PRIMARY HEALTH CARE DELIVERY SERVICES IN AIZAWL: FUNCTIONS & CHALLENGES

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Submitted by

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CERTIFICATE

Certified that Ms. Marie Zodinpuii, a student of M.Phil Programme in the Department of Public Administration, Mizoram University has prepared the present dissertation titled 'Primary Health Care Delivery Services in Aizawl: Functions & Challenges'. This is an original work of research which has not been used previously and which has not been submitted to any other University for any purpose. It covers the topic of research adequately.

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DECLARATION

I, Marie Zodinpuii, do hereby declare that the subject matter of this dissertation is the record of work done by me, that the contents of this dissertation do not form the basis of the award of any previous degree to me or to the best of my knowledge, to anybody else, and that the dissertation has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to the Mizoram University for the degree of Master of Philosophy in Public Administration.

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LIST OF ABBREVIATIONS

AEFI	Adverse Events/Effects Following Immunization
AFP	Alpha Fetoprotein
AMC	Aizawl Municipal Corporation
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BHU	Basic Health Unit
BMS	Baptist Mission Society
BP	Blood Pressure
CHC	Community Health Centre
CMO	Chief Medical Officer
CVD	Cardio Vascular Diseases
DDK	Disposable Delivery Kits
DGHS	Directorate General of Health Services

DH&ME	Directorate of Hospital & Medical Education
DHQ	District Headquarters
DHS	Directorate of Health Services
DHs	District Hospitals
DOTs	Directly Observed Treatments
GDP	Gross Domestic Product
GP	General Practitioner
HWF	Health Worker Female
HWM	Health Worker Male
ICDS	Integrated Child Development Services
IDSP	Integrated Disease Surveillance Project
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IUCD	Intra Uterine Contraceptive Devices
LHV	Lady Health Visitor

MCH&FW	Maternal and Child Health and Family Welfare
MDGs	Millennium Development Goals
MDT	Multi Drug Therapy
MO	Medical Officer
MPW	Multipurpose Workers
MTP	Medical Termination of Pregnancy
NACP	National AIDS Control Programme
NGOs	Non Governmental Organization
NHRM	National Rural Health Mission
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control of Blindness
NPPCD	National Programme For Prevention and Control of Deafness
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
ORS	Oral Rehydration Therapy
PHC	Primary Health Care

PHCs	Primary Health Centres
PNC	Post Natal Care
PPH	Postpartum Haemorrhage
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Test Kit
RHC	Rural Health Clinic
RMO	Regional Medical Office
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendance
SC	Sub Centre
SCHIS	Senior Citizen Health insurance Scheme
SDGs	Sustainable Development Goals

SDHs	Sub District / Sub Divisional Hospitals
SECC	Socio Economic Cast Census
SHs	State Hospitals
STI	Sexually Transmitted Infection
THQ	Tehsil Headquarters
TT	Tetanus
UHC	Universal Health Coverage
UNICEF	United Nations Children's Funds
VHND	Village Health and Nutrition Day
WCD	Women and Child Development
WHO	World Health Organization

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PREFACE

Primary Health Care is the first point of contact that people have with the health care system of the country. It provides reachable, community-based care that meets the health needs of individuals all through their life. Primary Health Care comprise a range of services from promotion and prevention to basic level of curative care including management of chronic health conditions and palliative care. The primary focus is also on reproductive health, family planning, immunization, prevention of locally endemic diseases, treatment of common diseases or injuries, provision of essential facilities, health education, provision of food and nutrition and adequate supply of safe drinking water.

Although Primary Health Care is all inclusive, it is more particularly important for the poor and the needy. A defining feature of Primary Health Care is that the services should be acceptable and suitable to the specific community, accessible to all members of the community and there must be dynamic participation of the community in every and all stages of service delivery. The services should form the groundwork and foundation of health care delivery services and as such be an integral part of the country's health system. The programme must be well-organized and capable, as well as multi- sectorial because health does not subsist in seclusion.

The first chapter starts with the basic concept of health, its importance and role in the advancement and development of the nation, as well as its value, in terms of it being an asset and a resource, that ranks higher than any other factor, towards contributing to a richer and fuller life of the nation and the people. The Chapter also touches upon the role of Primary Health Care(PHC) as a vital strategy that remains the backbone of health service delivery and the importance and significance of the present study. The chapter also explains the different sources of literature that have been reviewed, statement of the problem, scope and objectives of the study ,the Research Questions, Methodology applied and Chapterization of the present study.

The second chapter deals with conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives. It discusses elements of Primary Health Care ,the Millennium Development Goals, the Sustainable Development Goals with health related indicators, the organising and financing of health care delivery system from the national level, State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level, approaches ,strategies and the resources of health care - human, financial, material and technological-as available or that should be available to the people at the grassroots level.

The third chapter explains the setup of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular highlighting the role played by the Christian missionaries as well as the government. The present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system, is discussed. Sub-centres are expected to provide promotive, preventive and few curative primary health care services and lay emphasis on Reproductive and Child Health (RCH) as well as Non-Communicable Diseases related services. The Sub Centres are also expected to be involved in the implementation of National Health Programmes relating to Communicable Diseases such as National AIDS Control Programme (NACP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Eradication Programme (NLEP) and Revised National Tuberculosis Control Programme (RNTCP).

The fourth chapter contains the results and discussions of the field study focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services ,people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics, as

well as the ideas and opinions of the officials working in the Sub Centres/Clinics, suggested remedial measures as well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl-–Republic Vengthlang Sub Centre Clinic, Zonuam Sub-Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East. There exists no real difference between the Sub Centre and Sub-Centre Clinics, they basically perform the same type of functions and have similar role and responsibilities.

The fifth chapter is divided into two parts. The first part covers summary of all the previous chapters, Chapter One, Chapter Two, Chapter Three and Chapter Four. The Second part discusses the research questions and general conclusion, highlighting the major findings of the study. And also it contains possible remedial solutions and suggested measures to be taken for effective Primary Healthcare Delivery Services in Aizawl through the working of the Health Sub-centres and Health Sub-Centre Clinics, in providing promotive, preventive and basic level of curative services to the people of Aizawl, set up and functioning in various parts of Aizawl.

CONTENTS

CHAPTER I

INTRODUCTION

Health is of crucial importance for the advancement and development of a nation. Since, development, in its ultimate analysis is about improving the wellbeing of the people and opening out opportunities to them for a richer, happier and more varied life. Of the many factors that contributes towards a richer, happier and fuller life, health ranks very high. In terms of resources, nothing can be of higher value to a nation than the health and well-being of the people. Health should not only be understood as the mere absence of illness and diseases. It is, in fact, a state of complete and harmonious functioning of the body and the mind and mental, physical and social well-being that enables an individual to fully explore his potentiality and talent and allow him to enjoy and take advantage of the opportunities available to him as a person and as a citizen of a nation and also to fulfil his obligations and responsibilities in the family, in the society and the nation.

In terms of resources, nothing can be of higher value to a nation than the health and well-being of the people. In this context the report of the Commission on Macroeconomics and Health (MCH)[1] published by the WHO established the link between health and wealth by arguing

[1]Jeffrey D. Sachs (2001), '*Macroeconomics and Health: Investing in Health for Economic Development*'(Geneva:WHO,2001)

that healthy people generate wealth, and ill health and disease significantly impact the growth momentum. In an ageing world, India's 40 percent young and productive population can be, and is, an enviable advantage, but only if they are healthy. Sick people do not produce wealth.[2]

Healthcare covers a broad spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis and treatment and rehabilitation. The term health services imply organisation, delivery, staffing, regulatory and quality control [3].Primary Health Care is the first and foremost level of contact of individual, family and community with the health system of the state. It forms the base of all health care delivery services in a country and is most effective and closest to the people. Primary health care (PHC) is essential health care made universally accessible to individuals and acceptable to them, through full participation and at a cost the community and country can afford. Primary healthcare is a vital strategy that remains the backbone of health service delivery. Primary Health Care embodies certain fundamental values common to the process of overall development. It is a key to the achievement by

[2]K.S. Rao (2017), '*Do we care? India's Health Care System*', New Delhi, Oxford University Press.preface x.

[3] B.Thangdailova (2003), '*Modernization of Health Care Services in Mizoram*' in R.N. Prasad and A.K.Aggarwal (ed.). Modernization of Mizoram, Mittal Publications, New Delhi,p.30

the people a level of health that permits them to lead a socially and economically productive life.[4]

India was one of the first countries to recognize the value and importance of primary healthcare approach. Long before the Declaration of Alma-Ata of 1978, India adopted a primary healthcare model based on the principle that incapacity to pay should not prevent people from access to health care services. The recommendations of the Health Survey and Development Committee (Also and more commonly known and referred to as The Bhore Committee) Report 1946, under the chairmanship of Sir Joseph Bhore, the Indian Government resolved to focus health care delivery services on rural people. The Bhore Committee Report gave importance to social orientation of health care services and gave priority to community participation in public health care delivery mechanisms. Community Development Programme was launched in 1952 when first five year plan formulation (1951-1955) was started and health care planning in India was started in a systematic manner. It was envisioned as a multipurpose program covering health and sanitation through establishment of primary health centres (PHCs) and sub-centres to provide health care services nearest to the people, in a manner that

[4] A.B.Hiramani (2016), ' *Health Education in Primary Health Care'*, New Delhi: B.R. Publishing Corporation.p.1

could be acceptable and most friendly for them, with their full participation, that could be affordable to them and to the country, at every stage of their development while at the same time respecting their spirit of self-reliance, self-determination and free-will.

With this approach, the country seeks to achieve more meaningful and more equitable distribution of health services. Also it recognises the fact that the people and the community themselves are the makers of their health, because many decisions on health matters are and should be taken by individuals and the family members; and this is a truism in the context of India where family bonds are still strong. But to enable them to take correct and sensible decisions in matters of health, individuals in community, and the community itself, as a whole, need to be equipped with knowledge and skills which will help them make informed decisions and exercise their responsibilities for a healthy individual and community life. Primary Health Care offers a composite package of services through health institutions, health workers ,groups and community.[5]

Providing as well as maintaining quality primary care to large, diverse populations is immensely difficult, and that is certainly true in the case in India. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies persistently, even after six decades of independence, continue to be leading causes of deaths, non-

[5] Ibid,pp.1

communicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are also on the rise .Mental health disorders are also on the increase taking a considerable toll of human lives. The health issues related to elderly population are common due to increase in life expectancy. India has been witnessing rapid urbanization particularly in recent decades. Currently one-fourth of the urban population lives in slums with severely compromised health and sanitary conditions. While the primary healthcare system is struggling to provide services, there is an emerging need for addressing the above mentioned issues. This presents huge challenge to the current primary healthcare delivery services in India.

Review of Literature

Since Health systems and administration in developing countries are so much constrained by various challenges such as prevention of both communicable and incommunicable diseases, promotion of healthy lifestyles, provision of affordable but good quality health care, protection from the financial consequences of ill health etc., issues of public health and illness, primary health care, health education are matters of concern for writers and scholars in Public Administration. As such there vast arrays of articles and books related to these topics and issues. However, researches on Primary Health Care Delivery Services in Mizoram are practically non-

existent although there have been few studies carried out on some facets of Health System in Mizoram. With the purpose of facilitating the proposed study, a few books and articles relevant to the context at hand have been chosen. Some of the books and articles are reviewed as follows:

R.N.Prasad and A.K.Agarwal(eds)(2003)[6] in their edited volume *Modernisation of the Mizo Society*, which consists of nineteen research papers, all touching upon various issues and contemporary aspects of modernisation-the challenges, problems and constraints associated with modernisation and development of the Mizo Society. Relevant issues like planning in urban areas, urban local government perspectives, forest management, agriculture development and most importantly and also relevant to this research work, the book also contains a valuable research paper *Modernisation of Health Care Services in Mizoram* written by B.Thangdailova, who traces the evolution of health care services in Mizoram ,health policy and important factors influencing Health. The paper also explains the concept of Health in general and Primary Health Care, in particular, in the context of Mizoram, as one of the states of the Indian Union, a signatory of the Alma Ata Declaration. The paper provides a

[6] R.N. Prasad and A.K.Aggarwal (2003) (ed.), '*Modernization of the Mizo Society*' , Mittal Publications, New Delhi.

comprehensive overview of health care services in Mizoram and the level of modernisation of health services in Mizoram.

Sumedha Gupta (2009)[7] in *A Textbook of Healthcare Management* attempts to describe the health care system in India in the global perspective and the importance of management in improving overall outcomes and delivery of health care services. The author discusses, in adequate details, the general principles and techniques of management which are to be applied by health care administrators to achieve maximum efficiency in providing health care services. The role of Information Technology in health care services has also been emphasised. Major challenges and problems in health care system in India are discussed and examined, with suggestions and ways to overcome these problems, through efficient and proper management practices.

