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International Journal of Current Research
Vol. 7, Issue, 03, pp.13579-13584, March, 2015

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

RESEARCH ARTICLE

A STUDY OF FAMILY WELFARE PROGRAMMES IN SOUTH 24 PARGANAS DISTRICT, WEST BENGAL

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ARTICLE INFO

Article History:
Received 18th December, 2014
Received in revised form
09th January, 2015
Accepted 07th February, 2015
Published online 17th March, 2015

Key words:
Family welfare,
Quality of life,
Intrauterine devices,
Human resources,
Standard of living.

ABSTRACT

The formulation of proper Population Policies are indeed important for any Government since unrestrained population growth can be a hindrance for the socio-economic development of a nation. In India the Family Welfare Programmes were undertaken since the First Five Year Plan initiated way back in 1951-56. Since then various measures ranging from permanent and temporary methods of birth control, sterilization, sex-education, counseling, regulation of age at marriage etc has been initiated by Government under different plan periods. The paper is an attempt to trace the achievements and failure of these programmes in South 24 Parganas District of West Bengal considered as one of the fastest developing districts within the State. The study has been carried out through analysis of secondary data collected from various Government departments and through extensive field investigation, personal interview and focused group discussion to bring out the real scenario of implementation of these programmes in the district under study.

INTRODUCTION

The concept of welfare is very comprehensive and is basically related to quality of life. The family welfare programme aims at achieving a higher end that is improve the quality of life of the people (Park, 2005). The term 'family welfare' signifies the improvement of the quality of health and welfare of the entire family. A sets of attributes like sex education, pre-marital test, counseling, regulation of age at birth of first child, supply of contraceptives, screening for reproductive system diseases, investigation and treatment of sterility, antenatal and post natal care, proper spacing and limitation of births etc. are included under this system. Mainly married couples adopt these practices to improve their standard of living and a better welfare for themselves and for their children. Anticipating the impending population increase, the Government of India took certain steps after Independence to curb population growth. Along with socio-economic development plans, population control was also taken up in the name of family planning. In ancient India, large families were seen due to certain social and religious obligations as well as due to the high infant and child mortality rates prevailing at that time. But on the eve of Independence, the Health and Development Committee popularly known as the Bhore Committee (1943-1946) expressed concern about the steady growth of population (Voluntary Health Association India, 1992).

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Objectives

A sets of objectives have been formulated to fulfill the study. These are as follows:

- To know about the standard of living of the people in the area under study
- To study the success and failure of family planning methods in the district
- To enhance the awareness among people about effects of population explosion
- To evaluate the efficacy of permanent method and temporary methods for birth control

MATERIALS AND METHODS

The work is based on both primary and secondary data. Extensive literature survey has been done for the work. The secondary data have been collected from different Government sources. Primary data have been generated through questionnaire survey meant for target groups of families within the district of South 24 Parganas following purposive method of sampling technique. After collection of both the data, they have been computed through cartograms followed by interpretation.

RESULTS AND DISCUSSION

A Discussion on Five-Year Plans and Family Welfare Programmes

After Independence, Government has realized that socio-economic development is largely dependent on human resource. To enrich the socio- economic development, various family welfare programmes which are related with human resource had been included in five-year plans. Some major objectives of five-year plans were rising the age at marriage for girls, improvement in the standard of living, and internal limitations of families.

First Five- Year Plan (1951-1956)

In first five- year plan, two advisory panels were appointed, one for health and another for social welfare. The heath panel appointed a sub-committee for population growth and family planning. The objectives during first five year plan were:

- To obtain an accurate picture of the factors which contribute to the rapid increase of population
- To devise speedy ways of educating the public
- To make family planning advice and services an integral part of the services in hospitals and health centres

Second Five -Year Plan (1956-1961)

The Planning Commission was aware of the possible constraints on the impact of family planning during this period and was apprehensive of future economic growth. During this period the Government of India delineated the following measures:

- To develop services, and the research and training programmes initiated during the first five year plan
- To establish the number of service clinics
- Introduce sterilization services, free of cost, for male and female
- To offer 100 percent central assistance to the State Government to provide sterilization facilities for the benefit of people in all parts of the country

Third Five- Year Plan (1961-1966)

