“Evidence based policy planning for women and girls in poor urban areas in an indigenous context”

Shillong- Meghalaya, India

**Background**

Institute of Development Studies, UK along with the Indian Institute of Public Health (IIPH) Shillong is engaged in a case study of sexual and reproductive health policies and the lived experiences of urban women in Meghalaya. The study explores how health issues are prioritised in the state and how women can participate in public health decision making. The approach highlights the need to recognize different types of evidence in planning including women’s own lived experiences. The case study of Meghalaya is part of a larger study entitled ‘Strengthening Evidence-based Policy’, funded by the Policy Division of the UK’s Department for International Development (DFID).

**Objectives**

1. How are health system data used for urban health policy formulation processes, e.g. on Sexual and Reproductive Health (SRH) for women and girls in poor urban areas?
2. How can women in urban areas participate in city and state policy development and public decision making on SRH?
3. How are urban and state health priorities developed at the state level?

**Study Setting**

1. Meghalaya is a landlocked state, in North-East India with a population of approximately 3 million (Census, 2011). It is inhabited by indigenous peoples of Khasi-Jaintia and Garo tribes.
2. Shillong, the capital city and Tura town accounts for 71.93% of the total urban population.
3. Meghalaya Slum Areas (improvement and clearance) Act, 1973; there are 45 notified slums in Meghalaya; 19 slums in Shillong city (Meghalaya State Development Report, 2008-09).
4. Shillong city has a population of 0.36 million of which 21.5% of urban population is reported to be living in slum areas (Shillong PIP 2010–14, Govt. of Meghalaya).
5. Slum residents are rural indigenous migrants from within the state, migrants from other parts of India (e.g. Bihar and Bengal) and international migrants from Bangladesh and Nepal.
6. (six) urban slums were randomly selected by drawing a straight line across the city map. Slums falling on the lines were selected.

**Methods**

1. Review of Secondary Data
   - Policy review: National policies pertaining to Sexual and Reproductive Health were reviewed
   - Review of existing health data related to SRH and identification of data gaps.
2. Sampling Participants and Recruitment
   - Stakeholder mapping based on the potential to provide different perspectives on the study objectives was used in identification of participants. NGOs representatives, government officials from Department of Health and the Urban Development Department and media representatives were interviewed in addition to residents from urban community.
   - 37 community members from slums (35:F, 2 M) were recruited using key informants and their social networks. They include women leaders, traditional headman, lay women and community based workers.
3. Qualitative methods
   - In-depth Interview: 15 (13:F, 2 M) IDIs with community members were conducted at home / safe place in the slums. The duration of each interview is about 30-45 minutes. And 4 interviews with officials.
   - Focus Group Discussion: 5 Focus were conducted each with 5-7 number of women participants from urban slums
   - Digital Story Telling workshop: 6 poor urban women documented/developed a film on their life experiences using I-pads.

**Results**

1. Health Financing and Urban Health Policy
   - Meghalaya does not have its own State Health or UrbanPolicy.
   - State health programmes are financed by the Central government in a ratio of 90:10, National guidelines are the default policies being implemented.
   - Health system data are lacking in quality and quantity for policy makers; no disaggregated data are available for slum areas.
   - Urban health policies fall in the cracks between the municipality and the indigenous authorities.

2. System and Procedure for community participation
   - There is little engagement of civil society that is capable of engaging with the Government on policy matters. Civil society would require capacity building for meaningful engagement.
   - In the traditional ‘Dorbar’ (Local Council) women have no representation. ‘Seng Kynthra’ the traditional women organisation have limited role and capacity in decision making on community matters.
   - Traditional indigenous leaders – headman- are valued when they provide state benefits, especially material resources.
   - Headman do not interact directly with the state. Interaction with the state takes place at another separate level with separate election processes for leaders and with some hereditary leaders (kings).

3. Dominance of Public Health Care
   - Predominantly, the urban poor access SRH services from government managed health centers. Biomedical services are considered accessible and are utilized although out-of-pocket expenditure especially for test and medicine are incurred.

4. Narrowing of SRH
   - Poor understanding of sexual reproductive health. Understanding of SRH is disease/problem focused and limited to accessing services.

5. Gender and Health
   - Women face particular barriers to public political participation due to institutionalized and internalized gender roles and norms.
   - Vulnerable section of women have internalized sense of inferiority that prevents them active participation.
   - Peer to Peer and informal networks is the main source of information and motivation to access SRH services amongst women.

6. Poverty and Health:
   - Out of pocket expenditure prevents urban poor from accessing adequate health services.

7. Digital Story Telling : Lived experiences of 6 poor urban women were developed into a film using I-pad. Besides reproductive health issues a striking observation that occurred to the research team was the huge impact that alcoholism (of family members) has on the lives of these women.

**Discussion**

- What does citizen participation mean in a context where 90% of income and all state policies are made by the central state?
- There is a tension between women’s civil and political rights and overall indigenous civil and political rights. Although Khasi are matrilineal and matrifocal women are excluded from local indigenous political systems and processes in multiple ways. Local representation is at a different level from the level that directly interacts and negotiate with the state. Women reproduce their own exclusion by subordinating to a headman –who is also in many ways powerless in relationship with the government.
- SRHR is not an issue in this male dominated political context
- “Gender mainstreaming” in this context can mean many things. It could mean mainstreaming the durbar by allowing women to vote and hold office. Or it could mean mainstreaming the state by creating more room for indigenous women.

**Challenges**

- Concepts like policy process, community participation and reproductive health are difficult terms to explain in local terms.
- Entry into localities for any activity requires the sanction and permission from the headman. Obtaining permission was time consuming.
- Receiving the consent of Government official was a difficult procedure fraught with delays.

**References**

- State PIP 2013-2014, Government of Meghalaya