K.B.Saxena (2010)[8] in *Health Policy and Reforms - Governance in Primary Healthcare* examines various facets of rural health care and major issues of governance which impact its performance in the context of health policy and changes introduced in it after the onset of economic reforms. It also covers major interests which impose upon health governance. The National Rural Health

[7] Sumedha Gupta(2009), '*A text book of Health Care Management*', New Delhi,Kalyani Publishers.
[8] K.B.Saxena(2010), '*Health Policy and Reforms-Governance in Primary Healthcare*', New Delhi,Aakar Books.

Mission, a major policy intervention by the Government, has also been briefly dealt with. The book provides a broad overview of major problems faced in the public health system in the rural areas, why they arise and why they have failed to get resolved.

Alia Ahmad et al. (eds.)(2013)[9] in their edited book *An Institutional Perspective on Provision of Primary Health Care in India and Bangladesh* which consists of collection of essays on Primary Health Care in India and Bangladesh, brings to light the functions, responsibilities and obligations of the providers of primary health care. In doing so, the authors note that decentralisation or devolution of functions, finances and functionaries in health care delivery has not happened in both the countries because of lack of social mobilisation. On the other hand, public-private partnership (PPP) in health care services may be a workable option. In India, PPP is in embryonic stage, but there is evidence that people are willing to pay for certain health services, including access to essential drugs, thereby raising hope that some innovative alternative of PPP may succeed. An important suggestion emerging out of this study is to make Panchayats and grassroots NGOs as primary channels for the delivery of primary health care in rural areas.

[9] Alia Ahmad.et al.(eds.)(2013), '*An Institutional Perspective on Provision of Primary Health Care in India and Bangladesh*', New Delhi, Academic Foundation.

A.B.Hiramani (2016)[10] in *Health Education in Primary Health Care* examines the role and importance of primary health care in the Indian society characterised by low literacy, poverty, ignorance and traditional way of thinking based on beliefs and superstitions. The book, based on field investigations explores some important health issues such as health communication, population education, health educators, sexually transmitted diseases, water and sanitation. The author offers various approaches that can facilitate solution of health problems through the intervention of health educators and health research.

Rajendra Pratap Gupta (2016)[11] in *Health Care Reforms in India-Making up for the Lost Decades* presents a detailed and comprehensive account of India's healthcare sector, its evolution and development, performance and the way ahead. The author has made a situational analysis of the health system of USA, UK, Canada and India and points out that India's expenditure in health, as percentage of GDP remains lower than many of the emerging economies. The book discusses, among other important issues, the politics and economics of health, health care challenges, health care reforms in India and foreign influence on the health care system. Despite so many reforms in the health sector, the country still suffers from huge infrastructural gap and

[10] A.B. Hiramani (2016),op.cit.
[11] Rajendra Pratap Gupta (2016), '*Health Care Reforms in India-Making up for the Lost Decades*' ,New Delhi, Reed Elsevier India Pvt. Ltd.

financial constraints. The author also discusses at length, the challenges to health care but remains hopeful and optimistic as he believes that India has potential to adopt innovations in the health care policies and make it sustainable.

K.S Rao (2017)[12] in Do *we care? India's Health Care System* details and documents the history of health policy initiatives in India and examines the efforts to strengthen the public healthcare system that have been made in the last decade. The author, drawing on her valuable experience as the former union health secretary, provides an insider's account of the making of India's health policy in contemporary times. India is one of the fastest-growing economies in the world. Yet, health is not a part of our ambitious development story. In fact, India's disproportionately miserly healthcare budget makes some of the poorer nations look better in comparison. We have one of the highest numbers of women dying in childbirth and under-five mortality rates. Every year nearly sixty million people get pushed below the poverty line due to the health expenditures that they incur. The author fervently suggests increasing the health budget, greater use of technology, and providing leadership and good governance. She argues that unless good health is prioritized as a national goal, India's growth story will remain largely self-congratulatory.

[12] K.S Rao (2017), '*Do we care? India's Health Care System*', New Delhi, Oxford University Press.

Arun K Agarwal (2008)[13] in their article *Strengthening Health Care System in India: Is Privatization the Only Answer?* takes a closer look at how low productivity of public health sector has led to more public-private partnership(PPP). Although PPP does not imply privatization alone, it may lead to privatization in its existing set-up. In India, already 80% of the curative care is being sought after by people from the private sector. Privatization will not only broaden the gap between rich and poor but also encourage 'survival of the richest,' which cannot be considered the goal of any civilized society. The author suggests that, instead of privatization of health services, one should think of ways and means of using the taxpayers' money, which runs into crores of rupees, to bring the health benefit to the poorest people.

H.T.Pandve et al. (2013)[14] in their article *Primary Health Care in India: Evolution and Challenges* stressed the vital role of Primary health care in protecting, maintaining and restoring our health. Primary Health care is both the first point of contact with the health care system and the most frequently used health service. They explored the evolution and improvements in primary health care services,

[13] Arun K Agarwal (2008), 'Strengthening Health Care System in India: Is Privatisation the Only Answer', *Indian Journal of Community Medicine* ,33(2).

[14] H.T.Pandve et al. (2013), 'Primary Health Care in India: Evolution and Challenges', *International Journal of Health System and Disaster management*,Vol-1,Issue-3.

infrastructure and related healthcare indices of our country since independence from the Bhore Committee Report(1946) to the National health Policy, 2002 which set out a new framework to achieve public health goals under the socio-economic circumstances prevailing in the country, to the launching of the National Rural Health Mission in 2005 in carrying out necessary architectural correction in the basic healthcare delivery system especially for the rural poor women and children. While the primary healthcare system is struggling to provide services, challenges to Primary Health Care system in India are many and continue to increase, the existing infrastructure, resources, manpower are severely deficient to cope with the challenges. The article clearly mentions that considerable progress has been achieved in the field of basic universal education, gender equality in education as well as in global economic growth in recent years, there is little progress in the improvement of health indicators related to mortality, morbidity and various environmental factors contributing to poor health conditions.

Rajiv Yeravdekar et al. (2014)[15] in their article *Strengthening of Primary Health Care: Key to Deliver Inclusive Health Care* clearly mention the two root causes of ill health-inequity and poverty. Access to quality health care and service on and affordable and equitable basis

[15] R.Yeravdekar, et al. (2014), "Strengthening of Primary Health Care: Key to Deliver Inclusive Health Care*", Indian Journal Of Public Health*,Vol-57,Issue-2.

remains an unfulfilled aspiration in many parts of the country. Disparity in health care is interpreted as a compromise in the Right to Life. The status of health in India is not a matter to be proud of when India has the largest burden of communicable diseases, maternal and infant mortality rate in some poor districts in India are worst than the Sub-Saharan Africa and diarrheal diseases are the primary causes of early childhood mortality. It is imperative to define 'essential health care,' which should be made available to all citizens to facilitate inclusivity in health care. The suggested methods for this include optimal utilization of public resources and increasing public spending on health care, capacity building through training, especially training of paramedical personnel and improvement in delivery system of health care.

Krishna D Rao et al. (2015)[16] in their article *Urban Health in India: Many Challenge, Few Solutions* provides a national perspective on the state of both population health and health systems in the context of an increasingly urban India. The extent to which India's health system can provide for this large and growing city-based population will determine the country's success in achieving universal health coverage and improved national health indices. Urban India has a high concentration of health-care providers, yet, not everyone has easy

[16] K.D.Rao et al. (2015), "Urban Health in India: Many Challenges, Few Solutions", *The Lancet Global Health*,Vol-3,No.12.

access to health care. Although the quality of health care accessed by the urban poor needs more research and policy attention, the large presence of unqualified providers in urban areas highlights the low quality health care that poor people in urban areas receive. Government efforts to strengthen urban health systems have focused on programmes such as the National Urban Health Mission (now part of the National Health Mission). However, without a substantial increase in public funding for health (currently it is around 1% of GDP), India's urban health system will have difficulty in meeting the challenge of achieving universal health coverage.

M.Chokshi et al.(2016)[17] in their article *Health Systems in India* explores the critical role of Health systems and polices in determining the manner in which health services are delivered, utilized and how they affect health outcomes. This article briefly describes the public health structure in the country and traces the evolution of the major health programs and initiatives with a particular focus on newborn health. Report on the Health Survey and Development Committee, commonly referred to as the Bhore Committee Report, 1946, has been a landmark report for India, from which the current health policy and systems have evolved. A brief description of the status of Public Healthcare Infrastructure in India and the major

[17] M.Chokshi, et al.(2016), " Health Systems in India", in *Journal of Perinatology*,36 (Suppl 3).

initiatives under NRHM for architectural correction of the rural health system is given. Looking at the pace of achievements of the targets so far and future targets, they suggest the needs to focus more on framing of the policies in terms of building capacity of existing human resources and enhancing further allocation of finances.

P.Kumar (2016)[18] in his article *How to strengthen Primary Health care* stress the need to realise the importance of Primary Health Care (PHC) as also the need to build financial viable and sustainable PHC based on rational principles to fulfil the goals of providing quality health services with an affordable and equitable basis and also ensuring fiscal prudence. The author gives an overall view of current challenges and weaknesses in Primary Health Care and also provides a Healthcare Model for the future. PHC aims to provide quality and comprehensive health care in a cost-effective and equitable manner and is the foundation for health systems strengthening. Innovations in the field of health care to reduce health-care expenditure with quality care are the need of hour. Planning and management is necessary to reduce wastage of public funds and resources. Various reports have shown significant wastage of medicines and health-care equipment because of poor planning. Preventive care, chronic disease management, and

[18] P.Kumar (2016), " How to strengthen Primary Health Care", *Journal of Family Medicine and Primary Care*, Vol-5,Issue-3.

diagnostic triage with control of hospital referral should be the areas of major concern.

After reviewing the aforementioned sources of literature including books and articles, it has been found out that although there are significant literary sources on Primary health Care Delivery Services, there is no proper study on Administration of Primary Health Care Delivery Services in Mizoram, or for that matter ,in Aizawl. For this reason, the present study is proposed to be undertaken to fill in the gap and to enrich literature on the subject.

Statement of the Problem

Primary Health Care in India has been a great challenge because of its diversity and disparity. The current status of Primary Health care (PHC) in India is very grim. Besides low rates of institutionalised delivery and immunization coverage, high maternal and infant mortality rate which is definitely a concern and priority, availability of formal primary care in urban and rural areas particularly is low. Public health System is rigid, appallingly underfunded and inadequate to cater to health-care demands of 1.28 billion population of India. There are gross shortages of skilled health-care workers at primary care level. Whatever little resources are available, they are either overburdened or underutilized.

Mizoram is one of the states of the Indian Union, which is a participant of the Alma Ata Declaration of 1978. Primary Health Centres and Community Health Centres were started in Mizoram as early as 1966 when there were 3 PHC/CHC in the state, one more was added by year 1972 when it became a Union Territory and over the past, its numbers has steadily increased to meet the increasing demand for primary healthcare services.

After attaining statehood the emphasis was on the increasing and extension of the healthcare establishment. By 2013, there were 64 PHC/CHC and 367 Sub centres. At present there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state.

In Mizoram, the growth of healthcare facilities in the state has been slow. There were two pioneering agencies that started and carried on the health care delivery services in Mizoram; one under the Christian missionaries as charity services and another under the government. Both these agencies have continued to work side by side. The contributions of early Christian missionaries were commendable for the growth and development of modern healthcare system in Mizoram. Dispensaries, which started earlier were gradually replaced by Primary health centre and Community health centre. People living in remote rural areas were provided with simple modern healthcare

system like Sub-centre & Sub-Centre Clinics only after Mizoram attained statehood in 1986.

There are 22 rural development blocks in Mizoram. Most of the block headquarters in Mizoram have Primary Health Centre (PHC) or Community Health Centre (CHC) health institutions. The pattern in the growth of healthcare facilities, reveals a strong urban bias particularly in Aizawl district. Nearly one-third (132/451) of all health institutions are concentrated in the district. This is mostly attributed to the enormous concentration of population in Aizawl district compared with the other districts. It must be mentioned here that mere availability of health institutions is not a guarantee of quality healthcare.

There is a need to study, in depth the nature, role and status of primary healthcare delivery services in Aizawl, problems and challenges in primary healthcare delivery mechanism. Therefore, the present study has tried to provide an overview of primary healthcare delivery services in Aizawl, identify the problems and challenges encountered and fetch possible suggestions that may contribute towards solutions of the problems and meet the challenges so identified.