In third five year plan emphasis on social measures such as education, particularly women, employment, rural water supply and expansion of family planning programmes. During this time family welfare programmes were given high priority and people were reluctant to accept the good clinical services facilities. Some measures were adopted during this period;

- Various conventional contraceptives were made available to the people free of cost in both rural and urban areas through hospital, clinics, primary health centres etc.
- To maintain the voluntary nature of the family planning programme, the choice of contraceptive method was left to acceptors
- The Intrauterine contraceptive Device (IUD) , commonly known as the 'loop' insertion was introduced in the programme as a measure of birth control during the last year of the third plan

Fourth Five- Year Plan (1969-1974)

In fourth five year plan, the main goal was to achieve a faster rate of reduction of birth rate. Objectives of this plan were;

- Bring about group acceptors of the small family norm
- Enhance knowledge about family planning methods
- Make supplies and services readily available

Fifth Five- Year Plan (1974-1979)

In fifth five year plan, family planning had been provided through multi-purpose workers who will pay special attention to family planning motivations and services. Some approaches of this plan were;

- National minimum needs programme was introduced for the rural areas to ensure a minimum uniform availability of public health facilities, family planning, nutrition and detection of morbidity
- Family planning programme would be carried forward in an integrated manner along with health, maternity and child health care and nutrition, as a proper service delivery of family planning components
- Newly married couples and in the age group between 25 to 35 , would taken two children

Sixth Five – Year Plan (1980-1985)

The sixth five - year plan was formulated, taking into consideration past failure and achievements and keeping in view the vision of the future. Some objectives during this plan were:

- Reduction in the incidence of poverty and unemployment
- Improvement in the quality of life of the people
- Promotional policies to control the growth of population through voluntary acceptance of the small family norm

Seventh Five- Year Plan (1985-1990)

The major approaches during this plan period were;

- Effective couple protection rate would be 42 percent by 1990
- Crude Birth Rate per 1000 population would have to be comedown in 29
- Crude Death Rate per 1000 population would have to be come down 10.4
- Immunization coverage would be 100 percent by 1990
- Antenatal coverage of pregnant cases would have to be 75 percent in this period

To achieve these goals, the plan emphasized the various components of the family welfare programme as also declined to undertake certain other measures outside family planning

which would help persuade people to adopt family welfare measures and thus bring down the birth rate.

Eighth Five- Year Plan (1992-1997)

The objectives of eighth five- year plan were;

- Generation of adequate employment to achieve near full employment by the turn of the century
- Containment of population growth through active people's co-operation
- Universalisation of elementary education and eradication of illiteracy in the age group of 15 to 35
- Provision of safe drinking water and primary health care facilities, including immunization

Ninth Five -Year Plan (1997-2002)

The objectives of ninth five- year plan include;

- Ensuring food and nutritional security for all, particularly vulnerable section of the society
- Providing the basic minimum services of safe drinking water, primary health care facilities
- Containing the growth rate of population

Tenth Five – Year Plan (2002-2007)

The main aim of this plan was to improve the quality of life of the people. To fulfill this aim some approaches had taken; Bringing down the decadal population growth rate to 16.2 percent in 2010-2011 Reduction of maternal mortality ratio to two percent and infant mortality rate to 45 per 1000 live birth, provide potable drinking water to all the villages.

Eleventh Five-Year Plan (2007-2012)

The eleventh five-year plan is designed to reduce poverty and focus on bringing the various divides that continue to fragment our society. Other objectives during this plan were, to reduce Infant Mortality Rate to 28 and maternal Mortality Rate to1 per 1000 live births, to reduce fertility rate to 2.1 and provide drinking water to all by 2009.

Twelfth Five-Year Plan (2012-2017)

Some approaches have been taken during this plan. These are;

- Health sector expenditure by the centre and states, both planed and non-plan, will have to substantially increased by the end of the twelfth plan
- Financial and managerial systems will be redesigned to ensure more efficient utilization of available resources and to achieve better health outcomes
- Effective regulation in medical practice, public health, food and drug is essential to safeguard people against risk, and unethical practices
- The health system in twelfth plan will continue to have a mix of public and private service providers

Norms for Family Welfare Programme

Aims of the programme was to extend the delivery system into the community. Here it is said that 100,000 populations will serve in a PHC. The population target for Sub-centres has been revised to one sub-centre per 5,000 population by the end of seventh plan. At least one Village Health Guide and one trained Dai will distribute family planning materials like oral pills, Condom, IUD etc. per 1,000 rural people.

