

**FAMILY WELFARE MEASURES ADOPTED
BY WOMEN IN IMPHAL DISTRICT**

By

ELANGBAM JENITA DEVI

A THESIS SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND
HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY), COIMBATORE - 641 043
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE
IN HOME SCIENCE EXTENSION EDUCATION

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Certified as bonafide research work


Signature of the
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Department

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Introduction

INTRODUCTION

Health is Wealth ; even more valuable than wealth. Health is fundamental to natural progress in any sphere. In terms of resources for economic development nothing can be considered of higher importance than the health of the people. Healthy life is within the reach of everyone, provided the individual is willing to adopt a sensible pattern of living. Health relates to all aspects of our lives from our physical well-being to our social interactions, our mental and emotional capacities and even our spiritual lives (Greenberg and Dintiman, 1992). It is not possible to raise the health status and quality of life of people unless all efforts are integrated with the wider effort to bring about the overall transformation of a society. Good health and good society go together. This is possible only when supportive services such as nutrition, environment and education reach a higher level (Basu, 1993).

A United Nations Expert Committee listed twelve factors which would need to be improved if levels of living were to be raised. They are : health including demographic conditions, food and nutrition, education including literacy and skills, conditions of work, employment situations, aggregate consumption and savings, transportation, housing, clothing, recreation and entertainment, social security and human freedom. Conversely all

these factors are involved in the striving for better health (Kumaraswami, 1989).

Since health is an integral part of development, all sectors of society have an effect on health. In other words, health services are no longer considered merely as a complex of solely medical measures but a "subsystem" of an overall socio-economic system. Human health and well-being are the ultimate goal of development.

Women and the children are the live wires of the family. If they are not healthy and happy, entire family life will not be in peace. Hence, the health of women and children is very important. Further, it is said that the development of human resources is as important as the development of material resources for the progress of the nation. The best way of developing human resources is taking care of the children as they constitute the nation's principal human assets (Rao, 1986).

The single great problem that confronts the country today is the growth of population which has in a way, neutralized the developments made in different fields during the plans period. The most effective way to limit the size of the family and to improve the quality of living standard is to implement/provide family planning services with all seriousness and sincerity at different levels. It means, an improved standard of living is

impossible unless the small family norm is strictly followed (Gupta, 1995).

India was the first country in the world to have started an official Family Planning Programme in 1952. In the beginning "clinic" approach was adopted. Finally "cafeteria" approach was adopted with the intention of providing services in respect of as many family planning methods as possible, so that couples can choose any method of their liking. Sterilisation was introduced in the Family Planning Programme in 1956. Later on Medical Termination of Pregnancy was also legalised (Singh, 1989).

An Expert Committee (1971) of the WHO, defined family planning as, "a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country".

A WHO Expert Committee (1970) has stated that family planning includes in its purview : The proper spacing and limitation of births, advice on sterility, education for parenthood, sex education, screening for pathological conditions related to the reproductive system, genetic counselling. premarital consultation and examination, carrying out pregnancy

tests, marriage counselling, the preparation of couples for the arrival of their first child, providing services for unmarried mother, teaching home economics and nutrition and providing adoption services. These activities vary from country to country according to national objectives and policies with regard to family planning. This is the modern concept of family planning (Park, 1995).

The term "Maternal and Child Health" refers to the promotive, preventive, curative and rehabilitative health care for mothers and children. It is the integrated health care given from the time of conception till the child reaches 15 years or attains adolescence. Maternal and child care is hence inseparable like the two-sides of a coin. The health of the pregnant mother has its impact on the child, as is seen by way of varying birth weight and maturity, presence or absence of congenital abnormalities, congenitally acquired diseases and the ability of children to thrive (Rural Health and Family Welfare Trust, 1989).

The Maternal and Child Health Programme was so large that soon the government decided to give it more urgency and emphasis. For this purpose, it was designated as one of the Technology Missions. Though expansion of the programme was phased out, it was extended to all districts in the country by

the year 1989-90. Now it has become a major and essential component of the Family Planning Programme (now called Family Welfare Programme) and the importance stands on its own (Talwar, 1995).

The National Population Policy, 1976 envisaged a series of political, economic and social measures to promote family planning. The policy which was modified in 1977 eliminated all forms of compulsion and coercion in the Family Planning Programme. It includes all aspects of family welfare : maternal and child health, nutrition, female education, women's right and envisages involvement of non-governmental organisations, trade unions, women's organisations and local bodies (Kitchlu, 1994).

Family Welfare Programme is a package of measures designed to improve the welfare and well being of the family by hastening the process of fertility decline, enhancing child survival rate and improving maternal health and care (Kidwai, 1985).

The Family Welfare Programme in India aims to provide family planning services within the broader context of maternal and child health care. It disseminates information and education to enable couples to make voluntary and informed choices regarding the size of the family and spacing through contraception. The objective of Family Welfare Programme is to

reduce the birth rate to the extent necessary to stabilise the population at a level consistent with the requirements of the "National Economy".

A Technology Mission on vaccination and immunization of vulnerable population, especially children, was taken up by the Ministry of Health and Family Welfare in 1988 with the objective of reducing morbidity and mortality of infant and children and achieving self sufficiency in vaccine production. Besides extending the coverage under the present immunization programme and building up the logistic support, the mission aims to develop a surveillance system, promote community participation and encourage research and development of new vaccines. The Universal Immunization Programme has proved itself to be the most cost-effective of the health programmes and is vital for attaining the objectives of Health for All by 2000 A.D (Dhanoa, 1988).

Family Welfare Programme was started in Manipur State since 1956 with a District Family Welfare Bureau at Imphal. With the gradual expansion of the programme, State level, District level and Block level Family Welfare Centres have been established.

Family Welfare has been perceived generally as a government programme, more so a central government programme. It

has not been adopted by the people to become a programme of their own where they would demand services. Also the infrastructure created has not been able to cater to the needs of the entire area specially the difficult area.

Health depends upon the health consciousness of the people, economic conditions, availability of health services and the way of living. If people do not make use of available health services, they have to face the problems of diseases, resulting to higher morbidity and mortality rates (Arasu, 1988).

In this situation, the present study was carried out with the following objectives :

1. To study the background informations of the women selected for the study and
2. To understand the Family Welfare measures adopted by women in the selected areas of Imphal District, Manipur State.

Reviews of Literature

II REVIEW OF LITERATURE

The literature pertaining to this study are reviewed under the following headings :

- A. Health Situation in India
- B. Family Welfare Programmes in Operation
- C. Efforts taken by Manipur State towards Family Welfare
- D. Research Studies Related to Family Welfare Programme

A. Health Situation in India

There was virtual absence of basic health services for a large section of the population of India at the time of Independence in 1947. However, with independence, there was a political commitment to improve health ; and a systematic programme for the establishment of primary health centres and subcentres begin in 1952 in the community development areas. At present, primary health centres form the nucleus of health services in rural areas. At the village level, a band of voluntary health workers eg. village health guides and trained dais has been created. They are selected by the local community and trained to deliver primary health care. Secondary health care is provided by the district hospitals and newly created Community Health Centres, which are also the main referral centres in support of primary health care. Territory health care is provided by the teaching hospitals and institutions and

other apex hospitals. Both in the rural and urban areas, the public and private sectors exist side by side. A large number of voluntary organisations are also involved in providing health care to the people.

At the end of March 1992, there were about 22,441 Primary Health Centres and 1,31,318 Subcentres. However, the basic requirements for health, namely, safe water supply and excreta disposal facilities are lagging behind in both rural and urban areas. At present, safe water is available to 80 percent of urban and 47 percent of the rural population, and adequate sanitation facilities are available to only 30 percent in the urban and one percent of the rural population.

The Ministry of Health and Family Welfare, Government of India evolved a "National Health Policy" in 1983 keeping in view the national commitment to attain the goal of Health for All by 2000 A.D. The policy was approved by Parliament in 1983. It lays stress on the provision of preventive, promotive and rehabilitative health services to the people. The National Health Policy also takes into account the need to reorient medical and health education so as to serve the emerging requirement of delivery of services (Park, 1995).

India's population size was 844.3 million in 1992, which grew by 2.36 percent per annum during 1981-91. According to the growth trends, the population is expected to cross one

billion mark by 2001. In 1990, the birth and death rates stood at 30 and 9.6 per 1000 respectively yielding a natural growth rate of 2.04 percent per annum. Given this natural growth rate, India's population is expected to double in 34 years. In contrast, the most popular country in the world, China, will require over 70 years to double its population, because of a very low growth rate. According to the population growth trends, India's population size will overtake China's by 2010 (Parasuraman, 1994 and Mukherjee, 1993).

The steadily declining ratio of females to males in India has been attributed to a higher death rate of females till the age of 35 years, i.e. till the end of the reproductive years. The figure for 1991 was 929. Ratio starts falling further from 957 to 927 by the time the girl is nineteen. About 13 per cent of females die before the age of 24 years are due to complications in pregnancy/child birth.

Till recently the life expectancy of females in India was less than for males but now the females have a slight edge over males (male 58.01 years, and female 59.1 years). It is interesting to note that the life expectancy of females was higher than males upto 1911-21 and thereafter the male life expectancy became higher (Ghosh, 1995).

According to Sample Registration System (1990), India's birth rate was 29.9. The Total Fertility Rate (TFR) was

estimated at 4.1 and the Total Marital Fertility Rate is (TMFR) around 5.4 births. A comparison across states shows wide variations in the birth rates ranging from 19.0 in Kerala to 36.9 in Madhya Pradesh. Among the 14 major states which contribute about 94 percent of the country's total states have birth rates which are above the national average. Madhya Pradesh tops the list with a birth rate of 36.9 and is closely followed by Uttar Pradesh (35.7), Rajasthan (33.1) and Bihar (32.9) (Khan, 1992).

The 1991 census, estimated Crude Death Rate as 9.8 which ranged from 10.6 in rural and 7.1 in urban areas. The Crude Death Rate for females is significantly higher in rural areas as compared to urban areas. Similar striking difference is visible in death rates for male population in rural and urban areas. Female death rates have been estimated relatively lower than the national averages and even that of their counterpart in both rural and urban settings (Ministry of Human Resource Development, 1995).