Scope of the Study

The present study attempts to provide a conceptual overview of primary healthcare delivery services in Aizawl. Efforts were made to study the growth and development of primary healthcare delivery system in Mizoram. For the purpose of health administration and delivery of health services, Aizawl District has been divided into East and West Aizawl District. At present, there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state. In Aizawl, at present, there are 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East. The main focus of the present study is on the administration of primary healthcare delivery services in selected Sub Centres/Clinics as the most peripheral and first contact point between the primary health care system and the community with the objective of exploring their role and functions. The study has further highlighted the problems and challenges concerning the Health Sub-Centres and Clinics in Aizawl and has attempted to provide suggestions arising out of the study. While studying the Primary Health Care Delivery Services in Aizawl, particularly in the selected areas and health units, the indicators and dimensions have been analysed as representatives of the situations in different districts and also in the state of Mizoram, in general. The

present study has indicated any kinds of gaps or otherwise which has been looked into with a view to providing possible suggestions for remedial measures as primary health care delivery services contributes to the general well-being of the citizens.

Objectives of the Study

At this backdrop, the broad objectives of the present research are:

i.to examine the role and functions of Primary Health Care Delivery Services in Aizawl.

ii.to identify the problems and challenges of Primary Health Care Delivery Services in Aizawl.

iii. to suggest remedial measures for effective delivery of Primary Health Care Services in Aizawl .

Research Questions

Given the context and the broad objectives of the research, the following research questions have been placed for obtaining an adequate answer:

i. What are the role and functions of Primary Health Care Delivery Services in Aizawl?

ii. What are the problems and challenges of Primary Care Delivery Services in Aizawl?

iii. What are the remedial measures for effective delivery of Primary Health Care Services in Aizawl?

Methodology

The present study is an analytical and descriptive study of Primary Health Care Delivery Services in Aizawl. Both Primary and Secondary data has been used. The primary data has been collected from six Sub-Centres & Sub-Centre clinics –Republic Vengthlang Sub Centre Clinic, Zonuam Sub Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub Centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East with the help of Questionnaire along with personal interactions with government officials, health care providers, ASHA(Accredited Social Health Activists) and fifty one beneficiaries covering the six health care units. Convenience sampling has been used to represent the functionaries and beneficiaries. The total size of the sample is 69. The secondary data has been collected from published and unpublished works on the related topics, books, articles, journals, publications of the World Health Organisation, Government of India and Government

of Mizoram, Web sources also formed an important source of secondary information.

Chapterization

The present dissertation is organised into five chapters.

Chapter I : Introduction

The introductory chapter deals with a brief introduction on the topic, the concept of health and primary health care, importance and significance of the study, a review of different sources of literature, statement of the problem, scope and objectives of the stud ,the Research Questions, Methodology applied and Chapterization of the present study.

Chapter II : Primary Health Care Delivery Services: A Conceptual Study

Chapter II deals with conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives. It discusses elements of Primary Health Care ,the Millennium Development Goals, the Sustainable Development Goals with health related indicators, organising and financing of health care delivery system from the national level, State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level, approaches

,strategies and the resources- human, financial, material and technological-as available or that should be available to the people at the grassroots level.

Chapter III : Administration of Primary Health Care Services in Aizawl: Functions and Role

Chapter III explains the setup of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular highlighting the role played by the Christian missionaries as well as the government. The present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system, is discussed.

Chapter IV : Results and Discussion

Chapter IV deals with results and discussions of the field study focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services, people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics, as well as the ideas and opinions of the officials working in the Sub Centres/Clinics,

suggested remedial measures as well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl.

Chapter V : Conclusion

Chapter V is divided into two parts. The first part covers summary of all the previous chapters- I, II, III and IV. The second part presents a summary of conclusions and attempt has been made to give suggestions regarding primary health care delivery system based on the research findings.

The present chapter which is the introductory chapter covers a brief introduction of the concepts and theoretical dimensions of Primary Health Care, review of literature, statement of the problem, cope, objectives of the study, research questions, methodology and research questions.

CHAPTER II

PRIMARY HEALTH CARE DELIVERY SERVICES:

A CONCEPTUAL STUDY

The previous and introductory chapter deals with a brief introduction on the concept of health and primary health care, importance and significance of the study, a review of different sources of literature, statement of the problem, scope and objectives of the study ,the research questions, methodology applied and chapterization of the present study. In the present chapter, we will discuss conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives, approaches, strategies and the resources- human, financial, material and technological-as available or that should be available to the people at the grassroots level

Health is a dynamic concept, central to life and happiness of human beings. It tends to be something one often takes for granted when one has it, but once lost, leads to untold adversity, in mind, body and spirit, robbing one of the zest to enjoy life in all its various dimensions. So goes the adage ‘Health is Wealth’, in fact, health is so much more than wealth, it is the key to living a fulfilled life. A healthy man is a happy man- and happiness is a state of mind that can only be

achieved when one has a sound mind in a sound body, free of diseases. The World Health Organisation (WHO) has defined health as: “a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity”[1]. The state is responsible for the health of its people. Governments all over the world are determined to extend, expand and improve their health care services.

It is difficult to pin down a universally accepted definition of health and different approaches on understanding and explaining the concept of health has evolved over the years. Three leading approaches include the "medical model", the "holistic model", and the "wellness model"[2]

(1) The *medical model* was prevalent in North America throughout the 20th century, which regards the human body as a machine that could be fixed when broken. It emphasizes treating specific physical diseases and does not give importance to mental or social problems. It is more concerned with curing rather than preventing health problems .Thus it measures health by its absence, and so, health is defined as the absence of disease and the presence of high levels of function. It could more commonly be understood as "A state characterized by anatomic,

[1] (WHO Definition of Health 1948)World Health Organization: The Constitution of the World Health Organization. *WHO Chronicle* **1**:29, 1944.

[2] www.medicine.uottawa.ca/sim/data/Health_Definitions_e.htm viewed on 01.09.2018

physiologic and psychologic integrity; ability to perform personally valued family, work and community roles; ability to deal with physical, biologic, psychologic and social stress..."[3] When applied to population health, the medical model might define a healthy population as one in which its members of the community are physically healthy. Thus, according to this model, a healthy society is one in which the various systems (economic, legal, governmental, etc.) function smoothly.

(2) The *holistic model* of health which is illustrated by the 1946 WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[4] The holistic model broadened the medical perspective, and also introduced the idea of 'positive' health, a term, although not used by the WHO, seems most befitting. When applied to a population, the holistic model would again either sum appropriate individual indicators, or would record measures of the well-being of the population as a whole.

(3) The third model-the *wellness model* was developed through the WHO health promotion initiative. In 1984, a WHO discussion document proposed moving away from viewing health as a state,

[3] J.Stokes et.al.(1982) "Definition of terms and concepts applicable to clinical preventive medicine" *Journal of Community Health* ,8:pp.33-41

[4] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946 (it entered into force on 7 April 1948)

toward a dynamic model that presented it as a process or a force. This was augmented in the 1986 Ottawa Charter for Health Promotion. The definition held that health is "The extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a *resource for everyday life*, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities." [5] Similar definitions include some that view health in terms of resiliency e.g., "the capability of individuals, families, groups and communities to cope successfully in the face of significant adversity or risk." [6]In regard to population health, the definition might include elements such as the success with which the population adapts to change such as shifting economic realities or natural disasters.

Levels of Health Care

There are three different levels of health care service:

1. Primary care level :
2. Secondary care level
3. Tertiary care level

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[5] Health Promotion: *A discussion document on the concept and principles of health promotion*, Copenhagen, 9-13th July,WHO, 1984.

[6] Vingilis & Sarkella, *Social Indicators Research* 1997;40:159

Primary Care Level

This is the very first level of contact of individual, family and community with the health system. It forms the foundation of all health care delivery services in a country. It is most effective and closest to the people and includes:

- Primary Health Centre
- BHU(Basic Health Units), RHC(Rural Health Clinic), THQ(Tehsil Headquarters)
- Clinics
- RMO(Regional Medical Office)
- GP(General Practitioner)

Secondary care level

This level includes a higher level of care at which stage more compound problems are dealt with. It includes:

- DHQ
- THQ
- Health centres
- Hospitals

Tertiary care level

Specialized health care is provided at tertiary care level. Specialised

health workers with specific facilities are available. It includes

- Teaching hospitals,
- Regional hospitals
- Central hospitals
- Specialized hospitals

Primary Health Care Delivery Services: The Concept

Primary Health Care is typically, the first point of contact that people have with the health care system. It provides broad, reachable, community-based care that meets the health needs of individuals all through their life. Primary Health Care includes a range of services from promotion and prevention to management of chronic health conditions and palliative care. According to Alma Atta Declaration of 1978, Primary Health care was to serve the community; it included care for mother and children which comprise reproductive health, family planning, immunization, prevention of locally endemic diseases, treatment of common diseases or injuries, provision of essential facilities, health education, provision of food and nutrition and adequate supply of safe drinking water.

Primary health care may be defined as: Essential Health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost

that the country and community can afford.(Alma Ata Declaration,1978)[7]

The Universal Declaration of Human Rights established a breakthrough in 1948, by stating in Article 25 [8]"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." The WHO Constitution also affirms [9]"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Growing import has been given to social justice and equity, acknowledgment of the decisive role of community participation, shifting ideas about the nature of health and development, the consequence of political will has brought in new approaches to make health services more important in the service of humanity.

Alongside the above backdrop, the 30th World health Assembly decided in May 1977 at Alma Ata, that "the main social target of

[7] Primary Health Care (PHC) is usually associated with the declaration of the 1978 International Conference in Alma Ata, Kazakhstan known as the "Alma Ata Declaration".
[8] http://www.un.org/en/universal-declaration-human-rights/index.html viewed on 01.09.2018
[9] http://www.who.int/about/mission/en/ viewed on 01.09.2018

governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".The Alma-Ata Declaration, for the first time, put health equity on the international political agenda and Primary Health Care (PHC) became a core concept of the World Health Organization's (WHO) goal of HEALTH FOR ALL by the year 2000 as the social goal of all governments. In this joint WHO – UNICEF international conference in 1978 at Alma – Ata (USSR), the governments of 134 countries and many voluntary agencies called for a revolutionary approach to health care.Declaring that "The existing gross inequality in the health status of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable"

Health for all means that health is to be accessible and is to be brought within the easy reach of every one in a particular community. It also implies the elimination of obstacles to health -

- Malnutrition leading to ill health.
- Ignorance about the source and cause of diseases and its scientific prevention and cure.
- Disease
- Contaminated water supply, which is a breeding ground of diseases of all kinds

- Unclean and unhygienic housing etc.

Alma Ata Declaration urged all governments to formulate national policies, strategies and plans of action to initiate and furthermore sustain primary health care as part of a national health system. It is left to each country to innovate, according to its own situation and circumstances to provide primary health care. This was followed by the formulation and adoption of the Global Strategy for Health for all by the 34th World Health Assembly in 1981.Primary Health care got off to a good start in many countries with the theme "Health for All by 2000 AD" Primary Health Care is a novel approach to health care, which combine together at the community level all the factors required for improving the health status of the entire population.

Although Primary Health Care is all inclusive, it is more specifically significant and meaningful for the poor and the needy. A defining feature of Primary Health Care is that the services should be acceptable and suitable to the specific community, accessible to all members of the community and there must be dynamic participation of the community in every and all stages of service delivery. Primary health care needs to be effective, preventive, promotive and curative. The services should form the groundwork and foundation of health care delivery services and as such be an integral part of the country's

health system. The programme must be well-organized and capable, as well as multi- sectorial because health does not subsist in seclusion.

Principles of Primary Health Care

Primary health care has four basic principles:

1. Equity and fairness in service delivery
2. Community Participation in planning, implementation and maintenance
3. Intersectoral synchronization
4. Suitable and acceptable (for concerned community) Technology

Equity and justice

The first principle in primary health care strategy is equity in delivery of health services. It implies that health services must be equitably distributed to all- rich or poor, urban or rural - irrespective of their ability to pay and all members of the community must have equitable access to health services. The problem in most developing worlds is that the health services are mainly concentrated in urban areas as compared to the urban areas.

Community Participation and Involvement

Another key principle in primary health care strategy is the active participation/involvement of individuals, families, and communities in promotion of their own health and welfare although, on the whole,

responsibility lies with the State. Objectives of PHC and its delivery services cannot be achieved without the active involvement of community in planning, implementation and preservation of health services.

Intersectoral Coordination

As very clearly underlined by the Declaration of Alma –Ata, the PHC engage, in addition to the health sector all other related sectors and other aspects of national and community development, in particular education, agriculture, animal husbandry, food and nutrition, water supply, sanitation, industry, housing, public works and communication.

Appropriate/Suitable Technology

PHC requires technology that is scientifically sound, compliant with the local needs, and suitable to those who apply it and those for whom it is used and can be maintained by the people themselves with the resources of the community and at a cost the country can afford.