Programmes under Family Welfare

Ministry of Health and Family Welfare Programmes have introduced some methods to reduce birth rate. There are two main methods one is permanent method which is also called sterilization and another one is temporary method. Various materials like condom, foam tablets, oral pill, Intrauterine Device, etc are included in temporary method.

Permanent method or Sterilization

Sterilization is a permanent contraceptive procedure of couples for small family sizes. Both male and female can sterilize. The method of male sterilization is called Vasectomy and female sterilization is called Tubectomy. To cover the risk of mortality the couple is normally unwilling to accept sterilization before having son.

Table 1. Family Welfare Norms

Level	Functionaries	Family PlanningServices Provide
PHC(1 per 10,000 population)	Medical Officer and supporting Staff	I)Condom, diaphragram, jelly II)IUD III)Vasectomy IV)Tubectomy and Abortion
Sub- centre (Covering 5000- 10000 populations at present	One Male and One Female Multi Purpose Worker	I)Condom II)Oral pill III)IUD
Village (approx 1000 populations)	One Village Health Guide and One Trained Dai	I)Condom II) Oral pill

Source is Sharma, 1989

Vasectomy

Vasectomy being a comparatively simple operation can be performed even in Primary Health Centers by trained doctors (Park, 2005). Failure rate of vasectomy is very low that is 0.15 percent. In South 24 Parganas district, during 2007-08 the vasectomy rate was high in Baruipur subdivision and was nil in Canning subdivision.