It is observed that female infants face higher mortality as compared to their counterpart in the state of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Three states namely Assam, Madhya Pradesh and Orissa indicate IMR higher than the national average. Higher IMR for male and female infants has been registered in Orissa state. Kerala is the only state with the lowest IMR for female population (16) and for male population

(17) which is very close to the IMR for any developed country (Durgaprasad, 1995).

There is considerable direct and indirect evidence of a higher morbidity among female children in the community even though hospital and clinic attendance records show a preponderance of males. The response to illness is delayed in the case of girls. In Narangwal, Punjab, 48 percent of female children relative to 64 percent male children received care in the first 24 hours of their terminal illness.

B. Family Welfare Programmes in Operation

From the time of launching of the First Five-Year Plan in 1951, the Union Government has been according top priority to the population problems. However, during the earlier period, more emphasis was laid on the research in the field of demography, communication and physiology of human reproduction. Only after 1966, Family Planning Programme became target oriented and was fully integrated with the Maternal and Child Health (MCH) Programme.

The basic thrust of the Family Welfare Programme is on :

1. Voluntary acceptance of family planning
2. Creation of favourable demand for the adoption of the small family norm by imparting awareness, information and education and making availability of contraceptives and services and

3. Integrating Family Planning and Mother and Child Health Services and implementing it through countrywide network of Primary Health Centres and supportive institutions (Pathak and Parasuraman, 1993).

In the Eighth plan, about 50 percent of the total state health plan allocation is being spent on providing medical facilities to the rural areas by the introduction of 'Mobile Clinics', so as to provide health facilities to the rural people nearer their door steps. These mobile facilities will be in addition to the health infrastructure already created to provide medical facilities to the rural population (Pal, 1992).

Family Welfare Programme

Family Welfare Programme is being implemented through the state governments with cent percent central assistance. The performance of the programme was low during 1977-78, it was a good year in as much as the programme moved into new health direction. The 42nd Amendment of the Constitution has made "Population Control and Family Planning" a concurrent subject, and this provision has been made effective from January 1977. The acceptance of the programme is now purely on voluntary basis. The National Health Policy was approved by Parliament in 1983. It has laid down the long-term demographic goal of Net Reproduction Rate (NRR) = '1' by the year 2000, which implies a '2'

child family norm. Through the attainment of a birth rate of 21 and death rate of nine thousand population and a couple protection rate of 60 percent by the year 2000. The National Health Policy has also called for restructuring the health care delivery system to achieve Health For All by 2000 A.D and Family Planning has been accorded a central place in health development (Ministry of Social and Women's Welfare, 1985 and Manorama Year Book, 1994).

MATERNAL AND CHILD HEALTH PROGRAMME

One of the important aspects of Family Welfare Programme is the promotion of health of mothers and children. The following specific programmes have been under implementation in the country as 100 percent centrally sponsored schemes (Sidhu, 1983, Mehta, 1988 and Tiwari, 1992).

UNIVERSAL IMMUNISATION PROGRAMME

The Universal Immunisation Programme (UIP) was launched in 1985 as a part of the overall national strategy to bring down infant and maternal mortality in the country by providing immunisation to all infants against six vaccine preventable diseases and pregnant women against tetanus. With effect from 1990-91, the target for UIP has been increased to 100 percent i.e to cover all infants.

PROGRAMME OF ORAL REHYDRATION THERAPY

In the Seventh Five-Year Plan, as a step towards enhancing child survival by decreasing the morbidity and mortality due to diarrhoeal diseases in children under five, a National Diarrhoeal Diseases Control Programme through promotion of Oral Rehydration Therapy was started. During the year 1987-88, a sum of Rs.423 lakhs out of 500 lakhs were allocated to 26 states for implementation of ORT programme (Mathur, 1992).

PROPHYLAXIS SCHEMES

Prophylaxis scheme was launched during the Fourth Five-Year Plan and being continued through successive plans seeks to supply iron and folic acid tablets to pregnant and lactating women and children between 1 to 5 years of age. The doses for the adult are 60 mg iron with 0.5 mg folic acid to be given daily for a period of 100 days. In case of children, 20 mg, elemental iron and 0.1 mg folic acid is given daily for a period of 100 days and child is administered 2 lakh I.U doses of Vitamin A every six months between 1 to 5 years of age.

MEDICAL TERMINATION OF PREGNANCY (MTP)

It is estimated that about one fourth of the maternal mortality and morbidity are due to illegal abortions. In order to prevent these health hazards to women the Medical Termination of Pregnancy Act, 1971 was promulgated. Under this Act, Medical

Termination of Pregnancy can be done in pregnant women upto 20 weeks if, pregnancy is likely to result in birth of a congenitally malformed child or continuation of pregnancy is likely to harm the mother in existing circumstances and in case of contraceptive failure (India, 1992).

CHILD SURVIVAL AND SAFE MOTHERHOOD

The package of services under Child Survival and Safe Motherhood project are to be expanded under two major components: (a) Child Survival component under which the Acute Respiratory Infection (ARI) Control Programme will be expanded along with provision of the kit based supply of drugs. In addition essential new born care for ensuring survival of new borns is being introduced. Exclusive breast feeding is being promoted as an intervention for child survival and (b) Safe Motherhood component under which first referral units will be set up in the six states of Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh (India, 1995).

MINIMUM NEEDS PROGRAMME

The Minimum Needs Programme was first introduced in the Fifth Five Year Plan (1974-79) to combat poverty with an outlay amounting to Rs.2607 crores. There are nine components under the revised minimum needs programme, namely elementary education, adult education, rural health, rural

electrification, housing for landless households, environment and improvement of slums and nutrition programmes. In the fields of nutrition, the revised norms are mid-day meals for one fourth of children in the age group of 0 - 6 years (Mehta, 1988).

EXPANDED PROGRAMME OF IMMUNIZATION

This was launched in January 1988, to deliver an integrated immunisation services through Primary Health Centres and Subcentres in rural areas and hospitals and dispensaries in urban areas and to reduce the incidence of diphtheria, whooping cough, tetanus, polio, tuberculosis and typhoid fever by making vaccination services available to all children and pregnant women (Srivastava, 1988).

The immunisation coverage given to our children with three doses of Oral Polio Vaccine (OPV) and three of Diphtheria Pertussis Tetanus (DPT) vaccine about 50 percent of children under two years and 50 percent of children under one year in urban areas and 30 percent in rural areas (John, 1986).

NATIONAL WATER SUPPLY AND SANITATION PROGRAMME

The National Water Supply and Sanitation programme was initiated in 1954 with the object of providing safe water supply and adequate drainage facilities for the entire urban and rural population of the country. In 1972 a special programme known as the Accelerated Rural Water Supply Programme was started as a

supplement to the National Water Supply and Sanitation programme (Panickar, 1980).

ALL INDIA HOSPITALS POST PARTUM PROGRAMME

All India Hospitals Post Partum Programme (AIHPP) was introduced in 1969. It is a hospital based maternity centered approach to family planning. The primary objective of the Post Partum Programme is to improve the health of the mother and children through MCH and Family Welfare Programme which includes antenatal, neo-natal and post-natal services, immunisation services to children and mothers and prophylaxis against anaemia and blindness. In order to detect cervical cancer among women acceptors and non-acceptors of various family welfare methods, the PAP smear test facility programme has been introduced in all the medical colleges of the country (India, 1991).

STERILISATION BEDS SCHEME

Under the scheme, beds are provided to voluntary organisations/local bodies/institutions on the basis of their performance of previous years and on the recommendations of the state government and regional director of health and family welfare of the respective state. Maintenance grant under this scheme of the rate of Rs.3,000 per bed per annum is provided to each institution subject to a minimum performance of 75/60 tubectomies per bed per annum for government institutions and

local bodies/ voluntary organisations respectively. A total of 3,610 sterilisation beds have been reserved under the scheme.

URBAN FAMILY WELFARE CENTRES AND URBAN REVAMPING SCHEME

Urban Family Welfare Centres are on the ground since 1950 to provide family welfare services in the urban areas. These are of different categories depending upon the staff sanctioned and area covered by them. In all 1,469 urban family welfare centres functioning in the states/union territories ; 208 urban centres are under the Ministry of Railways and Ministry of Labour (India, 1993).

TRAINING OF HEALTH WORKERS OF SUBCENTRE

Subcentre is the only peripheral health institution which caters to a population of 5,000 in plain and 3,000 in hilly tribal area. Each subcentre is manned by one male and one female health worker (India, 1994).

INTENSIFIED DAIS' TRAINING PROGRAMME

An Intensified Dais' Training Programme was started in 11 districts in six states in the beginning of 1989. The main components of this programme include training of Dais in aseptic delivery practices, provision of disposable delivery kits to them as well as to pregnant women and payment of a reporting fee of Rs.10/- when they interact with the ANM to promote ante-natal care and TT immunisation.

CONTROL OF ACUTE RESPIRATORY INFECTIONS (ARI) PROGRAMME

Acute Respiratory Infections (ARI) are also a major cause of morbidity and mortality in India, especially among children below 5 years of age. Therefore, in 1989-90 to launch an ARI Control Programme as a pilot project in 14 districts with the primary objective of reducing ARI associated mortality through provision of anti-microbials at the most peripheral level. Ten more districts were taken up under this pilot project in 1991.

AUXILIARY NURSE MIDWIFE (FEMALE HEALTH WORKER) TRAINING PROGRAMME

Each sub-centre is manned by one Male Health Worker and one Female Health Worker (Auxiliary Nurse Midwife). In order to train the required number of ANM's to the rural area there are 471 ANM Training Schools functioning in the country with an annual admission capacity of 19,900. Duration of the training is 18 months. It is expected that 10,000 to 12,000 ANMs are likely to qualify in the current year. It is proposed to utilise these training institutions for providing continuing education programme for ANMs besides providing basic training programme of 18 months duration (Ministry of Health and Family Welfare, 1995).

