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A brief analysis of the implementation of health care programmes at the grassroots level with special references to Sadar Hills and Churachandpur District Councils of Manipur: A decentralized perspective

DR. S HOHOI[1]

Introduction: Centralisation vs Decentralisation

Centralisation means concentration of authority at the top level of the administrative system. Decentralisation, on the other hand, means dispersal of authority among the lower levels of the administrative system. Thus the issue of centralisation versus decentralisation revolves around the location of the decision making power in the administrative system. In a centralised system of administration, the lower levels called field offices cannot act on their own initiative. They have to refer most of their problems to the higher levels called headquarters for decision making. They act as only implementing agencies. In a decentralised system of administration, on the other hand, the field offices can act on their own initiative in specified matters. They are given authority to take decisions without reference to the headquarters. Thus, the essence of decentralisation is the vesting of decision making power in the field offices. Certain merits of Decentralisation are as follows:

1. It increases administrative efficiency by reducing delays, curbing red tapism and encouraging faster action.
2. It reduces the workload of the head office and thus enables the top echelons to concentrate on vital issues like policy formulation, examining major problems , etc
3. It makes administration more responsive as the field units act with the knowledge of local conditions and requirements.
4. It facilitates people's participation in administrative process and thus strengthens democracy at the grass-root level.
5. It encourages the expansion and diversification of the organisation for effective goal achievement.

[1] *Assistant Professor at Tetso College, Dimapur, Nagaland.*

6. It facilitates the adaptation of national policies and programmes to the varying conditions of different regions
7. It alleviates the problem of communication overload in the organisation by reducing paper work at both higher and lower levels.

A perspective on the Headquarter Field Organisation

A look into the Patterns of Field Organisation according to W.F Willoughby who distinguished between two patterns of field organisations, namely, unitary and multiple, also known as Territorial and Functional respectively. In the unitary or territorial system, all the field offices of an area are placed under the supervision and control of a chief administrator who in turn is responsible to the headquarters for their working. In the multiple or functional system, the different divisions of the headquarters deal with their respective field offices directly. There is no intervention of the supervising and controlling authority in between them at the area level.

According to Luther Gullick, he distinguished between three types of field organisation. 1) "All Fingers" type, in this, the headquarters control the field offices directly; there being no regional subdivisions. (2) "Short Arms, Long Fingers" type, the regional sub-divisions are physically located in the headquarters itself. They control the field offices in their respective spheres. (3) "Long Arms, Short Fingers" type, the regional sub-divisions are physically located in the field itself, far away from the headquarters, and control the respective field offices. Keeping in mind the vastness of the geographical spread of the hilly areas of the state and the variant local conditions and situations, the adoption of "Long Arms, Short Fingers" type of field organisation is the most desirable one for efficient administration and effective outcome. Basic infrastructural deficits in the form of poor conditions of roads, irregular power and water supply, have led to hindrances in the effective working of the organisational arrangement to be undertaken.

It is important to transfer decision making power to involve the lowest level unit of organisation that is the village authority in the planning, implementation and reviewing of the works implemented at the village levels. The participation of the local people who are fully cognizant with the local problems and situations in matters of planning, implementation and reviewing is inevitable to enable people to avail of the benefits of the programmes and schemes which are meant for their upliftment. The setting up of the Village Health and Sanitation Committees for the implementation of the National Rural

Health Mission in the villages and the important role the village authorities play in planning village level health action plan at this level is worth applauding. Inputs and feedbacks through the village councils assume importance in order to touch the remotest corners of the hilly and the backward areas of the hill districts. From the Village councils to the district councils and then to the state government, a two way communication is to be maintained at all times to successfully implement developmental schemes and programmes.

The geographical areas under Sadar Hills and Churachandpur District councils are widely spread. Officials from the headquarters are not in the position to neither gather all the required informations nor implement the health and other educational programmes effectively and efficiently. Thus, the involvements of field agencies which are supported by the people at the grassroots levels assume importance. Here it is noted that both types of decentralisation that is territorial and administrative decentralisation take place. Political decentralisation is seen in the form of creation of Village Panchayats in the valley districts and Autonomous District Councils (ADCs) and Village Authority in the hill districts of the state which are autonomous local self governments.

Administrative decentralisation is further divided into territorial and functional decentralisation. Territorial Decentralisation stands for the establishment of area administrative units (field offices) by the higher authority (headquarters). These are districts, sub divisions, tribal development blocks, etc. which are created in the hilly districts of the state. These are vested with decision making powers within specified limits and thus function in an independent manner. Functional Decentralisation implies the vesting of decision making authority in the specialised units by the central agency. For example, the creation of technical or professional bodies likes Flood Control Board, Central Social Welfare Board, District Rural Development Agency (DRDA), etc.

