meghalaya from January to July 2015. Woman respondent belonging to age group 15 years to 45 years having at least one surviving child of less than five years of age from each household was interviewed. Thus, a total of 225 household were covered in the present study. Secondary data were also collected from Census report and Survey reports including various Government reports.

Findings

Socio-economic Condition

The present study comprised of Khasi currently married women in the reproductive age group 15-45 years. Out of 225, there were 43 respondents belonging to the age group of 15-≤ 25 years constituting 19.1 percent respondents, 106 respondents in the age group of >25-≤35 years constituting 47.1 percent respondents and 76 respondents in the age group of >35-45 years constituting 33.8 percent respondents. All the 225 respondents belong to ST category and practice Christianity as their religion. As regards to the educational qualification of the respondents, it was found from the data that 3.1 percent of the total sample were illiterate, 17.8 percent could read and write but no schooling, 44.9 percent of the respondents had primary schooling, 24.9 percent of the sample were up to secondary pass, 6.2 percent of the sample passed higher secondary, 2.7 percent of the respondents have passed graduation and only 1 respondent out of 225 constituting 0.4 percent have completed her post graduation. The primary occupations of the respondents revealed that 44.9 percent of the respondents were cultivators, 24 percent of the total samples were business people, 22.2 percent work as unskilled labours, 5.8 percent work as government employees, 3.1 percent were house wives. With respect to their annual income, it has been observed from the data that most of the respondents fall under low income category. It was found that 82.2 percent of the sample earn less than Rs.25,000 per annum, 9.8 percent respondents were belonging to the income slab of Rs.25,000-50,000 per annum, 3.1 percent of the sample earn Rs.50,000-75,000 per annum, 1.3 percent of the sample earn Rs.75,000-1,00,000 per annum, and 3.6 percent of the sample earn Rs.1,00,000 or more per annum.

Age at Marriage

In the context of age at consummation of marriage, it was found that majority of them (85 percent) got married below the legal age for marriage (i.e. 18 years for girls). The NRHM (2013) data indicates that the percentage of girls who were married below the legal age at marriage was highest in Ri Bhoi (38 percent). As regards to spacing of child birth, it has been found from the data that only 11.1 percent of the sample were aware of the benefits of spacing of child birth , whereas majority of them 88.9 percent of the sample were not aware of the benefits of spacing of child birth. The findings further revealed that regarding the place of delivery, institutional delivery constitutes only 6.7 percent while the rest 93.3 percent had home deliveries. According to Ministry of Health and Family Welfare (2006) data on safe deliveries, Meghalaya had reported less than 45 percent safe deliveries. Women also reported that there was lack of health care facilities including non availability doctors round the clock in the hospitals. In all the health centers viz., PHCs and CHCs most of the deliveries were conducted by the ANMs. Among them 71 percent of births took place at home and 29 percent births had taken place in the health facility. According to DLHS-RCH (2006) data indicates that three percent of caesarean deliveries and 37

percent of assisted deliveries took place at home. The extent of institutional deliveries varies from the lowest of 15 percent in Ri Bhoi to a highest of 73 percent in East Khasi Hills. The institutional delivery is much lower than the national average of 34 per cent for country as a whole. The proportion of births delivered in a health facility in Meghalaya is one of the lowest in the country. This has shown that the deliveries are by and large conducted at home. The percent of the institutional deliveries increases substantially with women's education and economic status. The presence of health facilities in the village has no impact on the choice of places for delivery as most of the deliveries still take place at home.

Fertility Preference

The distribution of currently married women desiring additional children and preferred sex of additional children by number of living children of the women is shown in Table 1 below. Among the currently married women, the desire for additional children decreases with increasing number of living children. As many as 40 percent are currently pregnant while 48 percent of them want additional children within two years, 4 percent after two years, 9 percent are undecided about the timing of the next child. Out of the 225 surveyed representative women, 16 percent desired to have additional children within two years, 14 percent after two years, 11 percent want no more children, and 15 percent are currently pregnant. A total of 225 women want additional children irrespective of the number of living children. Out of 23 women who has currently married and desire for additional children, 44 percent desired for girl, and for 57 percent, the sex of the child is immaterial. According to the RCH survey, women on the verge of completion of reproductive period have given birth to 4.7 children. The completed fertility in the states varies from the lowest of 3.3 children ever born per women in West Garo Hills to the highest of 6.7 children in Ri Bhoi district. Fertility in rural areas of Meghalaya, at 4.4 children per woman, is about two children higher than in the urban areas (2.3). Fertility in Meghalaya is higher than in all other Indian states, except Uttar Pradesh and Bihar. As per the NFHS 2, Meghalaya has one of the highest fertility rates in the country standing at 4.6. The NFHS 3 report puts Meghalaya's Total Fertility Rate (TFR) at 3.8 well above the national average of 2.8.

According to several micro studies (Deka, 1989; Khongsdier and Ghosh, 1998), the fertility rate among the Khasis seems to be higher than many populations in Northeast India. Fertility rates decline sharply with women's education from over five children among women who have no education to less than two children among women with 10 or more years of education. The median interval between births in Meghalaya is 32 months. One-fourth of births take place within 24 months of the previous birth, including 11 percent that occur within 18 months of the previous birth. About three-fifths of births (59 percent) occur within three years of the previous birth which is significant with my study as 40 percent of women are currently pregnant and again they (48 percent) wants another next birth within 2 years.