FEMALE HEALTH ASSISTANT TRAINING PROGRAMME (LHV)

One Female Health Assistant has to supervise the work of six subcentres in the rural area. She provides technical guidance and supervision to the ANMs, who are working in rural area. The senior ANM's are trained for six months to take up the post of Lady Health Visitor (LHV), which is a promotional post. There are 46 training schools with an admission capacity of 2873 functioning in the country. These training schools will also be utilised for giving Continuing Education Programme for the Female Health Assistant besides providing basic training programme of six months duration.

VILLAGE HEALTH GUIDE SCHEME (VHG)

The present Village Health Guide (VHG) scheme was started in 1981. According to the scheme, the village community selects a volunteer as VHG who educates the community in sanitation and personal hygiene. He/she also renders assistance in maternal care and educates the mothers about immunization and family welfare scheme. He/She also keeps track of communicable diseases and treats minor ailments and provide first-aid to the patients. The VHG is a vital link between the rural community on one side and the health delivery institutions on the other hand.

MULTI-PURPOSE WORKER (MALE)

This scheme was initiated in 1982 to meet the additional requirement of multi-purpose workers. It is a 100 per cent centrally sponsored scheme to provide pre-service basic training to a health worker (male) who is to be posted at a sub centre alongwith the health worker (female). An MPW (M) is one male counterpart of the Female Health Worker in rural areas to work for Primary Health Care in terms of preventive, curative, promotive and family welfare activities (Ministry of Health and Family Welfare, 1991).

HEALTH AND FAMILY WELFARE TRAINING CENTRES (HFWTCs)

Health and Family Welfare Training Centres are established in the country with the objective of giving in service training to health personnel in the rural health sector. These training centres are set up with 100 per cent financial assistance from the Central Government under the Family Welfare Programme.

CENTRAL LAPROSCOPIC TRAINING CENTRES

In order to impart training to doctors in laproscopic sterilisation techniques and provide better quality of service in this regard, 20 Central Laproscopic Training Centres have been established in the country (Ministry of Health and Family Welfare, 1988).

C. EFFORTS TAKEN BY MANIPUR STATE TOWARDS FAMILY WELFARE

The rapid growth of population in India is causing great concern. It is necessary to control this growth to save posterity from facing innumerable problems of inadequate means of livelihood, quality of life and environment. While over the years a massive health and family welfare infrastructure has been created in the country, it is still inadequate to meet full demand of the people. It has been estimated that the goals set forth in the National Health Policy to be achieved by the year 2000 A.D can now be achieved only by the year 2011 - 2016 A.D.

One of the important aspects of the Family Welfare Programme is the promotion of health of mother and children. It creates a sense of security in the mind of parents that the children born will live a healthy life which in turn contribute greatly to the acceptance of small family norm as a way of life. With the objective in view Maternal and Child Health Programme has been taken up as part of Family Welfare Programme. Family Welfare Programme was started in the state since 1965 with a District Family Welfare Bureau at Imphal. With the gradual expansion of the programme state level district level and block level family welfare centres have been established (State Family Welfare Bureau, Manipur, 1994).

1. ALL INDIA HOSPITAL POST PARTUM CENTRE INCLUDING PAP SMEAR TEST FACILITY

The Post Partum Programme is defined as Maternity Centered Hospital based approach to Family Welfare Programme and aims to motivate women within the reproductive age group (15-44 years) and their husbands for adoption of the small family norms through education and motivation, particularly during antenatal, natal and postnatal period.

PAP smear test to detect the dreadful disease invasive carcinoma of cervix, necessary facilities are available at the Post Partum Programme Centre. Regional Institute of Medical Sciences, Imphal. J.N.Hospital, Imphal is also conducting such test under the care of pathologist.

The following are the Post Partum Programme Centres in the State :

- (i) Post Partum Programme Centre A - Type : Teaching 10 bedded attached to Regional Institute of Medical Science (RIMS), Imphal, having PAP smear test facility run by North-East Council (NEC) and Government of India.
- (ii) Post Partum Programme Centre A - Type : Non-teaching 10 bedded, District Hospital, Imphal.
- (iii) Post Partum Programme Centre B - Type : 6 bedded District Hospital Churachandpur District.
- (iv) Sub-Divisional Level/Taluk Level Post Partum Programme Centre, Kakching 6 bedded, Thoubal District.

2. URBAN FAMILY WELFARE CENTRE AND URBAN REVAMPING SCHEME

The following are the Urban Family Welfare Centre in the state :

- (i) Urban Family Welfare Centre attached to the Post Partum Programme Centre, District Hospital, Imphal.
- (ii) Urban Family Welfare Centre attached to the Post Partum Programme Centre Churachandpur, Churachandpur District.
- (iii) Urban Family Welfare Centre attached to the J.N.Hospital, Porompat, Imphal.

There is no scheme of revamping of Urban Family Welfare Centre in the State.

3. STERILISATION BED SCHEME

As per the Government of India letter No.12020/1/94-SS dated 12th July, 1993, Sterilisation Bed Scheme has been confined to the Voluntary Organisation and Local Bodies Institutions.

4. RURAL FAMILY WELFARE CENTRE

There are 31 Rural Family Welfare Centres in the State. At present there are 70 PHCs under the health sector. In the opinion of the Department it is better to cover the rest 39 PHCs by attaching Rural Family Welfare Centres for effective implementation of the programme.

5. CRASH TRAINING PROGRAMME OF AUXILARY NURSE MIDWIFE (ANM)/
FEMALE HEALTH ASSISTANCE (LHV) IN INTRA-UTERINE DEVICE (IUD)
INSERTION AND ORAL PILLS ADMINISTRATION

Crash Training Programme of ANMs/LHVs in IUD insertion and Oral Pills administration has been undertaken from time to time when the Government of India provide specific fund for the programme. Out of 672 ANMs/LHVs, 432 numbers of ANMs/LHVs have completed crash training upto 1994-1995. However, the Department has determined to train the remaining 240 ANMs/LHVs during the current financial year if the fund is released by Government of India in time. Proposal to train 240 stated above at the rate of 30 trainees per District i.e., 30 x 8 Districts (Imphal, Thoubal, Bishenpur, Churachandpur, Chandel, Tamenglong, Ukhrul and Senapati) has also been submitted to the Government of India.

Training is given at :

- (1) Post Partum Programme Centre, Regional Institute of Medical Sciences, Imphal.
- (2) Post Partum Programme Centre, Imphal and
- (3) Post Partum Programme Centre, Churachandpur.

REVISED OBJECTIVES

- (i) To provide an integrated package of MCH and Family Welfare Services.

- (ii) To promote spacing methods as a health intervention to bring down Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR).
- (iii) To provide in-service training to Medical Officers, ANMs, LHV and Field Workers.
- (iv) To provide outreach services to the allotted population.
- (v) To undertake Information Education and Communication (IEC) activities.
- (vi) Decentralisation of monitoring based on performance indicators.
- (vii) Establishing referral linkages of management of high risk patients.

THE FOLLOWING SERVICES SHALL BE AVAILABLE AT POST PARTUM CENTRES

A. Maternal and Child Health Services

1. Intervention for Mothers

Essential obstetric care for mothers and children
Early registration.

Antenatal, natal and postnatal services.

Immunization - Tetanus Toxoid (TT).

Prophylaxis with Iron and Folic Acid (IFA) tablets and Vitamin A solution.

Health education and nutrition.

Early detection of complications of :

Anaemia, bleeding - ante partum haemorrhage

Post partum haemorrhage

Toxemia of pregnancy

Obstructed labour

Sepsis

Minimum Services as follows should be available

Vacuum extraction

Caesarian section

Blood transfusion

Manual removal of placenta

2. Child Health Intervention

To provide care to infants born in the hospitals.

Treatment to high risk infants referred from peripheral centres.

Immunization of all children born in the hospital and visiting out-patient department.

Immunization of all children of field areas.

B. FAMILY PLANNING

All contraceptives in adequate number must be made available.

Promote Family Planning as most important health intervention for health of mother and infant.

Follow up services must be available to acceptors.

Sterilisation methods should be available.

Provide Medical Termination of Pregnancy (MTP).

C. OUT REACH SERVICES

The visits by ANMs and LHVs to field area attached to Post Partum Centre and supervision by Medical Officers needs to be intensified.

Eligible couple register must be maintained and updated.

The population provided to each ANM shall be 10,000 in urban areas and 5000 in rural areas. All information about the area should be properly maintained in the register after survey.

Strategy for providing Reproductive Health Care services

Maternal Care

1. Essential antinatal care for all.
2. Detection of high risk pregnancies.
3. Detection of complicated pregnancies.
4. Prophylaxis against Tetanus and Anaemia.
5. Suitable and timely referral.
6. Safe and clean delivery.
7. Recognition of abnormal labours.
8. Emergency referral during labour.
9. Postnatal care of mothers.
10. Care of newborn.
11. Care of low birth weight babies.

RURAL FAMILY WELFARE CENTRES (RFWCs)

The Manipur State has 70 PHCs. However the state has only 31 RFW centres attached to the 31 PHCs. When the population has risen to 20,43,000 the services of the RFWC, cannot reach to all the hilly districts as well as far flung villages of the plain. If about 5 RFW centres are established to the existing PHCs phase wise every year. The Family Welfare Programme may be implemented

in an improved manner. If the Government of India offers the infrastructure with vehicles some RFW centres may be established during the current year 1995-96. Performance of Family Planning Methods for the year 1987-88 to 1993-94 (upto - November 1993) is given in the Table I (State Family Welfare Bureau, Imphal, 1996).

TABLE I
PERFORMANCE OF FAMILY PLANNING METHODS FOR THE YEAR
1987-88 to 1993-94 (UPTO NOVEMBER 1993)

Year	STERILISATION		IUD INSERTION		CC USER		OP USER	
	TARGET	ACHIEVE- MENT	TARGET	ACHIEVE- MENT	TARGET	ACHIEVE- MENT	TARGET	ACHIEVE- MENT
1987-88	7000	4711	7000	6158	6600	1541	900	192
1988-89	7000	5740	7000	8026	3900	2940	190	556
1989-90	7800	4631	8200	7151	4600	3790	220	565
1990-91	10000	3550	8000	7728	5100	2527	500	521
1991-92	7000	4005	8400	5536	8000	2471	4000	142
1992-93	7000	2275	8400	4116	8000	2301	6000	524
1993-94	3000	1092	20000	3914	15000	1398	6000	375

(April 1993 to November 1993)

(State Family Welfare Bureau, Manipur, 1995)

In the year 1984-85 for best performance in the group 'D' category states of India, Manipur state received cash award of Rs.50 lakhs.

