CHAPTER IV

ANALYSIS AND INTERPRETATION

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This chapter deals with analysis and interpretation of the study. In order to understand the chapter, it is mainly divided into five parts to fulfil the objectives of the study. The first part deals on the major health problems faced by respondents, second part highlights the availability, accessibility and utilization of health services by respondents, third part deals with the provisions of services and programmes provided by government, private hospitals and Non-governmental Organisations (NGOs), fourth part highlights on utilisation of traditional and religious practices by respondents and fifth part deals with perspectives of health services from Government, Private, NGOs and Traditional & Religious practitioners in Ukhrul district of Manipur**.**

4.1 Part – I: The major health problems faced by the respondents

To fulfil the first objective, this part I dealt with profile and socio-economic aspects of respondents who had undergone treatment for Reproductive health related problems, AIDS and TB illnesses.

As stated in the methodology of the study, altogether 250 respondents were collected; out of which 200 respondents were collected from gynaecology department/centre, HIV/AIDS department/centre and TB department/centre. 50 respondents were key informants, like doctors, nurses from both government and private hospitals, Community Health Centre (CHC), Primary Health Centres (PHCs); project director, counsellor from NGOs, Headman of the neighbouring villages of Community Health Centre (CHC), Primary Health Centre (PHCs) of Ukhrul district

and Traditional and Religious Practitioners. Interview schedules and questionnaire tools were used for collection of data from both patients and key informants and the data were further presented through tables and charts.

4.1.1 Sex, Age and Marital Status of the respondents

Sex, age and marital status represent the brief profile of a person in which category/status they belong. Sex, age and marital status are always interlinked with one another for identifying a person.

Table No. 4.1: Sex, Age and Marital Status of the respondents

Parameters		**Gynaecology Department/ Centre**	**HIV/AIDS Department/ Centre**	**TB Department/ Centre**
		Frequency (%)	**Frequency (%)**	**Frequency (%)**
Sex	Male	0	26 (40.0%)	26 (74.3%)
	Female	100(100%)	39 (60.0%)	9 (25.7%)
Total		**100(100%)**	**65 (100%)**	**35(100%)**
Age	15-25	30 (30%)	0	10 (28.6%)
	26-35	60(60%)	10 (15.4%)	13 (37.1%)
	36-45	10(10%)	30 (46.1%)	3 (8.6%)
	45 & above	0	25 (38.5%)	9 (25.7%)
Total		**100(100%)**	**65 (100%)**	**35 (100%)**
Marital Status	Married	100(100%)	55 (84.6%)	17 (48.6%)
	Unmarried	0	10 (15.4%)	18(51.4%)
Total		**100 (100%)**	**65 (100%)**	**35(100%)**

The Table No. 4.1 deals with profile of respondents who are availing services from both government and private hospitals and NGOs. The above table shows that respondents who have attended services at Gynaecology Department/Centre are represented by female only, since the title itself has indicated women group only.

Women who are at the age group of 26-35 represents the highest group with 60 percent which are followed by 30 percent of 15-25 age group and 36-45 age group represents only 10 percent respectively. So women whose age group ranging from 26-35 are in the highest group who have availed services more often for their health related problems, this may be because of their high reproductive age in the study area. According to 2011 census of India, the average marriage age of women is 22.2 which are similar with the finding that the average marriage age of respondents is 25.

The table further explained that both male and female were taken from HIV/AIDS centre and TB centre. During the course of data collection, the turnover of female respondents in HIV/AIDS department/centre were more as they were regular in availing ART from ART centres in compared to male counterpart, thus female respondents represented 60 percent followed by male with 40 percent. Moreover one third of the respondents who were suffering from AIDS was married couples and represented the highest group with 84.6 percent, while a small percent of 15.4 percent were unmarried group. According to MACS (2014), 350 male and 314 female are alive on ART in Ukhrul district. Here, it is found that respondents suffering from AIDS are found highest in the age group of 35-45 with 46.1 percent, which are followed by age group of 45 & above with 38.5 percent and 26-35 represent 15.4 percent. The age group of 35-45 stands to be highest in attending and availing ART from the centres, because this age group stands to be highest who are suffering from AIDS in the district. Government of India (2014) has given a statement that the national adult in the age group of 15 to 49 years has high HIV prevalence rate estimated 0.27 percent in 2011, and prevalence among young population 15 to 24 years at national level is estimated 0.11 percent in 2011. But according to study of Godwin (1998) has stated that the incidence of HIV in India in the age group of 35 to

44 years in urban is 2 percent only and in rural is 1 percent but high in the age group of 20 to 24 years with 5 percent in urban and 1.5 percent in rural respectively which is contradictory with the findings.

The table also reflected that in Tuberculosis (TB) department/centre, majority of the respondents were male with 74.3 percent followed by female with 25.7 percent. Here male respondents happen to be more in this study as they are more prone to pre-disposing factors of TB due to their life styles, mobility, habits of drinking, smoking and chewing pan, etc. Besides other social and cultural construct could be one of the reasons. During festivals and events; marriages, death ceremony services, social works, regional sports meet and other occasion, mainly male were served with alcohol, pan, cigarette, etc. as a traditional practice. Outcome of this practice make habituated and affected mainly the youth. Eventually air-borne communicable diseases like TB are more seen among the male in compare to female. In contradictory with the above cited point, Hynes (1987) has stated that during the general household survey in Great Britain, found that females are more vulnerable with TB disease than males, i.e. females have the chances of ill health with 22 percent than males 19 percent.

It is further seen among TB respondents that age group of 26-35 represents the highest percentage with 37.1 percent which is followed by 15-25 with 28.6 percent, while age group of 45 years and above represents 25.7 percent and age group of 36-45 represents the smallest percentage with 8.6 percent. In support of the study, Govt. of India (2008) has stated that the age group 25-34 has the highest cases of TB, this is due to TB primarily affects people in their most productive years of life.

According to AIDS Action, Asia-Pacific edition (1996) people who are infected with both tuberculosis and HIV are 25 to 30 times more likely to develop tuberculosis

disease, than people infected only with tuberculosis. This is because HIV stops the immune system of our body and thus tuberculosis bacilli are able to multiply rapidly. HIV/AIDS and TB are interlinked and vulnerable with one another. During data collection, it had come across that seven (7) respondents were diagnosed with both HIV/AIDS and TB. The respondents expressed that it was hard for them to take both ART and DOTS simultaneously due to excess of dosages which made them weak and unable to do anything. In some cases, when the patients faced these kinds of problems, they avoided treatment of DOTS but retained with ART. The reason for choosing ART than DOTS is that their health conditions are comparatively become better after availing ART, thus leading to drop out from DOTS centre.

4.1.2 Education, occupation and income of the respondents

Education, occupational and income of a person represent important indicators of human status. It plays a major role for individual, family and community in every aspects of development. The living standard and their life style could be indicated through their educational, occupational and income level of a person.

Table No. 4.2: Education, occupation and income of the respondents

Respondents having/Suffering		Educational Status		Occupation				Income per annum			
		Literate	Illiterate	Student	Farmer	Business	In service	No income	15000-50000	50001-1 lakhs	Above 1 lakhs
HIV/AIDS	Frequency /Percent	26 (40.0)	39 (60.0)	0	35 (53.9)	16 (24.6)	14 (21.5)	0	35 (53.9)	16 (24.6)	14 (21.5)
	Total	**65 (100%)**		**65 (100%)**				**65 (100%)**			
TB	Frequency /Percent	19 (54.3)	16 (45.7)	6 (17.1)	20 (57.1)	0	9 (25.8)	6 (17.1)	13 (37.1)	7 (20.0)	9 (25.8)
	Total	**35 (100%)**		**35 (100%)**				**35 (100%)**			
Women related health problems	Frequency /Percent	76 (76%)	24 (24%)	0	57 (57%)	19 (19%)	24 (24%)	0	57 (57%)	19 (19%)	24 (24%)
	Total	**100 (100%)**		**100 (100%)**				**100 (100%)**			

In Table No. 4.2 it depicts about the education status, occupation and income per annum of the respondents. In education status, researcher used two parameters: literate and illiterate, to understand the knowledge of their illnesses about HIV/AIDS,

TB and Women health related problems. Majority of HIV/AIDS respondents were found to be illiterate (60 percent), while 40 percent were literate. This inference indicated that respondents under the study area were more vulnerable to AIDS due to lack of knowledge/awareness of the disease. Thus, ignorance and illiteracy of the disease might have increased in indulging in drugs, sharing used needles, practising of unprotected sex among different partners. Since agriculture was the main occupation and livelihood for the people, farmers occupied the highest group (53.9 percent) with annual income range Rs. 15000-50000, followed by businessmen (24.6 percent) with income of Rs. 50000-1 lakh, and in-services as 21.5 percent with annual income of more than Rs. 1 lakh respectively.

In case of tuberculosis, it was observed that literate respondents had highest infections with 54.3 percent, while illiterate respondents represented 45.7 percent. Majority of respondents were aware of available services in health centre, still they were not well acquainted of the main causes of TB. The data indicated that farmers' profession occupied the highest percent of TB cases with 57.1 percent with annual income ranges from Rs. 15000-50000 and Rs. 50000-1 lakh. This may be due to farmers (mainly male) usually take cigarette excessively in their work place in order to get relief and relax from their tiresome. In addition to smoking, many of them are in habits of drinking and chewing tobacco. The respondents testified that even if they were sick with minor ailments (like cough, fever, headache, dysentery, etc.), they hardly visited doctors for treatment; instead they had taken treatment from traditional/religious practitioners. The finding shows that there is still ignorance and lack of knowledge/awareness among the farmers about the disease. Their ignorance can lead to further complications of developing drug-resistant cases (it is the prevalence of patient excreting tubercle bacilli resistant to anti-tuberculosis drugs).

Regarding women health related problems; literate women are more in availing the health services from hospitals than that of illiterate women. With 76 percent of the respondents testified that they could read and write and had attended at least high school (very few with graduation and master), while 24 percent were illiterate as they had not attended any formal schooling. According to 2011 census, the female literacy rate in the district was 77.47 percent, this revealed that majority of the female in this district had known how to read and write. This further reflected that majority of women respondents were aware of and availing services of Antenatal Care (ANC) and Postnatal Care (PNC) from health centres. Though the data showed that majority of women were literate but they were mainly engaged with agricultural work (57 percent with annual income ranges from Rs 15000-50000) along with raring and selling of cattles, chickens, dogs, cats, etc. at home and 19 percent of women were engaged in private business who ran shops, vegetable vendors, etc. with an annual income ranged from Rs 50000-1 lakh respectively, and only 24 percent of respondents were in-service with annual income above 1 lakh.

4.1.3 Mode of transmission of HIV/AIDS and its signs & symptoms

Sickness is common for everyone; it is caused by various factors, like virus, bacteria, germs, environment and more. The general household survey in Great Britain found that about 30 percent of the population suffered from some form of chronic sickness (Hynes, 1987). Person who is suffering from any kinds of diseases can be diagnosed through their signs and symptoms.

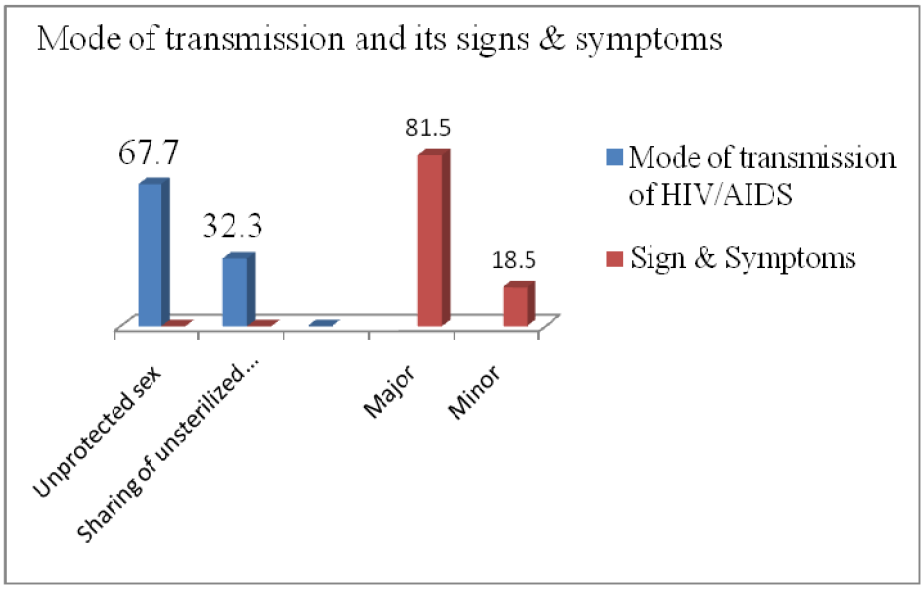

Chart No. 4.1: Mode of transmission of HIV/AIDS and its signs & symptoms

In the above Chart No 4.1 mentions the mode of transmission of HIV/AIDS and its signs & symptoms. The mode of transmission of HIV/AIDS is associated with people indulging in unprotected sex and sharing of unsterilized syringes while injecting drugs. Unprotected sex has the highest level of infections of HIV with 67.7 percent which is followed by using of unsterilized syringes and injecting drugs as 32.3 percent. According to NACO (2011), HIV prevalence rate has been recorded among Female Sex Workers at national level is 2.67 percent; among Men who have Sex with Men are 4.43 percent and Injecting Drug Users (7.14 percent) respectively. The findings show that the prevalent rate of injecting Drug Users is almost 4(four) times higher than the NACO report.