Subdivision-wise permanent method of sterilization in south 24 pargans district

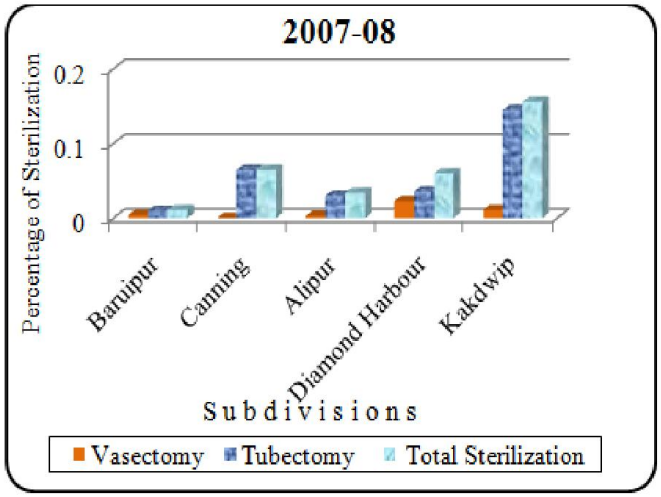

Fig.1. Permanent Sterilization Method, 2007-08

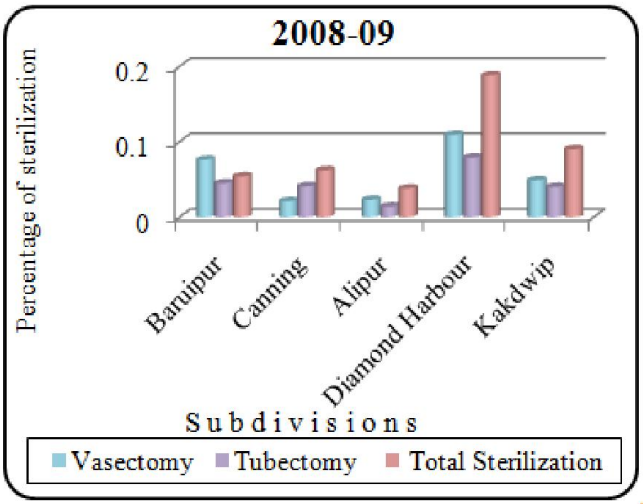

Fig.2. Permanent Sterilization Method, 2007-08

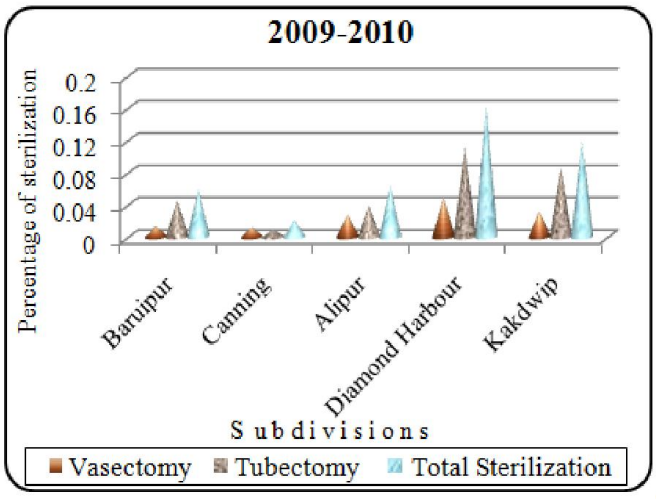

Fig.3. Permanent Sterilization Method, 2009-10

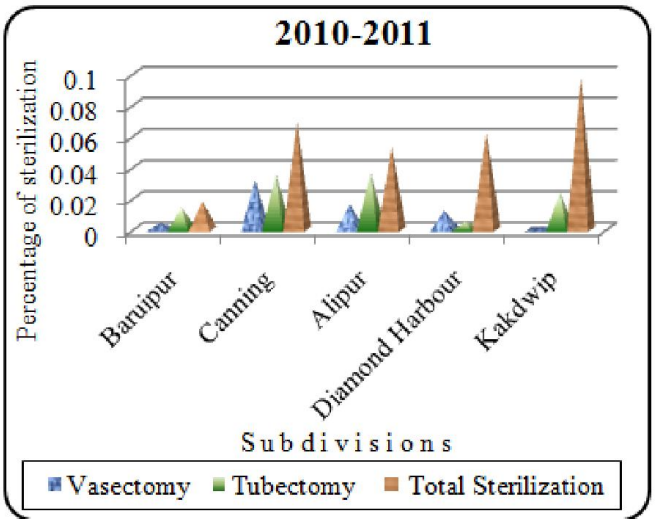

Fig.4. Permanent Sterilization Method, 2010-11

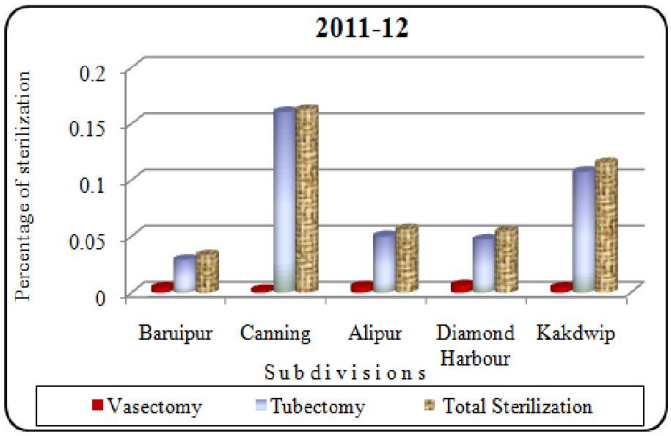

Fig.5. Permanent Sterilization Method, 2011-12
Data source: CMOHII, South 24 Parganas

But from the year 2008-09 to 2011-12, the vasectomy rate was more in Diamond Harbour and Alipur subdivisions. In Diamond Harbour, during 2008-09, 0.19 percent male person had undergone sterilization and in the year of 2010-2011, 0.2 percent male person had undergone sterilization in Alipur subdivision. From the year 2007-08 to 2011-2012, the vasectomy rate was high in Diamond Harbour and Alipur subdivisions than other subdivisions in the study area.

Tubectomy

Tubectomy is the sterilization method applied only for female persons. Tubectomy or tubal legation is done either through a minilap technique or by the laparoscopic method (Rao, 2011). The failure rate of tubectomy is 0.5 percent. In the study area, it is observed that during 2007-08, the tubectomy rate was high in Kakdwip subdivision. Total sterilization rate was 0.16 percent in Kakdwip subdivision. Out of total Sterilization, tubectomy rate was 0.15 percent in Kakdwip subdivision. In Canning subdivision, total sterilization rate was 0.06 percent and where vasectomy rate was nil. During 2008-09, sterilization rate was high in Diamond Harbour subdivision. From the year 2009-10 to 2011-12, total sterilization rate was high in Diamond Harbour and Kakdwip subdivisions. It is

known that sterilization is accepted at a late stage in family formation, after bearing the desired number of living children. Through personal interview, it is known that two living children are desired by respondents before getting sterilized. Every couple wants to have at least one son surviving to their old age to provide them with economic support. But in the study area as well as in our country, female sterilization is about more than 80 percent where male sterilization is only about nearer to 10 to 15 percent. Though, male operation is simpler, safer and cheaper than female operation (Bhate, 1978).