Since the inception of the Family Welfare Programme in Manipur state so far the department achieved 73887 sterilisation, 83624 IUD cases, 49780 Oral Pill user, 7249 CC user. Number of

couples protected so far, since the inception of the programme is 1,04,062 in term of equivalent sterilisation upto the end of 31st March 1992 the Department could achieve 33.5 per cent couple protection rate

CSSM, UIP, ORT being priority programme, the Directorates in co-ordination with the District level staff are alertly doing the works regularly for better aspects of the health of mother and children of this state (State Family Welfare Bureau, Manipur, 1995).

D. RESEARCH STUDIES RELATED TO Family Welfare Programme

Richard et al (1987) in their study on 'Use of Maternal and Child Health services and immunizations coverage in Panama and Guatemala' attempted to assess the extent to which maternal and child health services were being used and estimated the prevalence of the use of contraception and provided population based data on the use of maternal and child health services, including immunization levels, in order to measure programme impact in each country. The Panama survey obtained information from 8,240 women, while the Guatemala survey obtained from 3,670 women in 15-44 years of age. Women residing in the urban area of Panama reported a higher percentage using maternal and child health than in Guatemala. The levels regarding the immunization coverage of young children were also relatively higher in Panama than Guatemala.

Walker et al (1987) in their study on "Maternal deaths in Jamaica" revealed that almost two thirds were attributable to pre-eclampsia/eclampsia, haemorrhage, ruptured ectopic pregnancy, or sepsis. Avoidable factors that might have increased the probability of death were identified and recommendations aimed at reducing maternal mortality were presented.

A study on "Knowledge, Attitude and Practice of Family Planning among Fisherman in Tamil Nadu" by Rao et al (1993) revealed that good knowledge and favourable attitudes (80 percent) towards family planning was prevalent among the fishermen community of coastal Tamil Nadu. However, only 37.8 percent were found to have accepted some form of family planning, among which sterilisation and abstinence were most widely practised. In fact, not a single vasectomy case had been performed in the study area, the major reason being the fear that it would affect their health and consequently their day-to-day activity of fishing which is their only source of income. The knowledge of permanent methods and abstinence among them was more than that of temporary methods.

Nayar et al, (1988) through their study on "The status Family Welfare in Rural Areas of District Wardha" revealed that out of 3,348 study couples 1,544 (46 percent) had one partner sterilized. 300 (9 percent) of the couples were using condoms to control their family size. Methods like Oral Pills and IUDs were

less commonly used. Nearly 43 percent of the couples were not using any family planning method. The condoms (20.75 percent) and oral pills (6.68 percent) were used by more couples in joint families as compared to nuclear families (2.54 percent and 0.14 percent, respectively).

A study conducted by Gupta (1995) on "How to Make the Rural Family Programme More Effective in Kanpur Dehat District of Uttar Pradesh" revealed that both educated and uneducated respondents had cent percent (95.88) faith in family planning. But due to inadequacies of medical care and indifferent attitude of the concerned staff towards the programmes of family planning, only a very less percentage (37.05) of people from rural areas accepted the small family norms. It was also observed that due to laxity in administration a few (21.56 per cent) were aware about the benefits of small family and they were also not knowing even about the incentives and facilities provided by the Government from time to time for accepting small family norms.

Verma et al (1988) undertook a study on "A Profile of Acceptance of Terminal Methods of Family Planning in a Rural Community, Bathinda District, Punjab" over a twelve years period between the biennium 1975-76 and 1985-86, the number of acceptors increased three fold, but their profile showed the development of unfavourable trends. A majority of the cases accepted the operation much later in their married life. This

failed to serve the objective of the National Family Welfare Programme. Hence, suggestions had been made to eliminate such infructuous sterilisation. Considering the present size of the country's population and its high growth potential, a plea is made for propagating one-child families.

Schaap (1993), his study on "Intra-Utrine Device (IUD) Acceptance in Rural Madhya Pradesh : Results of an acceptor's interview" showed that most IUDs were found to have been inserted to females by multi purpose workers (MPW/F) (87 percent). The majority (83 percent) of acceptors were between 20 and 35 years. The removal was performed mainly by the MPW/F (76 percent), half of the acceptors (49 percent) did not have any complaint regarding the device. The main reasons for IUD discontinuation were excessive bleeding (26 percent), pain (23 percent) and desire for a child (21 percent) and most of the acceptors (86 percent) said that they would advice positively on the IUD as a family planning method.

Methodology

III METHODOLOGY

The methodology for the study included the following steps:

- A. Selection of the Area
- B. Selection of the Sample
- C. Selection of the Research Tool
- D. Preparation of the Tool
- E. Collection of the Data and
- F. Analysis and Interpretation of the Data

A. Selection of the Area

A sample is a portion of the population which is examined with a view to estimating the characteristic of the population (Saha, 1995). A sample is a collection of some, but not all, of the elements of the population under study, used to describe the population (Levi and Rubin, 1992 and Lawson, Hubbard and Pugh, 1995).

Manipur is bounded by Nagaland in the north, Mizoram in the South, Upper Myanmar in the east and Cachar district of Assam in the west. It has a total area of 22,327 sq.kms with a population of 18,37,149 (1991 census). The sex ratio i.e females per 1000 males is 961. The density of the state is 82 with a urban population 27.52 percent. The literacy rate of the state is 60.96 percent where that of males is 72.98 percent and 48.64 percent for females.

Imphal District, the capital of Manipur State, has a total area of 1,201 sq.kms with a population 707,184 (1991 census).

The area selected for the study is Imphal District of Manipur State. There are eight districts in Manipur State. They are Imphal, Thoubal, Bishennpur, Churachandpur, Senapati, Ukhrul, Tamenglong and Chandel. Among these districts, the investigator had selected Imphal City, part of Imphal District as study area, due to easy accessibility and co-operation assured by the people. It happens to be the native city of the investigator, which again was a possibility for mobilising local resources like the expertise of Assistant Director - State Family Welfare Beurea (Plate I).

There are 26 municipal wards in Imphal city. Among them, four wards were selected for the study, using simple random method. Each ward is constituted of five to eleven localities (Leikai). For the study purpose, one locality from each ward was randomly selected. The selected localities are given in Table II (Figure I).

TABLE II
SELECTION OF LOCALITIES

S.No	Name of the locality (Leikai)	Ward Number
1.	Thangmeiband Sinam Leikai	1
2.	Sagolband Thangjam Leikai	7
3.	Sougaijam Mamang Leikai	14
4.	Nongmeibung Chakpram Leikai	21



PLATE I : CONSULTING THE ASSISTANT DIRECTOR,
(STATE FAMILY WELFARE BUREAU, IMPHAL)

MAP OF IMPHAL MUNICIPAL BOUNDARY



Figure.1

LOCALE OF THE STUDY

B. Selection of the Sample

Purposive sampling method was used to select the women as the sample for the study. Purposive sampling is a method where the investigator has the power to select or reject any item in an investigation. The choice of sample items depends on the judgement of the investigator. The investigator has the vital role to play in collecting the information (Pillai and Bagavathi, 1995).

For the selection of the sample the following points were kept in mind by the investigator :

1. Women having at least a child of 6 months old
2. Age of the women must be between 20-40 years, as it is the reproductive period.

If there were more than two women in the selected age group in a joint family, one woman was selected by lottery method. Under lottery method, all items of the universe are numbered or named on separate slips of paper of identical size and shape. These slips are then folded and mixed up in a container. A blind fold selection is than made of the number of slips required to constitute the desired sample size. The selection of items thus depends entirely on chance (Gupta, 1996).

Following the above criteria, 25 women from each of the four localities were selected to make the total size of the sample as 100.

C. Selection of the Research Tool

The research tool selected for the study is direct personal investigation. In direct personal investigation, the investigator has to collect the information personally from the sources concerned, on the spot, for conducting the enquiry and has to meet people from whom data have to be collected (Elhance, 1984).

This method is selected for the study, due to the following advantages :

1. The first hand information obtained by the investigator is bound to be more reliable and accurate since the investigator can extract the correct information by removing the doubts, if any, in the minds of the respondents regarding certain questions. In case, the investigator suspects foul play on the part of respondents in supplying wrong information on certain items he can check it by some intelligent cross questioning.
2. The investigator can extract proper information from the respondents by talking to them at their educational level and if needed ask questions in their language of communication and using local connotations, if any, for the words used (Gupta, 1982).

D. Preparation of the Tool

An interview schedule is prepared for the study. Schedule is the name usually applied to a set of questions which are asked and filled in a face to face situation with another person. The enumerators contact the informants, get replies to the questions contained in a schedule and fill them in their own handwriting in the questionnaire form (Gupta, 1995).

The schedule prepared included different aspects to elicit information regarding family background, information about selected women, family planning details, Medical Termination of Pregnancy and informations pertaining to Maternal and Child Health (Appendix I). A pilot study was conducted to finalise the schedule.

E. Collection of the Data

The investigator visited the households during the convenient hours of the respondents, developed good rapport and collected essential informations related to the study, with the help of the interview schedule (Plate II).

F. Analysis and Interpretation of Data

The data collected with the help of interview schedule, were tabulated, analysed, interpreted and presented in Chapter IV.



PLATE II : INTERVIEWING THE RESPONDENT

Results and Discussion

IV RESULTS AND DISCUSSION

The results of the study on "Family Welfare Measures Adopted by Women in Imphal District, Manipur State" are discussed under the following heads :

- A. Profile of the Sample
- B. Family Planning Programme and
- C. Maternal and Child Health Programme

A. Profile of the Sample

1. Family background of the sample

The background informations about the families of the sample were collected and presented below :

a. Type of the family

The type of the family of the respondents are presented in Table III.