The signs and symptoms of HIVAIDS are associated with major and minor sicknesses. 81.5 percent of the respondents have major problems (like weight loss, chronic diarrhoea for more than one month and prolong fever for more than one month), which is followed by 18.5 percent having minor sicknesses (like, cough for more than one month, pharyngitis, herpes zoster and lymphadenopathy).

4.1.4 Mode of transmission of TB and its signs & symptoms

Tuberculosis is a social disease with medical aspects; it has also been described as a barometer of social welfare. The social factors include many non-medical factors such as poor quality of life, poor housing, and overcrowding, population explosion, under nutrition, smoking, alcohol abuse, lack of education, large families, early marriages, lack of awareness of causes of illness, etc. All these factors are interrelated and contributed to the occurrence and spread of tuberculosis (Park, 2015).

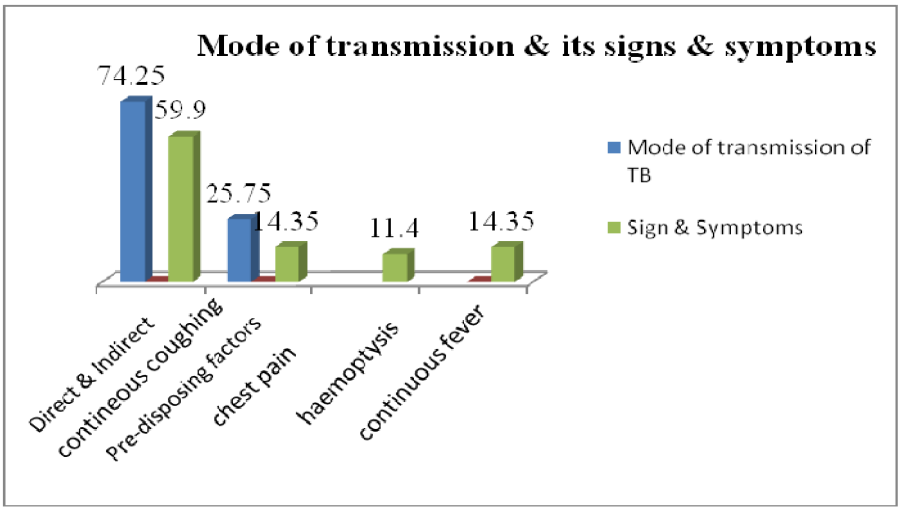

Chart No. 4.2: Mode of transmission of TB and its signs & symptoms

The above Chart No 4.2 discussed about the mode of transmission of TB and its signs and symptoms of the sickness. 74.25 percent of the respondents have stated that the main causes of their illnesses are by direct (droplet infection) and indirect (droplets nuclei) contacts, is followed by 25.75 percent due to pre-disposing factors like taking alcohol, smoking & chewing pan. Park (2015) has stated that tuberculosis is transmitted mainly by droplet infection and droplet nuclei which are generated by sputum-positive patients with Pulmonary Tuberculosis. TB is spread by inhalation, that is by breathing in air loaded with tubercle bacilli; these may be sprayed directly from an infectious person's mouth when speaking or coughing, or from dust carrying the bacillus which can live for many weeks in dark places if undisturbed; dried

infection sputum mingled with dust can be potent source of infection (Sheena & Buchanan, 1955). The signs and symptoms of TB consist of four kinds; they are chest pain, haemoptysis, continuous coughing and continuous fever. 59.9 percent of respondents said that they had continuous coughing for more than three to four weeks, followed by 14.35 percent with chest pain and continuous fever, while 11.4 percent of the respondents had complained of haemoptysis while coughing.

4.1.5 Family members having the same symptoms of TB

Sickness is one of the obstacles for growth and development of the whole society. When sickness occurs within the family members it makes every individual of the family face the burden.

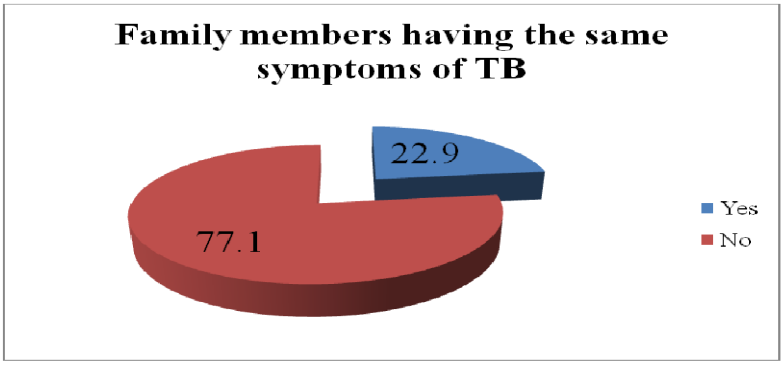

Chart No. 4.3: Family members having the same symptoms

The above Chart No 4.3 discusses about family members having similar signs and symptoms, illnesses and their measures taken. The data depicted that 22.9 percent of the respondents stated that they had seen similar symptoms and sicknesses among their family members, while 77.1 percent of respondents did not experience of any sicknesses in their families. It showed that there were high chances of being infected among family members who had similar signs and symptoms of TB due to its easy ways of transmission from an infectious person to another through air borne while speaking, coughing, sneezing or from formites. Moreover, it could be because of

closed ventilation, poor housing, poverty, unhygienic surroundings, ignorance and lack of knowledge/awareness and habits taking alcohol, smoking and pan, etc. It is observed that all the respondents with 100 percent revealed that they have taken preventive measures by using separate utensils at home, covering their mouths with clothes while coughing, sneezing and even in talking and they are also regular in availing DOTS services in order to prevent from the disease.

4.1.6 Common sicknesses faced by women during Ante-natal and Post-natal period

Health and illness are dynamic states that are influenced by a wide variety of biological, environment, behavioural, social and health service factors. The complex interaction of these factors results in the occurrence of disease or injury which in turn contributes to health status of individuals and populations (Turnock, 2001). Pregnancy related sicknesses are a natural cause due to physiological and hormonal changes in body. Each and every of women during their pregnancy have faced some or other sicknesses.

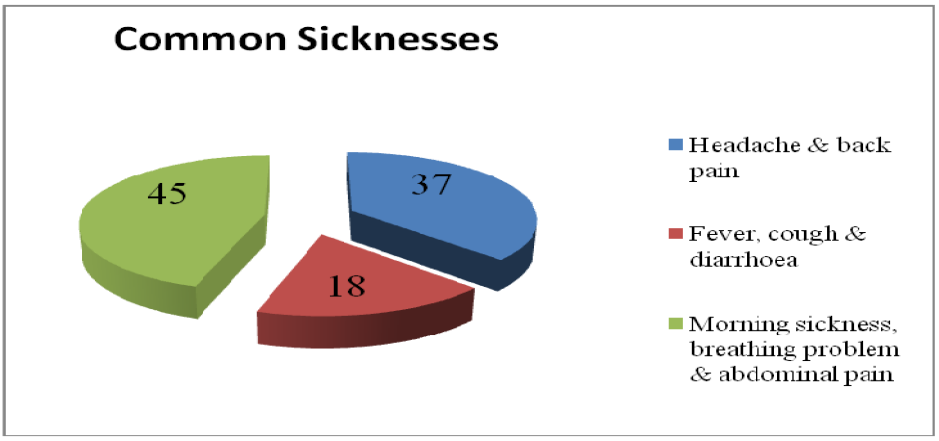

Chart No. 4.4: Common sicknesses faced by women during ANC & PNC

Chart No 4.4 shows the signs and symptoms of their sicknesses during ante-natal and post-natal. Majority with 45 percent of the respondents had morning sickness, breathing problem and abdominal pain during ante-natal and post-natal period, followed by 37 percent having headache and back pain problems, while 18 percent of them had fever, cough and diarrhoea. Each and every one of the respondents had suffered from some or other kinds of sicknesses during their ante-natal and post-natal period. The study is supported by Loganathan & Huirem (2016) have stated that during pregnancy, women have some common health related problems like, paleness/giddiness, swelling of hands and feet, vomiting, hypertension, abdominal pain, excessive fatigue and excessive bleeding.

4.1.7 Societal stigma with TB and HIV/AIDS diseases

Stigma is one of the drawbacks for the development or upliftment of society. Stigmatization in the community could increase spreading of more diseases. Attitudes of people affect their mental and physical health depending on their social status and economic position (Kamble, 1984). Stigma is occurred within the community due to lack of awareness, ignorance and different mindset.

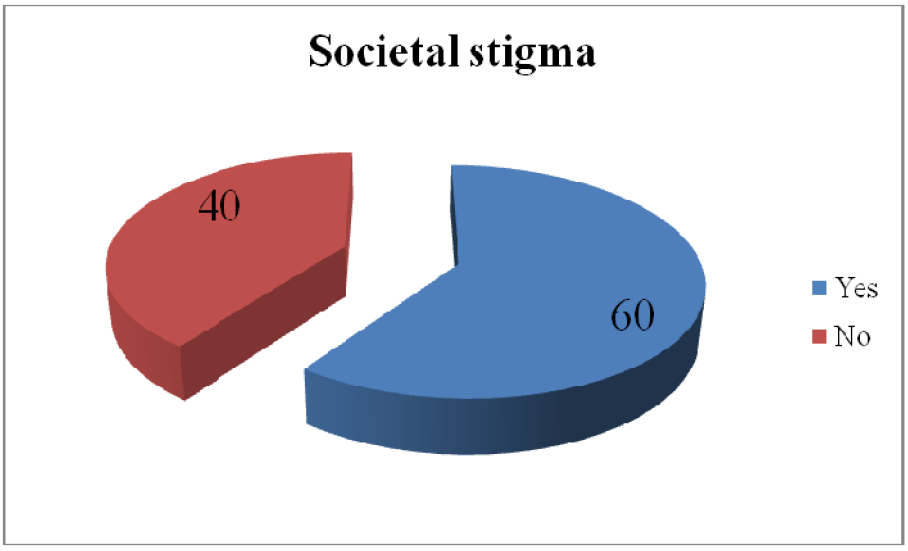

Chart No. 4.5: Societal Stigmas attached with the illness of TB and HIV/AIDS

Chart No 4.5 has shown percentage of respondents facing societal stigma due to their status of living with HIV/AIDS. Among the HIV/AIDS respondents, 60 percent of them revealed that there is strong social stigma attached with HIV illness in their area. This is quite visible when they visit religious places and attend societal functions. But it is interesting to note that all TB respondents (100 Percent) and 40 percent of AIDS respondents have shared their observations that they have not experienced of any kinds of social stigma. Prevailing of societal stigma among the people living with HIV/AIDS is due to unclear concepts of HIV/AIDS, lack of awareness and knowledge of the disease among the mass. Having general awareness among the people will not only give benefit to their own health problems but also to the community as a whole by acquainting with various aspects of the diseases encircling them with preventive methods available and measures in existence to prevent and eradicate the diseases (Balan, 1989).

4.2 Part – II: Availability, Accessibility and Utilization of Services

This part II dealt with availability, accessibility and utilization of government and private hospitals and NGOs services by respondents. The easy accessibility and availability of treatment from health centres are indicated by provisions of good services in health institutions; and establishing a good relationship between the health care providers and the community people. Health centres serve as the first referral point for any health related issues.

4.2.1 Reasons for visiting hospitals

Health is one of the most important determinants for the development of Nation. People with health problems visit to health services centres for taking treatment, and services are provided by government and private health providers.

Table No. 4.3: Reasons for visiting hospitals

Parameters			**Frequency of visiting to hospitals**					**Total**
Reason for visiting Hospitals	**Women health related problems**		**First Trimester**		**Second Trimester**	**Third Trimester**		
			1 time	2 times	1 time	1 time	2 & more times	**100**
		Ante-natal check up	17	8	16	25	34	
	Total		**15**		**16**	**59**		**100**
	HIV/AIDS		**Every day**		**2 to 3 times in a month**	**More than 3 times in a month**		**Total**
		ART	15 (23.1)		0	0		**15 (23.1)**
		ART & counselling	0		33 (50.7)	0		**33 (50.7)**
		ART, condom, counselling and supplement vitamin	0		0	17(26.2)		**17(26.2)**
	Total		**15 (23.1)**		**33 (50.7)**	**17(26.2)**		**65 (100)**
	Tuberculosis	DOTS	0		24 (68.6)	11 (31.4)		**35 (100)**
	Total		**0**		**24(68.6)**	**11(31.4)**		**35(100)**

The above Table No. 4.3 discussed on the reasons for visiting hospitals. Utilization of reproductive health services was measured by using the ante-natal and post-natal care, maternal immunization and the use of save delivery (Savigny *et al.,* 2005). 59 percent of women health related problems visited hospitals for one to two times in their third trimester, followed by 25 percent who visited one to two times during their

first trimester, and 16 percent had visited only one time during their second trimester. During first and second trimester, majority of them had visited only one time for normal check up and immunisation services. Here maximum of women had visited for more than two times for their antenatal check up during third trimester; this might be because of closer to the delivery date.

