CHAPTER I

INTRODUCTION

CHAPTER I

INTRODUCTION

1.1 Profile of Manipur

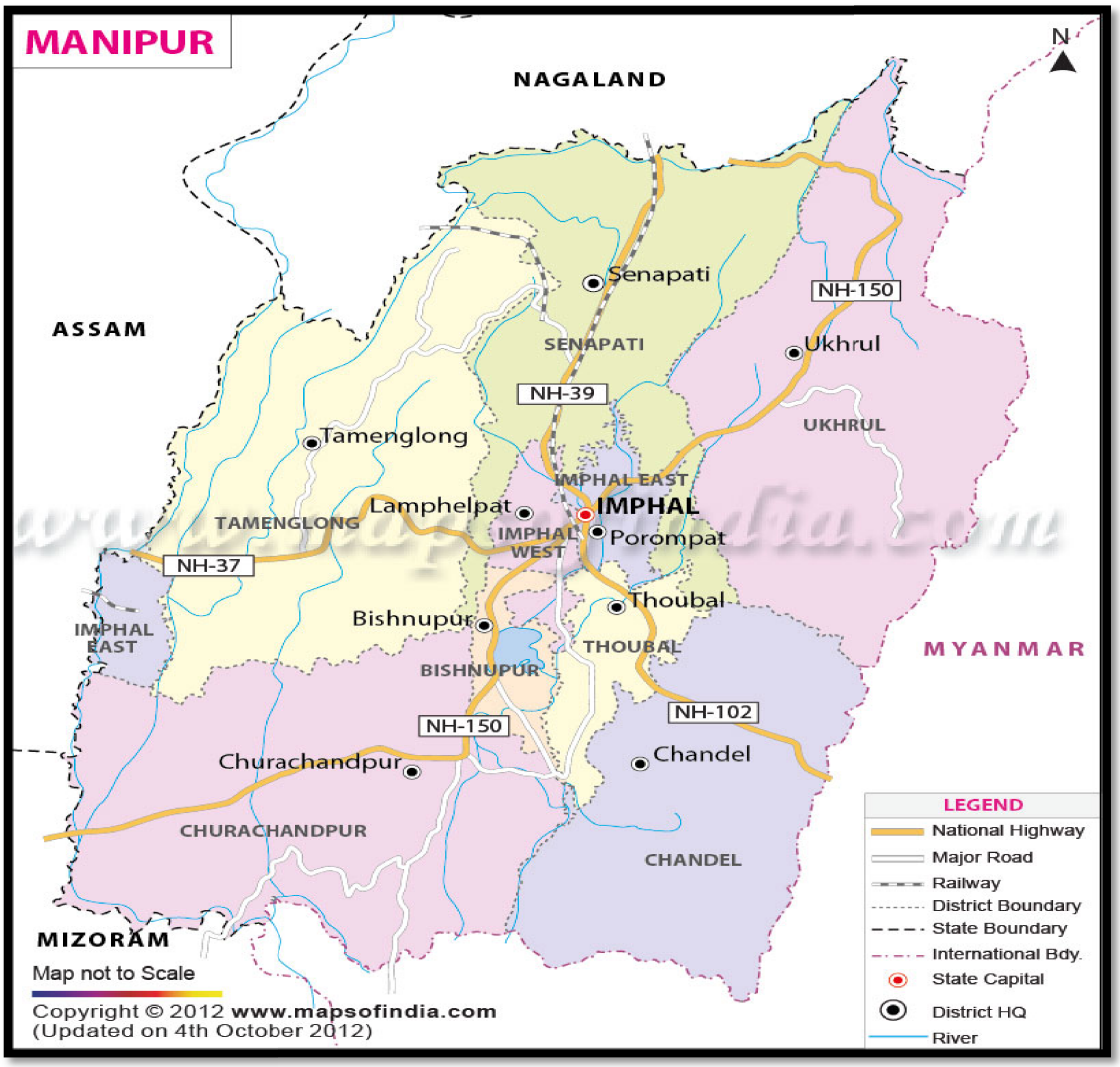

Chart No. 1.1: Map of Manipur

The Manipur is a small State lying in the extreme North Eastern corner of India. It is bounded on the north by Nagaland State, on the south-east by Myanmar and on the west by Mizoram and Cachar District of Assam. Manipur is literally known as "Land of Jewel" by Pandit Jawaharlal Nehru. The State has an area of 22,327 sq.km of which constitutes 0.7 percent of the total land surface of the country. The State has 29 Scheduled Tribes (ST) and 7 Scheduled Caste (SC) having their unique languages,

tradition and culture with ethnic diversity. The state is divided into 9 districts and of which 5 districts are the Hills districts. They are Chandel, Tamenglong, Ukhrul, Churachandpur and Senapati. The four plain districts are Imphal West, Imphal East, Thoubal and Bishnupur. In addition to these, there are three sub-district administrative units. They are Kangpokpi in Senapati, Jiribam in Imphal East and Moreh in Chandel District. The state has 37 sub Divisions.

Table No. 1.1: Population of the Manipur in district wise

Sl. No	**Name of the district**	**District Population**
1	Imphal West	514683
2	Imphal East	452661
3	Thoubal	420517
4	Senapati	354972
5	Churachandpur	271274
6	Bisnupur	240363
7	Ukhrul	183115
8	Chandel	144028
9	Tamenglong	140143
	Total population	**1,721,756**

Source: Census 2011

Table No. 1.2: Population of male and female and literacy rate in Manipur

Population of male and female		Literacy rate of both male and female (Given in both Percentage and figures)
2011		2011
Male	1,369,764	(86.49%) 1,026,733
Female	1,351,992	(73.17%) 864,463
Differences of number between man and female	17772	(13.32%) 162270
Total	2,721,756	(79.85%) 1,891,196

Source: Census 2011

According to 2011 Census, the total population of Manipur is 2,721,756 in compared to 2001 census the total population, 2,293,896. The male population is 1,369,764 and the female population is 1,351,992. The total population growth since last decade was 18.65 percent and the population of the state forms 0.22 percent of the entire population of India. The sex ratio in Manipur is 987 for each 1000 male and has increased from 978 per 1000 male since 2001. The child sex ratio is 934 per 1000 male and has decreased as compared to 975 in 2001. Manipur has a literacy rate of 79.85 percent, with male literacy at 86.49 percent and female literacy at 73.17 percent. In table 1.2, the total literates in Manipur are 1,891,196 out of which the male are 1,026,733 and female are 864,463 respectively.

1.1.1 Health Department of Manipur

The health service in the state is primarily under the government sector, although there are a few private hospitals/nursing homes. As per 2011 census and Directorate of Health Services, Government of Manipur, there is one state general hospital, one state TB hospital, one state leprosy hospital, seven district hospitals, one sub-district hospital, sixteen CHCs, eighty-five PHCs, four hundred twenty-one PHSC, twenty Allopathic dispensary, ten AYUSH dispensary. Under Ministry of Health and Family Welfare, Government of India, there is one Regional Institute of Medical Science (RIMS) and twenty-eight registered private hospitals & nursing home. The state has two thousand nine hundred and forty-six beds facilities in different hospitals and more than one thousand doctors are available.