TABLE III
TYPE OF THE FAMILY

S.No	Type of the Family	Percentage (N : 100)
1.	Nuclear	58
2.	Joint	27
3.	Extended	15

Concerning the type of family, 58 percent of the families, nearly more than half of the sample, were of nuclear type while 27 per cent were of joint families. Only 15 percent were extended families.

b. Size of the family

The distribution of the families according to their size, is given in Table IV.

**TABLE IV
SIZE OF THE FAMILY**

S.No	Size of the Family (No. of members)	Percentage (N:100)
1.	Small (1-3)	22
2.	Medium (4-6)	46
3.	Large (above 6)	32

The study revealed that 46 per cent of the sample were in medium (4-6) size and only 22 per cent were of small (1-3).

C. Sex wise distribution of the members of the families

The distribution of total family members of the sample, according to sex, is presented in Table V.

**TABLE V
SEX WISE DISTRIBUTION OF TOTAL FAMILY MEMBERS**

S.No	Sex	Number	Percentage (N : 532)
1.	Female	286	54
2.	Male	246	46

In any study of the population, analysis of the sex composition plays a vital role. The sex composition of the population is affected by the differentials in the mortality conditions of males and females, sex selective migration and the sex ratio at birth.

Among the total members of the families of the study sample, 54 per cent were female and 46 per cent were male.

d. Age structure of family members

Age wise distribution of the members of the selected families are given in Table VI.

**TABLE VI
AGE WISE DISTRIBUTION OF FAMILY MEMBERS**

S.No	Age range in Years	Number	Percentage (N:532)
1.	0 - 5	118	22
2.	6 - 10	60	11
3.	11 - 15	23	4
4.	16 - 20	8	2
5.	21 and above	323	61

Out of the total members in the selected families, 61 per cent were in the age group of 21 and above. As a whole, it is obvious that majority of the respondents belonged to the active age group.

e. Educational level of the family members

Table VII depicts the educational level of the family members.

**TABLE VII
EDUCATIONAL LEVEL OF THE FAMILY MEMBERS**

S.No	Education	Number	Percentage (N:532)
1.	Post graduate	30	6
2.	Graduate	143	27
3.	Higher Secondary	34	6
4.	High School	192	36
5.	Illiterates	113	21
6.	Others	20	4

A majority (36 per cent) of the family members had completed high school and 21 per cent were illiterate. Among the total, 4 were either doctors, engineers or advocates.

It was a welcoming fact that literacy rate was 79 percent against the national literacy rate of 52.21 percent (Manorama Year Book, 1997).

f. Details of family income of the selected sample

According to Housing and Urban Development Corporation (1994), low income is having less than Rs.2000 per month, middle income ranges between Rs.2001 to Rs.6000 and income group which falls above Rs.6000 is high income.

The monthly income of the families of the respondents is indicated in Table VIII.

TABLE VIII
DETAILS OF FAMILY INCOME

S.No	Income per month in Rs.	Percentage (N:100)
1.	Low income (Less than Rs.2000)	12
2.	Middle Income (2001 to 6000)	48
3.	High income (more than 6000)	40

Forty eight per cent belonged to the income range of Rs.2001 to 6000 per month, 40 percent of the respondents families belonged to income range of more than Rs.6000 per month and only

12 per cent families of respondents belonged to the income range of below Rs.2000 per month.

2. Informations about the selected sample

As explained in Chapter III, 100 women were selected as the sample for the study. The informations about the selected sample are given in Table IX.

TABLE IX
INFORMATION ABOUT THE SELECTED SAMPLE

S.No	Aspects	Percentage (N:100)
1.	Age (in years)	
	20 - 25	7
	26 - 30	23
	31 - 35	40
	36 - 40	30
2.	Educational status	
	High school	20
	Higher secondary	16
	Graduate	49
	Post graduate	10
	Other (eg. diploma)	3
	Illiterate	2
3.	Marital Status	
	Married	96
	Separated	3
	Widow	1
4.	Having Children	
	One child	41
	Two children	35
	Three children	15
	Four and above	9

It is clear from the table that 40 percent of the respondents were in the age group 30-35, 30 per cent were in 35-40, 23 per cent in 25-30 and only seven per cent were in 20-25

age group. Most of the respondents, 70 per cent, are below 35 years of age.

It is obvious that about half of the sample (49 per cent) were graduates, 20 percent were having high school education, 16 per cent had completed higher secondary, 10 per cent had completed post graduate education and only two percent were illiterate.

The study revealed that 73 per cent of the respondents were fulltime homemakers and the other 27 per cent were employed.

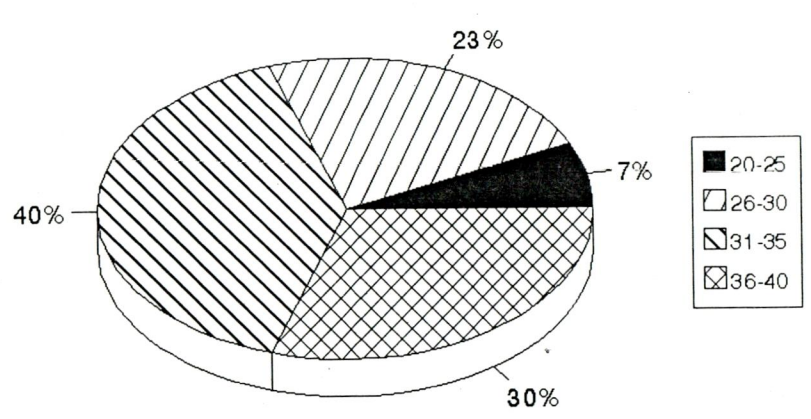
Ninety six per cent of the selected sample were having happy life, three per cent were separated and one was widow. It is heartwarming to learn that 76 per cent of the women had only one child or two children and only 24 percent had three and above number of children. It shows that the selected women were conscious of small family norm (Figure II).

a. Age level of the respondents at the time of marriage

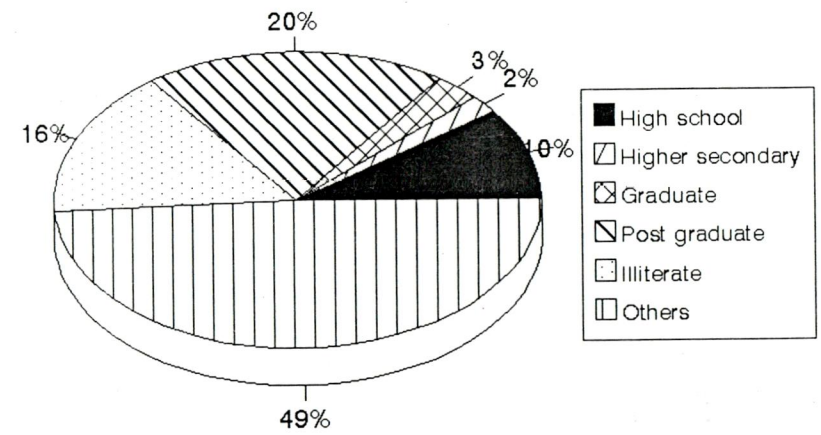
Age level of the respondents at the time of marriage is given in Table X.

TABLE X
AGE LEVEL OF THE RESPONDENTS AT THE TIME OF MARRIAGE

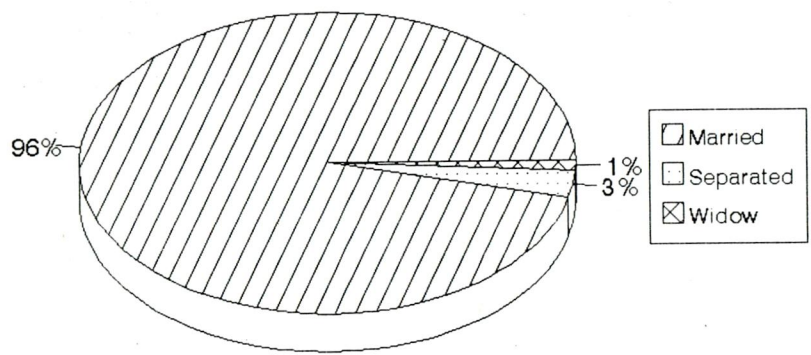
S.No	Age in years	Percentage (N:100)
1.	Less than 20	8
2.	21 - 25	40
3.	26 - 30	41
4.	More than 30	11



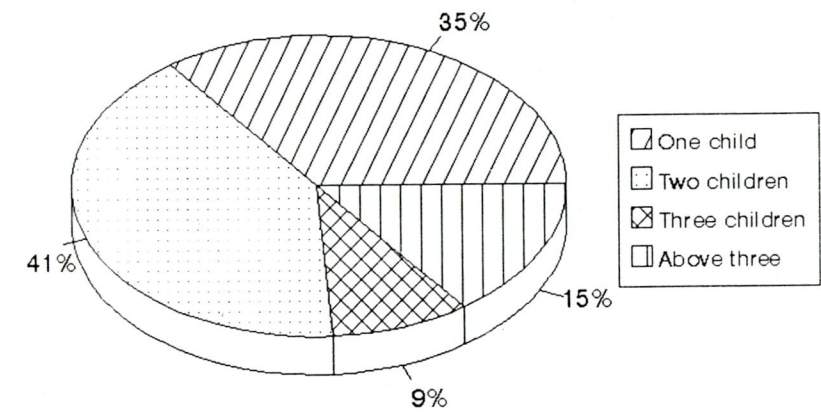
1. Age



2. Educational status



3. Marital status



4. Having children

INFORMATION ABOUT THE SELECTED SAMPLE
Figure 2

A majority (41 per cent) of the selected women got married between 25-30 years of age, 40 percent between 20-25 years, 11 per cent were more than 30 years and eight per cent less than 20 years, when got married.

b. Children born in the family of the respondents

Table XI gives the clear picture of the status of the children born.

TABLE XI
STATUS OF CHILDREN BORN

S.No	Aspects	Female	Male
1.	Number of children born in the past five years	55	36
2.	Number of infant deaths in the past five years	1	Nil

The number of children born during the past five years were 55 female and 36 male, It was heartwarming to note that there was only one infant death in the past five years, which shows that the rate of infant mortality is very low.

c. Mortality in the family of the respondents

Table XII brings out the mortality in the family of the respondents.