Ukhrul district has recorded as the highest rate in HIV/AIDS in the state. According to Manipur AIDS Control Society (MACS) (2014), there are 1285 pre-ART person and 664 persons are alive on ART. In case of HIV/AIDS, 50.7 percent respondents had visited ART centre two to three times in a month for availing ART and counselling services, followed by 26.2 percent who had visited more than three times in a month in availing ART, appetizer, condom and counselling services, while 23.1 percent visited the centre every day for availing ART, since the medicine were provided on daily basis especially for those respondents who were staying in the town (near by the health centre) but the respondents who were from far flung villages were provided the medicines with packet system for a week. Availing of ART and counselling services from the centre had helped them in improving their health conditions not only physically but also emotionally and psychologically.

Likewise every one of the respondents had visited DOTS centre from time to time to avail the services depending upon the nature and degree of illness. 68.6 percent of TB respondents had visited two to three times in a month for availing DOTS from the centre, followed by 31.4 percent who visited for more than three times in a month for availing DOTS from the centre. As majority of the respondents are from far flung villages, so the health care providers provide them the medicines on weekly basis.

4.2.2 Availability of doctors and equipments in hospitals

Hospital is considered here as a social system and the doctors and patients are the sole occupants who mutually interact to form relationship directed by their specific goals and the general goals of the system (Advani, 1980). Availability of doctors and equipment is a must and necessary to run effective health institution. Thus availability of doctors and equipments should always go hand in hand in order to provide good services to the people.

Misra *et al., (*2003) in his study stated that there was still shortage of manpower, poor working conditions and lack of transparency in posting especially in rural areas makes people unsatisfactory with the government hospital. Many respondents (women health related problems) have complained that there is no specialised doctor in women reproductive health (Gynaecology) department. One specialised doctor from valley (Imphal) areas who is posted in the department (Gynaecology) never comes for her duty; this makes patients face difficulties in availing services from Ukhrul district hospital. The hospital is functioning with 12 medical officers (MOs), 14 staff nurses against the actual sanction post of 24 (Rural Family Welfare Centre, 2012).

Thus, respondents mostly tend to avail the services from private hospitals. Likewise respondents from HIV/AIDS and TB departments complained that doctors who posted from valley (Imphal) areas hardly came to the department. Even if they come, they remain only for five to six days in a month, this makes the conditions worsen and people face hurdles in accessing the specialised doctors.

Regarding availability of equipments in District hospital, women respondents revealed that Ultra sound machine and ECG had been installed; however the machines lied unused due to shortage of trained technical staff. So respondents are needed to

consult private hospitals for check-up which are again very expensive for them. Further the respondents from TB and HIV/AIDS department expressed, there were lack of equipments like (X-ray, Liver Functioning Test, Kidney Functioning Test and CD4 count) in Ukhrul district hospital. Often such equipments are damaged or non-functional. In support of the above statement, Grant (1941) in his study has stated that hospital facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay for the cost of the care they need.

4.2.3 Availability of counselling services and its benefits to AIDS respondents

Counselling becomes important for a person who has problems or stress in the environment where they live or to their respective work place. It gives suggestions and guidance to solve problems of individuals for their proper social and emotional development. Certain principles for effective and meaningful counselling and guidance which will be of immense help to those involved in the care and also provides emotional support to the victims of HIV and their family members (Thomas, 1997).

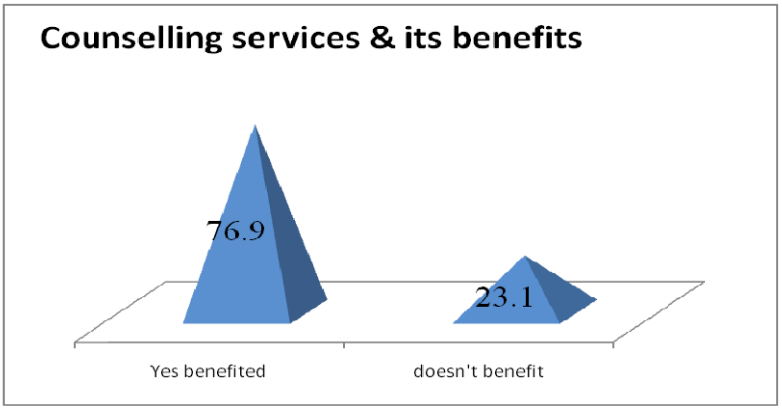

Chart No.4.6: Availability of counselling services & its benefits to AIDS respondents

The Chart No 4.6 shows the availability of counselling services in Ukhrul district hospital and in NGOs especially for HIV/AIDS respondents. 76.9 percent of the respondents said that there were counselling centres available for them and they had got benefited in coping up with their illnesses and stresses through counselling (in terms of motivation, encouragement, information, awareness). They further mentioned that counselling helped their family members by providing information on the causes of HIV/AIDS and thus changed their mindsets. It is also seen that 23.1 percent have mentioned unsatisfactory with the counselling services in both Ukhrul district hospital and NGOs as counselling are done just for namesake.

4.2.4 Availability of minor and major operation theatre (OT)

Availability of operation theatre is essential for all the hospitals. Operation theatre is a place to operate and save the life of people who required operations for their health problems.

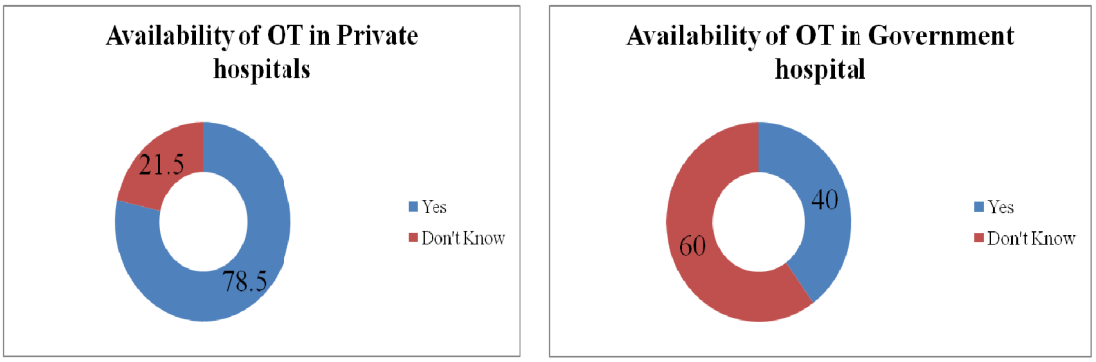

Chart No. 4.7: Availability of operation theatre (OT)

In the above Chart No 4.7, it shows the availability of OT for minor & major operations in both Ukhrul district hospital and private hospitals. In government hospital, there is minor OT for minor injuries, causalities. But in case of major operations, there is a room (mentioned OT) which is non-functional due to non-availability of surgeons, OT nurses, instruments, autoclave machine, etc. Thus, in case

of serious illnesses or pregnant women were in need of caesarean were referred to private hospitals in Ukhrul or hospitals at Imphal which is almost 84 Km far from Ukhrul.

In the above Chart No. 4.7, in case of private hospitals 78.5 percent of the respondents had accessed the services and was aware of OT facilities, whereas 21.5 percent were not aware of OT facilities as they accessed only ANC services and delivered their babies at home with the assistant of traditional attendance. And again in case of government hospital, 60 percent of the respondents were not aware of the OT facilities, since they only accessed the services for normal check up, immunization, etc. during their pregnancy period; however their deliveries were taken place at home and at private hospitals. Moreover doctors from district hospital referred them to private hospitals when complicated delivery cases arise in district hospital. While 40 percent who happened to deliver in government hospital with normal delivery process had revealed that there were only minor OT facilities.

4.2.5 Accessibility of health care services

In developed countries, there is not much problem for travelling to centres of medical excellence in larger towns and cities. But in poorer countries most of the people live in the rural areas where communications are difficult, expensive, and sometimes non-existent due to lack of accessibility (Skeet & Elloitt, 1978).

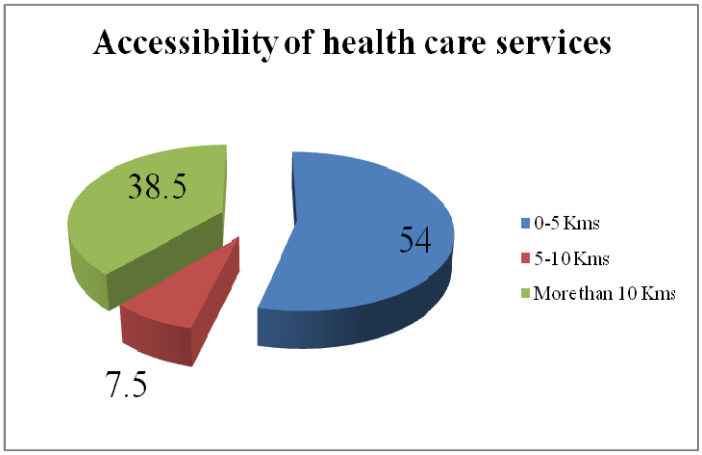

Chart No 4.8: Accessibility of health care services

Chart No 4.8 highlights the accessibility of health care services by the respondents. It is seen that majority of the respondents are living at a distance of 0-5 Kilometres from the hospitals. They are mainly from the main town and neighbouring villages of the health centres. 7.5 percent of the respondents stay within a distance of 5-10 kilometres from the health centres. However, a significant number 38.5 percent of respondents are staying at a distance of more than 10 kilometres from the hospitals. It is important to note that the landscape of the Ukhrul District is totally hilly. It is very difficult for the respondents to avail the services of hospitals not only due to distance but also by difficult geographical terrain and poor road conditions. The situation becomes worse during rainy seasons.

Health centres and family medicine schemes are supposed to serve as the first point of contact. However, the provisions for ART and DOTS were not available at Primary Health Centre (PHCs), Community Health Centre (CHC) and the two private hospitals in the district. Thus, the respondents who are suffering from TB and HIV face maximum challenges in accessing the services from hospitals.

4.2.6 Mode of communication

The transport systems for the patients are extremely significant to reach the hospitals for treatment. In certain cases, due to long distance and transportation problems, the patients could not reach hospitals on time for their treatment and therefore, the patients went into critical conditions.

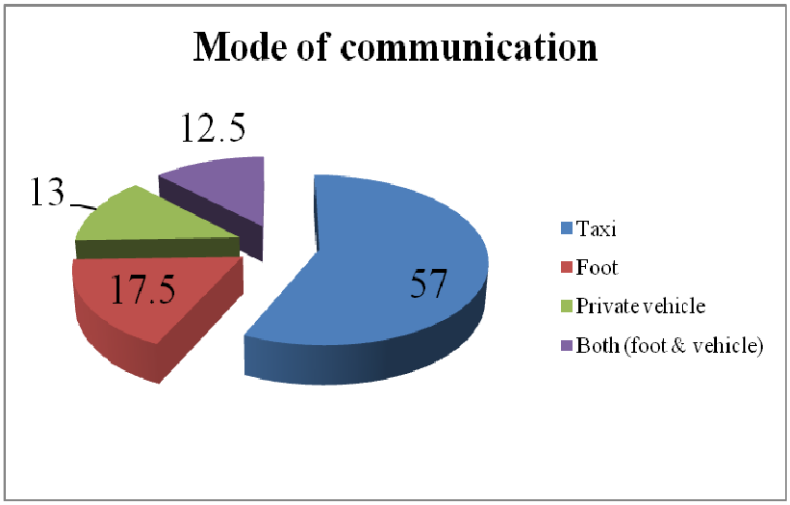

Chart No. 4.9: Mode of communications

Chart No 4.9 highlights the mode of communications of respondents to health centres. Their mode of communications are either by own vehicles, taxi services, by foot or both (Vehicle and Foot). 57 percent of them reached hospitals from their villages through taxi services, followed by 17.5 percent walked to the health centres. 13 percent went in their private vehicles to the health centres and 12.5 percent of the respondents covered some distance on a vehicle and then walked on foot to access to services for DOTS, ART, ANC, immunization, medicines, etc. Respondents who are accessing the services are mostly from the villages where their professions are farming or working in the field. In the Tangkhul society, farmers live in the villages whereas employees/ in service and business people are mostly resided and lived in town. Thus, farmers have to travel for more than 10 kilometres for accessing, availing and utilizing the health services from their respective villages. There were times that it

became difficult for the respondents to access or avail the services due to bad road conditions during heavy rains, strikes, bandhs, etc. called by different organizations. Moreover, villagers staying in distant places mainly in hilly terrain have no access to vehicle services for around two to three months as the condition of the roads get worsened and washed out during rainy season.

4.2.7 Provisions of Ambulance services

The government of India has provided ambulance services for medical health for emergency cases. There are two such services 108 and 102, where 108 is basically an emergency response system, primarily to attend to patients who are in critical care, trauma and accident victims, etc. And on the other hand 102 services consist of basic patient transport aim to cater to the needs of pregnant women and children. The services of 102 falls under JSSK entitlement (free transfer from home to facility, inter-facility transfer in case of referral and drop back of mother and child from facility to home). Thus, availability of ambulance services 24x7 is necessary in dealing with emergency cases.