Essential Components / Elements of PHC

1. Education and awareness regarding prevailing health problems and the methods of identifying, preventing and controlling them.
2. Promotion of adequate and hygienic food supply and proper nutrition, an adequate supply of safe water and basic sanitation.

3. Maternal and child health care as well as family planning.
4. Immunization against major infectious diseases.
5. Prevention and control of locally prevalent diseases.
6. Treatment and management of common diseases and injuries.
7. Promotion and education in the area of mental health.
8. Provision of essential and critical drugs, free of cost.

Extended Elements in 21st Century

1. Expanded options of immunizations
2. Reproductive Health Needs
3. Provision of essential technologies for health
4. Health Promotion
5. Prevention and control of non-communicable diseases
6. Food safety and provision of selected food supplements

Millennium Development Goals (MDGs) and Primary Health Care[10]

The MDGs give high prominence to health: three of the eight development goals, nine of the 18 targets spread over six of the goals

[10] Primary health care and the Millennium Development Goals: Issues for discussion Pertti Kekki, MD, ScD; Professor of General Practice and Primary Health Care; University of Helsinki, Finland (pertti.kekki@helsinki.fi) available at https://pdfs.semanticscholar.org/d4e0/52b93043cd8a36607c4b93f08805329df509.pdf viewed on 20.10.2018

and 18 of the 48 indicators are health-related. Overall, the MDGs propose outcomes relevant to the development of national health policy frameworks and for tracking the performance of health programmes and systems. Although the MDGs do not cover the whole span of public health domains, it was believed that a broad interpretation of the goals provides an opportunity to address important cross-cutting issues and key constraints to health and development.

The MDGs with health related indicators

The Millennium Development Goals[11] situate health at the centre of development and urge governments throughout the world to deal with ill health by:

1. Eradicating extreme poverty and hunger(Goal 1)
2. Reduce child mortality (Goal 4)
3. Improve maternal health (Goal 5)
4. Combat HIV/AIDS, malaria, and other communicable diseases(Goal 6)
5. Ensure environmental sustainability(Goal 7)
6. Develop global partnership for development (Goal 8)

[11] Ibid.

Primary Health Care and Sustainable development Goals (SDGs) [12]

After the eight Millennium Development Goals that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September, 2015. SDG3 explicitly relates to health—to "Ensure healthy lives and promote well-being for all at all ages". This goal is translated into 13 targets: three relate to reproductive and child health; three to communicable diseases, non-communicable diseases, and addiction; two to environmental health; and one to achieving universal health coverage (UHC). Four further targets relate to tobacco control, vaccines and medicines, health financing and workforce, and global health risk preparedness.

A lot of the challenges summarized in SDG3 as seen in different countries ,although expected differences exist between different countries, are related to reproductive and child health, communicable diseases, chronic illnesses , addiction, and other mental health problems which can be tackled through an individual and community based approach to primary health care. Well-functioning

[12] Pettigrew, Luisa & Maeseneer, Jan & Anderson, Maria & Essuman, Akye & R Kidd, Michael & Haines, Andy. (2015), "Primary health care and the Sustainable Development Goals", *The Lancet.*,Vol 386,pp. 2119-2121

and organized primary health care can contribute to the accomplishment of many of the 16 other SDGs.

Organisation and financing of health care delivery system in India

India has a tradition of understanding health in a holistic manner through traditional systems of medicine –yoga and Ayurveda. Its comprehension of disease and its causation is in many ways superior to the allopathic system where treatment is largely symptomatic.[13] The traditional wisdom were brushed aside first by the Portuguese who introduced the modern medical system in India, and later on by the Britishers who imposed modern medicine on the reluctant Indians. Health was not a priority to the British who only spent 0.15 percent of their revenues on health, it was only after exceptionally high death rates caused by malaria, cholera, typhoid and venereal diseases on their troops that they were forced to get involved in the area of public health. Preventive health measures as well as a spate of health enactments were vigorously implemented mostly to serve their needs.

[13] K.S. Rao (2017), '*Do we care? India's Health Care System'*, New Delhi: Oxford University Press.p.7

India's federal system of government has divided the operations, financing, responsibilities and delivery system of health sector between the central and state governments. The Union Ministry of Health & Family Welfare is responsible for implementation of various programs on a national scale (National AIDS Control Program, Revised National Tuberculosis Program, to name a few) in the areas of health and family welfare, prevention and control of major communicable diseases, and promotion of traditional and indigenous systems of medicines and setting standards and guidelines, which state governments can adapt. In addition, the Ministry assists states in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance. The states, on the other hand, are responsible for organizing and delivering health services to their residents including hospitals, sanitation and so on, making health a state subject. However, areas having wider ramification at the national level, such as family welfare and population control, medical education, prevention of food adulteration, quality control in manufacture of drugs, are governed jointly by the union and the state government.[14]

[14] M.Chokshi et al ,(2016), "Health Systems in India", *Journal of Perinatology*,36 (Suppl 3).

The draft National Health Policy 2015[15] proposes that health be made a fundamental right and underlines that the primary aim of the policy is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions-investment in health, organization and financing of healthcare services, prevention of diseases and promotion of good health through cross sectoral action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and legislation for health.

It is commonly understood that in theory and principle, although all services provided at government facilities, including preventive and primary care, diagnostic services, and outpatient and inpatient hospital care, are delivered free of cost. In reality, however, extreme shortage of staff and provisions limit access to healthcare delivery services. Medications on the essential drug list are distributed free, albeit short in supply and other prescription drugs are purchased from private pharmacies. India has the largest publicly financed HIV drug programs, and all drugs and diagnostic services for vector-borne diseases, such as dengue fever and malaria, are free, as are insecticide-

[15] National Health Policy Draft, 2015 available on https: //www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf viewed on 02.09.2018

treated bed nets for malaria control. Immunizations and maternal and child health services are also distributed free of cost Most of the services under health packages like the Central Government Health Scheme and Employees State Insurance Scheme are free. These remain the most generous of health coverage programs catering to a small section of the population, raising issues around equity.[16]

The health care services organisation in India extends from the National Level to the Village Level. From the total organisation structure, we can break up the structure of healthcare system at national, state, district, community, PHC and sub-centre levels. Indian health care delivery system includes the Ministry of Health and Family Welfare at the Central level, state governments, and municipal and local bodies. Each state has its own Directorate of Health Services and Department of Health and Family Welfare. District-level health services provide a link between each state and primary care services. Other agencies involved in health system governance include the Insurance Regulatory and Development Authority. There is lack of clarity in India with respect to which entities are responsible for

[16] I.Gupta and S.Chowdhury(2014), 'Public Financing for Health Coverage in India: Who Spends, Who Benefits and At What Cost?', *Economic & Political Weekly*, Aug. 30, 2014 49(35).

regulating the private sector and for ensuring quality of care, as there are multiple agencies under different ministries.

National Level: The Union Ministry of Health and Family Welfare is at the apex of health administration in India. Ministry of Health and Family Welfare comprises the following two departments, each of which is headed by a Secretary to the Government of India:-

1. Department of Health and Family Welfare
2. Department of Health Research.

Directorate General of Health Services (DGHS) is attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS renders technical advice on all Medical and Public Health matters and is involved in the implementation of various Health Services.

State Level: The health administration of the state is under the State Department of Health and Family Welfare in each state headed by Minister and with a Secretariat under the charge of Secretary/Commissioner belonging to the Cadre of Indian Administrative Service (IAS).By and large, the organisational Structure adopted by the state is in conformity with the pattern of the Central Government. The State Directorate of Health Services, as the technical wing, is an attached office of the State Department of Health and Family welfare and is headed by a Director of Health Services.

However, the organisational Structure of the State Directorate of Health Services is not uniform throughout the country. Every State Directorate has supportive categories comprising of both technical and administrative staff.

Regional Level: Each regional /zonal set-up covers three to five districts and acts under authority delegated by the State Directorate of Health Services. The status of officers/in charge of such regional/zonal organisations differ and are known as Additional/Joint/Deputy Directors of Health services in different States.

District Level: The District Level structure of health services is a middle level management and it is a link between the state as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side. It receives inputs and information from the state level and convey them to the periphery by appropriate modifications to meet the local need. The Chief Medical &Health Officer, as he is commonly designated, is the district officer in charge of health administration at the district level. He is responsible for implementation of programmes and policies laid down and financed at state and central levels. He is usually assisted by Deputy Chief Medical Officers and other programme officers.

Sub-Divisional/Taluka Level: Sub-district (Sub-divisional) hospitals are below the district and above the block level (CHC) hospitals and act as First Referral Units for the Tehsil/Taluk/block population in

which they are geographically located. They have an important role to play as First Referral Units in providing emergency obstetrics care and neonatal care and help in bringing down the Maternal Mortality and Infant Mortality. They form an important link between SC, PHC and CHC on one end and District Hospitals on other end. At the Sub-Divisional Level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer. He is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centres.

Community Level: The Community Health Centres (CHCs) constitute the secondary level of healthcare, were designed to provide referral as well as specialist health care to the rural population. The Community Health Centres (CHCs) constitute the secondary level of health care, were designed to provide referral as well as specialist health care to the rural population. For effective primary healthcare delivery service, there is a need to provide effective referral support. In order to fulfil this need, Community Health Centre (CHC) has been established for every 80,000 to 1,20,000 population and this CHC provides basic

specialty services in general medicine, paediatrics, surgery, obstetrics and gynaecology.[17]

Primary Health Centre Level: Primary Health Centre is the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-Centres for curative, preventive and promotive health care. A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 6 indoor/observation beds. It acts as a referral unit for 6 Sub-Centres and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level. However, as the population density in the country is not uniform, the number of PHCs would depend upon the case load. PHCs should become a 24 hour facility with nursing facilities.[18]Each PHC has one medical officer, two health assistants-one male and one female and the health works and supporting staff.

Sub-centre Level: The Sub-centres are vital peripheral institutions for providing primary health care to the people and play an important role in the implementation of various Health & Family Welfare

[17] Indian Public Health Standards(IPHS),Guidelines for Community Health Centres ,Revised 2012,Directorate of Health Services, Ministry of Health and Family Welfare, Government of India.p.1

[18] Indian Public Health Standards(IPHS),Guidelines for Primary Health Centres, Revised 2012,Directorate of Health Services, Ministry of Health and Family Welfare, Government of India.p.1

programmes at the grass-root level. It is at this level that the primary health care delivery service really comes into play. The primary focus of Sub-centre remains the Reproductive and Child Health (RCH) services. However, services in respect of important Non-Communicable Diseases have also been included. It has been envisaged not to promote all Sub-centres for intranatal facilities. The Sub-centres which are well located with good infrastructure, adequate catchment area and good caseload will be promoted for providing intranatal services at the Sub-centre in addition to all other recommended services. Such Sub -Centres will be categorized as Type B. The other type of Sub-centres (Type A) will provide all recommended services except the facilities for conducting delivery will not be available here. This type of categorization is expected to result in service provision as per the need of population.[19]

A Sub-centre provides interface with the community at the grass-root level, providing all the primary health care services. As Sub-centres are the first contact point with the community, the success of any nationwide programme would depend largely on the well-functioning Sub-centres providing services of acceptable standard to the people.[20] It is the lowest rung of a referral pyramid of health facilities consisting of the Sub-centres, Primary Health Centres,

[19] Indian Public Health Standards(IPHS),Guidelines for Sub-Centres, Revised 2012,Directorate of Health Services, Ministry of Health and Family Welfare, Government of India.p.1

[20] Ibid,p.1

Community Health Centres, Sub-Divisional/Sub-District Hospitals and District Hospitals. The purpose of the Health Sub-centre is largely preventive and promotive,

but it also provides a basic level of curative care.[21]

The Indian Health care services are delivered by a complex system of public and private health care providers, ranging from single, private doctors to specialty and multispecialty tertiary care hospitals.[22]Thus, the Indian health care system can be broadly understood as a three-tier structure comprising primary, secondary, and tertiary facilities. In the rural areas, primary health care services are provided through a network of sub centres, primary health centres, and community health centres.[23]The sub centre is the basic and primary position of contact, connecting the health care system with the community, designed to handle maternal and child health, disease control, and health counselling for a population of 3,000 to 5,000. At least one auxiliary nurse midwife or female health worker, one male health worker, and one female "health visitor" supervise six sub centres.

[21] Ibid,p.3

[22]Indrani Gupta and Mrigesh Bhatia, '*The Indian Health Care System*', London School of Economics and Political Science found in https://international.commonwealthfund.org/countries/india/ viewed on 03.09.2018

[23] Ministry of Health and Family Welfare, Annual Report, Chapter 1: Organization and Infrastructure, 2015.