TABLE XII
MORTALITY IN THE FAMILY OF THE RESPONDENTS

S.No.	Aspects	Number
1.	Male death	8
2.	Female death	5
Total		13

The data revealed that among the 13 deaths occurred in the last five years, eight were male and five were female.

B. Family Planning Programme

1. Sources of information about family planning

Table XIII brings out the sources of information to the respondents about family planning.

TABLE XIII
SOURCES OF INFORMATION ABOUT FAMILY PLANNING

S.No	Sources	Percentage (N : 100)
1.	Elders	38
2.	Books/magazines	38
3.	Friends	24
4.	Television	24
5.	Radio	23
6.	Government Hospital	13
7.	News papers	7
8.	Private Clinic	5

Majority of the sample received information from elders (38 percent) and books/magazines (38 per cent). Only five obtained the details from private clinics (Figure III).

2. Details of family planning methods adopted

The following table gives the details of the family planning methods adopted by the respondents :

TABLE IV
DETAILS OF FAMILY PLANNING METHODS ADOPTED

S.No	Method	Percentage (N: 55)
1.	Intra-Uterine Device (IUD)	44
2.	Condoms	20
3.	Oral pills	16
4.	Tubectomy	4
5.	Any other (self control)	16

Out of 100 respondents, 55 women had adopted family planning. There was a strong son preference because most of them felt that having a son was a necessity for continuation of the lineage of the family.

Out of 55 women who had adopted family planning methods, 44 per cent used IUD method, 20 per cent used condoms, and only four per cent opted tubectomy. No one of the woman's husband had undergone vasectomy. It was surprising to know that 16 percent were having 'self-control' as a family planning method.

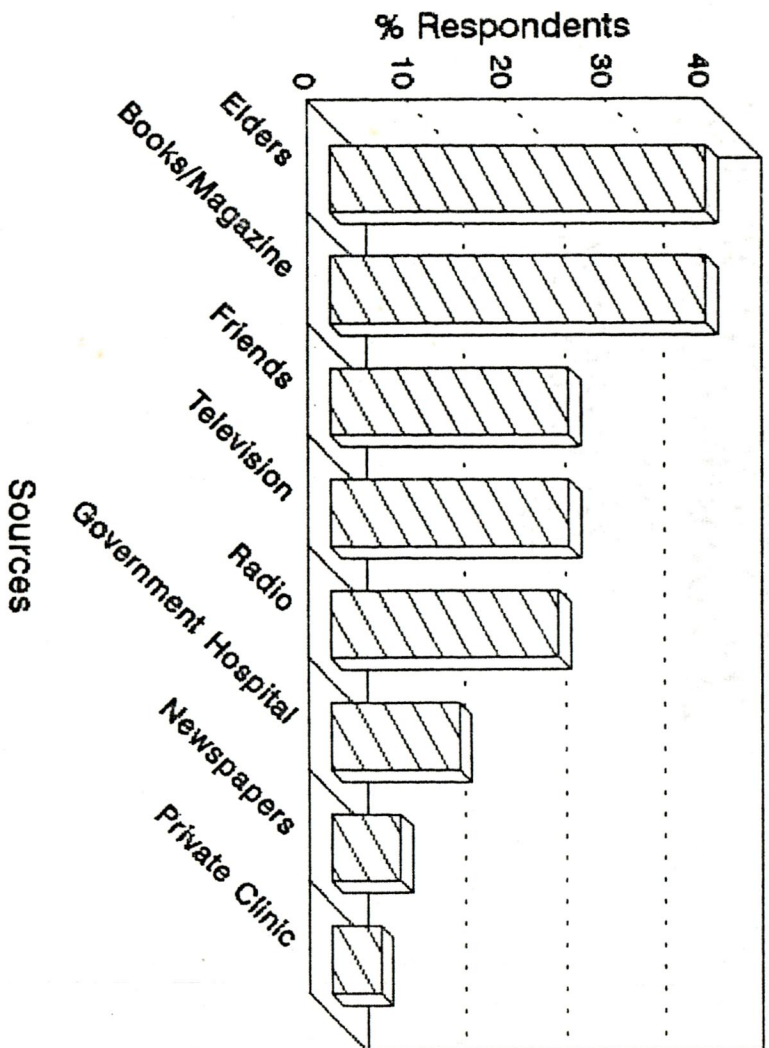


FIGURE 3
SOURCES OF INFORMATION ABOUT FAMILY PLANNING

3. Reasons for adoption of family planning

The reasons given by the sample for adopting family planning methods are presented in Table XV.

TABLE XV
REASONS FOR ADOPTION OF FAMILY PLANNING

S.No	Reasons	Percentage (N:55)
1.	Preference for small family	78
2.	Could not afford to manage large family with available income	13
3.	Health condition of the sample	9

Among the 55 women who had adopted family planning, 78 percent preferred small family norm, 13 percent could not afford to manage large family with available income and 9 percent accepted due to the health condition of the mother.

4. Views about oral pills

Table XVI reveals their knowledge about the advantage and disadvantage of oral pills.

TABLE XVI
VIEWS OF THE SAMPLE ABOUT ORAL PILLS

S.No	Aspects	Percentage (N:11)
Advantages		
1.	Easy to adopt	73
2.	Good for spacing	18
3.	Suitable for newly married women	9
Disadvantages		
1.	There is side effect	46
2.	It leads to loss of weight	27
3.	There is gain in weight	27

About advantages of oral pills, majority (73 percent) felt that it was an easy method to adopt ; 46 percent of women agreed that it had side effects, 27 per cent experienced weight loss and 27 percent felt the gain in weight.

5. Use of contraceptives and adoption of sterilization

Contraceptive methods are, by definition, preventive methods to help women avoid unwanted pregnancies. They include all temporary and permanent measures to prevent pregnancy resulting from coitus.

Voluntary sterilization is a well-established contraceptive procedure for couples desiring no more children. Sterilization offers many advantages over other contraceptive methods - it is an one time method, it does not require sustained motivation of the user for its effectiveness, provides the most effective protection against pregnancy, the risk of complication is small if the procedure is performed according to accepted medical standards and it is most cost effective (Park, 1995).

Totally 55 per cent of the women were adopting family planning methods. Among them, 29 women had been to the private clinics to get contraceptives at their own expenditure. Two women had undergone sterilization at their own expenses. Twenty four women had been to the Government Hospital for getting contraceptives.

6. Views on Medical Termination of Pregnancy (MTP)

The Medical Termination of Pregnancy Act was passed by the Indian Parliament in 1971 and came into force from April 1st, 1972 (in Jammu and Kashmir, it came into effect from November 1, 1976). Implementing rules and regulation initially written in 1971, where revised again in 1975. The Medical Termination of Pregnancy Act is a health care measure which helps to reduce maternal morbidity and mortality resulting from illegal abortion. It also affords an opportunity for motivating such women to adopt some form of contraception (Park, 1995).

In the study, among the 100 women, 65 supported Medical Termination of Pregnancy. Table XVII depicts the views of the 65 women supporting Medical Termination of Pregnancy.

TABLE XVII
REASONS FOR SUPPORTING MEDICAL TERMINATION OF PREGNANCY

S.No	Reasons	Percentage (N:65)
1.	To have a small family	34
2.	To protect the health of the mother	32
3.	To reduce population explosion	28
4.	To keep spacing between the births	6

Out of the 65 respondents who supported Medical Termination of Pregnancy, the reasons stated were to have a small family (34 per cent) to protect the health of the mother (32 per cent), to reduce population explosion (28 per cent) and to keep spacing between the births (6 per cent).

Reasons for not supporting Medical Termination of Pregnancy

Table XVIII brings out reasons for not accepting MTP by 35 members.

TABLE XVIII
REASONS FOR NOT SUPPORTING MEDICAL TERMINATION OF PREGNANCY

S.No	Reasons	Percentage (N:35)
1.	It affects the health of the mother	69
2.	It is a sin	17
3.	Others	14

Out of 35 women, who were not supporting MTP, 69 per cent had given the reason as it might affect the health of the mother, 17 per cent said that it is a sin and 14 per cent expressed other reasons as fear of death and not accepted by the elders in the family.

Reasons for abortion

Among the total sample, 24 women had undergone abortion. The reasons for having abortion as a method of family planning, are presented in Table XIX.

TABLE XIX
REASONS FOR ABORTION

S.No	Reasons	Percentage (N:24)
1.	Unwanted pregnancy	67
2.	Health condition	8
3.	Preference of sex	8
4.	Large family	4
5.	Others	13

Out of 24 samples who had undergone abortion, 67 per

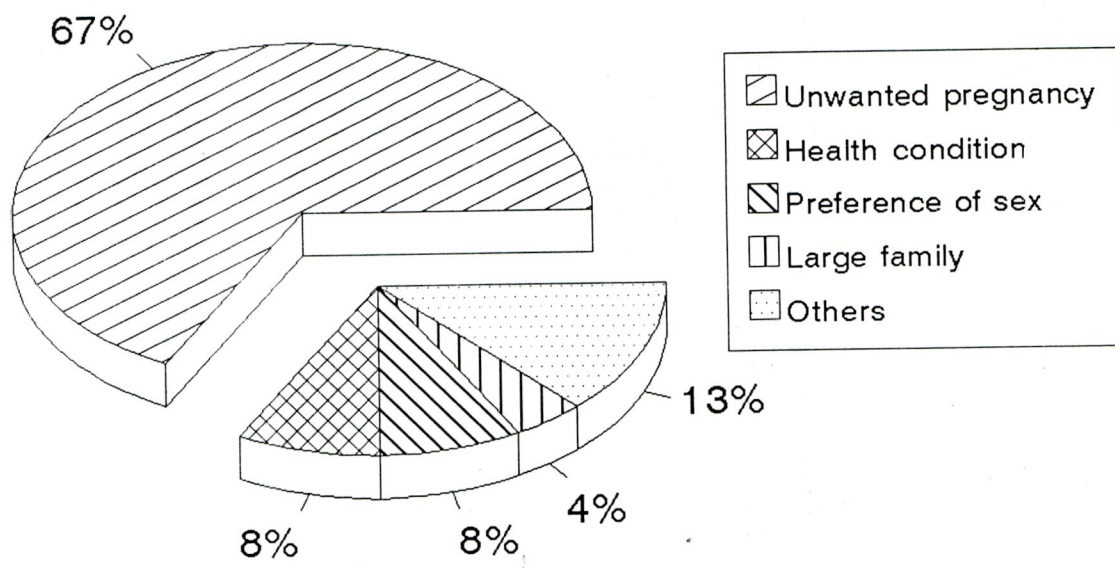
Out of 24 samples who had undergone abortion, 67 per cent had unwanted pregnancy, 8 per cent had it due to health condition, 8 per cent had preference of sex and 4 per cent had large family and 13 per cent had other reasons like miscarriage (Figure IV).