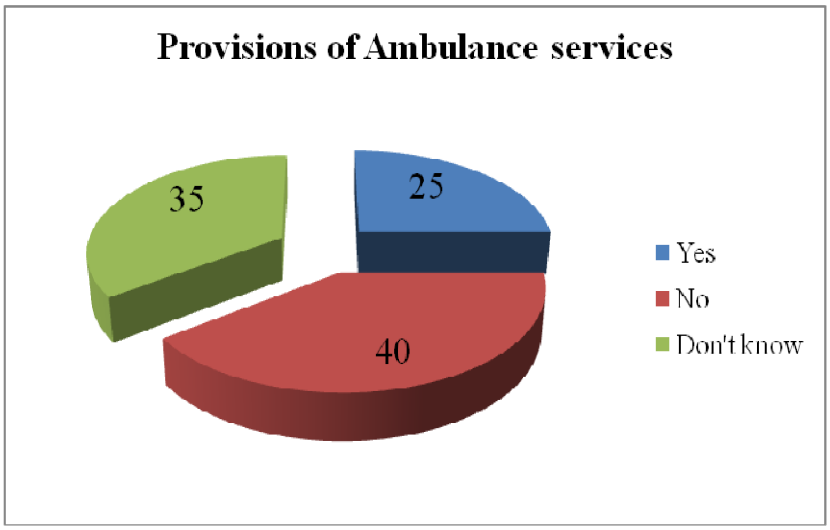

Chart No. 4.10: Provisions of Ambulance services

The above Chart No 4.10 highlights the availability of free ambulance services for the respondents in both Ukhrul district and private hospitals. All the respondents reflected that till now there is no provision of 108 emergency ambulance services in the government as well as in private hospitals of Ukhrul district.

But 102 services are available for ANC mothers. It showed that majority with 75 percent did not avail ambulance services from both government and private hospitals. Out of this 75 percent, 35 percent of the respondents were not even aware of provisions of free ambulance services especially for pregnant mothers. While 25 percent of the respondents were aware of and had already availed ambulance services from government and private hospitals. They further mentioned that provision of ambulance services was subjected to the health conditions of patients. For example, ambulance services are provided when the patients have serious health problems (and are already admitted in the hospitals) and need further referral to better hospitals in Imphal. In such cases, patients were provided ambulance services but they were charged an amount of Rs. 1500-2000 for filling the ambulance fuel. Thus, there is still a shortage of ambulance services in the district. As they are not availing the services, majority of respondents had to hire private vehicle which was another burden for poor families. During rainy season, it became more difficult for respondents to access or avail services from health centres, since vehicle services had to cease for a month as the condition of the roads get worsened due to heavy rain. Thus such cases had made the villagers to opt for home delivery despite of their serious illness.

4.2.8 Place & Reasons for Institutional delivery & home

Place is one of the most important part in accessing and delivering health services from health providers, it indicates the easy availability and accessibility of services by people who are suffering from some common sicknesses. Accessibility and availability of health care services is an important determinant of quality of care, women should understand the full range of health care services at the lowest appropriate level of the system close to where they live (Prakasam & Raju, 2006).

Table No. 4.4: Place & Reasons for Institutional delivery & home

Parameters		Reasons for Institutional delivery & home		
		More faith with doctors & nurses	Availing of traditional expert birth attendance	**Total**
Place of delivery the child	Hospitals	65%	0	**65%**
	Home	0	35%	**35%**
Total		**65%**	**35%**	**100%**

The above Table No 4.4 shows place and reasons for delivering their children. The currency policy of Government of India under National Health Mission (NHM) and Reproductive Child Health (RCH) is to encourage institutional delivery which is an important step in reducing maternal mortality rate. On other hand, the place of delivery is a crucial factor which affects health and well-being of mother and new born baby. Out of 65 percent, 51 percent of women had delivered their children in private hospitals, whereas 14 percent had delivered in government hospital and in both cases it was attended by doctors and nurses. The respondents preferred institutional delivery than home delivery for easy accessibility of doctors and support staff which would further prevent them from any complications or emergency. Thus majority of them have opted institutional delivery as they have more faith with health

care providers than traditional birth attendance. The finding of the study is supported by Loganathan & Huirem (2016) that in Manipur and Assam where there were large numbers of private practitioners, private set up was suggested as a place for institutional delivery to a larger extent and it was also noted that care givers were encouraged for caesarean delivery, especially in private practice. While 35 percent have delivered their children at home for easy accessibility and available of traditional birth attendance and its cost effective nature. It is noted that in most cases, it is the poor households that prefer home deliveries in order to save hospital and travel expenses.

4.2.9 Money spent during delivery

Predominantly by culture and traditions, the mindset of rural communities amidst money as their life. Some of families fear in spending too much of money during institutional delivery as doctors often suggested for caesareans than normal delivery. Some of the families were unable to afford the expenses thus they opted for home delivery.

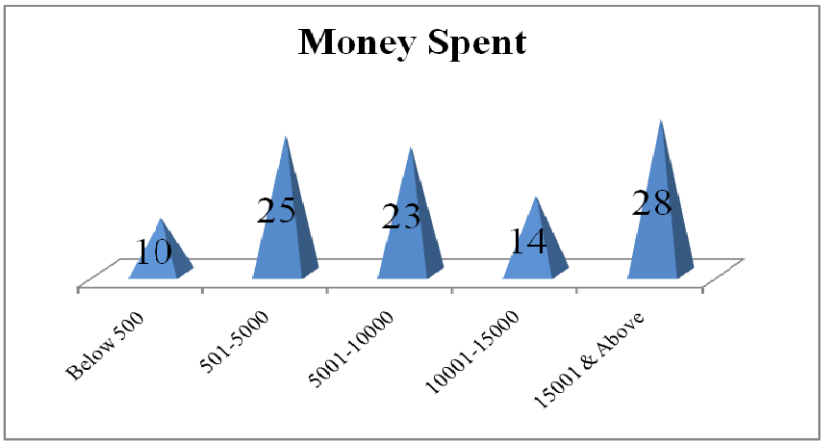

Chart No. 4.11: Money spent during delivery

Chart No 4.11 deals with the amount of money they spent during delivery both in hospitals and at home. The amount differed according to the types of their deliveries.

65 percent of respondents had taken their delivered from hospitals (private and government), out of which 28 percent and 14 percent who did caesarean had spent Rs 15001 & above and Rs 10001-15000 respectively and was followed by 23 percent who spent Rs 5001-10000 for normal delivery. Some of respondents who had spent higher amount excluding caesarean was due to the reasons that sometimes they (both the baby and mother) needed further observations for another 2-3 days, might be due to excessive bleeding and premature birth, etc. Moreover 35 percent had taken their deliveries at home, and out of which 25 percent were attended by traditional birth attendance and they spent Rs 501-5000, while 10 percent spent below Rs 500, this might be due to relatives and family members attended their deliveries.

Respondents of ANC mothers especially the primi mothers have to take treatment or deliver their babies through caesarean in nearby private hospitals. This becomes very expensive for poor people and sometimes they remain untreated or delivered at home without proper supervision. Such cases can increase both maternal and neonatal death in the study area.

4.2.10 Role of ASHA

ASHA acts as inter-mediator between health care providers (hospitals) and community people. It provides first hand information for any government programmes like JSY and immunization services that are meant especially for women and children.

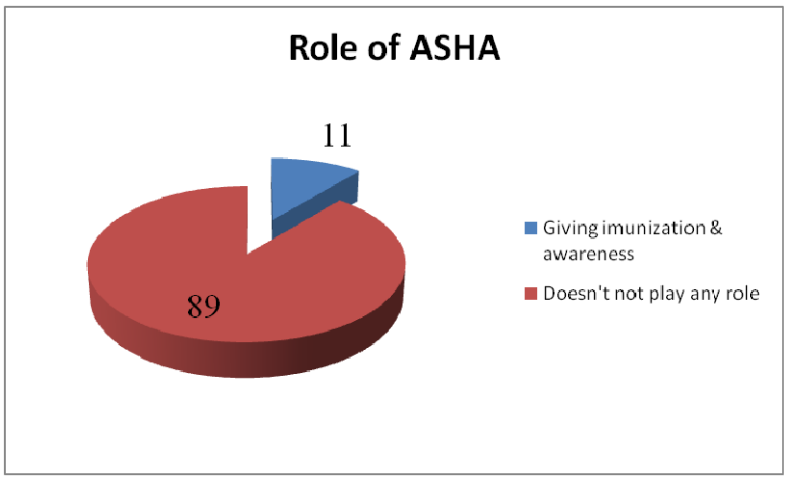

Chart No. 4.12: Roles of ASHA

The Chart No 4.12 indicates the role of ASHA under the study area. The main role of ASHA is to register the names of the pregnant mothers and monitor their health. They also escort pregnant mothers at the time of institutional delivery and also build awareness of health through mobilizing the indigenous health planning, increasing utilization and accountability of the existing health services, providing a minimum packages of curative care and making timely referrals such as immunization, ante-natal care, post natal care, supplementary nutrition, sanitation, etc. (Ministry of Health & Family Welfare, Government of Health & Family Welfare, 2014). But from the above chart, majority of the respondents with 89 percent claimed that ASHA did not visit at all to their villages/locality during ante-natal and post-natal period. The respondents have shared their views that they have heard of ASHA from friends and others sources but most of them are not aware of the roles played by ASHA. This indicated that ASHA did not perform their duty well in their concern areas. The study of the finding was supported by Loganathan & Huirem (2016) that in Manipur ASHA personnel were not so active. Rather self-motivation was foremost in Manipur, while 11 percent revealed that ASHA visited their villages during ante-natal

and post-natal period and gave immunization to both mothers and children and also provided awareness of availability of JSY.

4.3 Part – III: Government, Private Hospitals and Non-Governmental Organization: Programmes and Services

Part III deals with different programmes, policies and services available in Ukhrul district hospital, private hospitals and NGOs.

4.3.1 Available of JSY programme for pregnant mother

The JSY programme states that a pregnant mother (belonging to a BPL household) receives at least 3 ante-natal checkups during pregnancy both in rural and urban areas for availing cash assistance (Park, 2013) and envisages free cashless services to pregnant women including normal deliveries and caesarean operations and also treatment of sick new born up to 30 days after birth especially in all government health institutions.

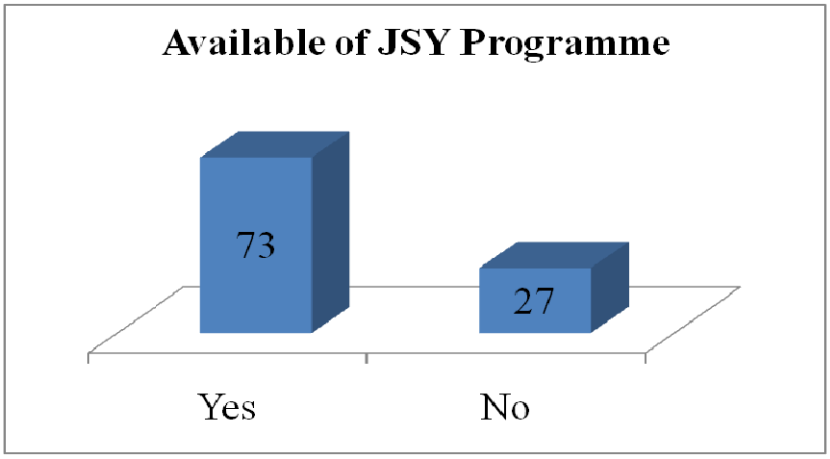

Chart No. 4.13: Available of JSY programme for pregnant mother

Under the National Health Mission, to fulfil the millennium development goals the district government hospital is implementing Reproductive and Child Health Programme II which helps in reducing the Maternal Mortality Rate and Infant

Mortality Rate. The district hospital has implemented Janani Suraksha Yojana (JSY) but the success rate of the programme is minimal due to lack of awareness and transparency in the health system. Janani Suraksha Yojana (JSY) provides cash assistance to the mother after their deliveries and further encourages them for institutional deliveries. There is public-private partnership between the government hospital and the two private hospitals under National Health Mission (NHM) in provision of the JSY program to the respondents in order to make the programme better and ensure the availability of services for the general population especially for women.

Chart No 4.13 shows the availability of JSY program for the pregnant mothers. Majority of respondents with 73 percent availed and benefited from JSY before and after they delivered their babies, whereas 27 percent of the respondents said that they did not get any benefits from JSY. The women health related problems respondents had received cash incentive in order to reduce financial barriers to access institutional care for delivery, increased institutional births to reduce MMR and free medicine from the health care providers through JSY programme.

4.3.2 Provision of cash assistance through JSY

Availability of health care facilities within the vicinity will help to receive antenatal care in time; it also helps to provide timely assistance during pregnancy, delivery and monitoring of post-partum period (Prakasam & Raju, 2006). JSY provides cash assistance to mothers after their deliveries and further encourage them for institutional deliveries.