The state health system is based upon the primary health care approach as envisaged in the National Health Policy of 1983 with the objective of attainment of "Health for All" and "All for Health." The state Administration of Ministry of Health and Family Welfare is headed by Secretary, who usually belongs to the Indian

Administrative Service (IAS). He was assisted by Director of health services and family welfare. The secretariat is responsible for the key function of policy formulation, planning personal and financial administration (Durgaprasad & Srinivasan, 1993). The state had three tier administrative set up in the health care services. They are: firstly the highest level, it includes a Cabinet Minister as a head of the administrator and it is assisted by a Commissioner/ Secretary, Joint Secretary, Deputy Secretary and Under Secretary of Manipur Secretary; Secondly it is the second highest level where the department is headed by Director as the technical and health administrator of the state, and he is assisted by additional directors, joint directors, joint directors and deputy directors in giving direction and undertaking planning, supervision, evaluation and monitoring of various health programmes of the state. And thirdly the lowest level of the administration. In the district level Chief Medical Officer is the functional head of the health care services and he is assisted by the district level programme officers. The district health organization has to look into the implementation of various health programmes under primary health care through the network of various health care centres and hospitals in the district.

ORGANISATIONAL CHART OF DIRECTORATE OF HEALTH

GOVERNMENT OF MANIPUR

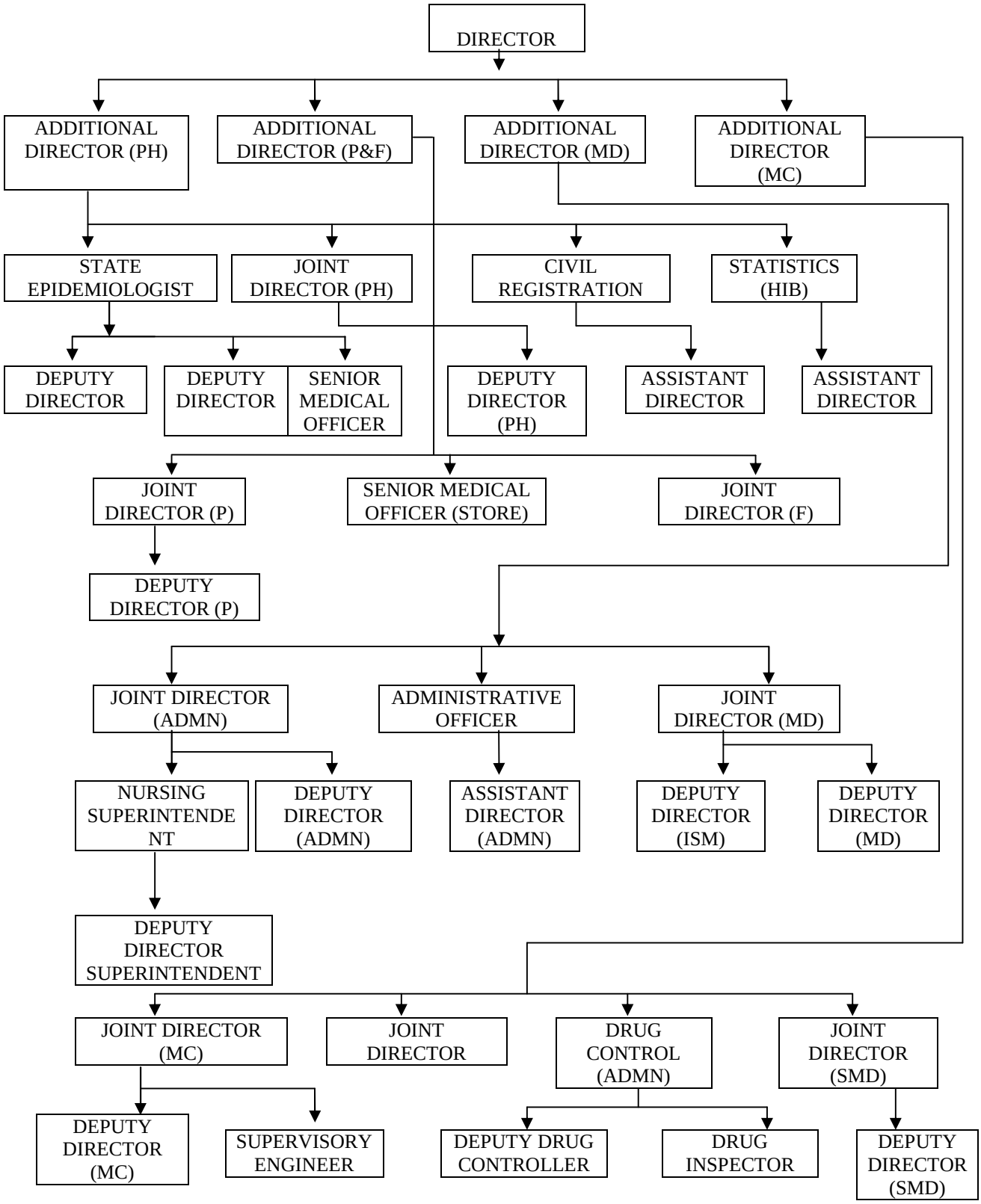

Chart No. 1.2: Demographic or Structure of Health Setting in Manipur

ORGANISATIONAL SETUP AT DISTRICTS LEVEL

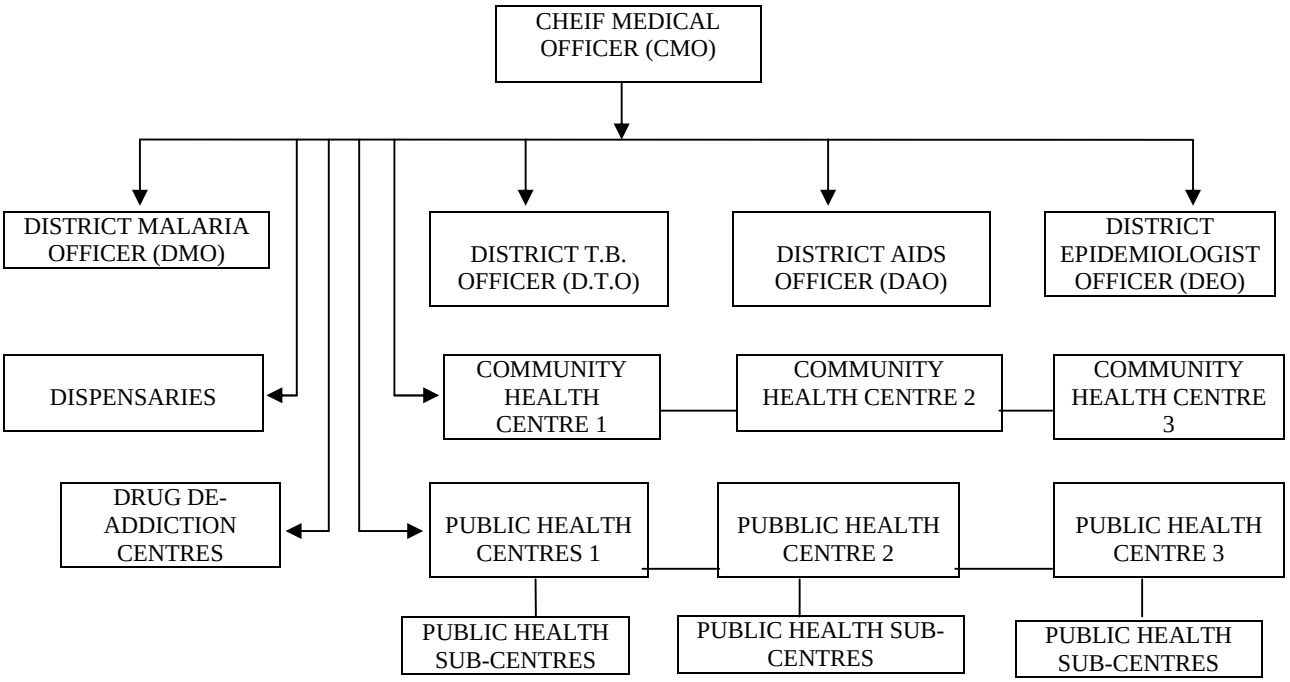

Chart No. 1.3: Organisational Setup at Districts Level

Table No. 1.3: Health indicators in the State

SL. No	Item	Manipur State	All India Average
1.	Infant Mortality Rate	11 (SRS-11)	44 (SRS-11)
2.	Crude Birth Rate	14.4 (SRS-11)	21.8 (SRS-11)
3.	Crude Death Rate	4.1 (SRS-11)	7.1 (SRS-11)
4.	Maternal Mortality Rate	64 (RIMS-2010-11) 80 (RIMS- 2011-12)	212 (SRS- 07-09)
5.	Percentage of Mother with full ANC	46.7 (HMIS-10)	26.5 CES-09 (UNICEF)
6.	Institutional Delivery Percentage	68.3 HMIS-10	47.0 DLHS-3
7.	Percentage of Delivery by Skilled Health Personnel	90.3 (HMIS-10)	76.2 CES-09 (UNICEF)
8.	Early Institution of Breast Feeding	75.1 CES-9 (UNICEF)	33.5 CES-09 (UNICEF)
9	Percentage of Child Exclusively Breast Fed for 6 Months	79.2 DLHS-3	57.1 DLHS-3
10.	Fully Immunized Children 12-23 Months	81.4 HMIS-10	61.0 CES-09 (Unicef)

Source: Directorate of Health Services Govt. of Manipur.

1.2 Background of the Study

1.2.1 Health Theories

(i) Germ theory of disease:

The discoveries of Pasteur and Koch confirmed the germ theory of disease. It was the golden age of bacteriology. Microbe after microbe was discovered in quick succession-gonococcus in 1874: typhoid bacillus, pneumococcus in 1880: tubercle bacillus in 1882: cholera vibrio in 1883: diphtheria bacillus in 1884, and so on (Park, 2015). According to the modern germ theory of disease, infectious diseases are caused by the presence of pathogenic microorganisms within the body. In other words, the germ is that which gives rise to the development of disease. Today, in popular usage, the word “germ” generally refers to a pathogenic microorganism, but the term is also used by biologists to describe the earliest form of an organism, that is, something that serves as the basis of further development. Commonly used phrases like “the germ of an idea” retain the more general meaning of the word. Though the germ theory brought many fundamental changes to the understanding of diseases and epidemics, society has continued to assess contagious diseases in terms of ideas that have a much longer history. Germ theory had important implications for the way in which people cleaned their homes, selected foods and prepared their meals.

Disease agent ⟶ Man ⟶ Disease

(ii) The Four Humors:

Health is a harmonious balanced and interworking of the humors. When the humors are harmonious, balanced and working well together is called eucrasia or good mixture. When the humors are unbalanced, aggravated or out of sorts, which is a condition called dycrasia or bad mixture. The four humors consist of 1. Blood-Air, 2.