Effects of Sterilization

Through personal interaction it was observed that, people sterilized by their consent. Nobody could be forced to accept sterilization. Very few people have undergone the operation to obtain the money provided as incentive by Government. Some people said that they have sterilized because to reduce the family member and to maintain minimum standard of living. The satisfaction also depends on the psychological side one gets from avoiding the risk of further pregnancy. There are some side effects of sterilization which have been known through primary survey. Sometimes they feel discomfort and ailments. The male person said that after operation they feel pain and suffer infection. After tubectomy operation, female person said that they suffer lower abdominal pain. Someone replied that after operation they suffer urinary infection, back-ache etc.

Temporary Method or Spacing Method

Spacing methods have increased in popularity quite recently because of certain contraceptive and non-contraceptive advantages. The main contraceptive advantage is the absence of side effects associated with the pill and IUD. The non-contraceptive advantages include some protection from sexually transmitted disases (Park, 2005). The temporary methods are use of Condom, IUD, Vaginal sponge, Foam, Copper-T, Abortion, Birth control Vaccine, Oral pill etc. In the study area, the usual temporary methods for birth control under family welfare programmes are Intra Uterine Device, Oral pill and distribution of Condom.

Intra Uterine Device

Intra Uterine Devices are mainly two types. One is medicated and another one is non-medicated.

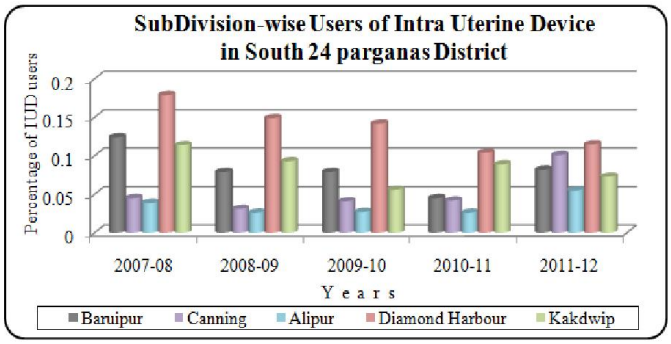

Fig.6. Subdivision-wise users of Intra Uterine Device in South 24 parganas District

Data source: CMOH II, South 24 Parganas

The non-medicated or inert IUDs are often referred to as first generation IUDs. The copper IUDs comprise the second generation of IUD. At present, another IUD in introduced which is called hormone- releasing IUDs that are the third generation of IUDs (Park, 2005). Both first and second generation of IUDs is distributed in the study area. The couples are slightly more interests about it than sterilization. From 2007-08 to 2011-12, the user of IUDs were maximum in Diamond Harbour subdivision than other four subdivisions in the district. In Alipur subdivision, the percentage of IUD user is low.

Oral Pill

Oral pill is one of the popular spacing methods of contraception. Most of the couple use this spacing method. Usually female person take it for spacing birth between two children. During 2007-08, the number of oral pills distributed was more in Diamond Harbour Subdivision. From the year 2008-09 to 2011-12, the number of oral pills distributed was more in

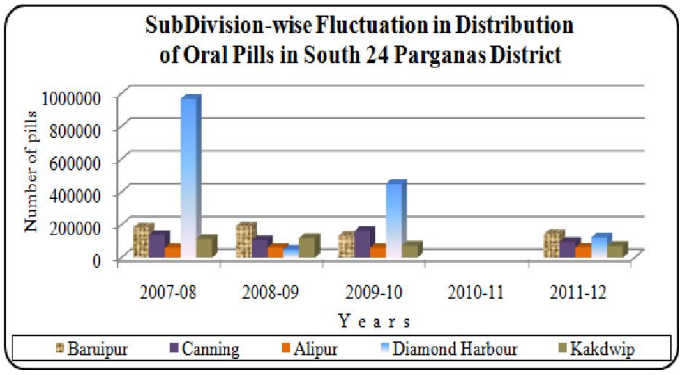

Fig.7. Subdivision-wise Fluctuation in Distribution of Oral Pills in South 24 District

Data source: CMOH II, South 24 Parganas

Kakdwip subdivision than four other subdivisions in the district. Out of five subdivision in the study area, number of oral pill distributed was minimum in Alipur subdivision.