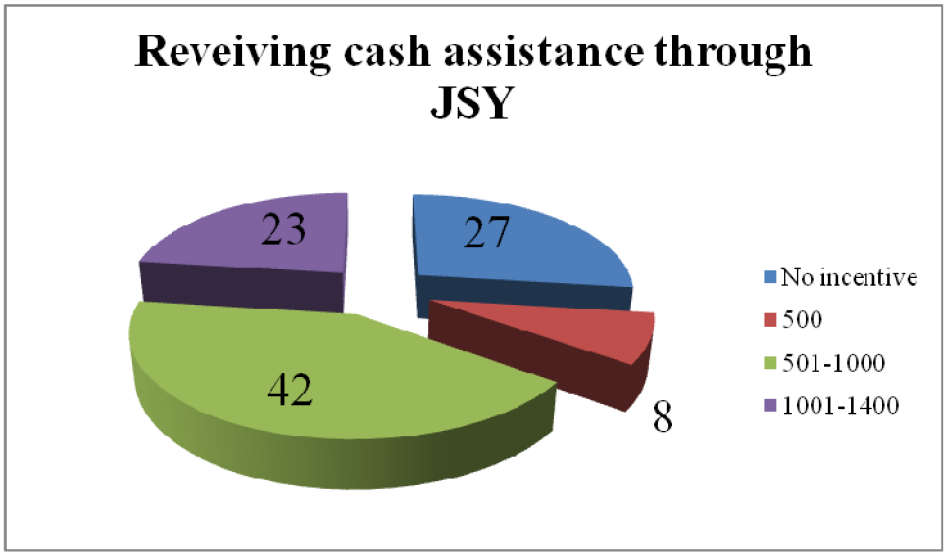

Chart No. 4.14: Provision of cash assistance through JSY

The above Chart No 4.14 shows the cash assistance which was availed under the JSY programme. Here 27 percent of the respondents did not get any incentive before and after delivery. They claimed that even after they had fulfilled the criteria, no incentive was provided from government. They further expressed that they inquired hospital staff of Ukhrul district for the incentive, but they were being told that they were supposed to be accompanied by ASHA personnel. Since they were not aware of presence of ASHA worker, they were left without any incentives. While 65 percent of respondents expressed that they had received JSY services. Out of 73 percent, only 25 percent of respondents got incentives from Ukhrul district hospital (including 8 percent of respondents who had delivered at home were given an amount of Rs. 500 through ASHA), and the remaining 48 percent received incentives from private hospitals. But out of 73 percent, 42 percent respondents, have got Rs 501-1000 as cash assistance through JSY after they delivered their babies followed by 23 percent who received a sum of Rs 1001-1400. There is no uniformity in availing the incentives. Some of the reasons have been observed that relatives of some mothers who happen to be working in the health care institution had got more benefits (in

terms of money) of JSY than to those mothers who do not have relatives but have accessed the same services.

It is interesting to note that majority of the respondents who delivered at private hospital received cash incentives through JSY. It is further seen that majority of the respondents have preferred private hospital than the Ukhrul district hospital not only for getting cash incentives but because of positive attitudes of health care providers and timely availability of doctors. Thus, availability of health care facilities within the vicinity helps to receive services in time (Prakasam & Raju, 2006).

4.3.3 HIV/AIDS and TB programme and its effectiveness

HIV/AIDS and TB are the major public health problems seen in Ukhrul district. Ukhrul has been recorded as the highest rate in HIV/AIDS in Manipur with 1285 cases. In Ukhrul District Hospital, Revised National Tuberculosis Control Programme – DOTS Centre has been introduced since 2005 onwards. They provide sputum testing examination and provide multi-drug therapy to TB patients. Likewise the hospital has also implemented National AIDS Control Programme in collaboration with NGOs but the implementation of ART services started only in 2005. They provide services like (i) Integrated Counselling and Testing Centres (ICTC), (ii) Anti-retro Treatment (ART), (iii) Care Support and Treatment (CST), (iv) Operationalization of First Referral Unit (FRU), and (v) Awareness and Health education Programme.

But in both the private hospitals, the programmes like Revised National Tuberculosis Control Programme and National AIDS Control programme are not implemented and they focus more on generic health services.

Table No. 4.5: Effectiveness of HIV/AIDS and TB programme

Parameters			Frequency	Percentage	Total
Effectiveness of the available programmes	HIV/AIDS	Satisfactory	40	61.5	**40 (61.5)**
		Not satisfactory	25	38.5	**25 (38.5)**
	Total				**65(100)**
	TB	Satisfactory	19	54.3	**19 (54.3)**
		Not satisfactory	16	45.7	**16(45.7)**
	Total				**35 (100)**

The Table No 4.5 discussed on effectiveness of HIV/AIDS and TB programmes under the study area. 40 (61.5 percent) of HIV/AIDS respondents expressed their satisfactions that the programme implemented were very effective and useful for them as it helped them to gain more knowledge on the disease (through counselling) and timely and easy accessible of ART. They further revealed that NGOs played important roles in providing awareness/information of the programme which had been benefited in accessing the services. But, 25 (38.5 percent) of respondents showed their dissatisfaction of the services of programme due to unavailability of doctors on time, non-functional of equipments like, CD4 count, LFT, KFT, etc. and ineffectiveness of counselling services.

Likewise TB respondents mentioned on effectiveness of Revised National Tuberculosis Control Programmes. 54.3 percent of the respondents have stated that programme has become effective as people are regular in availing the treatment/services, which was not there before. According to them, health care providers, relatives, neighbours and friends have played a good role for better utilization of the available services. Whereas a good amount of percentage, 45.7 percent of respondents showed their unsatisfaction with the services because the

illiterate farmers (mainly who are the neediest group) had faced lot of problems in utilizing the services. They have revealed that doctors are not available on time, X-ray machine does not work properly thus they have spent more money in repeating X-ray in private clinic in Ukhrul district or at Imphal (state capital) which is 84 Km from the district. Moreover farmers who work mostly till late evening have faced difficulty in visiting and collecting medicines from DOTS centre. Though DOTS centre is open from 10-3 pm daily but medicines are available only on particular days i.e. Monday, Wednesday and Friday that have resulted inconvenient in availing the services.

4.3.4 Measures taken by GO and NGOs for prevention and control of HIV/AIDS

Taking measures to prevent the disease is one of the most important tasks for government and NGOs. The fact is that, theoretically, everyone is at risk of HIV/AIDS. But everyone can also protect themselves and others from acquiring it through informed action (Ramasubhan & Rishyasringa, 2005).

There are different measures taken by Ukhrul district hospital and NGOs in prevention and control of HIV/AIDS. The entire respondents (100 percent) shared that both Ukhrul district hospital (government) and NGOs provided awareness programme in the community, school, colleges through different programme medias, like publicity in All India radios, providing leaflets, lectures in religious places, seminars, conferences, workshops, skits and dramas, etc.

They further mentioned that besides the public awareness, they were given counselling services, ART, condom and syringes. Therefore government and NGOs have taken positive measures in order to reduce HIV among people in Ukhrul district.

4.3.5 Types of treatment and satisfaction level of TB respondents

In this sophisticated era in medical science, foremost requirement for the service providers is equipments which help in diagnosing and making customers satisfy with the treatment. If there are no adequate facilities available for the people, it is difficult to provide proper treatment.

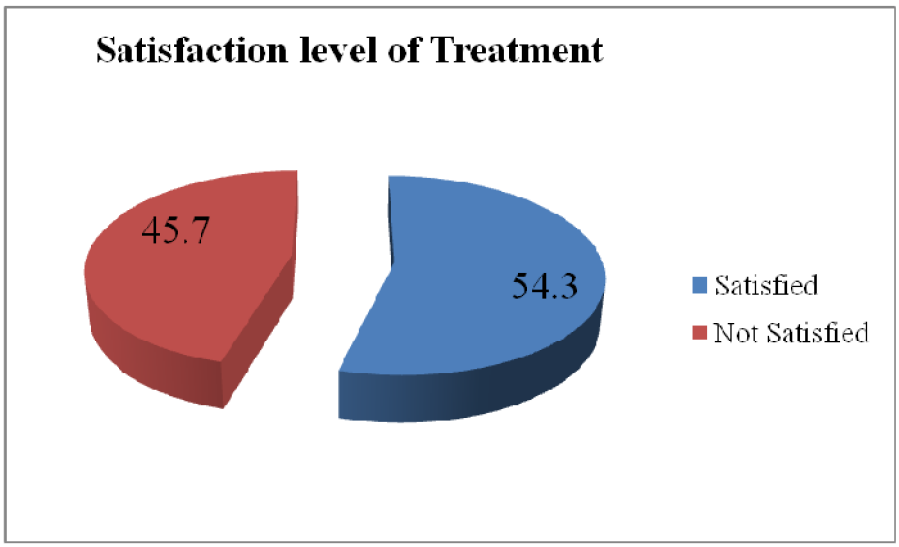

Chart No. 4.15: Satisfaction levels of TB respondents

The above Chart No 4.15 discussed on satisfaction level of TB respondents of the treatment provided in TB department/centre of Ukhrul district hospital. 54.3 percent of the respondents expressed their satisfactions with the treatment/services provided by DOTS centre of Ukhrul District hospital as they were given free medicines and X-ray services; whereas 45.7 percent of them expressed their unsatisfactions with the services. They further revealed that though they got free medicines, they still needed to pay Rs 50 for X-ray; however, the results of X-ray did not come clear. Thus, they needed to take another X-ray (as advised by the doctors to repeat the test) from private clinic or at Imphal (state capital). This becomes a burden for them as they have to travel for almost 80-85km to reach Imphal. Besides most of the respondents who do not know Manipuri language (common language of Manipur) speak only

Tangkhul language (Tangkhul is a Sino-Tibetan language of the Tangkhul branch and is spoken in 168 villages of Ukhrul district, Manipur) (Wikipedia, 2015) have faced difficulty in communicating while staying at Imphal. It further complicates them in communicating with health care providers at Imphal, as Manipuri language is a common spoken language in the state capital. Moreover some of them who don't have any relatives in Imphal have faced more problems financially as they have to stay at hotels that resulted in spending of more than Rs 3000 to Rs 4000. Thus, few of respondents have neglected in consulting doctors as they avoid going to Imphal for further X-ray examination thus lead to complicate to their illnesses.

4.3.6 Availability of medicines in different departments/centres

Medicine brings relief and improvement to people. Adequate and timely available of medicines and health care providers' increase the satisfaction level of respondents.

Table No. 4.6: Availability and accessibility of medicines in hospitals

Women Health Related Problems		**HIV/AIDS**		**TB**	
Tetanus Injections	71	ART and Counselling	100	DOTS	100
Iron Folic Acid Tablets, etc.	29				
Total	**100**	**Total**	**100**	**Total**	**100**

Table No 4.6 shows the provision of medicines in different departments (Gynaecology Centre, TB Centre and HIV/AIDS centre) in Ukhrul district hospital. Among women who had availed medicines from gynaecology department in Ukhrul District, majority with 71 percent of women revealed that they had availed only Tetanus injections as they did not get any pregnancy related medicines like Iron table, Folic Acid tablets, Calcium, etc. Whereas 29 percent of the respondents got

medicines like Iron Folic Acid Tablets, calcium, etc. at free of cost. It is seen that due to shortage of medicines in Ukhrul district hospital, the essential drugs are not available, which is a serious lapse in the health system. Thus, respondents were asked by health care providers to buy medicines at their own costs. At times the patients had to buy expensive medicines from market. It is more evident that the government's initiative to provide free medicines to rural poor who cannot afford has miserably failed in Ukhrul district. They invariably failed to provide even one out of 4–5 medicines prescribed by doctors of District Hospital. Instead, one has to buy all the prescribed medicines by doctors from Chemist shops thereby incurring huge expenses when provision of free medicines is officially in place.

In case of HIV/AIDS and TB patients, all respondents have availed ART and Multi-drug therapy through ART centre and DOTS centre respectively from Ukhrul district hospital. It is evident that Manipur government is trying to curb the problems of HIV/AIDS and TB by providing all the necessary medicines to patients in Ukhrul district. Further, 52.4 percent of HIV/AIDS respondents have received ART services for more than 2 years, is followed by 27.6 percent who have availed the services/facilities for 1-2 years, while 10.8 percent and 9.2 percent have availed it for the last 6-11 months and 1-5 months respectively. 51.5 percent of TB respondents had availed DOTS for 6-8 months from the centre, followed by 34.3 percent who availed it for 3-5 months, while 8.6 percent and 5.6 percent availed the services for more than 8 months and 1-2 month respectively. It shows that respondents are regular in accessing and utilizing the services of ART and DOTS centres.

4.4 Part – IV: Utilization of Traditional and Religious Practitioners' Services

Part IV deals with respondents' utilization of health related services from traditional and religious practitioners under the study area.

4.4.1 Importance of traditional and religious practitioners under the study area

According to Kalla & Joshai (2004), to understand the meaning of tribal health, it is important to understand the people themselves, their social, economic and cultural aspects and their indigenous medicines. The health status of the tribal is marked by poverty, illiteracy, malnutrition, lack of personal hygiene, poor sanitation, poor mother and child health services, absence of health education, lack of national programmes and lack of available health services.