The primary health centre is, thus, the first point of contact between a village community and a medical officer and provides curative and preventive services to 20,000 to 30,000 people. It serves as a referral unit for six sub centres and has four to six beds for patients.

Community health centres are managed and maintained by state governments and are required to have four medical specialists supported by 21 paramedical and other staff, with 30 beds, laboratory, X-ray, and other facilities. It covers 80,000 to 120,000 people.

Finally, an existing facility like a district or sub divisional hospital or a community health centre is named as a fully operational first referral unit if it is equipped to provide round-the-clock emergency obstetric care and blood storage. District hospitals function as the secondary tier of public providers for the rural population. Of a total of 628,708 government beds, 196,182 are in rural areas.

In spite of this complex infrastructure, severe shortages of staff and supplies in public-sector health facilities remain. India has a doctor-to-population ratio of 1:1,674, compared with the World Health

Organization norm of 1:1,000, a situation that results in acute shortages and uneven distribution of doctors.[24]

The poor people in the urban areas of India are especially susceptible since the primary health care facilities in the cities are more poorly organized than in rural areas. Lack of access to care appears to take a toll: nearly 60 percent of urban poor children have not received all recommended immunizations before age 1. Life in slums also exposes people to a variety of diseases.[25]

Primary Health Care Services in India

In India, Primary Health Care has been recognised as a vital strategy and the backbone of the entire health care delivery system. Even before the Alma-Ata Declaration, In 1946, a committee under Joseph Bhore was constituted in 1943 to examine the state of health in India submitted a blueprint for action-a three volume Health Survey and Development Report. The Committee resolved to concentrate on rural population, based on principles that must guide a health system that is close to the people, provision of health care irrespective of the ability to pay, active promotion of health through community participation and also linking ill health to environmental hygiene.

[24] . Parliament of India, Rajya Sabha, The Functioning of Medical Council of India (Ministry of Health and Family Welfare), Report No. 92, March 8, 2016.
[25] https://international.commonwealthfund.org/countries/india/ viewed on 02.09.2018

Health planning began in India ,first five year plan was formulated (1951-1955) and Community Development Programme launched in 1952 which envisaged covering health and sanitation through establishment of primary health centres(PHCs) and sub centres. At the end of the second five year plan (1956-1961) Health Survey and Planning Committee (Mudaliar Committee) was appointed by Government of India to review the progress made in health care system after submission of Bhore Committee report. The major recommendations of this committee report was to limit the population served by the PHCs with the improvement in the quality of the services provided and provision of one basic health worker per 10,000 population. The Jungalwalla Committee of 1967 recommended the integration of the health services delivery from the highest to lowest level in services, organization, and personnel. The Kartar Singh Committee on multipurpose workers in 1973 laid down the norms about health workers. Shrivastav Committee (1975) suggested creation of bands of para-professionals and semi-professional worker from within the community like school teachers and post masters as also the development of referral complex by establishing linkage between PHCs and high level referral and service centres. Rural Health Scheme was launched in 1977, wherein training of community health, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community

participation, the community health volunteer "Village Health Guide" scheme was launched. The Alma-Ata Declaration of 1978 launched the concept of health for all by year 2000. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health services. Several critical efforts outlined Government of India's commitment to provide health for all of its citizens after Alma-Ata declaration. The study group on "Health for All: An Alternative Strategy" commissioned by Indian Council for Social Science Research (ICSSR) and Indian Council for Medical Research (ICMR) (1980) argued that most of health problems of a majority of India's population were amenable to being solved at the primary healthcare level through community participation and ownership. Alma-Ata declaration led to formulation of India's first National Health Policy in 1983. The major goal of policy was to provide universal, comprehensive primary health services. Nearly 20 years after the first policy, the second National Health Policy was presented in 2002. The National Health Policy, 2002 set out a new framework to achieve public health goals in socioeconomic circumstances currently prevailing in the country. It sets out an increased sectoral share of allocation out of total health spending to primary healthcare. [26]

[26] Pandve, H.T. et al, (2013), "Primary Health Care in India: Evolution and Challenges", *International Journal of Health System and Disaster management*,Vol-

There are noteworthy disparity with respect to health care access, delivery and outcome between different states of the Indian Union, the rural and urban areas, different socio-economic groups, castes, and genders. For instance, children in rural areas are about 1.6 times more likely to die before their first birthday and 1.9 times more likely to die before their fifth birthday than those in urban areas. From 1991 to 2013, neonatal mortality declined by 53 percent in urban areas, compared with 44 percent in rural areas.[27] The social determinant of health play a significant role in health equity, with income, education, caste, and social group determining to an important extent the distribution of health outcomes. In regard to access, it is estimated that the urban rich obtain 50 percent more health services than the average Indian citizen. Also, the number of government hospital beds per population in urban areas is more than twice the number in rural areas, and urban areas have four times more health workers per population.[28]

Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural

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1, Issue-3.

[27] National Institute of Public Cooperation and Child Development, An Analysis of Levels and Trends in Infant and Child Mortality Rates in India, 2014

[28] Planning Commission of India, High Level Expert Group Report on Universal Health Coverage for India, Nov. 2011.

Health Mission in 2005 to carry out necessary architectural correction in the basic healthcare delivery system. The goal of the mission is to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children[29].

Through the program, more than 900,000 accredited social health activists work at the community level to promote immunization, disease control, effective breastfeeding, and healthy nutrition. Other initiatives seek to reduce maternal mortality—for example, by incentivizing women, including through cash payments, to deliver their babies in government health facilities.

Containing Costs

The Indian health system does not endorse proper control costs. As is the problem in other sectors, lack of competition has made the public health services and its infrastructure inefficient and costly. Some state governments have been able to control costs, especially for drugs. Tamil Nadu, for example, has a drug procurement system that relies on a centralized process that lowers prices and makes a wider

[29] Mission document, National Rural Health Mission.
Available
from: http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf viewed on 03.09.2018

range of drugs available.[30]Since 2011, Rajasthan has provided essential medicines free of cost to patients visiting public facilities. Evidence indicates that this initiative has resulted in increased financial protection of households and better health outcomes.[31]There also have been efforts to make medicines more affordable and accessible by increasing the supply of generic pharmaceuticals. Launched in 2008 by the Department of Pharmaceuticals, the Jan Aushadhi scheme has opened stores to sell high-quality generic medicines at low prices.[32] The Ministry of Labor and Employment's attempt to enlarge health coverage through RSBY has also been significant. In fact, the Prime Minister has, in recent times, announced a similar scheme, the National Health Protection Scheme, to further extend health coverage to more of India's poor. The scheme will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. Ayushman Bharat - National Health

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[30] M. Chokshi, H. Farooqui, S. Selvaraj et al., 'A Cross-Sectional Survey of the Models in Bihar and Tamil Nadu, India for Pooled Procurement of Medicines', *WHO South-East Asia Journal of Public Health*, Jan.–June 2015 4(1).

[31] World Health Organization (WHO), '*Universal Access to Medicines in India. A Baseline Evaluation of the Rajasthan Free Medicines Scheme'*, 2014 viewed on 03.09.2018

[32] Department of Pharmaceuticals, '*Jan Aushadhi: A Campaign to Ensure Access to Medicines for All*' viewed on 03.09.2018

Protection Mission will subsume the on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). Ayushman Bharat - National Health Protection Mission will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data covering both rural and urban. The scheme is designed to be dynamic and asprational and it would take into account any future changes in the exclusion/ inclusion/ deprivation/ occupational criteria in the SECC data.

To sum up, the present chapter deals with conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives. It discusses elements of Primary Health Care ,the Millennium Development Goals, the Sustainable Development Goals with health related indicators, organising and financing of health care delivery system from the national level, State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level, approaches ,strategies and the resources- human, financial, material and technological-as available or that should be available to the people at the grassroots level.

CHAPTER III

ADMINISTRATION OF PRIMARY HEALTH CARE SERVICES IN AIZAWL:

FUNCTIONS AND ROLE

The previous chapter deals with conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives. It discusses elements of Primary Health Care ,the Millennium Development Goals, the Sustainable Development Goals with health related indicators ,organising and financing of health care delivery system from the national level ,State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level. The present chapter will focus on the set up of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular. It will also discuss the present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system.

Mizoram, which means 'Land of the Highlanders', is one of the youngest states of the Indian Union and one of the seven sisters of Northeast India, bordered by Myanmar (formerly known as Burma) to

its east and south, Bangladesh to its west, and the states of Manipur, Assam, and Tripura to its north. Mizoram is the 7th most urbanised state in the country, as per 2011 Census (51.51%). Census 2011 indicates that the total population of the state is 10,91,014. Out of this total population, 5,61,977 people are living in the urban areas which is 51.51% of the total population of the state.

The Mizo Hills, which dominate the state's topography, rise to more than 2000 m (6560 ft) near the Myanmar border. Aizawl, the state capital, is 1220 m (4000 ft) above sea level. An amalgam of the former North and South Lushai Hill districts, Mizoram is a land of great natural beauty, an endless variety of landscape with rich flora and fauna, clusters of whispering pines and quaint villages with houses on stilts.[1]

Mizoram has a total of 8 districts and 830 villages. The decadal growth rate of urban population is 27.43% (urban) and 18.2% (rural) for the decade 2001-2011. Sex ratio is 976 per 1000 males. The per capita income in the state is Rs 85,356 (Economic Survey 2015-16).The percentage of people living below the Poverty Line is 14.8% (2008),and a total Birth Rate and Death Rate of 15.5 (SRS 2016) and 4.2 (SRS 2016) respectively. The Doctor Population Ratio is 1:1633 IMA(1:2997 government) and Nurse Population Ratio is 1: 320 with ANM (1:2039 government).(See Table No.3.1)

[1] https://www.mapsofindia.com/mizoram/ viewed on 19.10.2018

Table No. 3.1

Basic Data of Mizoram

Population	1,091,014 (Census 2011)
Area	21,087 sq.kms
Number of Districts	8
Number of Villages	830 (Census 2011) (704 inhabited, 126 uninhabited)
Decadal Growth Rate	27.43% urban, 18.2% rural
Autonomous Districts	3
Sex Ratio	976
Density/Km square	52
Literacy 91.33%	(lowest Lawngtlai 65.88%, highest Serchhip 97.91%)(Census 2011)
Per Capita Income (2014-15 Provisional)	Rs 85,356 (Economic Survey 2015-16)
Below Poverty Line	14.8% (2008)
Birth Rate	15.5 (SRS 2016)
Death Rate	4.2 (SRS 2016)
Natural Growth Rate	11.3 (SRS 2016)
Doctor Population Ratio	1:1633 IMA(1:2997 government)
Nurse Population Ratio	1: 320 with ANM (1:2039 government)

Source :Compiled by the Department of Health and Family Welfare, Mizoram in *Overview of Health Status in Mizoram*,2018

Aizawl, the capital of Mizoram, is situated at about 1132 meters above sea level. It is a fine-looking city set on ridges of steep hills. Flanked on the north by the peaks of Durtlang, the hill city overlooks the valley of the river Tlawng and ranges of blue hill beyond. It has a mild, sub-tropical climate due to its location and altitude. Aizawl is connected by road with Silchar through National Highway 54, with Agartala through National Highway 40 and with

Imphal through National Highway 150. It is air- linked by daily flights from Kolkata and Guwahati. As per 2011 Census, the population of Aizawl is 291,822. Sex ratio is 1029 per 1000 males. Average literacy rate of Aizawl city is 98.80 percent of which male and female literacy was 99.30 and 98.31 percent. It is the largest city in the state. It is also the centre of administration containing all the important government offices, state assembly house and civil secretariat. The population of Aizawl strongly reflects the different communities of the ethnic Mizo people.[2]

Urban Administrative Set up in Aizawl

One of the most significant administrative developments of Aizawl District is the establishment of the Aizawl Municipal Corporation(AMC). Previously known as Aizawl Municipal Council, it is the only existing and functioning Urban Local Body in Mizoram State. The Aizawl Municipal Corporation (AMC) is the authority of civic administration of Aizawl city. It was formed in 2010 with 19 Members when the Congress-ZNP party coalition was voted to power in the state legislative assembly. The AMC office is being administered by Mayor, Deputy Mayor and Commissioner. It consists of 19 elected members representing 19 wards of the city and others appointed by the Governor of Mizoram. One-third of the total

[2]Censusindia.gov.in/2011census/dchb/DCHB_A/.../1503_PART_A_DCHB AIZAWL.pdf viewed on 19.10.2018.

membership is reserved for women, these six seats shall be rotated after every five years. The tenure of the Corporation is five years. There is a Ward Committee in every ward that consists of a Chairman, who is an elected councillor from that ward, and two members each from all the local council within the ward. There are 83 local councils having a term of 5 years.[3]

Genesis of Primary Heath Care Services in Aizawl.