Antenatal Check-Ups

Women who had given birth during the three years preceding the survey were asked whether they had gone for antenatal check-ups outside the home, and if they had, what type of service was provided to them. They were also asked whether any health worker had visited them at home to provide antenatal check-ups. Table 2 present the percentage of women who had given birth during three years preceding the survey, and information regarding antenatal check-ups they had by source of antenatal check-ups according to some selected background characteristics. Results show that 48 percent of women received antenatal check-ups during the three years preceding the survey, 26 percent of women received antenatal check-ups from doctors and 15 percent from ANM/Nurse/midwife/LHV. Only 7 percent women received antenatal check-ups at the doorstep from the Dai/TBA, Aganwadi/ICDS worker and other health personnel. It has been observed that Antenatal check-ups (ANC) are more common among younger women ages below 35 years than among older women. It is more common among those women who had given their first birth. The percentage of women who received antenatal check-ups from auxiliary nurse midwife, nurse or LHVs was 15 percent and the percentage of women who received antenatal check-ups from doctors is 26 percent. Only 32 percent of illiterate women received antenatal check-ups against 57 percent who had educational level of 10 years and above. Only about one-fourth of the female belonging to age group 15-49 in Meghalaya have completed 10 or more years of schooling.

Table 1 Fertility Preferences by Number of Living Children

Percent distribution of currently married women 15-45 by desire for children, according to number of living children					
	Number of living children				
Desire for children	1	2	3	4	Total
	Desire for additional child				
Want another soon	48.8	18.4	13.7	9.8	16.4
Want another later	4.4	8.2	19.6	16.7	14.2
Want another, undecided when	8.7	38.7	29.4	25.5	27.6
Undecided	0.0	20.4	7.8	16.7	13.8
Want no more	0.0	0.0	9.8	18.6	10.7
Sterilized	0.0	0.0	2.1	3.9	2.2
Currently pregnant	39.1	14.3	17.6	8.8	15.1
Total percent	100	100	100	100	100
Number of women	23	49	51	102	225
	Preferred sex of additional children				
Boy	0.0	4.1	1.9	2.0	2.2
Girl	43.5	34.7	37.3	22.5	30.7
Doesn't matter	56..5	61.2	60.8	75.5	67.1
Total percent	100	100	100	100	100
Number of women	23	49	51	102	225

Table 2 Antenatal Check-Up

Percentage of women• who received any antenatal check-up (ANC) during pregnancy by source of antenatal provider, according to selected background characteristics.								
Background characteristic	Doctor'	ANM/ /nurse/ midwife/LHV	Other health personnel	Dai/ TBA	Anganwadi/ ICDS worker	No one	Total	No. of women
Age at birth								
15 to ≤ 25	18.6	25.6	0.0	7.0	0.0	48.8	100.0	43
>25 to ≤35	30.6	17.9	0.9	7.5	2.8	34.9	100.0	106
>35 to 45	17.1	3.9	0.0	1.4	0.0	77.6	100.0	76
Children ever born								
1	30.4	21.8	0.0	8.7	0.0	39.1	100.0	23
2	14.3	14.3	0.0	4.1	0.0	67.3	100.0	49
3	11.8	7.8	0.0	5.9	2.0	72.5	100.0	51
4+	38.2	16.8	0.9	4.9	1.9	37.3	100.0	102
Education								
Illiterate	8.5	2.1	4.3	6.4	10.6	68.1	100.0	47
0-9 @ years	20.8	24.8	1.0	1.9	0.0	51.5	100.0	101
10 years +	49.3	3.9	1.3	2.6	0.0	42.9	100.0	77
Standard of living index								
Low	32.9	10.3	0.0	1.6	0.0	55.2	100.0	185
Medium	34.2	13.0	0.0	3.1	2.8	46.9	100.0	32
High	87.5	0.0	12.5	0.0	0.0	0.0	100.0	8

The proportion of women who received antenatal check-ups from a doctor increased steadily with the level of education and the standard of living index. 9 percent illiterate women as compared to 49 percent having education of more than 10 years received ANC from doctors. Similarly, 33 percent of women belonging to households with a low standard of living against 88 percent of that from a high standard of living received ANC from doctors. The present study results is more or less similar with that of NFHS 3, NRHM 2013 and DLHS-RCH 3 in terms of the reasons stated by them for not seeking or receiving antenatal care.

DISCUSSION AND CONCLUSION

A close observation of the analysis reveals that in Meghalaya, son preference, though the existing degree of variation is not large enough with respect to the number of living children and preference for additional male children. This apart, a sizeable proportion of women desiring additional children expressed that sex of the child is immaterial. Findings of the present study reveals that more than half of the mothers who did not have any antenatal check-ups felt that ANC in not necessary during pregnancy. This is so because pregnancy has always been considered a usual phenomenon and they thing that that they can manage pregnancy related problems without special medical attention. The reason for not receiving an antenatal check-up was mainly due to lack of knowledge and poor economic condition as it has been observed that most of the respondents fall under low income category. It is a well-known fact that, Children are the backbone of any society and thus of a nation and good health of a mother is a pre requisite for a healthy child. Therefore, improvement of health care services and health awareness are major areas that should be given top priority and utmost importance for promoting maternal health development in Meghalaya. The real challenge, however, is to bring the benefits of development to the backward and poor sections of the society, especially in the remote rural areas. A multidisciplinary approach among the government, non-government organizations and other relevant department is the urgent need of the hour to improve the maternal as well as child health status of the rural areas.

Various measures including, health awareness, health education, and maternal healthcare facilities with adequate health staff etc. are to be taken into account to improve the overall health status of the community especially the maternal health.

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