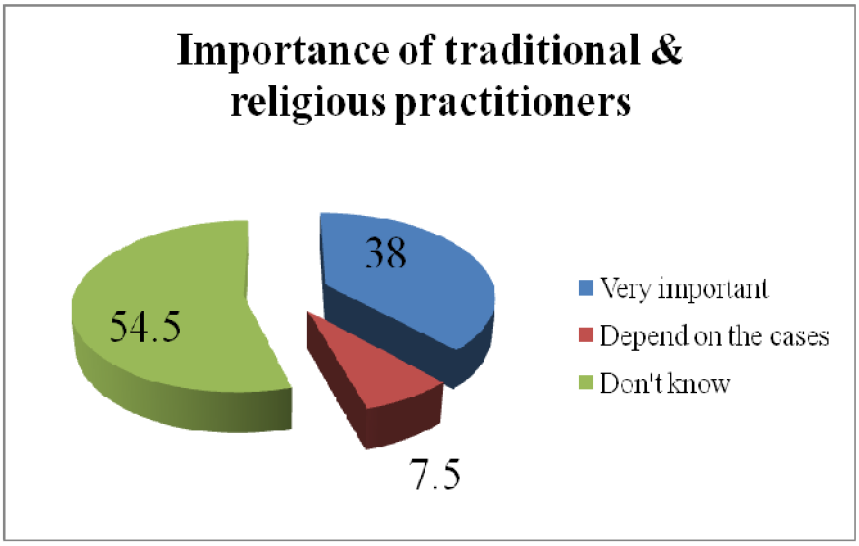

Chart No. 4.16: Importance of traditional and religious practitioners

Chart No 4.16 combined all the respondents from gynaecology, HIV/AIDS and TB, and discussed the importance of traditional and religious practitioners under the study area. Maximum of the respondents (54.5 percent) were not apprehend in reflecting the importance of traditional and religious practices to their illnesses, since

they did not utilize the services from the practitioners. It is seen that 45.5 percent had utilized the services from the practitioners, out of 45.5 percent, 38 percent of the respondents expressed the importance of traditional and religious practitioners. They revealed that the traditional and religious practitioners gave services to the community as the first point of contact or referral agent in absence of doctor. They treated different types of sickness like fracture, joint pain, gastritis, kidney problem, bleeding problem, evil spirit, cough, headache, giving birth, conceive of baby, etc. Their forms of treatment are different, as they give treatment in the form of massage, medicines and prayers, etc. which give immediate relief. They further expressed that their treatments are culturally accepted in the society and also less expensive and easily accessible. Therefore traditional and religious practitioners played an important role in rendering the services. While 7.5 percent of respondents had stated that role of their treatment depends on the types of illnesses.

They also revealed that though AYUSH doctors are there in hospital, they still preferred traditional medicines than AYUSH as they had to depend on AYUSH for long period of time which didn't give immediate relief.

4.4.2. Availability and utilization of services from traditional and religious practitioners

Treatment of sicknesses took place in three steps, diagnosis of the cause, removal of the agent, to satisfy the psychological need and the clinical treatment to alleviate the physical need, the treatment include prayer, sacrifices, wearing armlets or charms (Gesler, 1984). The practice of older beliefs in the sickness and environment has reduced with the discoveries of science and changing of medical knowledge and treatment of disease (Manderson, 1996).

Table No. 4.7: Availability and utilization of services from traditional and religious practitioners

Parameters		Utilization of services and its number of visits					Total
		One time	**Two times**	**Three times**	**More than three times**	**None**	
Women health related problems	Yes	5(5.0)	13(13.0)	21(21.0)	27(27.0)	00	**66(66.0)**
	No	0	0	0	0	34(34.0)	**34(34.0)**
Total		**5(5.0)**	**13(13.0)**	**21(21.0)**	**27(27.0)**	**35(35.0)**	**100(100)**
HIV/AIDS	Yes	9(13.8)	4(6.2)	2(3.1)	0	0	**15(23.1)**
	No	0	0	0	0	50(76.9)	**50 (76.9)**
Total		**9(13.8)**	**4(6.2)**	**2(3.1)**	**0**	**50 (76.9)**	**65(100)**
Tuberculosis	Yes	3(8.6)	2(5.7)	0	5(14.3)	0	**10(28.6)**
	No	0	0	0	0	25(71.4)	**25(71.4)**
Total		**3(8.6)**	**2(5.7)**	**0**	**5(14.3)**	**25(71.4)**	**35(100)**

In the above Table No 4.7 shows the availability and utilization of services from traditional and religious practitioners. It is seen that 66 percent of women have revealed that they have consulted traditional and religious practitioners for their illnesses besides allopath medicines. Out of 66 percent, maximum of women had taken treatment for more than one time in complaints of backache, changing of baby location, stomach problems, etc. They had also received treatment like massages, prayers and medication depending with the cases of their sicknesses and thus the treatment they received gave immediate relief, whereas 34 percent of the respondents didn't consult any traditional and religious practitioners and were not aware of availability of traditional birth attendance in their villages so they preferred only medical (allopathy) doctors. The literacy rate of women might be high in the study area, but still most of the women got services from traditional and religious practitioners due to the nature of curing of illnesses like immediate relief of pain,

cold, cough, fever, etc. In addition, traditional and religious practitioners' play an important role in the villages, where there are no doctors and health centres are far away from villages. Availability of birth attendance could help the villages to deliver babies on time. It is seen that there is traditional birth attendance in the village; they help the pregnant mothers in delivering their children. Tribal's are unwelcoming the modern medical sciences, instead showing more interest in continued adopting their traditional practices partly because of their poor economic conditions. It also revealed that traditional method of delivery is less expensive as compared to the modern health practices (Khan, 1986).

Likewise, few HIV/AIDS respondents have consulted traditional and religious practitioners for more than one time for their illnesses such as loss of appetite, body pain, joint pain, etc. With believe that their illnesses of HIV/AIDS would be cured, they had availed medicines from traditional healers costing for Rs 1000 to 1500 per litre, however it did not cure their illnesses. But in case of minor illnesses like loss of appetite, body pain, joint pain, etc. they have seen a sign of improvement to their health. The practitioners also provided massage to the affected area and did prayers for them. Sometimes, respondents felt relief and improvement in their health. Whereas 50 (76.9 percent) went for allopath medicines only as they believed that their illnesses were not at all related with traditional and religious practices. As new medical technology, new medicines and new treatment materials continued to be developed and the nation's demands for those new medicines and materials is increased (Rout, 2011).

It is similar with tuberculosis respondents that very few of them have availed treatment from traditional and religious practitioners on the issues of chest pain, loss of appetite, persisting cough and weaknesses. In West Bengal 19% preferred Indian

Medicine, 16% preferred God men, 15% quacks and 4% Homeopathy for their treatment (Durgaprasad & Srinivasan, 1993). Majority believe that in case of tuberculosis disease, doctors are the sole person who can cure their illnesses.

4.5 Part-V Perspectives and Views of Health Care Providers on the Services

This part V highlights the perspectives and views of health care providers on the services in Ukhrul District Hospital, two Private Hospitals, NGOs, traditional and religious practices.

The government of India had made different programs and policies for Women health, people living with HIV/AIDS and Tuberculosis patients. The health department of Manipur plays an important role in providing the said services under the study area. As justified in methodology, the stakeholders and health care providers from government health/centres, private hospitals, NGOs, traditional and religious practitioners shared their views and perceptions on the services provided to respondents under the study area. They include Doctors, Nurses, Project Directors, Counsellors, and Field Workers, Traditional and Religious practitioners and Headmen/Chairman.

4.5.1 Profile of Ukhrul district hospital

The Ukhrul government hospital is named as District hospital, which is located in the main town of Ukhrul and it was established on 18th June 1976 with 50 bedded capacities. Under Ukhrul district hospital, it has one Community Health Centre (CHC) in Kamjong, the Centre has 30 bedded capacities with two rooms and three

doctors and five staff nurse. There are six Primary Health Centres (PHCs) and 43 sub-centres in the study area.

The district health care centre follows the three tier system of health care system of India i.e. bottom up approach from sub-centre to primary health centre, and primary health centre to community health centre, and community health centre to district hospital. Unfortunately, in practical, the referral system from sub centres to primary health centres are not seen due to non-functioning of sub centres and PHCs.

It is also seen that there is shortage of medicines, manpower and insufficient of equipment in diagnosing the diseases in community health centre. There are only three doctors and fives nurses and out of 30 bedded capacities only 16 bedded is useable, since the rest of the beds are damaged. There are X-ray and laboratory facilities in CHC, but there is no technician that resulted more problems in diagnosing and facilitating the patients of their illnesses.

(*1) At Gynaecology department*.

A. Programmes available in gynaecology department of district hospital

The Government of India (2004) has given minimum services to be provided under Reproductive and Child Health programmes in health care institution are:-

I. Ministry of Health and Family Welfare has provided services to the women health related problems through National Health Mission (NHM). National Rural Health Mission was launched in 12th April 2005, in order to provide accessibility, affordability and quality health care services to the rural areas especially to the poor child and women. It main objectives are, to reduce child and maternal mortality, provision of nutrition, immunization, sanitation and hygiene through education or awareness, access to health care services and prevention of communicable and non-communicable diseases.

II. Maternal and Child Health care:

- ❖ Antenatal care:

(a) Early registration of pregnancy and minimum three antenatal check-ups

(b) Minimum laboratory investigations such as haemoglobin, urine albumin and sugar, etc

(c) Nutrition and health counseling;

(d) Supplementation of folic acid and iron tablets and tetanus toxoid immunization

(e) Identification of high risk pregnancies and appropriate management

(f) Referral to First Referral Unit or other hospital in case of high risk pregnancy beyond the management capability of medical officer in PHC

(g) 24 hours services for normal delivery

(h) Promotion of institutional delivery

(i) Conducting assisted deliveries including forceps and vacuum delivery whenever required

(j) Manual removal of Placenta; and

(k) Appropriate and prompt referral for cases needing specialist care.

- ❖ Postnatal care:

(a) A minimum of two post-partum home visits, first within 48 hours of delivery and second within seven days through sub-centre staff

(b) Initiation of breast-feeding within half-hour of delivery and

(c) Education on nutrition, hygiene and contraception

III. Facilities of referral transportation for pregnant women during emergency to the nearest referral centre and Safe abortion services, Blood storage facility and Essential laboratory services.

IV. Government of India (2006) Annual Report 2005-2006, Ministry of Health and Family Welfare, New Delhi has modified National Maternity Benefit scheme into a new scheme called Janani Suraksha Yojana (JSY). It was launched on 12th April 2005. Under the National health Mission, it integrates the benefit of cash assistance of Rs 500 who deliver at home and upto Rs 1500 in case of obstetric complications who deliver in government institutions to all women including those from SC and ST families up to first live two live births, delivering in government health centres like sub-centre, Primary health centre, community health centre, first referral unit, general wards of district and state hospitals or accredited private institutions, during antenatal, delivery and immediate post-partum care.

V. Government of India (2011) Annual Report to the people on Health, Ministry of Health and Family Welfare, New Delhi. Janani-Shishu Suraksha Karyakram (JSSK) was launched in Ist June 2011 by the Government of India. It is a new national initiative to make available for better health facilities of women and child. It provides all pregnant women delivering in public health institutions to have absolutely free and no expense delivery, including caesarean section. The entitlement include free drugs and consumable free diet up to three days during normal delivery and up to seven days for caesarean section, free diagnostic and free blood whenever require. This initiative would also provide for free transport from home to institution between facilities in case of referral and drop back home.

VI. Selected surgical produces for family planning, like vasectomy, tubectomy (including laparoscopic tubectomy), Medical Termination of Pregnancy (MTP), hydrocelectomy and cataract surgeries.

The above mention programmes has laid down the minimum requirement for government hospital in order to meet the demands of patients, but most of the programmes are not available in hospital.

B. Response from health care providers about gynaecology department and their services

Some of the facilities and services available in Ukhrul district hospital for women reproductive health related program are given below:

I. The pregnant mothers were provided free treatment services during ante-natal and post-natal period.

II. There is provision of medicine like Folic Acid Tablets, calcium, immunization, etc. for pregnant mother and cash assistance through JSY programme.

III. There is provision of ambulance services for the pregnant mother when the cases are complicated and for further referral from one hospital to other hospitals.

IV. There are separate wards for male, female and children.

V. There are X-ray and laboratory facilities in the centre.

VI. Intra-uterine contraceptive device (IUCD) and contraceptive pills, etc, are provided for family planning and so far there is no procedure undertaken for permanent family planning (both tubectomy and vasectomy) in the centre.

The health care providers have stated that Reproductive and Child Health Centre (phase-III) is presently going on. The health care providers explained that some of the common sicknesses found among the pregnant mothers were white discharge, backache, Pelvic Inflammatory disease, etc. The health care providers further opined that the district dispensaries and health centres were not functioning properly due to lack of equipments and shortage of medicines and staffs. In addition to the problems,

staffs from the plain areas especially gynaecologist are not coming regularly in the department. This makes the women who come for reproductive health related problems is needed to undergo treatment in general ward from Medical Officer (MO). The hospital charge Rs 10 for OPD and Rs 20 for the casualty. Moreover the centre has only minor operation theatre (OT), because there is no surgeon to conduct major operation cases. Thus, the health care providers used to refer patients to private hospitals or hospitals at Imphal (Capital of Manipur).

The hospital also conducted health camp and awareness programmes in neighboring villages. They provide free medicines to community people and aware them on different topics like reproductive health, importance of breast feeding and immunization scheduled.

(2) At Tuberculosis department/centre

A. Programme available in TB centre of District Hospital

National Tuberculosis Programme (NTP) has been in operation since 1962. However the treatment rates were unacceptably low and the death and default remained high (Park, 2015). In view of this in 1993, in order to overcome these lacunae, the Government of India decided to give new thrust to TB control activities by revitalizing the NTP, with the assistance from international agencies. The Revised National TB Control Programme (RNTCP) thus formulated adopted the internally recommended Directly Observed Treatment Short-course (DOTS) strategy, as the most systematic and cost-effective approach to revitalize the TB control programme in India (Govt. of India, 2012).