The administrative sub divisions under the jurisdiction of the Autonomous District Council of Sadar Hills are three which are Saitu- Gamphajol, Saikul , Kangpokpi and three newly created sub divisions like Champhai, Tujang Waichhhong, Kangchup and Island. While under the Churachandpur Autonomous District Council , there are five sub divisions which are Tipaimukh, Henglep, Thanlon,Churachandpur and Singhat. There are 10 tribal development blocks. During the period 2006-2009, National Rural Health Mission (NRHM) implementation has helped the district in decentralizing the

programme activities. There is a close convergence with the Village Authorities from the sub centre level institutions to the district level institutions. This communization has helped in making the people work with the health providers. As per the District Health Action Plan, 2010 -2011, the issues which require a deeper look in terms of planning are: 1. the constitution of the Village Health and Sanitation Committee being the pivot of village level planning. 2. The capacity of the Village Authorities in Village Level Planning.

Recent initiatives under the Autonomous District Councils

Manipur (Hill Areas) District Council (Third Amendment) Act, 2008 has clearly stated that the functioning of dispensaries and primary health sub centres in the hilly districts is under the control of the five Autonomous District Councils. Health sector and the functioning of this sector under the Autonomous District Councils (ADCs) in Manipur is still at its nascent stage. The set up of primary health sub centres, primary health centres and community health centres in the hill districts of the state are significant outcome of the major efforts of the state government. The health care initiatives under the ADCs have not been very forthcoming. Few medical officers and few nurses and other staff personnel manned the health department under the district councils. The health department under the district councils carries out the normal duties of health checkups and conduct health camps in the areas under the councils. The State Department of Health and Family Welfare have been playing the main role of implementing the centrally sponsored schemes like the National Rural Health Mission (NRHM).

A nation-wide scheme which aimed to impact every nook and corner of the country and Manipur being one of the focus states inevitably require the administrative structure of the Autonomous District Councils (ADCs) for its effective implementation. The ADCs have just restarted their functioning since 2010 and the administrative machinery of the councils is going through restructuring a after a long hiatus. Some of the important works conducted after the reconstitution of ADC Sadar Hills are to be noted. For instance, a free medical camp was organised at Sinam Khaitong Village along NH- 37 in New Keithelmanbi area under Saitu block, Sadar Hills in 2013. This was taken up under the initiative of an Executive Member ADC Sadar Hills, incharge of veterinary and Medical. The Medical team who were engaged in the camp comprised of four doctors, five nurses and three pharmacists. An assertion by the Executive member was that there were no medical facilities like dispensary, primary health centre, etc between Keithelmanbi and Tupul except the lone Primary Health Sub Centre at Charaipandongba where there are

no doctors and nurses available. A visit to Molkon village in Saikul sub- division of Sadar Hills shows misuse of the health sub centre for personal use. Nurses from the primary health centre of Saikul visit these centres few times in a week especially for the immunisation of children under the National Rural Health Mission. This is a clear evidence of lack of monitoring and evaluation at the field level by the concerned authorities of the head quarter. A recent initiative by the state government to provide mobile health care service is the provision of ambulances to the Autonomous District Councils.

Under the Thirteenth Finance Commission award, the distribution of the ambulances took place. Each of the ambulances will have one doctor, one staff nurse and required medical equipment of a standard ambulance. The first free medical camp organized and sponsored by the Autonomous District Sadar Hills was at Chalwa village along the Imphal – Tamenglong road under the 13th Finance Commission. It was a combined team of the Veterinary and the Medical departments consisting of 20 members.

Another free medical camp at K. Orphanage UJB School was organized. More than 40 students of the orphanage and others from the adjoining areas avail the facilities and medicines free of cost at the camp. Sponsored by the ADC Sadar Hills, another camp was conducted at T. Gamnom village which is situated some 25km from Saikul town in Saikul sub-division within Sadar Hills. The programme was conducted under the supervision of the Medical Department of ADC Sadar Hills. It was conducted particularly in view of the non - availability of medical facilities in the area. It was also seen that not even a single Primary Health Sub Centre exists in the area that covers more than 70/80 villages.

National Rural Health Mission in the state

National Rural Health Mission (NRHM) has been renamed National Health Mission with the aim to achieve progress in providing universal access to equitable, affordable and quality health care, which is accountable as well as responsive to the needs of the people. Important initiatives for reducing child and maternal mortality as well as stabilizing population have been taken, immunization has been accelerated and human resources development and training of doctors, nurses and paramedics have begun in all earnest. All the states have operationalised the Mission and the Health Delivery System is being rejuvenated through additional management, accountancy and panning support at all levels. By placing Accredited Social Health Activists (ASHAs) in every village, basic

health care has been brought closer to the vulnerable groups by giving a boost to health education and promotion. AYUSH systems have also been integrated in NRHM. At the state level, the Mission functions under the overall guidance of the State Health Mission headed by the Chief Minister. The Chief Secretary and the Secretary/Commissioner, Health and Family Welfare are the Chairmen of the General Body and Executive body of the State Health Society respectively. A designated officer is identified as the State Mission Director who is directly supported by a state programme management unit. The organisational set up at the district level is given below:

Governing Body, District Health Society headed by the Deputy Commissioner

Executive Body, District Health Society headed by the Chief Medical Officer

District Programme Management Unit , Medical Officers Of Community Health (CHC) District Family Welfare Officer/ District Immunisation Officer, District Health Officers

Medical Officers of Primary Health Centres(PHC)

Auxiliary Nurse Midwife of Primary Health Sub Centres (Sc)
Public Health Services in the rural areas are delivered through the CHCs, PHCs and SCs.

NRHM strives for a decentralised and participatory planning process with a bottom up approach from village level to ensure that need based and community owned Health Action Plans form the basis for interventions in the health sector. The plans were to be carried out on the basis of household and facility surveys at village, block and district levels based on the Indian Public Health Standard (IPH) standard norms. However, a comprehensive household survey could not be carried out except Imphal West District. The state health society was required to prepare a perspective plan for the entire period (2005-2012) as well as annual plans covering the gaps in health care facilities, areas of interventions and probable investments. The audit report of the programme in 2010 noticed that perspective plans were not prepared at the state or district level. No proper

State Programme Implementation Plan, District Health Action Plans and Block Health Action plans were prepared. Hence, community participation in planning as envisaged in the Mission remains unachieved (2010).

In all the tribal areas, according to the audit report it was seen that there was acute shortage of health centres in those areas as in 6 CHCs as against 11 CHCs, shortage of 5 of 43 PHCs and shortage of 59 of 289 SCs. The upgradation of CHCs to Indian Public Health standards and PHCs to 24x7 services as envisaged in the NRHM was not done. The constructions of buildings for sub-centres were not completed. It was also seen that health facilities were quite inadequate in a large number of health centres. All these resulted in failure to provide accessible and reliable health care facilities in the hilly areas. Uninterrupted water supply and uninterrupted power supply are inevitable in PHSCs. The table below is a list of the Primary Health Sub Centres in Saikul sub division. They are as follows:

1. Molkon Primary Health Sub centre.
2. Lhungjang Primary Health Sub Centre.
3. Gangpikon Primary Health Sub Centre.
4. Utonglok Primary Health Sub Centre.
5. Jangnoi Primary Health Sub Centre.
6. Sijang Mongjang Primary Health Sub Centre.
7. Chingdai Khullen Primary Health Sub Centre.
8. Thangal Surung Primary Health Sub Centre.
9. Khongbal Tangkhul Primary Health Sub Centre.
10. Dongsum Khunou Primary Health Sub Centre.
11. Mapao Christian Primary Health Sub Centre.

The geographical locations of these Primary Health Subcentres are widely spread. The distance of these sub centres from the Primary Health Centre (PHC) of Saikul subdivision is a long one again. Adding to the woes of the people is the bad conditions of roads and in the worse case the absence of accessible roads leading to certain remotest parts of the sub division. However, efforts are on now for constructing roads but a lot still needs to be done. The basic infrastructural deficits in the form of bad conditions of roads, absence of roads, inadequate power supply, inadequate drinking water supply, etc have been in the picture for a long time.

As per the Indian Public Health Standard norms, the population criteria of Primary Health Sub- Centre is 5000 heads in plain areas and 3000 in hill areas. Even with the physical presence of these subcentres, a more worrying factor was the absence of quality health care services. The irregular attendance of nurses or the absence of nurses and other staff personnel was one such factor. The lack of medical equipments, the absence of drugs and medicines are another cause of concern. Accredited Social Health Activists (ASHAs) are the most critical component of the health care delivery system under the National Rural Health Mission (NRHM). Although the state has selected 3878 ASHAs according to the data given in the final draft of the state programme implementation plan, 2010-2011 and completed the training up to the 5th module for most of them, however , the incentive system for them is not streamlined because of the multiple chains of command and control. This has led to fair degree of demoralization and demotivation of some of the ASHAs.

ASHAs workers play a major role to bridge the gap between the community and health care delivery system under NRHM. One ASHA worker covers 1000 population in the valley districts while one ASHA worker covers 200 populations in the hill districts. The role of ASHAs assumes critical importance especially in the hilly remote parts of our state. This is one such credible innovation in the health care sector of our country.

Churachandpur District has 16 Primary Health Sub-centres with no ANMs, lamented the Chief Medical Officer District Hospital, Dr.Thangchinkhup during the observance of World Population Day last year. He also added that the absence of ANMs directly means that there is no one to give immunization to the poor infants and children in those sub-centres and their coverage villages. This is a serious case as the satate government is providing adequate manpower to man these sub centres.