Phlegm-Water, 3. Yellow Bile-Fire and 4. Black Bile-Earth. The four humors are responsible for nutrition, growth and metabolism of the organism. Blood promotes a feeling of joy, mirth, optimism, enthusiasm, affection and well-being. Phlegm induces passivity, lethargy, subjectivity, devotion, emotionalism, sensitivity and sentimentality. Yellow Bile provokes, excites and emboldens the passions. Being inflammatory, irritating and caustic, it provokes anger, irritability, boldness, ambition, envy jealousy and courage. Black Bile makes one pensive, melancholy and withdrawn. It encourages prudence, caution, realism, pragmatism and pessimism.

(iii) Theory of Contagion:

It has always been the case that not everyone exposed to a particular germ gets sick, and that some people are more likely to become ill than others. Certain kinds of sicknesses are associated with particular places, such as the tropics, or with certain times of the year, such as the summer. Some socio-economic groups shoulder very different disease burdens than others, even within the same society. The disease burden in urban areas can be different from the disease burden in a rural environment. A person infected with a disease germ can spread it to others, but may not show any sign of the disease.

(iv) Culturally-based Beliefs about Illness Causation

- **Personalistic:** In a personalistic system of belief, illness is believed to be caused by the intervention of a supernatural being or a human being with special powers. A supernatural being might be a deity or a dead ancestor. A human being with special powers might be a witch or a sorcerer. Evil forces cause illness in retaliation for moral and spiritual failings. If someone has violated a social norm or breached a religious taboo, he or she may invoke the

wrath of a deity and their sickness is explained as a form of divine punishment. Similarly, illness is seen in many cultures as punishment for failing to carry out the proper rituals of respect for a dead ancestor. Evil spirits possess the living to revenge the dead. Finally, illness in many cultures is accepted as simply bad karma or bad luck.

- **Naturalistic:** In the naturalistic system of belief, a person's health is closely tied with the natural environment. A proper balance must be maintained and harmony is protected. When balance is disturbed, illness results. Three of the widely-practiced naturalistic approaches to health are humoral, Ayurvedic, and vitalistic. In Humoral a naturalistic approach illnesses may be categorized into hot and cold imbalances in the body. Ayurveda naturalistic approach therapy includes a vast array of preparations made from herbs and minerals, and dietary advice also forms part of every prescription. It focuses on exercise, yoga, meditation, and massage. The practice is closely connected to religion and mythology. Vitalism is based on a core belief that disease is the result of some imbalance in the vital energies which distinguish living from non-living matter. If energy within a person's body is flowing harmoniously, their health is deemed good. Illness results when this smooth flow of energy is disrupted and therapeutic measures are aimed at restoring a normal flow of energy in the body.

(v) Supernatural Theories of Disease:

In ancient and primitive medicine, disease was often seen either as a form of punishment sent by the Gods, or attributed to demons, ghosts, and evil spirits. Because it was thought to be caused by supernatural agents, magic was part of its diagnosis and treatment. Shamans, medicine men, diviners, and priests served as

healers because of their special relationship to the supernatural. Such healers used divination, exorcism, magic spells, and nauseating drugs to drive away evil spirits. Although humans were born healthy, their bodies were susceptible to many disease-causing threats, including intestinal putrefaction, worms and insects, noxious winds, spirits, and ghosts. Whatever the cause of illness, the cure involved driving the agents of disease from the body by purging or exorcism. The drugs used to drive out disease-causing demons were powerful poisons; instead of swallowing the drug the patient might wear the prescription or the drug itself as an amulet.