It is a commonly accepted fact that the modern Health Care Services in Mizoram was introduced in Mizoram by the British Administration and the Christian missionaries. Until 1894 scientific health care facility was by and large non-existent in Mizoram.[4] The year 1890, following the second British Expeditions against the Mizo (1889-1890), was an important milestone in the history of Health Services in Mizoram because the first proposal for the sanction and appointment of the first Medical Officer for Mizoram was made this particular year, although there seems to be no known records of exact names and dates. Since then, seeds of Health Care Services continue to germinate in Mizoram.[5]The early missionaries had had some training

[3] https://amcmizoram.com/ viewed on 19.10.2018.

[4] http://shodhganga.inflibnet.ac.in/bitstream/10603/60708/10/10_chapter%202.pdf viewed on 19.10.2018.

[5] B.Thangdailova (2003) '*Modernization of Health Care Services in Mizoram*' in R.N Prasad and A.K.Aggarwal (ed.). Modernization of the Mizo Society, Mittal Publications, New Delhi, p. 28

in tropical hygiene and medicine, and always carried simple remedies with them. The medicines they gave established mutual confidence and the Mizo were very sensitive to the kindness shown.[6]

Before the missionaries arrived on the scene, the people were rather ignorant of modern medicines and doctors, they had little knowledge about the importance of proper nutrition, personal hygiene, sanitation, healthy diet etc. Before the advent of Christianity, the Mizo believed that life was subjugated to the control of a number of spirits who could only be appeased by sacrifices. They believed that every big tree, hill, big stone and such other objects and places were inhabited by various spirits who were responsible for sickness, death, drought, storm, bad crops or accidents which befall the people. They were often careful not to incur the displeasure of the spirits which might harm them. In each village a *bawlpu* (priest or exorcist) would be available to deal with the spirit that caused such diseases and afflictions.[7]The British missionaries were influential in changing the common perception of health, hygiene and the causes of diseases and ailments of the Mizo people, by establishing a relationship of trust and understanding with the Mizo people by bringing the Gospel to them and by showing them the power of sincere prayers and the efficacy of

[6] J.M Lloyd (1991) '*History of the Church in Mizoram'*(Harvest in the Hill) Synod Publication Board
,Aizawl, p.31

[7] V.L Siama (1978) '*Mizo History'*, Aizawl Reprint, p.25

modern medicines in healing diseases and ailments. The first Christian missionaries, J.H Lorraine and F.W Savidge during their time (1894-1897),known affectionately as 'Sap Upa and Pu Buanga' were deeply concerned about the health education or lack of it, among the Mizo. Although they had no formal training in medicine, distributed medicines among the sick, which the people found to be very affective in curing illness. Rev D.E Jones and Rev E. Rowland were also responsible for educating the Mizo on the effectiveness of modern medicines. It was Rev D.E Jones who brought Dr Peter Fraser (Dr.Fraser-a)[8] "The Beloved Physician"[9] to the Mizo. The shining contribution made by Dr Peter whose stay in Mizoram was short but extraordinary in providing healthcare to Mizo people. Since there was not a single hospital, a tent was erected where Dr Fraser would open a clinic, in Mission Veng, treating 50-100 patients in a day. The kindness and empathy he afforded to his patients was remarkable, he would gently explain the health conditions to the patients, with patience and understanding and also giving out medicines to the sick and the needy, He made home visits during day and night, if essential, simultaneously preaching the gospel and providing necessary medical care, like a true

[8] J.V.Hluna(2016) '*Mizoram Welsh Missionary-te Chanchin'*(Revised and Enlarged),The Synod Press, Aizawl, Mizoram pp.110-113

[9] "The Beloved Physician" was how Dr Fraser was affectionately referred to on the memorial stone erected in his honour and placed near the main gate of the Mission Veng Church.

Christian. In 1910, he opened a dispensary and kept beds ready in it for those who needed admission.[10]

Table No. 3.2

North Mizoram: Health Centres under the Missionaries

Health Centre	Year of Opening	Remarks
Health Clinic, Mission Veng	1897	Opened at the arrival of the First Missionary doctor, Peter Fraser
Dispensary, Durtlang	1910	Few beds were Kept ready for those who needed admission.
Welsh Mission Hospital, Durtlang	6.3.1928	With the help of two Mizo trained staff.
Rural Health Centre, Sihfa	29.1.1956	4 day Journey on foot from Durtlang, Aizawl
Rural Health centre, Sawleng	4.4.1956	4 day Journey on foot from Durtlang, Aizawl
Rural Health Centre, Pukzing	4.8. 1956	7-8 day Journey on foot from Durtlang, Aizawl
Rural Health centre, Chhawrtui	29.5.1958	6 day Journey on foot from Durtlang, Aizawl

Source: Zarzoliana (2005) Availability and *Utilization of Healthcare Facility in Mizoram: A Geographical Analysis.* (Unpublished Thesis) & Primary Survey, 2012

The Durtlang Synod Hospital in Aizawl was started in the year 1928,under the aegis of Dr John Williams then named the 'Welsh

[10] Zarzoliana (2005) '*Availability and Utilization of Healthcare Facility in Mizoram: A Geographical Analysis',* (Unpublished Thesis) & Primary Survey, 2012

Mission Hospital' by the Welsh Presbyterian Christian missionaries who also opened Rural Health Centres in remote rural areas of Mizoram-Sihfa, Sawleng, Pukzing and Chhawrtui.(See Table No. 3.2)These Rural Health Centres can be regarded as the first institutions of primary health care in the state, and were manned by trained nurses and the Christian missionaries who visited these centres on a regular basis.. When insurgency broke out in 1966,it was no longer possible to carry on with the rural health centres and they had to close down then and there.

Concurrently, in the south, the Baptist Mission was responsible for acquainting modern medicines and treatment to the Mizo people.In 1919 the first dispensary was built and was inaugurated in 1923. Later it was used as hospital at Serkawn, Lunglei. From the year 1919-1977 there were 9 nurses and one doctor of European origin who settled and served in Mizoram under the Baptist Mission Society (BMS). Nursing training school was started at Serkawn in 1952 with a course in Auxiliary Nursing and Midwifery. These institutions continue to play important role in providing training and healthcare to many people. [11]It is evident that the Christian missionaries played a pioneering role in

[11] K.C.Lalmalsawma(2013) '*The Hill Geographers'*, Geographical Society of the North eastern Hill Region(India). Vol.XXIX:2 (2013)/ISSN 0970-5023.pp 43-54
https://www.researchgate.net/publication/327745383_Health_Care_Facility_in_Mizoram_Spacio-Temporal_Analysis

the development of healthcare delivery services in both the northern and southern part of Mizoram, and also established an abiding impact and base for development of primary health care in the state.

The Welsh Mission in North Mizoram, as well as the BMS Mission in South Mizoram both had opened commendable Nursing Schools and over the years a good number of students were provided education in nursing, reproductive health, and midwifery contributing towards health education and improvement of primary healthcare services in the community and society. It goes without saying that the role played by the missionaries were unparalleled in educating the general public about health and sanitation. They used to visit even the distant, remote and secluded rural areas to spread awareness on sanitation and hygiene among the people. The missionaries therefore tried to inculcate hygienic habits among the Mizo through various organizations they introduced. A few such organizations are: [12]

Bible women, an organization introduced primarily to spread Christianity among the Mizo women. But side by side, it guided the womenfolk in cleanliness. The organizers threw light on sanitation, maternity care and the like.

Child Welfare Organization was established by the Presbyterian Mission at Aizawl which aimed to give instructions to

[12] Zarzoliana (2005),op.cit.pp.39-40.

mothers on how children should be taken care of, how to keep house and household things clean and its advantage in the maintenance of family health. In south, the Baptist Mission also opened one orphanage which not only looked after motherless babies but also had trained a number of Mizo mothers how to bring up children, how to keep children in good health.

The Mission Schools, besides literacy instructions, acted as centres for hygienic training. Teacher in schools used to instruct pupils on hygiene and its effect. Besides, the missionaries also exerted their influence in changing the indigenous housing pattern to promote hygienic conditions of the Mizo.

Thus, the role played by the Christian missionaries in providing "essential Health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the country and community can afford"[13] or what we, now, understand as the essence and foundation of primary health care was initiated, facilitated and laid down by the Christian missionaries in Mizoram. Aizawl was the headquarters even in those days and the starting point of primary health care delivery services in the state of Mizoram.

[13] Definition of Primary Health Care given by the Alma Ata Declaration,UNO

Role of Government in Healthcare Delivery Services

Mizoram (the then Lushai Hills) was annexed to British India in the year 1892, and was put under the overall administrative control of the British Superintendent, who had absolute administrative powers. In 1952 the first general election to the District Council was held. It was elevated to an Union Territory in 1972, and then to Statehood in 1986,all during the murky period of Insurgency which had started in 1966 and lasted till 1987.As such, during the aforementioned period from District Council hood to Statehood, the pace of development, including growth in the area of healthcare was understandably slow and sketchy.

Before being elevated to the status of a District Council in 1952, Mizoram was a part of the State of Assam. The first Civil Hospital in Mizoram, Aizawl Civil Hospital had a humble beginning, in the year 1894,when it started to function in a small tent as health centre for coolies and named 'Kuli Dispensary'. A couple of years later, in 1896 it was designed as a full-fledged dispensary having 8 beds and later on upgraded to 12 beds capacity.[14] During 1896-1920, a total of seven dispensaries were set up in remote rural areas of the state- Champhai, Kolasib, Sairang, N.Vanlaiphai, Sialsuk, Tlabung and Tuipang with 5-6 emergency beds each. In 1947, 2 Hospitals i.e

[14]K.L. Remsanga and John Zohmingliana (2018),'*Progress of Civil Hospital, Aizawl*' in 19th Annual Magazine of MGDA,p.47

Aizawl Hospital (with 36 indoor beds) and Lunglei Hospital had been established with qualified Doctors and Nursing Staff. Until Mizoram enjoyed the status of Union Territory, on 20th Feb 1972, Mizoram Health Services was under one Civil Surgeon (District Chief Medical and Health Officer) as one District of Assam state and SDMOHO was the administrative head of Lunglei Sub-Division to assist Civil Surgeon Aizawl. [15]

After Mizoram attained the status of Union Territory on 21st January 1972, a separate Department, Health and Family Welfare Department was established, headed by Director. In the absence of proper and systematic records it is difficult to trace the history of the origin and development of the Health Department. Whatever accounts are obtainable, they are inadequate and somewhat erratic, particularly in the formative years. What can be said with some amount of certainty is that it is in fact one of the oldest functional department to be established in Mizoram.

The functions of Health Department, according to Government (Allocation of Business) Rules, 1987 are as follows:-[16]

1. Administration of Government Hospitals, Dispensaries and Primary Health Centres (PHCs).

[15] Thangdailova(2003),op.cit,p 34.
[16] https://health.mizoram.gov.in/page/history,official website of the Health and Family Welfare Department, Government of Mizoram viewed on 21.10.2018.

2. Prevention of Food Adulteration.

3. Drug Control Acts.

4. Implementation of National Schemes in Health and Family Planning(Welfare).

5. Administration of Medical Services.

6. Indian Lunacy Act/Poison Act.

7. Maternal and Child Health Programmes.

8. TB, Leprosy and Child Health Programmes.

9. Matters relating to Indian Medical Council.

10. Health Education Schemes.

In addition to the above, many areas related to preventive, promotive, curative and rehabilitative health care and new health problems and issues come under the jurisdiction of the Health Department

The Health and Family Welfare Department has been bifurcated into Directorate of Health Services (DHS) and Directorate of Hospital & Medical Education (DH &ME), each having a separate budget. Directorate of Health Services, is responsible for establishment, administration, regulation and monitoring of Medical and Health Institutions along with handling the necessary supporting infrastructure within the state, medical education, food safety and drug control and monitoring and implementation of various programs

related to public health and disease control. Directorate of Health Services, MCH&FW (Maternal and Child Health and Family Welfare) is responsible for monitoring and implementation of the centrally sponsored schemes implemented in the State to cater to the health needs of women and children.

DHS look after rural health institutions i.e., Community Health Centres (CHCs), Primary Health Centres (PHCs), Sub-Centres (SCs), Sub-Centre Clinics and Rural Hospital, Tlabung. Similarly, Civil Hospital(Aizawl), Kulikawn, Hospital and all the district hospitals come under the jurisdiction of Directorate of Hospital & Medical Education.

At the State level, two Directors are assisted by Programme Officers, Deputy Directors (Administrators), an Executive Engineer and his team, Medical Officers, Research Officers, Finance & Accounts Officers, Officer Superintendent and ministerial as well as contractual staff.