Nirodh

Nirodh is a simple and convenient method of contraception (Rao, 2011). It is used to protect the unwanted pregnancies. Most of the couple used this method. It is a conventional contraceptive method, most widely used by males (Seshu babu, 2004).From the year 2007-08 to 2011-12 the number of Nirodh pieces distributed was more in Diamond Harbour subdivision. Comparatively, number of Nirodh pieces distributed was lowest in Canning subdivision than other subdivisions.

Non-users of Contraceptives

From the personal interview in the study area it is known that some couples have not accepted any of these methods under family welfare programmes. They do not accept these methods because of some socio-economic barriers. Some of them said that artificial birth control is not allowed in their religion.

Another group who have one or more girl child, said that they are trying to give birth to a son. So, they do not want to accept such contraceptive method.

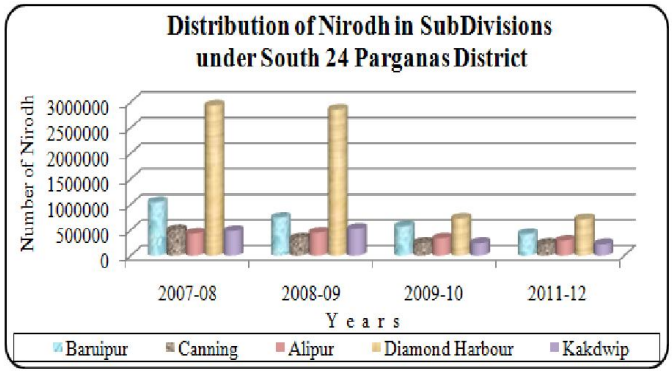

Fig.8. Distribution of Nirodh in Subdivisions under South 24 Parganas District

Data source: CMOH II, South 24 Parganas

Findings

The Family Welfare programme occupies an important position in the socio-economic developmental plans. It plays a crucial role in the human resource development and in improving the quality of life of the people. India was the first country in the world to have a Government – level programme of family welfare and planning. It became an integral part of economic planning right from the first five-year plan (Sharma, 1989). From the entire study, it is revealed that use of the family welfare programmes have increased in the study area than during past. In the district, couples usually preferred temporary method for birth control. Most of the rural people do not accept the sterilization or permanent method of birth control. From the year, 2007-08 to 2011-12, it has been observed that number of tubectomy cases is more in the district than vasectomy cases. Most of the couples want to accept the spacing method of contraception which includes Intrauterine Device, Oral pills, Nirodh etc. Number of acceptors of Family Welfare Programmes is more in Diamond Harbour subdivision than other four subdivisions in study area. During primary survey, it is observed that, most of the respondents particularly women said that health workers do not visit regularly at their locality. They visit occasionally. Rural people are not yet health conscious. But at present, number of acceptors of these programmes has increased. As a result birth rate could be slightly controlled.

Conclusion

Family welfare Programme in our country has been developed under consecutive five-year plans. In the past, it was tough to motivate couple for birth control. But in recent years, it is easy to motivate themselves to reduce the family member. Health workers, NGOs and Medical officers take significant role to activate these programmes. Trained Medical officers should be appointed for permanent method of birth control. There is a need for health education and motivation to use the health services. It is required to enhance awareness among the couples' conception about 'small family happy family'. But in recent times, the annual rate of acceptors of these programmes has increased.

Acknowledgement

I would like to convey my sincere thanks to the Department of Health and Family Welfare for providing me with necessary data and inputs for carrying out my work uninterruptedly. The local people of the district under study both from rural as well as urbanareasdeserve special mention for supporting me to carry out the primary survey smoothly. They have been kind enough to participate in group discussions to analyze the problems and suggest ways for their effective solution. At last, i would like to thanks Ms. Anandita Dawn for encouraging this work.

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