1.2.2 Concept/Definition of Health

Health is the level of functional or metabolic efficiency of a human being. The World Health Organization (1946) defines health in its broader sense as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". The maintenance and promotion of health is achieved through mental, physical and social well-being, which together can be sometimes called as health triangulation. The WHO's Ottawa Charter for Health Promotion (1986) states that health is not just a state, but also "a resource for everyday life, health is a positive concept emphasizing social and personal resources, as well as physical capacities". Dubos (1965) defined health that "health implies the relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function".

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the "absence of disease". Health is not perceived the same way by all members of a community. In other world of continuous change, new concepts

are bound to emerge based on new pattern of thought. Health has evolved over the centuries as a concept from an individual concern to a worldwide social goal and encompasses the whole quality of life (Park, 2015).

The history of health care has been considered as an account of human's efforts to deal with sickness and injuries among others from the past history to the present complex of specialties and treatments. The past history of health treatment has equally important with the present in the utilization of medicine and health care services. To understand the multi-professional of public health, it is important to look at the contributions of knowledge in the health systems. Public health had moved into two distinct areas. Firstly it involved in the contact of social improvements and secondly it is concentrated in preventative and curative health services.

There are also other factors causing of diseases namely, social, economic, genetic, environmental and psychological factors which are equally important. Most of the factors are linked to man's lifestyle and behaviour (Park, 2015). The development in modern medicine may be reviewed broadly under the following heads. (i). Curative Medicine: the primary objective is the removal of disease from the patient. In the middle of 20th century a profound revolution was brought in "allopathic medicine" which has been defined as "treatment of disease by the use of drug which produces a reaction that itself neutralizes the disease by the introduction of antibacterial and antibiotic agents (WHO, 1984). With the discoveries and advancement of medical technology specialities have emerged, such as surgery, radiology, anaesthesia, ENT, ophthalmology, cardiology, gynaecology etc. (ii). Preventive Medicine: the primary objective is prevention of disease and promotion of health. New strategies have been developed for combating specific such as nutritional blindness and iodine deficiency disorders.

Utilization of health care services cannot be achieved if information is not made available to the community at large. Decision making is one of the most important process in the health sectors, in order to provide information to the whole population. Health is a pre-requisite for human development index and is essentially concerned for the well-being of an individual. It is an overall integrated development through social, culture, economic, education and political. Seeking of health behaviour pattern varies from tribe to tribe and region to region. Study of health culture of a particular community is important because the health problems and other health practices are influenced by the social factors and without the knowledge of the community traditional health culture it would be difficult to implementation the health services . Today there is an urgent need for initiating a comprehensive study on health changing scenario.

1.2.3 Rights to Health

(i) The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights. The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 General Assembly resolution 217 A as a common standard of achievements for all peoples and all nations. It sets out, for the first time, fundamental human rights to be universally protected.

Article 25 proclaims that (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and

childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

(ii) Right to Health and the Constitution of India

The Preamble to the Constitution highlights some of the core values and principles that guide the Constitution of India. The Preamble directs the state to initiate measures to establish justice, equality, ensure dignity, etc. which have a direct bearing on people's health. Part IV of the constitution contains the Directive Principles of State Policy (DPSPs), which include all the social, economic and cultural rights, such as the right to education, the right to livelihood, the right to health and housing, etc. Initially the Supreme Court of India enforced right to health among the people through various public interest litigations which came before the Indian judiciary. With the passage of time, the judiciary found that right to life under Article 21 is incomplete without right to live with human dignity which includes various other rights like the right to education, the right to livelihood, the right to health and housing, etc.

In Article 42, it states that "Provision for just and human conditions of work and maternity relief the State shall make provision for securing just and human conditions of work and for maternity relief". And in Article 47 it also states that "Duty of the State to raise the level of nutrition and the standard of living and to improve public health, the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health". More recently the Supreme Court has addressed the epidemic of HIV/AIDS. In a case where the court had to decide whether an HIV positive man should disclose his condition to the woman he was to marry, the court

has held that “the woman’s right to good health to precedence over the man’s right to privacy”.

Right to Protection of Life and Personal Liberty (Article 21) ensures that no person shall be deprived of his / her life or personal liberty, except according to the procedure established by law. While the provision of health services is essential to ensure good health pregnancy, childbirth and the postpartum period are one of the riskiest stages of a woman’s life. The right to life can be extended to include the health rights of mothers to go safely through pregnancy and childbirth. However, this right has not been explicitly guaranteed, though the Indian Constitution does make reference to maternity related benefits for the women.

(iii) National Human Rights Commission and Right to Health

The National Human Rights Commission’s efforts in the area of public health and human rights were guided by the realization that the right to life with human dignity, enshrined in the Constitution, must result in strengthening of measures to ensure that the people of this country, and particularly those belonging to economically disadvantaged sections of the society, have access to better and more comprehensive health facilities**.**

1.2.4 National Health Policy

(i) National Health Policy -1983

The National Health Policy was last formulated in 1983 and aims to a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged and provides ‘Health for All by the year 2000 AD’, through the universal provision of comprehensive primary health care services. The initiatives under that policy were:- (i) A phased, time-bound programme for setting up a well-dispersed

network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves; (ii) Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies; (iii) Establishment of a well worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level.

(ii) National Health Policy (NHP)-2002

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach was to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at national level by the Centre. However, to optimize the utilization of public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached. The Policy also envisages that programme implementation be effected through autonomous bodies at state and district levels. The Policy also highlights the need for developing the capacity within the State Public Health administration for scientific designing of public health projects, suited to the local situation. The Policy envisages that apart from the exclusive staff in a vertical

structure for disease control programmes, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmes or other public health initiatives. It would be for Head of District Health Administration to allocate time of rural health staff between various programmes, depending on the local needs. NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria and HIV/AIDS that are prevalent in the country. Emphasis would also be laid on time bound applied research for developing operational applications. This would ensure the cost effective dissemination of existing /future therapeutic drugs/vaccines in general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules/ vaccines, inter alia, through fiscal incentives.