At the district levels, Chief Medical Officer (CMO) and Medical Superintendent represent the DHS and DHME respectively. Also, Aizawl District has been functionally divided into Aizawl East and Aizawl West districts for health care service delivery, each headed by a CMO. At present, Health Care delivery Services in Mizoram is

provided through one State Hospital (an upgraded district hospital), 7 district hospitals,1 Sub-District Hospital in Kulikawn, located in West Aizawl,1 Regional Cancer Hospital in Zemabawk and State Referral Hospital in Falkawn and a total of 18 private hospitals in the whole state,8 of which are in Aizawl.(Table No. 3.3).Population norms set by the Central Government need to be relaxed for Mizoram in order to reach all members of the community. Different categories of technical and non-technical manpower work together in a coordinated effort to address the objectives and functions of Health and Family Welfare Department.

Primary Health Centres (PHC) and Health Sub centres were gradually started to provide healthcare services as close to the people as possible, even in the remotest, rural areas. In1966, there were 3 PHCs in Mizoram and the number increased to 4 in 1972.When Mizoram attained statehood in 1986,the number PHC/CHC had increased to 51 PHC/CHC and 314 sub centres. By 2013, there were 64 PHC/CHC and 367 Sub centres. At present there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state.In Aizawl,there are 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East (See Table No. 3.4).

Table No. 3.3

Hospitals in Mizoram

Sl.No.	Name of State Hospital	Location	Bed Strength
1	Civil Hospital, Aizawl	Aizawl District	276
Sl.No.	Name of District Hospital	Location	Bed Strength
1	Civil Hospital, Lunglei	Lunglei District	120
2	CivilHospital, Saiha	Saiha District	70
3	Civil Hospital Champhai	Champhai District	`60
4	Civil Hospital Kolasib	Kolasib District	60
5	Civil Hospital, Serchhip	Serchhip District	50
6	Civil Hospital, Mamit	Mamit District	30
7	Civil Hospital, Lawngtlai	Lawngtlai District	30
8	Kulikawn Hospital	Kulikawn, Aizawl	50
9	Regional Cancer Centre, Zemabawk	Zemabawk, Aizawl	30
10	State Referral Hospital	Falkawn	150

Source: Official Records of the Planning Section,Directorate of Health Services,Government of Mizoram,2018

Table No. 3.4.

No.of Health Institution including hospitals /CHC/PHC/Main Centre/Sub-centre & clinics

Sl No	Name of District	Hospital / District Hospital	Tertiary Centre	Private Hospital	SDH	CHC	PHC	UPHC under NUHM	M/C	S/C	Clinic
1	Aizawl West	1		4	1	1	5	3	8	41	33
2	Aizawl East	1	1	4	1	2	5	3	9	55	35
3	Kolasib	1		1		1	5		7	26	9
4	Mamit	1				1	7		8	33	8
5	Champhai	1		2	1	2	11		15	60	27
6	Serchhip	1				1	5		7	27	6
7	Lunglei	1		4	2		9	2	14	70	16
8	Lawngtlai	1		2		1	6		8	36	4
9	Saiha	1		1			4		5	24	11
	TOTAL	**9**	**1**	**18**	**5**	**9**	**57**	**8**	**81**	**372**	**149**

Source: Official Records of the Planning Section,Directorate of Health Services,Government of Mizoram,2018.

The structure of DH&ME is presented below[17]:-

- *State Hospitals (SHs)* report directly to the state directorate and are autonomous in function. SHs have bed strengths ranging from 100 plus to 500 and provide specific services like Preventive / Promotive / Curative Health Care, Training service, Disaster response, specialized mother and child facilities, specialized paediatric treatment facilities, 24-hour emergency facilities, etc.
- *District hospitals (DHs)* with bed strengths ranging from 30 number of beds plus to 200 number of beds are an essential component of the district health system and function as a secondary level of health care which provides curative, preventive and promotive healthcare services to the people in the district. Every district is expected to have a district hospital linked with the public hospitals/health centres down below the district such as Sub-district/Sub-divisional hospitals, Community Health Centres, Primary Health Centres and Sub-centres. In Mizoram District Hospitals are as below :-
- *Sub-district/Sub-divisional hospitals (SDHs)* are below the district and above the block level (CHC) hospitals and also act

[17] https://health.mizoram.gov.in/page/history,official website of the Health and Family Welfare Department, Government of Mizoram viewed on 21.10.2018.

as First Referral Units with bed strength ranging from 10 number of beds to 30 number of beds. Specialist services are provided through these sub-district hospitals. These hospitals should play an important referral link between the Community Health Centres, Primary Health Centres and sub-centres. Sub-Divisional Hospitals are at Tlabung and Chawngte in Mizoram.

Primary Health Care Delivery Services in Aizawl

Mizoram is one of the states of the Indian Union, which is a signatory of the Alma Ata Declaration of 1978.Therefore,it prepared an ambitious innovative plan scheme to attain the goal of "Health for All" by the year 2000 AD through Primary Health Care approach.[18] Primary Health Centres and Community Health Centres were started in Mizoram as early as 1966 when there were 3 PHC/CHC in the state, one more was added by year 1972 when it became a Union Territory and over the past, its numbers has steadily increased to meet the increasing demand for primary healthcare services. After attaining statehood the emphasis was on the increasing and extension of the healthcare establishment. It must, however be realised that mere increase in number of healthcare services across the state does not ensure sufficient facility for qualitative improvement in primary

[18] Thangdailova(2003),op.cit,p.29.

healthcare delivery services. Healthcare covers a broad spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis and treatment and rehabilitation. The term health services imply organisation, delivery, staffing, regulatory and quality control (Thangdailova, 2003)[19].

The scope of Primary Health Care comprise a range of health interventions including Reproductive and child health services which comprise a range of women related health interventions, often provided under the fabric of maternal and child healthcare which, itself, can be substantially integrated into primary healthcare, child care including essential nutrition and basic immunization, hygiene and sanitation , and also includes treating a growing need to fix basic health concerns in the areas of communicable diseases like HIV, malaria, tuberculosis, and diarrhoea.

Role and functions of Health Sub-Centres and Sub-Centre Clinics in Primary Healthcare Delivery Services in Aizawl

Primary Health Centres and its Sub-Centres are 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 present study focuses on the role of the Sub-centres as the primary, most peripheral

[19] Thangdailova(2003),ibid,p.30.

and first contact point between the primary health care system and the community. While the primary focus of the Health Sub Centres/Clinics remains the Reproductive and Child Health(RCH) services, services relating to non-communicable diseases as well as communicable diseases have also been included, with prime focus on the promotive and preventive aspect of health care through imparting awareness and informed advice, guidance and counsel whenever and wherever suitable and required.

The Curative aspect of diseases-communicable as well as non-communicable also comes under the functions of the Health Sub-Centres to a considerable extent. It must be mentioned here that the list of services and functions performed and carried out by the Sub-Centres is rather long, extensive and fairly exhaustive. When service delivery points, such as the Sub-Centres, are at such close proximity to the people, there are scores of challenges because it is at the cutting edge of administration and touches the lives of the people so much more.

At the national level, Sub-Centres with good infrastructure, adequate catchment areas and good caseload are promoted and equipped for providing intranatal services at the Sub-centre in addition to all other recommended services. Such Sub -Centres are categorized as Type B. The other type of Sub-centres (Type A) provide all recommended services except the facilities for conducting delivery is not be available here. This type of categorization is expected to result

in service provision as per the need of population. The present study has established that such type of classification does not exist in the case of Aizawl, and the Sub-Centres in Aizawl are not properly equipped for providing intranatal services, the most obvious reason being that beneficiaries mostly go for institutional delivery in full-fledged public and private hospitals, which are more sufficiently equipped ,and not too difficult to reach. Urban Health centres are also equipped to deal with deliveries and are more or less located in close proximity. However, it is desirable that sub centres /clinics in Aizawl be equipped to deal with deliveries in cases of emergencies in this regard.

Sub-centres are expected to provide promotive, preventive and few curative primary health care services and should lay emphasis on Reproductive and Child Health (RCH) as well as Non-Communicable Diseases related services. The Sub Centres are also expected to be involved in the implementation of National Health Programmes relating to Communicable Diseases such as National AIDS Control Programme (NACP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Eradication Programme (NLEP) and Revised National Tuberculosis Control Programme (RNTCP).

However, their primary role and functions revolve around Reproductive and child health services (RCH) which comprises of a wide array of women's health interventions, including family planning Information, Education and Communication(IEC); contraceptive counselling and provision of contraceptives, free of cost; basic screening of sexually transmitted infections; prenatal or newborn care; and breastfeeding support. The ANMs are available at the Sub-centre and the Sub-centre remains open for providing OPD services on all working days, besides providing outreach services to the community at large.

The following is the consolidated list of services provided through the Sub-centres. The services have been classified as Essential (Minimum Assured Services) or Desirable (that all States/UTs should aspire to achieve):[20]

I. Essential (Minimum Assured Services)

1.Maternal and Child Health

Maternal Health

i. Antenatal care:

(i) Early registration of all pregnancies, preferably within first trimester (before 12th week of Pregnancy).

[20] Indian Public Health Standards (IPHS), Guidelines for Primary Health Centres, Revised 2012, Directorate of Health Services, Ministry of Health and Family Welfare, Government of India. pp. 6-14.

(ii)Associated services like general examination such as height, weight, B.P., anaemia, abdominal examination, breast examination, Folic Acid Supplementation (in first trimester),Iron & Folic Acid Supplementation from 12 weeks, injection tetanus toxoid, treatment of anaemia etc., and recording tobacco use by all antenatal mothers.

(iii) Minimum laboratory investigations like Urine Test for pregnancy confirmation, haemoglobin estimation, and urine for albumin and sugar and linkages with PHC for other required tests.

(iv)Name based tracking of all pregnant women for assured service delivery.

(v) Identification of high risk pregnancy cases.

(vi) Identification and management of danger signs during pregnancy.

(vii) Malaria prophylaxis in malaria endemic zones for pregnant women as per the guidelines of NVBDCP.

(viii)Appropriate and Timely referral of such identified cases which are beyond capacity

of management.

(ix) Counselling on diet, rest, tobacco cessation if the antenatal mother is a smoker or tobacco

user, information about dangers of exposure to second hand smoke and minor problems during pregnancy, advice on institutional deliveries, pre-birth preparedness and complication readiness, danger signs, clean and safe delivery at home if called for, postnatal care & hygiene,

nutrition, care of newborn, registration of birth, initiation of breast feeding, exclusive breast feeding for 6 months, demand feeding, supplementary feeding (weaning and starting semi solid and solid food) from 6 months onwards, infant & young child feeding and contraception.

(x) Provide information about provisions under current schemes and programmes like Janani

Suraksha Yojana.

(xi) Identifying suspected RTI/STI case, provide counseling, basic management and referral services.

(x) Counselling & referral for HIV/AIDS.

(xi)Name based tracking of missed and left out ANC cases.

ii. Intra-natal care:

(i)Promotion of institutional deliveries

(ii)Skilled attendance at home deliveries when called for

(iii) Appropriate and Timely referral of high risk cases which are beyond her capacity of management.

iii. Postnatal care:

(i)Initiation of early breast-feeding.

(ii)Ensuring post-natal home visits on 0,3,7 and 42nd day for deliveries at home and Sub-centre(both for mother & baby).

(iii)Ensuring visits for institutional delivery (both for mother & baby) cases.

(iv)In case of Low Birth weight Baby (less than 2500 gm), additional visits are made.

(v)During post-natal visit, advice regarding care of the mother and care and feeding of the newborn and examination of the newborn for signs of sickness and congenital abnormalities as per IMNCI Guidelines and appropriate referral, if needed.

(vi)Counselling on diet & rest, hygiene, contraception, essential newborn care, immunization, infant and young child feeding, STI/RTI and HIV/AIDS.

(vii)Name based tracking of missed and left out PNC cases.

2.Child Health

(i)Counselling on exclusive breast-feeding for 6 months and appropriate and adequate complementary feeding from 6 months of age while continuing breastfeeding. (As per National Guidelines on Infant and Young Child Feeding, 2006, by Ministry of WCD, Government of India).

(ii) Assess the growth and development of the infants and under 5 children and make timely

referral.

(iii)Immunization Services: Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of Government of India and Vitamin A prophylaxis to the children as per National guidelines.

(iv)Prevention and control of childhood diseases like malnutrition, infections, ARI, Diarrhoea, Fever, Anaemia etc.

(v)Name based tracking of all infants and children to ensure full immunization coverage.