B. Information provided by heath care providers

The health care providers provide Revised National Tuberculosis Control Programmes since 2005 and the services includes

I. X-ray and sputum test facilities,

II. Referral services to district hospital to JNIMS/RIMS Imphal,

III. In case of emergency cases, ambulance services will be provided through payment for the fuel by the patient for transportation,

IV. Distribute pamphlets, posters to TB patients about the importance of DOTS,

V. Free sputum testing and treatment for all the patients.

The health care providers explained that majority of the respondents were seen with sputum positive pulmonary tuberculosis with category-I type of tuberculosis. The health care providers revealed that some of the respondents did not take their illnesses seriously. They did not come for treatment at their initial stage, but came only after when their illnesses became serious and unbearable to them. The centre provides free treatment such as free sputum test, free X-ray and free medicines to the respondents. They further revealed that respondents were not aware of the importance of continuous treatment so they abruptly stopped taking medicines from DOTS after a sign of improvement in their health. Such cases complicate and become one of the challenges in providing services as they may develop multi-drug resistance. Thus it is necessary to provide awareness to the mass of DOTS programme.

(3) At HIV/AIDS Department/ Centre

A. Programme Available in HIV/AIDS Department

National AIDS Control Programme was launched in India in the year 1987. The Ministry of Health and Family Welfare has set up National AIDS Control

Organisation (NACO) as a separate wing to implement and closely monitor the various components of the programme. The aim of the programme is to prevent further transmission of HIV infection and to minimize the socio-economic impact resulting from HIV infection (Govt. of India, 2007).

The Govt. of India (2013), has given that the packages of services for prevention under NACP –IV are as follows

I. Targeted interventions for high-risk groups (female sex workers, men who have sex with men, transgender/hijras, injecting drug users) and bridge population (truckers and migrants).
II. Needle-syringes exchange programme and opioid substitution therapy for IDUs
III. Prevention and control of sexually transmitted infections/reproductive tract infections,
IV. Blood safety
V. HIV counseling and testing services
VI. Prevention of parent to child transmission
VII. Condom promotion
VIII. Information, education and communication and Behaviour Change Communication (BCC)
IX. Social mobilization, youth interventions and adolescence education Programme
X. Workplace intervention
XI. Laboratory services for CD4 testing and other investigations
XII. Free first line and second line Anti-Retroviral Therapy (ART) through ART centres

XIII. Paediatric ART for children

XIV. Early infant diagnosis for HIV exposed infants and children below 18 months

XV. Nutritional and psycho-social support through Care and Support Centres (CSC)

XVI. HIV/TB coordination (cross-referral, detection and treatment of co infections)

XVII. Drop-in centres for PLHIV networks.

B. Response from health care providers about HIV/AIDS department and their services

The department has taken up a project/programme namely National AIDS Control Program (NACP-III) 2007 to 2012, through Bill and Melinda Gates Foundation and World Bank as the funding agencies and they are still continuing with the project/programme. The government health care provider provides facilities and services for HIV/AIDS respondents, and that includes

I. Free testing facilities for CD4, KFT and LFT,

II. Integrated Counseling and Testing Centre (ICTC) for free of cost,

III. Awareness program/poster campaign/pamphlets through government and NGO's,

IV. Provision of Ante Retroviral Therapy (ART) and condom for free of cost, and

V. Prevention of Parent to Child Transmission (PPTCT).

They have come across HIV/AIDS respondents associating with some sicknesses like tuberculosis, fever, streptococcal meningitis, hepatitis and STI, etc. According to health care providers, the trend of this disease through sexual

transmission is increasing than Induced Drug Users since 2005, but the rate of transmission is slower down due to easy access and utilization of available ART treatment. They have further mentioned that the department is strongly interlinked with NGO's like, CARE, PASDO, Link worker and more to give better services to clients. They strictly follow the principles of client-centered approaches and also maintain confidentiality, if required they take consent for further referral.

The health care providers have shared their views that male are more prevalent with HIV/AIDS in the district; the main cause is lack of awareness which lead to sharing of unsterilized syringes while injecting drugs, practices of unprotected sex. They further mentioned that the level of awareness among people towards HIV/AIDS is still very low in the villages. The health care providers opined that there is a problem in dealing with HIV/AIDS respondents because regular follow up to the centre are not there by the respondents residing in far flung villages. They expressed their insufficiency in monitoring part due to far distances of the patients. They mentioned that when patients died, they were not being informed and when the patients themselves did not turn up for more than a month, are counted as death cases.

4.5.2 Profile of Leishiphung Christian Hospital, (Private hospital)

A. Background:

Leishiphung Christian Hospital was established in the year 1991 in Maizailung Ukhrul. In the beginning the hospital start with OPD services only, but later on, they envisage in giving referral services to the people in the long run. The hospital has all together 34 staff and 50 bedded capacities with separate male and female ward.

B. Objectives:

I. To provide IPD & OPD and emergency cases medical, surgical and gynaecology problems.

II. To provide training in medical nursing & auxiliary and paramedical services.

III. To undertake programs of counselling, training of preventive, such as immunization, sanitation and nutrition.

IV. Encourage co-operation of the villages, churches in development, comprehensive education, rehabilitation, relief and treatment for HIV/AIDS, drug abuse, smoking, alcohol, etc.

C. Mission: To provide in-patient and OPD general, surgical and preventive care to all people, regardless of ethnic origin or religious preference.

D. Vision: To help individual's families, villages assume responsibilities for their own health.

E. Area of Operation: Ukhrul and Senapati district.

F. Availability of facilities and services:

I. OPD, IPD and pharmacy facilities within the campus

II. Laboratory and labour room available for 24x7

III. ECG, X-ray and USG are available

IV. Operation theatre for both minor and major: The hospital conducts major operation related to Obstetrician and Gynecology and minor operation for all kinds. The hospital conducts surgery from time to time through a visiting General Surgeon and Anaesthetist.

V. Separate wards for both male and female are there

VI. Provision of JSY and JSSK scheme through public private partnership.

VII. Availability of family planning: for family planning they provide spacing and

permanent method along with cash incentive of rupees 600 under Reproductive and Child Health

G. Information provided by health care providers

The health care providers spend 5 to 7 hours in a day of 6 days in a week. Working hours of the doctors depend upon the cases of the patients. The health care providers have explained that around 21 to 30 people visit in a day in hospital for treatment purposes and the hospital charges Rs 100 for registration. Some of the major health problems have seen in the hospital are, cases relating to maternal health (like, Pelvic infection, urinary tract infection and STD) and water borne diseases, and this is more prevalent among women. The hospital has organized awareness programme for free eye/cataract surgery in the hospital, community health camp at Yaolan near Litan and Hungpung. They revealed some of the challenges they had encountered in the hospital was that up gradation of infrastructures were the foremost requirement along with appointment of specialties and surgeon doctors otherwise when serious cases were referred to them due to lack of specialized doctor they further needed to refer to Imphal.

4.5.3 Profile of Comprehensive Health Services and Research Centre

A. Background: Comprehensive Health Services and Research Centre were registered under Berean medical Association MSRA no: 88 (UB) of 1992, established by private mission/society in 15th January 2007 in Ukhrul district. It has all together 33 staff members and 25 bedded capacities with maternity child health – comprehensive department.

B. Objectives: To reach to the people of Ukhrul district and neighbouring villages of Myanmar of health care services/facility with faith driven ministry, addressing to the needs of the body, mind and spirit.

C. Vision:

I. To make all possible efforts to reach out to the poor rural dwellers especially of Manipur through faith driven ministry, addressing to the needs of body, mind and spirit to endow wholesome and health.

II. To give medical services especially emergency cases, Gynaecology services along with general medical services.

III. To send out mobile team to reach out to the rural poor especially the senior citizens and the women group.

IV. Research on various social issues related to health and thereby highlights the most effective remedial measures.

D. Area of operation: Ukhrul district and neighbouring villages of Myanmar

E. Availability of facilities and services available:

I. OPD, IPD and pharmacy facilities inside the hospital

II. Provision of JSY and JSSK through public private partnership.

III. Provision of free tubectomy of Rs. 600 and Vasectomy of Rs. 1100 for the patients who opt for permanent family.

IV. Comprehensive preconception, Ante-Natal Care (ANC), delivery, Post-Natal Care (PNC) and infertility services.

VI. Haematological, X-ray, Clinical laboratory, Ultrasonography, ECG and Ambulance services.

VII. Availability of both minor and major operation facilities with experienced doctor.

VIII. Health education, counseling and free medical camps

F. Information provided by health care providers:

The health care providers work for 40 to 50 hours in a week, the doctors work more than their normal timing because of shortage of man power in the hospital. The health care providers have explained that around 21 to 30 people visits in a day to hospital for treatment purposes and the hospital charges Rs 100 for registration of new cases and Rs 50 for follow up patients. Some of the major health problems have seen among the patients are cases relating to pregnant women unprecedented problems (like, Pelvic inflammatory disease, Vaginal Candidacies and STD) and these are more prevalent among women in reproductive age group. The hospital has conducted awareness in the remotes villages through provisions of medicines and treatment by their own resources.

4.5.4 Non-Governmental Organisation working on HIV/AIDS in Ukhrul District of Manipur

This section deals with the programs and policies of HIV/AIDS run by different Non-Governmental Organisation in Ukhrul District of Manipur.

A. <u>Name of the NGO: Citizen Alliance for Re-Empowerment (CARE)</u>

I. Background of the NGO: The organisation was established in 2004 under the registration No: 63 (UD) SR/) 04 under the leadership Mr. Leisan Columbus as chief functionaries. It is operated in three blocks of Ukhrul District, namely, Ukhrul, Kamjong and sinakeithei which falls under LM block**.** The funding of the organisation came from foreign funding agencies and some from state government of Manipur.

II. Mission and vision: To facilitate Development within citizens and common understanding to generate sustain people's responses towards promising larger interests of the society.

III. Objective: To save the lives of the people by providing services available and through linkages with other services.

IV. Area of operation: Ukhrul district

V. Organisational set up:

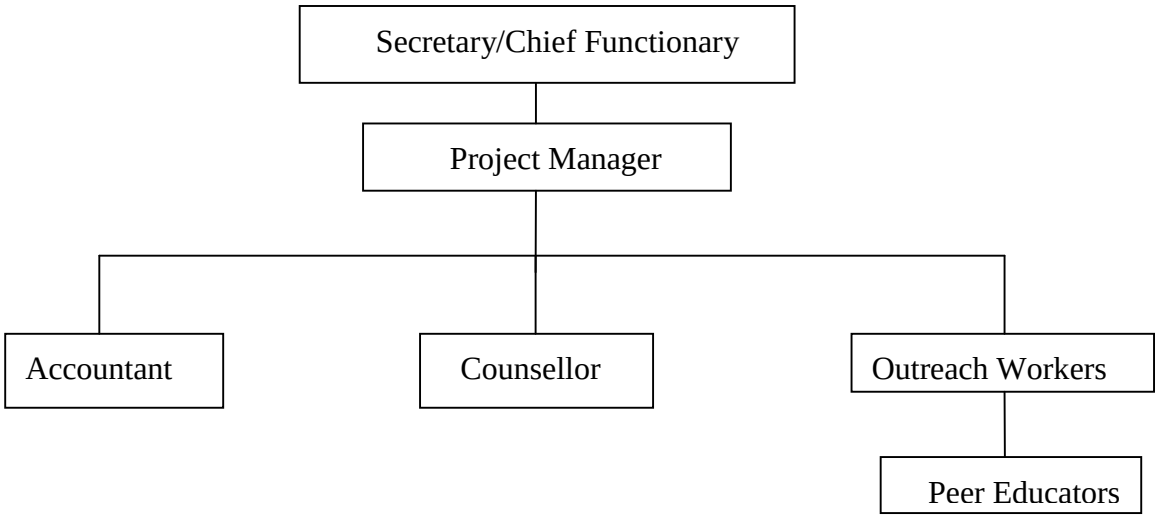

Chart: 4.17 Organization chart of CARE

VI. Programmes available for HIV/AIDS:

- The organization has provided services for drug users as they are the main in spreading HIV/AIDS diseases in the community. They provide recreational room, training room, clinic room for STI management and clinic room for drug dispensing room.
- They provide, Oral Substitute Therapy (OST), condom, syringes and needles and awareness programmes to the drug user and community as a whole in order not to spread HIV from infected person to a normal person. Around 1295 has been benefited from the programme.

B. <u>Name of the NGO: Participatory Action for Sustainable Development Organisation (PASDO): Women Health Clinic- TI Project.</u>

I. Background of the NGO: Participatory Action for Sustainable Development Organisation (PASDO) is a Non-Governmental Organisation registered under societies Registration Act (1989) Manipur in the year 1997 and under FCRA (1976). PASDO has two main offices in Ukhrul District, the main office deals with the sustainable development through people participatory action and the other branch deals with harm reduction for women as their target group.

II. Vision: A self sustained, empowerment, human and peaceful society

III. Mission: Support and strengthen peoples' action to sustain development through awareness, training, networking, lobbying and advocacy.