(iii) National Health Policy (NHP) - 2015

The goal of NHP 2015 is to attain the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. It's key Policy Principles are focussed with Equity, Universality, Patient Centered & Quality of Care, Inclusive Partnerships, Pluralism, Subsidiarity, Accountability, Professionalism, Integrity and Ethics, Learning, Adaptive System and Affordability. The organisation of health care services has seven key policy shifts they are**:** 1. Primary Care: From a

Selective Care that is fragmented from secondary/tertiary care to Assured Comprehensive care that has continuity with higher levels

2. Secondary and Tertiary Care: From an input oriented, budget line financing to an output based strategic purchasing

3. Public Hospitals: From User Fees & Cost Recovery Based Public Hospitals to Assured Free Drugs, Diagnostic and Emergency Services to all in Public Health Facilities

4. Infrastructure and Human Resource Development: From normative approaches in their development to targeted approaches to reach under-serviced areas

5. Urban Health: From token under-financed interventions to on-scale assured interventions that reach the Urban Poor and establish linkages with national programmes: Scaling up of the interventions with focus on the urban poor and achieving convergence among the wider determinants of health

6. National Health Programmes- Integration with health systems for effectiveness, and contributing to strengthening health systems for efficiency and

7. AYUSH services: From Stand-Alone AYUSH to a three dimensional Mainstreaming.

The NHP 2015 objectives aims to improve population health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided by the public health sector. It assures universal availability of free, comprehensive primary health care services for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable and non-communicable diseases in the population and enable universal access to free essential drugs, diagnostics, emergency ambulance services, and emergency medical and surgical care services in public health facilities,

so as to enhance the financial protection role of public facilities for all sections of the population. It ensures improved access and affordability of secondary and tertiary care services through a combination of public hospitals and strategic purchasing of services from private health sector. It also influences the growth of the private health care industry and medical technologies to ensure alignment with public health goals, and enable contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical. The National Health Programmes 2015 includes 1. RCH services, 2. Reduction of Maternal Mortality, 3. Cash Transfers, Quality of Care Issues, 4. Child and Adolescent Health, 5. Universal Immunization Programme, 6. Women Health & Gender Mainstreaming, and 7. Communicable Diseases under National Disease control programmes (i) Integrated Disease Surveillance Programme, (ii) The approach to integration, (iii) Control of Tuberculosis, (iv) Control of HIV/AIDS, (v) Leprosy Elimination, (vi) Vector Borne Disease Control, (vii) Non-Communicable Diseases, 8. Mental Health and 9. Emergency Care and Disaster preparedness.

1.2.5 Sustainable Development Goals (SDGS)

From 2016 onwards the Sustainable Development Goals (SDGS) has replaced the Millennium Development Goals (MDGs) and it has laid down certain objectives to achieve by United Nations members along with 23 international organizations. Each goal has specific targets, and dates for achieving those targets. To accelerate progress, the eight goal finance ministers agreed to provide enough funds to the World Bank, The International Monetary Fund (IMF) and the Africa Development Bank (AfDB). The Sustainable Development Goals as defined in transforming the world by 2030 Agenda for Sustainable Development has given that 1. End Poverty in all its forms everywhere by 2030. It targets to reduce at least half the proportion of men, women

and children of all ages living in poverty in all its dimensions according to national definitions. It ensures that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources and build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters. 2. End Hunger, achieve food security and improved nutrition and promote sustainable agriculture by 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round and address the nutritional needs of children adolescent girls, pregnant and lactating women and older persons. 3. Ensure healthy lives and promote well being for all at all ages by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births and end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. It also aims to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases and reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. It tries to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol and by 2020, half the number of global deaths and injuries from road traffic accidents. It ensures universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national

strategies and programmes and also aims to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all and substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

1.3 Context of the Study

1.3.1 Health Care System in India:

India was one of the pioneers in health service planning with a focus on primary health care. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended establishment of a well structured and comprehensive health service with a sound primary health care infrastructure.

Social development through improvement in health status can be achieved through improving and utilizing of Health and Family Welfare services with special focus on underserved and under privileged section of population.

1. Under the Constitution, health is a state subject.

2. Central Government can intervene to assist the state governments in the area of control/eradication of major communicable and non-communicable diseases, formulation of policy and prevention of food adulteration, Child Survival and Safe Motherhood (CSSM) and immunization programme.

3. Infrastructure like hospitals, sanitation, water and roads, are still lacking in rural areas of India. The shortages of healthcare professions, poor infrastructure of new born care and other related diseases like diarrhoea are the main problems to the high infant mortality rate.

(i) Ministry of Health and Family Welfare

Department of Health & Family Welfare provide preventive, promotive and curative quality health services at an affordable price to the people of the state. For this, a wide network of Health Institution consisting of hospitals, Community Health Centres, Primary Health Centres and Sub Health Centres/ Dispensaries to cater to the health needs of the rural and urban population through well trained medical and paramedical staff have been established in the State.

The Ministry of Health and Family Welfare (MHFW) has an attached office to the Directorate General of Health Services (DGHS), which is the apex technology institution for health matters in the government. It is headed by the Director General (DG), who is equivalent in salary and salutes to a secretary. The Directorate General of Health Services renders technical advice on all medical and public health matters and is involved in the implementation of various health services. The Ministry of Health and Family Welfare (MHFW) has three and the Directorate General of Health Services (DGHS) 101 subordinate offices, the later covering a very diverse range of institutions from medical colleges, nursing schools, hospitals and dispensaries, public health training institutions to drug controllers organization, laboratories and regional offices (Misra *et al.,* 2003).

The Administration of the Ministry of Health and Family Welfare at the state level is headed by the Secretary, who is a generalist administrator usually belong to IAS. He was assisted by the Director of health services and family welfare. The secretariat is responsible for the key function of policy formulation, planning personal and financial administration (Durgaprasad & Srinivasan, 1993). The Ministry of Health and Family Welfare comprises the following departments, each of which is headed by a secretary to the government of India:-

- Department of Health & Family Welfare
- Department of AYUSH
- Department of Health Research
- Department of AIDS Control (Rout, 2011).

Health care in India features is a universal health care which are run by the central and states government. The constitution stated that every state with “raising the level of nutrition and the standard of living of its people and improvement of public health are the primary duties”.

The Institute of Medicine has designed six “aims” for improving the delivery of care in India, they are (i) Safe - voiding preventable injuries, reducing medical errors; (ii) Effective - Providing services based on scientific knowledge - clinical guidelines; (iii) Patient Centered - Care that is respectful and responsive to individuals; (iv) Efficient - Avoiding wasting time and other resources; (v) Timely - Reducing wait times, improving the practice flow; and (vi) Equitable - Consistent care regardless of patient characteristics and demographics.

The Health Care Services Organization in the country extends from the national level to village level viz. (i) Central level; (ii) State level; (iii) Regional level; (iv) District level; (v) Community level such as (a) Community Health Centres (CHCs) (b) Primary Health Centre (PHC) (c) Sub-Centre and (d) Indian Public Health Standards (IPHS).

Central level: The organization at the national level consists of the Union Ministry of Health and Family Welfare. It has three departments viz. Department of Health & Family Welfare, Yoga-Naturopathy, Ayurveda, Sidha & Homeopathy (AYUSH), Unani and Department of Health Research. Each department is headed by respective Secretaries to Government of India. The Department of Health & Family

Welfare is supported by a technical section; it is looked after by Director General of Health Services (DGHS).

State level: The organization at State level is the State Department of Health and Family Welfare headed by Minister along with a Secretariat under the charge of Secretary or Commissioner (Health and Family Welfare). The State Directorate of Health Services functions as a technical office of the State Department of Health and Family Welfare, which is headed by the Director of Health Services. The Directorate of Medical Education and Research undertakes all the medical related education which is under the charge of Director of Medical Education accountable to the Health Secretary or Commissioner of the State.

Regional level: In some states the zonal or regional or divisional set-up has been created between the State Directorate of Health Services and District Health Administration. Each zonal/regional covers contain districts and acts under authority delegated by the State Directorate of Health Services.