C. Maternal and Child Health Programme

Family Welfare Programme creates a sense of security in the minds of parents that the children born will live a healthy life, which in turn will contribute greatly to the acceptance of small family norm as a way of life. With this objective in view, Maternal and Child Health Scheme have been sponsored by the Ministry of Health and Family Welfare.

As part of the overall strategy for reduction of infant, child and maternal mortality rates, the following specific programmes have been under implementation in the country.

- (i) Universal Immunization Programmes (UIP) for the control of vaccine preventable diseases namely, diphtheria, pertussis neonatal tetanus, tuberculosis, polio myelitis and measles.
- (ii) Oral Rehydration Therapy (ORT) Programme for control of deaths due to dehydration caused by diarrhoea.
- (iii) Prophylaxis schemes against nutritional anemia among pregnant women and against blindness due to vitamin 'A' deficiency among children of under 3 years of age (Ministry of Health and Family Welfare, 1995).



REASONS FOR ABORTION
Figure 4

1. Details of health check-up during pregnancy

The number of antenatal care visits and the timing of the first antenatal check-up are important for the health of the mother and the outcome of the pregnancy. Ideally, for normal cases antenatal care visits after confirmation of pregnancy should be scheduled at intervals of four weeks throughout the first seven months, then every two weeks until the last month and weekle thereafter (MacDonald and Pritchard, 1980). However, working women, particularly those from lower socio-economic groups, often find it difficult to make frequent visits to an antenatal clinic because they face a loss of wages whenever they attend (Park, 1995). The Child Survival and Safe Motherhood Programme has a slightly more modest goal of providing at last three antenatal check-ups to all pregnant women (Ministry of Health and Family Welfare, 1992 b).

The details of health check-ups obtained by the respondents during pregnancy is given in Table XX.

TABLE XX
DETAILS OF HEALTH CHECK-UP DURING PREGNANCY

S.No	No. of Health Check-up	Mothers Having										
		One Child N:41	2 Children N:35		3 Children N:15			Four and above N:9				
		Primary Pregnancy	1st Preg- nancy	2nd Preg- nancy	1st Preg- nancy	2nd Preg- nancy	3rd Preg- nancy	1st Preg- nancy	2nd Preg- nancy	3rd Preg- nancy	4th Preg- nancy	5th Preg- nancy
1.	1 Time	-	-	-	-	-	-	-	1	1	1	-
2.	2 Time	1	-	1	-	-	-	1	1	-	-	-
3.	3 Time	2	1	1	-	2	2	-	-	-	-	-
4.	4 Time	2	1	1	-	-	-	-	-	-	-	-
5.	5 Time	36	33	32	15	13	13	6	5	6	6	2

From the above table, it is clear that most of the respondents had the knowledge that they should go for health check-up during pregnancy.

Among 41 respondents, who had only one child, 36 respondents had health check-up for five times. Thirty five respondents had two children, 33 had health check-up for five times during the first pregnancy and 32 had five check-ups during second pregnancy.

2. Details of deworming

The details of deworming taken up by the respondents are given in Table XXI.

**TABLE XXI
DETAILS OF DEWORMING**

S.No	Aspects	Percentage (N:100)
Reasons for deworming		
1.	For better/good health	3
2.	Necessary for growth of foetus	1
Reasons for not deworming		
1.	Unaware of the information	61
2.	Doctor has not advised	29
3.	Did not feel the necessity	4
4.	Health condition	2

Three per cent of the respondents felt that it was for better/good health and only one woman gave the reason as it was necessary for growth of foetus. Whereas, the majority (61 per cent) were not dewormed because they had no idea or knowledge about the programme.

3. Immunization during pregnancy

According to the National Immunization Schedule, a pregnant woman should receive two doses of tetanus toxoid injection, the first when she is 16 weeks pregnant and the second when she is 20 weeks pregnant (Central Bureau of Health Intelligence, 1991). Reinoculation is recommended every three years. If the initial doses were received less than three years ago a single booster injection is recommended (National Family Health Survey, 1993).

The details of immunization taken up by the respondents during pregnancy are given in the Table XXII.

TABLE XXII
SOURCE OF GETTING IMMUNISED

S.No	Aspects	Percentage (N:100)
1.	Government hospital	56
2.	Private clinic	44
Immunization status		
Primary Pregnancy		
1.	Complete	99
2.	Incomplete	1
Multiple Pregnancy (N:59)		
1.	Complete	100
2.	Incomplete	

All the women selected as sample were immunised during pregnancy, 56 per cent had been to the government hospital for getting immunised. Out of 100, a majority (99 per cent) had been completely immunised during primary pregnancy; in multiple pregnancy also all had completed immunization (Plate III).



PLATE III : PREGNANT WOMAN RECEIVING TETANUS
TOXOID (TT) INJECTION

4. Vaccination for the children

It was heartwarming to note that all the selected women were aware of the need for vaccination for their children. But the knowledge of the mothers about the schedule in which the child should be given vaccination, varied from mother to mother. More than 75 per cent women were able to give the correct schedule whereas the rest of the women need education on this aspect. Effective Mass Media Net Work could be established to propagate this idea.

5. Immunization of the children

The Universal Immunization Programme, was launched on November 19, 1985 and was dedicated to the memory of Smt. Indira Gandhi. The National Health Policy aims at achieving Universal Immunization coverage of the eligible population by 1990.

One effective way of controlling the spread of infection is to strengthen the host defense. Under certain circumstances this may be accomplished by active immunization, which is one of the most powerful and cost effective weapons of modern medicine. There are some infectious diseases whose control is solely based on active immunization eg. Polio, Tetanus, Diphtheria and Measles. Vaccination against these diseases is given as a routine during infancy and early childhood with periodic boosters to maintain adequate levels of immunity.

In May 1988, World Health Assembly, a resolution was passed to achieve the goal of polio eradication by the year 2000. The goal of polio eradication is defined as no cases of clinical poliomyelitis associated with poliovirus, and no wild poliovirus found despite intensive efforts to do so.

In India, the Universal Immunization Programme has been able to increase the Oral Polio Vaccine (OPV) coverage levels among infants to over 90 per cent for five successive years, which is a commendable achievement, and the number of polio cases have dropped significantly.

The Government of India has decided to implement the strategy of National Immunization Days, i.e. Pulse Polio Immunization, beginning in 1995 to achieve polio eradication by the year 2000. Pulse Polio Immunization (PPI) is

- * From 1996, children of 0-5 years of age will be given OPV on one single day, irrespective of previous immunization status. This is repeated 4-6 weeks later. The purpose of PPI is to reduce the circulation of the wild polio virus.
- * PPI is organized during the low transmission season of polio viruses between November to February in India. The peak transmission is from May to September.
- * These additional rounds are in addition to sustaining high levels of immunization coverage of at least 85 percent in

infants with three doses of oral polio vaccine (OPV) all through the year .

It was expressed by the women that 98 per cent of the children had been immunized and possessed immunization card also. The details of immunization are given in Table XXIII.

TABLE XXIII
DETAILS OF IMMUNIZATION

S.No Aspects	Mothers Having										
	One Child N:41	2 Children N:35		3 Children N:15			Four and above N:9				
		1st Child	2nd Child	1st Child	2nd Child	3rd Child	1st Child	2nd Child	3rd Child	4th Child	5th Child
1. No. of Children Immunised	39	35	35	15	15	15	7	7	7	7	2
2. No. of Children Possessed Immunization Card	39	35	35	15	15	15	7	7	7	7	2

Among 41 respondents having only one child, 39 respondents had their child immunised. The remaining had not done it because they were scared that their child would get hurt. But those who had more than one child had their children immunised whether they were first child or not.

The immunization status of the children is given in Table XXIV.

TABLE XXIV
IMMUNIZATION STATUS

S.No Aspects	Mothers Having										
	One Child	2 Children		3 Children			Four and above				
	N:41	N:35		N:15			N:9				
	1st Child	2nd Child	1st Child	2nd Child	3rd Child	1st Child	2nd Child	3rd Child	4th Child	5th Child	
1. Complete BCG	39	35	35	15	15	15	7	7	7	7	2
2. Complete OPV	20	33	26	15	15	13	7	7	6	5	2
3. Complete DPT	20	33	26	14	15	13	7	7	6	5	2
4. Complete Measles	23	33	25	14	15	13	7	7	6	5	2

Out of 41 respondents having only one child, children of 39 respondents had complete BCG, 20 had complete OPV and DPT but 23 had complete measles vaccination. Regarding the others who had not completed, the children were yet to reach the age for completing the doses (Plate IV and V).

6. Prophylaxis against Anaemia and Vitamin A deficiency

The main aim of prophylaxis against blindness due to Vitamin A deficiency programme is to reduce the incidence of blindness occurring due to vitamin A deficiency.

It is an important aspect in the welfare of women and children. From the data collected for the study, it is derived that only 55 women received ferrous sulphate and eight children were administered with Vitamin A solution.



PLATE IV : A CHILD BEING VACCINATED



PLATE V : A CHILD GETTING ORAL POLIO VACCINE (OPV)

Among the 55 women, 44 received iron tablets on their own, and only 11 utilised the services of primary health centre. Regarding Vitamin A solution for children, only 8 received from PHCs. The reason given by the mothers for not taking iron tablets and Vitamin A for children were lack of knowledge of the mothers and they did not realise the importance of the programme.