IV. Objective:

- Strengthening and capacitating local people, sustainable livelihood & environment, human right/child right protection
- Harm reduction among the IDUs' and FSWs'

V. Area of Operation: Ukhrul District

VI. Organizational set up:

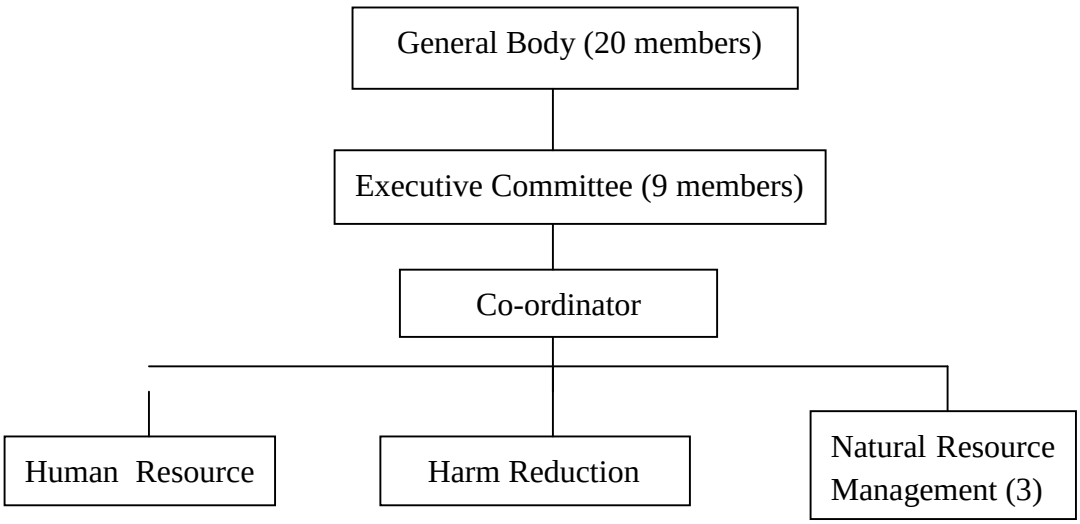

Chart: 4.18 Organization chart of PASDO

VII. Programmes available for HIV/AIDS: 1. Health camp for the community who could not access the services available in the organisation and institutions. 2. Distribution of condoms for safer sex, counseling for both IDUs' and FSWs' and referral services for STI treatment.

C. <u>Name of the NGO: Link Worker Scheme</u>

I. Background of the NGO: The Link Worker Scheme was established in the year 2009. The Link worker Project is implemented in selected districts across the country as a part of HIV/AIDS prevention under the National AIDS Control Programme, Phase III. In Manipur, it is jointly implemented by NACO, Manipur State AIDS control Society and Society for Promotion of Youth & Masses (SPYM) in all the nine districts of Manipur. It covers 100 villages in Ukhrul District focusing on referral and linkages of the client with services centres like STD/RTI clinic, ICTC and rehabilitation centre.

II. Objective: To reach out to vulnerable group of men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction**.**

III. Area of Operation: Ukhrul district

IV. Organizational set up:

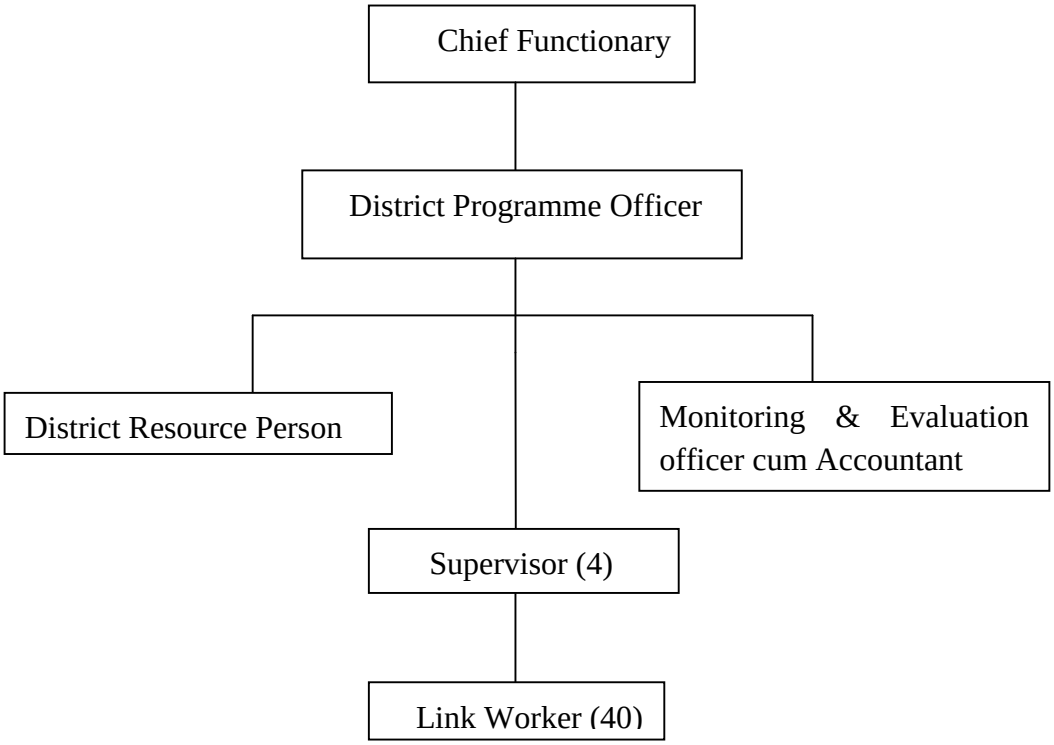

Chart: 4.19 Organization chart of Link Worker Scheme

V. Programs available for HIV/AIDS:

- Advocacy meeting in the village level with stakeholders every month
- PLHIV Networking meeting every month
- 100 information centres were located in each village at the residence of Link Worker or Link Worker Volunteer and anybody can get assistance of the service like counseling, information of HIV/AIDS and free distribution of condom
- Mid-Media campaign like folk media (street play, cultural events, song competition) wall writing, Hoarding, IEC material and other activities (like football tournament, quiz competition, debate) in village/district level
- Referral service in the nearby service centres like ICTC, TB/DOTS, STI/RTI, TI projects, ART centre and PLHIV network

- ❖ Giving training for capacity building in HIV/AIDS, safer practices and community mobilization and
- ❖ Health and Medical awareness camp with mass testing with ICTC mobile van in the village level.

D. <u>Name of the NGO: DIOCESAN Social Service Society, Ukhrul</u>

I. Background of the NGO's: The Diocesan Social Service Society (DSSS), Imphal is the development wing of the Archdiocese of Imphal, which initiates coordinates, plans, formulates, implements, monitors and evaluates the entire development project. It is a registered voluntary non-governmental organisation, registered under the societies Registration Act. Regd No – 253/M/SR/1991.

At present the organisation is implementing a community based programme on HIV/AIDS in three districts of Manipur namely Imphal East, Churachandpur and Ukhrul. It is supported by Federal Ministry of Economic Cooperation and Development through Caritas Germany since 2005-2014.

II. Mission and Vision: To build self sustaining development communities in partnership with people and civil society institutions through maintaining value education and organisation in the culture milieu.

III. Objectives:

- ❖ To increase community awareness on prevention and control of HIV transmission and drug use to 60% by the end of 2014
- ❖ To increase community stakeholders participation in the treatment and care of drug addicts and PLHIVs at the grass root level to 20% and to rehabilitate drug users in the community through proper care and support services including strengthening of their life skills resources by the end of 2014

- ❖ To strengthen the community based organisation in the villages in the prevention and control initiatives in order to response adequately to the needs of the drug addicts and PLHIVs and
- ❖ To enable and facilitate social integration of the clients in the main stream of the society through reduction of social stigma and discrimination.

IV. Area of Operation: Ukhrul district

V. Programmes available for HIV/AIDS: 1. Giving awareness and capacity building for prevention of HIV/AIDS and drug abuse in the district and 2. Peace building and conflict management

E. Comments/Responses from Project Managers, Counsellors and Field workers.

They (NGOs) provide services to respondents who are living with HIV/AIDS under the study area. They provide integrated and supportive services such as regular counselling of both Pre and Post-test Counselling, awareness, distributing syringes, condoms and conduct awareness programmes to mass through lecturer method in schools, colleges, villages, SHGs and churches; and also by distributing pamphlets, etc. Moreover, they also network with Ukhrul district hospital in giving awareness to the mass and providing facilities for HIV/AIDS testing in different pockets of district. The NGOs revealed that the general population particularly, the HIV/AIDS infected respondents were aware of the disease and had taken precautions in prevention and control of further transmission of disease to family members, relatives and their close ones. This helps in reducing the incident rate of HIV in the region. These are few achievements of NGOs.

The counsellors and field workers further revealed their difficulties in providing services to respondents due to social stigma attached with the disease. They narrated some examples that respondents took appointments for counselling sessions but they

would not turn up for days. So in return, field workers wanted to visit them but patients would avoid them and also showed unwillingness to come to agency due to societal stigma. It had so happened that patients would not turn up to agency for more than one month or so would be taken as drop out or death cases. They further stated that there was lack of man power and shortages of funds in NGOs for proper implementation of programmes. This sometimes becomes a barrier in providing services.

4.5.5 Information provided by Headman/Chairman

Headman/chairman of the neighboring health care centres villages are interviewed in regards to the services received from health care providers by community people from health centres. The community people hardly avail services from Sub-centre, PHCs, CHC, since there is no regular staffs and insufficient equipments available in the centres. This made them face difficulties in availing services when it is necessary. The headman/chairman has shared their views that there are some common sicknesses faced by the villagers; it includes Typhoid, women reproductive problems, diarrhoea, dysentery, back pain, gastritis, cold and cough, etc. These sicknesses are mostly because of Poor sanitation (unhygienic surrounding), scarcity of water, eating unwanted fruits & foods, seasonal changes, etc. The information given by health care providers regarding awareness programme was contradictory with the statement of headman/chairman. Most of the headman/chairman have shared their unhappiness that there is not even a single awareness programme conducted in their villages. Some of the headman/chairman has taken up steps/measures to improve health centres which are located in their villages and neighbouring villages. They had approached their concern ministers for non-functioning of primary health centres in their villages, but their claims were neglected by the ministers, since they did not take up any measures

to improve the working conditions of the PHCs. Further the headman/chairman also shared their views that traditional and religious practitioners had contributed great help to the villagers in giving treatment of different sicknesses, such as evil spirit, back pain, fracture, joint pain, women health related problems, etc.

4.5.6 Information provided by traditional and religious practitioners:

The traditional and religious practitioner of Ukhrul district has testified their opinions in regards to the treatment given to people under the study area. Foremost, they acknowledge to God by giving the statement, 'It is God's purpose and Will to serve the society'. They believed that all the healing powers they possessed were given by God. Therefore, before starting their treatment process they pray to God for strength and grace to diagnose the patients' sicknesses and also ask God to heal patients. Eventually some of the patients got cured and they believed that God answered their prayers. They further shared some of the sicknesses they had treated were infertility cases, pregnancy related problems like bleeding problem, delivery cases, fracture & joint pains, stomach problems- gastritis, kidney related problems, evil spirit, cough, headache, etc. They also have expressed their modes of treatment that they often do prayers, massages and provide their medicines (according to them medicines are made with the guidance of God). They believed that such medicines and treatments had helped many patients to heal from their sicknesses. They further explained that they had cured some of the sicknesses which doctors could not diagnose like infertility cases, evil spirits, etc.

The finding of the present section is based on rendering services and utilization of services by both health care providers of hospitals, NGOs and traditional practitioners and respondents from different departments (Gynaecology, Tuberculosis and HIV/AIDS). Diseases had become a stumble block for

development of the country among that women health related problems, tuberculosis and HIV/AIDS are also one of them. In order to overcome with the problems, government had provided different programmes and projects where private and NGOs had joined hand in hand with government to reach out the services to general population. These programmes include JSY, JSSK, Revised National Tuberculosis Programme, National AIDS Control Programme. As per National Family Health Survey (NFHS)-IV (2015-2016), in overall Manipur state, 54.1 percent had attended full ANC and 45.9 percent had opted for institutional deliveries. But in case of Ukhrul district only 27 percent had attended full ANC and 33.7 percent had institutional deliveries. In case of Tuberculosis, as per the information from TB statistical India-National and state statistics 2015, there are 1,881registered cases for TB treatment. And again according to the report of Manipur State AIDS Control Society, 2013, Manipur has 43,171 cases of HIV/AIDS. Out of nine districts of Manipur, Ukhrul has the highest cases of HIV/AIDS with 1285 cases.

It was also seen that maximum of the respondents did not utilize the services from sub-centres and primary health centres, these were due to non-functional of the centres. The health care providers (like, doctors, nurses, technicians, ASHA workers, etc.) who were posted in the government health centres did not turn up for their duties. These had made respondents inconvenient and difficulties in availing the government services that resulted to adopt services from traditional practitioners who were easily accessible and inexpensive in compared to hospitals. The services which are implemented by government for the communities are not implementing properly in all level of health sectors. Some of women respondents who happened to deliver their children at home did not get cash assistance through JSY. Moreover there is also shortage of medicines, manpower and insufficient equipments in

diagnosing the diseases. Therefore Government should take up proper steps in order to implement the programmes effectively in different level of health services for the benefits of the people.

Conditions of Health Care Institutions

I. Ukhrul District Hospital

Conditions of Ukhrul district hospital

II. Kamjong Community Health Centre (CHC)

Conditions of CHC in Kamjong, Ukhrul district

III. Ramva Primary Health Centre (PHC)

Conditions of Ramva PHC

IV. Chingai Primary Health Centre (PHC)

i. Remain closed: A picture of Chingai PHC

ii. Non-occupied Chingai PHC doctors quarters

V. Phungyar Primary Health Centre (PHC)

1. Remain closed: A picture Phungyar PHC

ii. Unused toilet of Phungyar PHC due to bad condition