District level: All Health Care programmes at district level are placed under a unified control. It is a link between the State/ regional structure on one side and the peripheral level structures such as PHC/ Sub-Centre on the other. The district officer is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM& HO). These officers are known as DMOs or CMOs, and are the in-charge of the health and family welfare programmes in the district. These DMOs or CMOs are assisted by Deputy CMOs/medical superintendent.

Community Health Centres (CHCs): CHCs are established and maintained by the State Government. It is manned by four medical specialists they are Gynaecologist, Paediatrician, physician and Surgeon respectively. It is supported by

other paramedical staff (s). It has 30 in-door beds with one X-ray, laboratory facilities and Labour Room. It serves as a referral centre for PHCs and also provides facilities for Obstetric care and specialist consultations. For this purpose one Community Health Centre (CHC) is meant for every 80, 000 to 1, 20, 000 populations, and this centre provides gynaecology, paediatrics, obstetrics, medicine and surgery.

Primary Health Centre (PHC): PHCs are the cornerstone of rural people in providing health services. The Bhore Committee in 1946 gave the concept of a PHC as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The Central Council of Health at its first meeting held in January 1953 had recommended the establishment of PHCs in Community Development Blocks. The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of one PHC for every 30,000 rural populations in the plains and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage. PHC is the first contact point between village community and the Medical Officer. The PHCs focus to provide health services to the rural population with emphasis on curative, preventive, Family Welfare Services and promotive aspects of health care. Primary Health Centre is looked after by a Medical Officer with 14 paramedical and other staff. PHC plays an important role in referral services from sub-centres to PHC and to Community Health Centres/district hospitals. It has 4-6 indoor beds for patients. From March 2007 there are 22, 370 PHCs functioning in the country.

Sub-Centre: The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioural

change and provide services in relation to maternal and child health, nutrition control of communicable diseases and diarrhoea programmes, immunization and family welfare. From March 2007 there are 1,45,272 Sub Centres functioning in the country. Currently a Sub-centre is staffed by one Female Health Worker commonly known as Auxiliary Nurse Midwife (ANM) and one Male Health Worker commonly known as Multi-Purpose Worker (Male). One Health Assistant (Female) commonly known as Lady Health Visitor (LHV) and one Health Assistant (Male) located at the PHC levels that are entrusted with the task of supervision in all the Sub-Centres.

1.3.2 In the Context of Major Health Problems

(i) Women Reproductive Related Health Problems

The vision of the World Health Organisation (WHO) in "Making Pregnancy Safer" is "a world in which skilled care at every birth is ensured for all women". The three "Pillars" of the agenda were family planning, skilled care during pregnancy particularly during delivery and emergency obstetric care to deal with complications (Park, 2007).

Globally, an estimated 289,000 maternal deaths occurred in 2013, a decline of 47 percent from levels in 1990. Sub-Saharan Africa 62 percent and South Asia 24 Percent accounted for 86 percent (249000 maternal deaths) of the global burden in 2013. At the country level, two countries account for a third of global maternal deaths: India at 17 percent (50,000) and Nigeria at 14 percent (40,000). The global MMR in developing regions (250) was 15 times higher than in developed regions. A woman is most vulnerable at the post-partum period. About 50-70 percent maternal deaths occur in the first 24 hours after delivering and more than two thirds during the first week. Between 11-17 percent of maternal deaths occur during child birth itself (WHO, UNICEF, & Work Bank, 2010).

The mortality risks for mothers are particularly elevated within first two days of delivery with complications like postpartum haemorrhage, infections, eclampsia and prolonged or obstructed labour- and complications of abortion. Puerperal infections, often the consequence of poor hygiene during delivery, or untreated reproductive tract infections account for about 15 percent of maternal mortality. Most of these direct causes of maternal mortality can be readily addressed if skilled health personnel, key drugs, equipment and referral facilities are available. Maternal mortality ratios strongly reflect the overall effectiveness of health systems; weak administrative, technical and logistical capacity, inadequate financial investment and a lack of skilled health personnel. Enhancing women's access to family planning, adequate nutrition, improved water sanitation facilities and affordable basic health care protection from abuse, violence, discrimination, empowerment of women, greater involvement of men in maternal and child care, would lower mortality rates (Park, 2015).

India is among those countries which have a very high maternal mortality ratio. It is seen that the MMR has reduced from 212 per lakh live births in 2007- 2009 to 178 per lakh live birth in 2010-2012, a reduction of 34 points over a period of three years period. States of Kerala, Maharashtra and Tamil Nadu have already achieved the goal of MMR of 100 per lakh live births. In some of the states like Assam the MMR per lakh live births is 328, Uttar Pradesh (292), Rajasthan (255), Madhya Pradesh (250) and Odisha (235) respectively. Assam, Madhya Pradesh and Rajasthan have shown acceleration in reduction in the last three years. The age distribution of maternal and non-maternal deaths from the 2010 -2012, Special Survey of Deaths shows that more than two thirds of the maternal deaths are of women in age group 20-34 years. In contrast, non-maternal deaths are more evenly distributed over the reproductive age span of 15-49 years. The major causes of maternal mortality according to 2001-2003,

Central Registration System survey are haemorrhage (38 percent), sepsis (11 percent), hypertension (5 percent), and obstructed conditions (34 percent). Anaemia (19 percent) is not only the leading cause of death but also an aggravating factor in haemorrhage, sepsis and toxaemia. Illegal abortions are also one of the leading causes of maternal death. Essential obstetric care and establishment of First Referral Units (FRUs) for emergency obstetric care is, therefore a high priority under the safe motherhood component of Reproductive and Child Health Programme (Govt. of India, 2013).

The lower status of women in the society coupled with their low literacy levels prevents the women from taking antenatal care even if services are available. Most deliveries take place at home without the services of the trained midwifery personnel. There is an inverse relationship between lifetime risk of maternal death and the availability of the trained health worker during pregnancy and at the time of delivery. The life time chances of maternal death in the world in 2010 as a whole is about 1 in 80. It varies from region to region and from country to country. In the least developed countries the chances are about 1 in 37, in the developing countries about 1 in 3,800. In Sub-Saharan Region the chances are very high-about 1 in 39 pregnancies (WHO, UNICEF, & World Bank, 2012)**.**

It is tragic situation as these deaths are not caused by disease but occurred during or after a natural process. It is one of the leading causes of death for women of reproductive age in many parts of the world. Most maternal deaths and pregnancy complications can be prevented if pregnant women have access to good-quality antenatal, natal and post natal care, and if certain harmful birth practices are avoided. Estimates of antenatal care coverage, deliveries conducted by skilled personnel, lifetime risk of maternal death and maternal mortality ration in some developing and

developed countries. Maternal health, however, goes beyond the survival of pregnant women and mothers. For every woman who dies from causes related to pregnancy-related illness or experience other severe consequences. The number is striking. An estimated 10 million women annually who survive their pregnancies experience such adverse outcomes (WHO, UNICEF, & World Bank, 2014).