7. Oral Rehydration Therapy (ORT)

Eighty three per cent of the selected sample were aware of Oral Rehydration Therapy (ORT). Among them 55 per cent obtained the solution from PHC. Others (45 per cent) prepared it by themselves. When the children suffered due to dehydration, they prepared Oral Rehydration Salts (ORS). When they felt that the diarrhoea was serious, the children were taken to the hospitals. Seven per cent preferred to give electrol, the readily available powder for dehydration.

Summary and Conclusion

V SUMMARY AND CONCLUSION

The study on "Family Welfare Measures Adopted by Women in Imphal District, Manipur State" was carried out in the selected four localities with a sample consisting of 100 women belonging to the age group between 20 and 40 years and having at least a child of six months old. The major findings of the study are summarised thus :

A. Profile of the Sample

Regarding the type of family, 58 percent of the selected families were of nuclear type. Concerning the size of the family, 46 percent of the respondents were of medium size having member (4-6). Out of the total family members (532) 54 percent were females. From the study it is found that 61 percent were in the active age group, i.e., 21 and 40 years. Among the total family members of the respondents, 36 percent had completed high school. Nearly half of the respondents, i.e., 48 percent, belonged to middle income group i.e., Rs.2001 to 6000 per month.

Looking into the information about selected sample, 40 percent of the respondents were in the age group of 30 to 35 years. About half of the sample (49 percent) had completed higher secondary education. Seventy three percent of the respondents were full time homemakers. About 96 percent of the

respondents were leading happy married life, three percent were separated and one was a widow. It is heartwarming to know that 76 percent of the respondents had only one child or two children, 41 percent of the respondents got married between 25 and 30 years of age.

The number of children born in the past five years, were 55 female children and only 36 male children. The infant mortality was very low, i.e., only one female death occurred in the past five years. In the last five years, the female death was low i.e., among the total 13 deaths occurred, eight were male and five were female.

B. Family Planning Programme

Thirty eight percent of respondents received information on family planning from elders and books/magazines. Fifty five sample women had adopted family planning method; 45 were yet to adopt because most of them felt that having a son was a necessity for continuation of the lineage of the family. Among 55 of the respondents 29 women had been to the private clinics to get contraceptives and two women had undergone sterilization at their own expenses. About 40 percent out of 55 respondents had adopted Intra-Uterine Device (IUD) as the best family planning method, twenty percent used condoms and only four percent opted tubectomy. No one of the woman's husband had undergone

vasectomy. Among the 55 respondents, 78 percent adopted family planning method because they preferred to have a small family. Among the eleven respondents, 73 percent expressed that the oral pill was easy to adopt. Out of 100 respondents, 65 had supported Medical Termination of Pregnancy (MTP). About 34 percent supported MTP to have a small family. Out of 35 respondents, 68.5 percent had not supported MTP because it might affect the health of the mother. Among the 24 respondents who had undergone abortion, 67 percent had given the reason for abortion as "unwanted pregnancy".

C. Maternal and Child Health Programme

Most of the respondents had the knowledge about the need for health check-up during pregnancy and they practiced it also. Only three percent had deworming for better/good health and the others did not adopt the practice because of their unawareness of the information.

About 56 percent went to the Government Hospital to get immunization during pregnancy. During primary pregnancy, 99 percent had completed immunization and 100 percent had completed immunization during multiple pregnancy. All the respondents were aware of the need for vaccination for their children. More than 75 percent women were able to give the correct schedule whereas the rest need education on this aspect. Regarding immunization

for the children, out of 41 respondents, who were having only one child, 39 had immunised and possessed immunization card and also had completed BCG vaccination.

Regarding prophylaxis against anaemia and Vitamin A deficiency, 44 respondents received iron tablets and 8 children received vitamin A solution.

Regarding Oral Rehydration Therapy, 83 percent were aware of the message ; among them, 55 percent obtained the solution from PHC and used it.

CONCLUSION

It is worth to study "Family Welfare Programme Adopted by Women ; the investigator found out that majority of the respondents were aware of Family Welfare Programme and most of the respondents had adopted Family Planning Methods, since majority of them preferred 'small family'. Efforts can be made to educate the women and the family members to make all the components of Family Welfare Programme being adopted by everyone and reach "Heal for All by 2000 A.D".

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Appendices

APPENDIX I

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION
FOR WOMEN (DEEMED UNIVERSITY), COIMBATORE - 641 043.

INTERVIEW SCHEDULE TO ELICIT INFORMATION REGARDING
FAMILY WELFARE MEASURES ADOPTED BY WOMEN IN
IMPHAL DISTRICT, MANIPUR STATE

Date :

Place :

I. GENERAL INFORMATION

Name of the Interviewee :
Address :

II. FAMILY BACKGROUND OF THE SAMPLE

Type of the Family : Joint () Nuclear () Extended ()
Size of the Family : Small () Medium () Large ()
(1-3) (4-6) (above 6)

S.No	Name of members in the family	Sex M F	Relation-ship with respondent	Age in years					Educational level					Occupation			Income of the family		
				0-5	6-10	11-15	16-20	21 & above	PG	UG	H.Sc	HS	Illi- trate	Others	Govt job	Non- govt job	Low <2000	Middle 2001-6000	High >6000

III BACKGROUND INFORMATION ABOUT SELECTED WOMEN

Age in Years

20-25 () 25-30 () 30-35 () 35-40 ()

Marital Status

Married () Seperated () Widow ()

Age level of women at the time of marriage :

Less than 20 () 20 - 25 ()
25 - 30 () More than 30 ()

Number of children having :

One () Two () Three () More than three ()

Number of children born : Male : Female :

Number of children living : Male : Female :

Number of births given during past five years in family :

Male Female

Number of Infant deaths occurred during past five years in family :

Male Female

Number of deaths occurred during past five years in family :

Male Female

IV. FAMILY PLANNING PROGRAMME

1. Are you aware of family planning ? Yes () No ()

2. If yes, source of information

Elders () Books/Magazines() Friends() Television()
Radio() Government Hospital() Newspaper() Private Clinic()

3. Have you adopted family planning ? Yes () No ()

If yes, method adopted by you : Intra-Uterine Device(IUD) ()
Condom () Oral Pills () Tubectomy () Vasectomy ()
Any other (specify)()

4. Reason for adoption of family planning :

Preference for small family ()

Could not afford to manage large family with available income ()

Health Condition ()

5. Views about Oral Pills :

Advantages

Easy to adopt () Good for spacing ()
Suitable for newly married women ()

Disadvantages

There is side effect () It leads to loss of weight ()
There is gain in weight ()

6. Source for contraceptives and sterilization

S.No	Government Hospital	Private Clinic
a.	Contraceptives	
b.	Sterilization	

V. MEDICAL TERMINATION OF PREGNANCY (MTP)

1. Do you support the idea of MTP ? Yes () No ()

If yes, reason

To have a small family ()	To protect the health of the mother ()	To reduce population ()	To keep spacing between the birth ()
----------------------------	---	--------------------------	---------------------------------------

If no, reason

It affects the health of the mother ()	It is a sin ()	Others (Specify) ()
---	-----------------	----------------------

2. Have you undergone any abortion ? Yes () No ()

If yes, reason is

Unwanted pregnancy () Health condition ()
Large family () Others (specify) ()

I MATERNAL AND CHILD HEALTH PROGRAMME

1. Number of health check-ups during pregnancy

Mothers Having

S.No	No. of health check-up	Mothers Having										
		One Child	2 Children		3 Children			Four and above				
		Primary Pregnancy	1st Preg-nancy	2nd Preg-nancy	1st. Preg-nancy	2nd Preg-nancy	3rd Preg-nancy	1st Preg-nancy	2nd Preg-nancy	3rd Preg-nancy	4th Preg-nancy	5th Preg-nancy

1. 1 Time
2. 2 Time
3. 3 Time
4. 4 Time
5. 5 Time

2. Does the mother deworm ? Yes () No ()

If yes, reason is . : For better/good health ()
 Doctor has not advised () Necessary for growth of foetus ()
 Others (specify) ()

If no, reason : Unaware of the information ()
 Doctor has not advised () Did not feel necessity ()
 Health Condition ()

3. Immunization during pregnancy :
 (i) Source : Government Hospital () Private Clinic ()
 (ii) Immunization status :

S.No	Complete	Incomplete
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- a. Primary pregnancy
- b. Multiple pregnancy

4. Immunization knowledge of mother :

1. Does the mother know that the child should receive vaccine ?

Yes () No ()

If yes, when ? ()

5. Immunization of the children :

(i) Do you possess immunization card for your child/children ?

Yes () No ()

DETAILS OF IMMUNIZATION

		Mothers Having									
		One Child		2 Children		3 Children			Four and above		
S.No	Aspects	1st Child	2nd Child	1st Child	2nd Child	3rd Child	1st Child	2nd Child	3rd Child	4th Child	5th Child
		Y	N	Y	N	Y	N	Y	N	Y	N

1. No of Children Immunised
2. No. of Children Possess Immunisation Card

II. IMMUNIZATION STATUS OF THE CHILDREN

		Mothers Having									
		One Child		2 Children		3 Children			More than 3 Children		
S.No	Aspects	1st Child	2nd Child	1st Child	2nd Child	3rd Child	1st Child	2nd Child	3rd Child	4th Child	5th Child
		Y	N	Y	N	Y	N	Y	N	Y	N

1. Complete BCG
2. Complete OPV
3. Complete DPT
4. Complete Measles

* Y - Yes N - No

6. Prophylaxis against anaemia and Vitamin A deficiency
Does the mother and child receive the following tablets :

S.No	Iron Tablets	Vitamin A
a. Mother		
b. Child		

If yes, source :

S.No	Government Hospital	Primary Health Centre
a. Mother		
b. Child		

If no, reason is : Lack of knowledge ()
Mother and child in good health () Any other(specify) ()

7. Oral Rehydration Therapy (ORT)

- (i) Do you know about ORT ? Yes () No ()
(ii) When your child have diarrhoea, what type of treatment do you give ?

Give ORT () Home Available Fluids (HAF) () Take to Hospital ()
Home treatment () Any other (specify) ()

- (iii) Do you get Oral Rehydration Salts (ORS) ? Yes () No ()

If yes, source
Government Hospital () Primary Health Centre ()
Own expenditure ()

If no, give reason