As per the Programme Implementation Plan 2010- 2011, Churachandpur District under the NRHM, the Primary Health Sub Centres are broadly divided into the following categories: 1. Building less Primary Health Sub Centre, 2. Primary Health Sub centres which need renovation, 3. Very Difficult and inaccessible Primary Health Sub Centre. A worrying factor is that the number of building less and inaccessible sub centres far exceed that of the number of the sub centres which need renovation. This shows the grim picture of the poor quality or in the worse case the absence of health care delivery to the

remote parts of the district namely to the hamlets and villages which have marginalized communities. The sub centre as to say is the first facility interface of community with health facility under the NRHM and is the key to improving access and reach the remotest and the undeserved areas. It is to be noted that large number of the SCs are still in need of new constructions, manpower, equipments, etc. Mention may be made of some of the buildingless primary health sub centres. They are as follows:

1. Phaibuong (under Henglep PHC).
2. Kangkap (under Singngat PHC)
3. Ukha Loikhai (underHenglep PHC)
4. Hiangtam K (under Behiang PHC)
5. Dailon (under Thanlon PHC)
6. Sumtuh (under Singnhat PHC)

Ukha Loikhai and Dailon also come under very difficult and inaccessible Primary Health Sub centres. Lungthulien under Parbung Primary Health Centre, Bukpi and Kaihlam under Thanlon Primary Health Centre are some of the sub centres which need renovation.

According to the final draft of the State Programme Implementation Plan (2010-2011) for the NHRM implementation, it was observed that the Village Authority in the hilly districts may be tapped for NHRM implementation. As such, the orientation programmes for village headmen were conducted. Reorientation for initiating community monitoring may be taken up like performance based incentive to ANMs may be given based on the attendance certificate provided by them. In the year 2010-2011 an extensive Panchayati Raj and Village Authority orientation on NHRM activities and community monitoring like social audit and exercising the power of controlling the sub centre staff was decided to be implemented in order to improve the availability of ANM staff at the place of posting.

A bottom up planning structure for the implementation of the NRHM.

At the state level, a state planning team was formed under the Chairmanship of the State Mission Director, consisting of Additional Director, Directorate of Health Service, Additional Director, Directorate of Health and Family Welfare, State Program Officers of Health and Family Welfare Sector, State Programme Management Unit officials and the key officials trained for district health Planning. Similarly, at the district level, District

Planning teams were formed comprising of District Mission Director, District Program Management Unit Officials, District level planning Officers of health and family welfare, senior medical officers and representatives of leading NGOs.

At Block levels, Block Planning Team was formed consisting of SDO/Bdo, CMO/MO of CHC/PHC along with Block Program Management Unit staff. At the lowest level, village health action plan team were also formed consisting of Pradhan/Village authority, ANM, ASHA, AWW, women leaders of the church wing/SHG,2/3 of Village Health Sanitation Committee. ASHA was the nodal person for coordinating the Village Health Action Plan preparation.

Conclusion

The *numerouno* key strategy of the National Rural Health Mission is to let the local governance structure be accountable and responsible for the health care delivery system. In the valley, there is the Panchayat system and in the hills there is now a resurgent District council system in place. As it has been observed, the presence of a weak local governance structure or absence of a functioning local governance institution as in the district councils in the hills was responsible for the lack of effective implementation of NRHM.

Another important observation that was made during the implementation of NRHM was the profound lack of monitoring and supervision in the state. Although the state and district data managers are identified as the Monitoring and Evaluation nodal officers at the state and district levels respectively and also Monitoring and Evaluation committee is formed at the state, their functionality is still questionable. Data triangulation through community monitoring is an essential activity under NRHM, but it is a neglected activity in the state. There is no data analysis and feedback system except that of a quarterly NRHM newsletter.

The condition of supervisory system is worse. State and district level officers hardly go to the field to monitor the work of the field level workers. If at all there is any, actions based on the supervisory findings are not taken up. There is an urgent need to strengthen the monitoring and supervisory system in the field. In this context, it can be said that the Autonomous District Councils in the hills must play as the overall monitoring and supervisory authority for the proper implementation of such an important scheme. In order to achieve better outcome, many innovations have been tried out in other states of

the country. For instance the initiation of community based monitoring in the case of ICDS (Integrated Child Development Service) in Ratlam district of Madhya Pradesh.

The formation of Ekta Samuha comprising elected Panchayat members , village level government service providers and citizens as well as development of user friendly community monitoring tools for collecting , collating and analysing data, building convergence between government departments and local self governing institutions in planning and service delivery through establishment of district, block and village level forums for collectively identifying gaps in services, and promoting a cadre of change agents at the village level, etc are some of the innovative mechanisms which can also be replicated with certain changes taking into account the prevailing local conditions in the hill districts of the state of Manipur .

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