Of the estimated 210 million pregnancies that occur every year, about 42 million end in induced abortion, of which only approximately 60 percent are carried out under safe conditions. More than 20 million induced abortions each year are performed by people lacking the necessary skills or in an environment lacking the minimal medical standards, or both. Around 8 percent of maternal deaths occur as a result of prolong or obstructed labour. One of the most significant is anaemia, which can cause death. Maternal anaemia affects about half of all pregnant women. Infectious diseases such as malaria and intestinal parasites can exacerbate anaemia, as can poor quality diet-all of which heighten vulnerability to maternal death. Severe anaemia contributes to the risk of death in cases of haemorrhage. Other important causes of indirect death are hepatitis, cardiovascular diseases, diseases of the endocrine and metabolic system and infections such as tuberculosis, malaria and increasingly HIV/AIDS (WHO, 1998).

(ii) Tuberculosis

Tuberculosis (TB) is a specific infectious disease caused by Mycobacterium Tuberculosis. The disease primarily affects lungs and cause pulmonary tuberculosis. It can also affect intestine, meanings, bones and joints, lymph glands, skin and other tissues of the body. The disease is usually chronic with varying clinical manifestations. Patients with infectious pulmonary tuberculosis disease can infect 10-15 persons in a year. Tuberculosis remains a worldwide public health problem despite

the fact that the causative organism was discovered more than 100 years ago and highly effective drugs and vaccines are available, making tuberculosis a preventable and curable disease. Technologically advanced countries have achieved spectacular results in the control of tuberculosis. This decline started long before the invention of BCG or chemotherapy and has been attributed to changes in the "non-specific" determinants of the disease such as improvements in the standard of living and the quality of life of the people coupled with the application of available technical knowledge and health resources (Park, 2015).

It is estimated that about one-third of the current global population is infected asymptomatically with tuberculosis, of whom 5-10 percent will develop clinical disease during their lifetime. Most new cases and deaths occur in developing countries where infection is often acquired in childhood. The annual risk of tuberculosis infection in high burden countries is estimated to be 0.5-2 percent (WHO, 2004).

Tuberculosis remains a major global health problem. The current global picture of TB shows continued progress but not fast enough. During the year 2013, an estimated 9 million people developed TB, which is equivalent to 126 cases per 100,000 populations. Most of the cases occurred in Asia (56 percent) and the African regions (29 percent). Of these incident cases 1.1 million (13 percent) were HIV positive and 3.5 percent of the new and 20.5 percent of previously treated cases were of MDR-TB (Multi-Drug Resistance TB). It is estimated that above 1.5 million people died of TB, of these 360,000 were HIV positive and 210,000 MDR-TB cases. About 60 percent of TB cases and deaths occur among men, but burden of disease (3.3 million) among women is high. In 2013 an estimated 510,000 women died as result of TB, more than

one-third of whom were HIV positive. An estimated 550,000 (6 percent of total cases) children under 15 years of age had TB of who 80,000 died (Park, 2015).

In many developing countries, acquired drug resistance remains high, because National Tuberculosis Control Programmes in these countries have not been able to achieve a high cure rate over a very long period of time, even after the introduction of short course chemotherapy. Poverty, economic recession, malnutrition, overcrowding, indoor air pollution, tobacco, alcohol abuse, and diabetes make populations more vulnerable to tuberculosis. Increase in human migration has rapidly mixed infected with uninfected communities. To make global situation worse, tuberculosis has formed a lethal combination with HIV (Park, 2015).

India is the highest TB burden country in the world in terms of absolute number of incident cases that occur each year. It accounts for one-fourth of the estimated global incident TB cases in 2013. As per WHO estimations, tuberculosis prevalence per lakh population has reduced from 465 in year 1990 to 211 in 2013. In absolute numbers, prevalence has reduced from 38 lakhs to 26 lakhs annually. Incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. Tuberculosis mortality has reduced from 38 per lakh population in 1990 to 19 in 2013. In absolute numbers, mortality due to TB has reduced from 3.3 lakhs to 2.4 lakhs annually. Among the new TB cases, 5 per cent of patients were in paediatric age-group (0-14 years). HIV among estimated incident cases of TB was about 5 per cent. MDR-TB among notified new pulmonary TB patients was about 2.2 per cent, and among retreatment case was about 15 per cent (Govt. of India, 2014).

(iii) HIV/AIDS

AIDS the acquired immune-deficiency syndrome (sometimes called “slim disease”) is a fatal illness caused by a retrovirus known as the Human Immune-deficiency Virus

(HIV) which breaks down the body's immune system, leaving the victim vulnerable to a host of life- threatening opportunistic infections, neurological disorders, or unusual malignancies (WHO, 1986). The term AIDS can be called our modern pandemic, affecting both industrialized and developing countries.

HIV incidence (the number of new HIV infections in a population per year) is the key parameter that prevention efforts aim to reduce, since newly infected persons contribute to the total number of persons living with HIV; they will progress to disease and death over time; and are a potential source to further transmission. Since 1997, the year in which annual new infections peaked to 3.2 million cases globally, the number of new infections has fallen to 2.3 million in 2012. This reduction in HIV incidence reflects natural trend of epidemic, as well as the result of prevention programmes resulting in behavioural changes in different context (UNAIDS, 2013).

Although HIV testing capacity has increased over time, enabling more people to learn about their HIV status, the majority of people are still unaware about their infective status. HIV is the leading cause of death among women in reproductive age. Gender inequalities, differential access to services and sexual violence increase women's vulnerability to HIV, and women, especially younger women, are biologically more susceptible to HIV (U.S Global Health Policy, 2012).

Available evidence on HIV prevalence and future statistical projections shows signs of stabilization of HIV epidemic in India at national level. Provisional estimates for the year 2012 show that there were 20.89 Lakh people living with HIV/AIDS with estimated adult HIV prevalence of 0.27 percent. Declining trends are noted in high prevalence of states indicating possible impact of sustained programme interventions. There is showing a declining trend even the prevalence among the pregnant women in the age group of 15-24 years, which is considered proxy for incidence/new infections

in general population. The national adult (15-49 years) HIV prevalence is estimated 0.27 percent for the year 2011, 0.32 among male and 0.22 in female. There is a steady decline from 0.49 percent in 2001. The prevalence among young population (15-24 years) at national level is estimated at 0.11 percent for 2011, and equal among men and women at 0.11 percent.

The primary drivers of HIV epidemic in India are unprotected paid sex/commercial female sex workers, unprotected paid sex/commercial female sex workers, unprotected sex between men, and injecting drug use. It is estimated that there are 8.68 lakh female sex worker, 3.13 Lakh Men who Have Sex with Men (MSM) with high-risk and 70,000 transgenders, 1.77 lakh injecting drug users in India and 110 lakh bridge population which include 80 lakh migrants and 30 truckers. Though sex workers account for 0.5 percent of adult female population, they account for seven percent of HIV infected females. Sex workers continue to act as the most important source of HIV infection in India due to the large size of clients that get infected from them. These men then transmit the infection to their wives affecting several risk women in the society. Long-distance truckers and single male migrants constitute a significant proportion of clients of sex workers (Govt. of India, 2014).

1.4 Statement of the Problem

Sickness is a major social problem and a universal one. Mankind is affected by numerous diseases, which are a constant threat to survival and prosperity. To the individual and community, sickness is not only a source of immediate suffering in terms of pain and discomfort, but widespread diseases can decimate the population and poor standards of physical fitness can lead to low productivity. Sickness can cause poverty, the break-up of families, the destruction of community life and

generally can hold up social and economic progress. Health is one of the most important determinants of social factors. The health of both the individual and the general population is determined by the social, biological, physical and behavioural factors. Poverty, literacy, fertility and nutrition are interlinked key areas that influence health outcomes. The critical shortage of key health manpower, particularly in public facilities, is explained by inadequate incentives, poor working conditions, and lack of transparency in posting especially in rural areas. The overall goals of health system are to reduce mortality and morbidity, ensure equity in health status, protect the poor against the financial costs of illness and increase public satisfaction (Misra *et al.,* 2003).

While accessibility to health care facility, it has been accepted as a fundamental human right in many countries, people of Ukhrul have been deprived of the same right. It has become a routine affair to send patients undergoing treatment in government hospitals to private clinics, hospitals and diagnostic centres for any kind of laboratory tests. As the doctors have gone to private clinics after OPD hours, the poor patients are literally left to their own fates even if their health conditions demand immediate attention of doctors. Doctors are instrumental for creating a situation where patients can only suffer and wait for death because of their absence in far flung hill areas.

With the passage of time, changes brought in the health care institutions such as improvement of equipment, tools, schemes and programmes and the system itself. Even though there have been improvement in health care institutions, people who are poor, unfamiliar or unknown to the employed staffs are facing much problem, like improper and untimely treatment. Besides faith of the people in the efficiency of hospital system is decreasing because of the negligence and indifference on the part of

hospital authorities (Goel & Kumar, 2007). Service is not to be merely accessible but must reach those most in need (Goel, 2001).

The resources sanctioned by the centres for health services are grossly inadequate for the community to provide even a fraction of the service needed. There is a shortage of drugs supply and also the equipment is not properly maintained (Rao, 1993). Mere provision of health family planning and nutrition services are not enough for rendering health care delivery effective in respect of women particularly in rural areas of Ukhrul district of Manipur. It can also state that one of the chronic problems of district hospital is overcrowding, it is seen that such overcrowding results basically from failure of sub-centres (SCs), Primary Health Centres (PHCs), and CHCs (Community Health Centres) to play their first referral roles. This thwarts the development of district hospitals as second level referral hospitals (Murthy *et al.,* 1996). For the above mentioned problems, people of the district tend to consult a pharmacist rather than to see a doctor unless they are considerably ill.

Some patients move from one hospital to another, one doctor after another, and they have consulted a number of doctors, they may even change the system of medicines. The time and the resources wasted on them are alarming. This is considerable in terms of physician's time and material resources. This poses a big problem and costs a substantial amount which if saved can be utilized for the patients who go unattended because of heavy pressure on the consultant's time as well as the hospital resources (Advani, 1980). There has been a gap between promise and performance with respect to practical of public health activities. While excellent plans have been drawn up at the central level, there has been little preparation at the intermediate and peripheral levels, the levels at which the plans are actually to be implemented (Yesudian, 1991).

In health matters, the advanced medical aids do not easily reach to the villages and thus recourse to traditional cures. The district run dispensaries and health centres are very poorly equipped and unattended regularly. It is a fact that at village level, there are no proper health care centres which provide general medicines and proper guidelines to the villages. The programmes implemented have never met the basic health needs of the masses that are living in the villages. People, who live in the rural villages especially in Ukhrul District, are the receiving end of the pockets of failed policies, bad governance, corruption, inappropriate regulation, unresponsive financial system. These factors add to the toll on people who are already deeply burdened and constraints in the utilization of health care services. Health office in Ukhrul district shows lacking of rendering qualitative services and the staff are unwelcoming or indifferent attitude towards the people who have come for utilizing health services.

In this study, the researcher attempted to describe and analyze the causes of some major health problems like Tuberculosis, HIV/AIDS and Reproductive Health Related Problems among women. It also studies the effects of socio-culture and religious practices of people towards the utilization of health services available in both government and public health settings. It had seen that maximum of pregnant mothers who stayed in far flung areas from the main town hardly availed the modern health care services. According to 2011 census, only 27 percent had attended full ANC and 33.7 percent had institutional deliveries. This shows that maximum of the pregnant mothers don't access the services, thus lead to increase in morbidity and mortality rate. Likewise Tuberculosis had become societal issues where many people are not aware of the disease because of lack of information/awareness. As per the report from the tuberculosis centres in Ukhrul district hospital, in 2015, there were around 345 TB registered cases in the hospital. Moreover out of nine districts of

Manipur, Ukhrul has the highest cases of HIV/AIDS with 1285 cases. There are many people who are not aware of their health status; since they are not willing to visit hospital for HIV/AIDS testing because of social stigma prevailing in the society.

Despite of the services available from government such as JSY, JSSK, DOTS and ART programmes, people do not wish to visit the health centres, because of unavailability of doctors and different attitudes of health care providers, poor mode of transportations. These worsen the conditions of patients in the study area. Further traditional and religious practitioners play a major role in providing the services in the study area. There were times where patient who stayed in far flung villages faced serious health issues where there were no doctors. In such cases traditional and religious practitioners play the first referral point in providing health services. The traditional and religious practitioners give treatment for different types of illnesses such as pregnancy related problems like bleeding problem, delivery cases, fracture & joint pains, stomach problems- gastritis, kidney related problems, evil spirit, cough, headache, etc.

At present, there is a yawning gap between health and medical services available in Ukhrul district. The vast majority of the people are not aware of the health and medical care services which is supposedly meant for them. The services rendered naturally fall short of expectations and both large areas and large sections of the population are unable to utilize these services because of distance, lack of communications, shortage of medicine and people's negligence (Ogale, 1976). Therefore, it is necessary for the researcher to study and understand the gap between the health services and the needs of people in terms of accessing, availing and utilizing the health services in Ukhrul district.

1.5 Significance of the study

The study of the utilization of health care services in Ukhrul district is to help in providing quality and effective health services in order to fulfil the needs of the people. It may help the authority of government and private hospitals, NGOs in providing proper treatment with quality medicines, equipments, and reaching out the available programmes and schemes to individuals of the district without barriers of nearby and far flung villages. It may also help to build up a better relationship among the doctors, nurses and patients in providing and receiving quality and patient friendly hospitals in the district. The purpose of this study will help to establish accountability and transparency in the functioning of hospitals, mobilization of resources, ensuring the accessibility of patients to hospitals, regular maintenance of equipment and building, timely procurement of equipment, installation and maintenance, provide qualitative caring in the hospital, and community involvement in the utilization of health care process.

1.6 Delimitation

The present study have confined only to the patients of women reproductive health problems, HIV/AIDS and TB who are availing services from government (Gynaecology department, HIV/AIDS department, DOTS Centre) and private hospitals, NGOs and traditional and religious practitioners in Ukhrul district of Manipur. Only those women (mother) who are in the age of 15 to 45 and having atleast one child were considered for the study. The findings cannot be generalized for the women reproductive health problem, HIV/AIDS and TB in Ukhrul district of Manipur in general but in consideration of highest HIV/AIDS in Ukhrul, the researcher tries to overcome the limitations of HIV/AIDS cases at certain extent.