(vi)Identification and follow up, referral and reporting of Adverse Events Following Immunization (AEFI)

3.Family Planning and Contraception

Education, Motivation and counselling to adopt appropriate Family planning methods. Provision of contraceptives such as condoms, oral pills, emergency contraceptives, Intra Uterine Contraceptive Devices (IUCD) insertions (wherever the ANM is trained in IUCD insertion).Follow up services to the eligible couples adopting any family planning methods (terminal/spacing) as well as Safe Abortion Services (MTP)which includes follow up for any complication after abortion/MTP and appropriate referral if needed.

4. School Health Services

Screening, treatment of minor ailments, immunization, de-worming, prevention and management of Vitamin A and nutritional deficiency anaemia and referral services through fixed day visit of school by existing ANM/MPW.Staff of Sub-centre provide assistance to school health services as a member of team.

5. Control of Local Endemic Diseases

(i) Assisting in detection, Control and reporting of local endemic diseases such as malaria, Dengue etc.

(ii)Assistance in control of epidemic outbreaks as per programme guidelines. Disease Surveillance, Integrated Disease Surveillance Project (IDSP)

(iii)Surveillance about any abnormal increase in cases of diarrhoea/dysentery, fever with rigors, fever with rash, fever with jaundice or fever with unconsciousness and early reporting to concerned PHC as per IDSP guidelines.

(iv)Immediate reporting of any cluster/outbreak based on syndromic surveillance. High level of alertness for any unusual health event, reporting and appropriate action.

(v)Weekly submission of report to PHC in 'S'Form as per IDSP guidelines.

6.Out reach/Field Services

Village Health and Nutrition Day (VHND)

(i)VHND are organised at least once in a month with the help of Medical Officer, Health Assistant Female (LHV) of PHC, HWM, HWF,ASHA, AWW and their supervisory staff, PRI, Self Help Groups etc. The ANM is accountable for these services, with the male worker also taking a due share of the work, and being in charge of logistics and organisation, especially vaccine logistics. Participation of

Anganwadi workers, ASHAs and community volunteers are essential for mobilization of beneficiaries and local organizational support. Each Village Health and Nutrition Day usually last for at least four hours of contact time between ANMs, AWWs, ASHAs and the beneficiaries.

The services provided at VHND are listed below and are further divided into essential and desirable services:

Essential

(i)Early registration and Antenatal care for pregnant women – as per standard treatment protocol for the SBA.

(ii)Immunization and Vitamin A administration to all under 5 children-as per immunization schedule.

(iii)Coordination with ICDS programme for Supplementary nutritional services, health check up and referral services, health and nutrition education, immunization for children below 6years, Pregnant & Lactating Mother and health and nutrition education for all women in the age group (15 to 45 years).

(iv)Family planning counseling and distribution of contraceptives.

(v)Symptomatic care and management of persons with minor illness referred by ASHAs/AWWs or coming on their own accord.

(vi)Health Communication to mothers, adolescents and other members of the community who attend the VHND session for whatever reason.

(vii)Meet with ASHAs and provide training/support to them as needed.

(viii)Registration of Births and Deaths.

Desirable

(i)Symptom based care and counselling with referral if needed for STI/RTI and for HIV/AIDS suspected cases.

(ii)Disinfection of water sources and promotion of sanitation including use of toilets and appropriate garbage disposal.

7.Home Visits

Essential

(i)For skilled attendance at birth- where the woman has opted or had to go in for a home delivery.

(ii)Post-natal and newborn visits – as per protocol.

(iii)To check out on disease incidences reported to Health Worker or she/he comes across during house visits especially where there it is a notifiable disease. Notifying the M.O., PHC immediately about any abnormal increase in cases of diarrhoea/dysentery, fever with rigors,

fever with rash, flaccid paralysis of acute onset in a child <15 years (AFP), Wheezing cough,

Tetanus, fever with jaundice or fever with unconsciousness, minor and serious AEFIs which she comes across during her home visits and take the necessary measures to prevent their spread.

Desirable

(i)Visits to houses of eligible couples who need contraceptive services, but are not currently using them e.g. couples with children less than three years of age, where women are married and less than 19 years of age, where the family is complete etc.

(ii)Follow up of cases who have undergone Sterilization and MTP, as per protocols especially those who cannot come to the facility.

(iii)Visits to community based DOTS providers, leprosy depot holders where this is needed.

(iv)Visits to support ASHA where further counselling is needed to persuade a family to utilize required health services e.g., immunization dropouts, antenatal care dropouts, TB defaulter etc.

(v)Taking blood slides/do RDK test in cases with fever where malaria is suspected.

8.House-to-House Surveys

These surveys are done once annually, preferably in April. Surveys are done with support and participation of ASHAs, Anganwadi Workers, community volunteers, panchayat members and Village Health Sanitation and Nutrition Committee members.The Male Health worker take the lead and is accountable for the organization of these surveys and the subsequent preparation of lists and referrals.

The surveys include.

Essential

(i)Age and sex of all family members.

(ii)Assess and list eligible couples and their unmet needs for contraception.

(iii)Identify persons with skin lesions or other symptoms suspicious of leprosy and refer: essential in high leprosy prevalence blocks.

(iv)Identify persons with blindness, list and refer: Identify persons with hearing impairment/

deafness, list and refer.

(v)Annual mass drug administration in disease endemic areas.

9.Coordination and Monitoring

Coordinated services with AWWs, ASHAs, Village Health Sanitation and Nutrition Committee, Local bodies etc.

10. Record Maintenance and Reporting

Proper maintenance of records of services is provided at the Sub-centres as the morbidity/mortality data is necessary for assessing the health situation in the Sub-centre area. In addition, all births and deaths under the jurisdiction of sub- centre are documented and sex ratio at birth are monitored and reported.

11.Curative Services

Provide treatment for minor ailments including fever, diarrhoea, ARI, worm infestation and First Aid including first aid to animal bite cases

(wound care, tourniquet (in snake bite) assessment and referral).Appropriate and prompt referral if required.

12.Adolescent Health Care

(i)Education, counselling and referral.

(ii)Prevention and treatment of Anaemia.

(iii)Counselling on harmful effects of tobacco and its cessation.

II.Role and Functions of Sub Centres in relation to National Health Programmes in Communicable Disease Programme

a. National AIDS Control Programme (NACP):

Essential

i. Condom promotion & distribution of condoms to the high risk groups.

ii.Help and guide patients with HIV/AIDS receiving ART with focus on adherence.

iii. IEC (Information, Education and Communication) activities to enhance awareness and preventive measures about STIs and HIV/AIDS, PPTCT services and HIV-TB co-infection.

Desirable

i. Linkage with Microscopy Centre for HIV-TB co-infection.

ii. HIV/STI Counseling, Screening and referral.

b. National Vector Borne Disease Control Programme (NVBDCP):

Essential

i. Collection of Blood slides of fever patients

ii. Rapid Diagnostic Tests (RDT) for diagnosis of Pf malaria in high Pf endemic areas.

iii. Appropriate anti-malarial treatment.

iv. Record keeping and reporting as per programme guidelines.

c. National Leprosy Eradication Programme (NLEP):

Essential

i. Health education to community regarding signs and symptoms of leprosy, its complications, curability and availability of free of cost treatment.

ii. Referral of suspected cases of leprosy (person with skin patch, nodule, thickened skin, impaired sensation in hands and feet with muscle weakness) and its complications to PHC.

iii. Provision of subsequent doses of MDT and follow up of persons under treatment for leprosy, maintain records and monitor for regularity and completion of treatment.

d. Revised National Tuberculosis Control Programme (RNTCP):

Essential

i. Referral of suspected symptomatic cases to the PHC/Microscopy centre.

ii. Provision of DOTS at Sub-centre, proper documentation and follow-up.

iii. Taking care to ensure compliance and completion of treatment in all cases.

iv. Ensuring adequate drinking water at Sub-centre for taking the drugs.

vi. Sputum collection and transport of sputum samples .

III. Role of Sub Centres in relation to National Health Programmes in Non-communicable Disease (NCD) Programmes

Note: These services are to be provided at both types of Sub-centres.

National Programme for Control of Blindness (NPCB):

Essential

i. Detection of cases of impaired vision in house to house surveys and their appropriate referral. The cases with decreased vision will be noted in the blindness register.

ii.Spreading awareness regarding eye problems, early detection of decreased vision, available treatment and health care facilities for referral of such cases. IEC is the major activity to help identify cases of blindness and refer suspected cataract cases.

iii.Assisting for screening of school children for diminished vision and referral.

b. National Programme for Prevention and Control of Deafness (NPPCD):

Essential

i. Detection of cases of hearing impairment and deafness during House to house survey

and their appropriate referral.

ii. Awareness regarding ear problems, early detection of deafness, available treatment and health care facilities for referral of such cases.

iii. Education of community especially the parents of young children regarding importance of right feeding practices, early detection of deafness in young children, common ear problems and available treatment for hearing impairment/ deafness.

c. National Mental Health Programme:

Essential

i. Identification and referral of common mental illnesses for treatment and follow up in

community.

ii. IEC (Information, Education and Communication) activities for prevention and early detection of mental disorders and greater participation/role of Community for primary prevention of mental disorders.

d. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases(CVD) and Stroke:

Essential

IEC (Information, Education and Communication) Activities to promote healthy lifestyle sensitize the community about prevention of Cancers, Diabetes, CVD and Strokes, early detection through awareness regarding warning signs and appropriate and prompt referral of suspect cases.

e. National Iodine Deficiency Disorders Control Programme:

Essential

IEC(Information, Education and Communication) Activities to promote consumption of iodized salt by the community. Testing of salt for presence of Iodine through Salt Testing Kits by ASHAs.

f. National Tobacco Control Programme:

Essential

i. Spread awareness and health education regarding ill effects of tobacco use especially in pregnant females and Non-Communicable diseases where tobacco is a risk factor e.g. Cardiovascular disease, Cancers, chronic lung diseases.

ii. Display of mandatory signage of "No Smoking" in the Sub-centre.

Desirable

i. Counseling for quitting tobacco.

ii. Awareness to public that smoking is banned in public places and sale of tobacco products is banned to minors (less than 18 years) as well as within 100 yards of schools and educational institutions.

iii. Spread awareness regarding law on smoke free public places.

h. Oral Health:

Desirable

i. Health education on oral health and hygiene especially to antenatal and lactating mothers, school and adolescent children.

ii. Providing first aid and referral services for cases with oral health problems.

i. Disability Prevention:

Desirable

i. Health education on Prevention of Disability.

ii. Identification of Disabled persons during annual house to house survey and their appropriate referral.

j. National Programme for Health Care of Elderly:

Desirable

i. Counseling of Elderly persons and their family members on healthy ageing.

ii. Referral of sick old persons to PHC.

iii. Promotion of Medicinal Herbs

Desirable

i. Locally available medicinal herbs/plants should be grown around the Sub-centre as per the guidelines of Department of AYUSH.

Record of Vital Events (Essential)

Recording and reporting of vital events including births and deaths, particularly of mothers and infants to the health authorities.

Thus, the Sub-centres/Clinics in Aizawl are fundamental, peripheral institutions for providing primary health care to the people and play an vital role in the implementation of various Health & Family Welfare programmes at the grass-root level. The Sub-centre/Clinics provides interface with the community at the grass-root level, providing all the primary health care services. They provide RCH services, run family planning programmes ,education for community health by teaching the importance of hygiene and sanitation, look after the general -health of the people and treating them for common diseases free or at a nominal cost, provide even costly medicines free or at nominal cost, provide vaccinations and inoculations against diseases like tuberculosis, cholera, polio and other epidemics, free of cost, organise drives to give people information about the prevention and causes of various communicable and non-communicable diseases etc. As Sub-centres are the first contact point with the community, the success of any nationwide programme would

depend largely on the well-functioning Sub-centres providing services of acceptable standard to the people.

To sum up, the present chapter explains the setup of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular highlighting the role played by the Christian missionaries as well as the government. The present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system, is discussed.

CHAPTER IV

RESULTS AND DISCUSSION

In the previous chapter, we have discussed the role and functions of Primary health Care Delivery Service in Aizawl, focussing mainly on the role and functions of health Sub-Centres as the first point of contact between the health system and the community. The Sub-centres are fundamental peripheral institutions for providing primary health care to the people and play an important preventive as well as curative role in the implementation of various Health & Family Welfare programmes of the Government at the grass-root level. A Sub-centre is at the cutting edge of grassroots health administration, providing all the primary health care services. As Sub-centres are the first contact point with the community, the success of any nationwide programme would depend largely on functioning of Sub-centres in providing services of adequate standard to the people.

The present chapter will discuss analysis of the field study in six selected sub centres/clinics in Aizawl, focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services, people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics, as well as the ideas and opinions of the officials working in the Sub Centres/Clinics, suggested remedial measures as

well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl.

The present study is an analytical and descriptive study of Primary Health Care Delivery Services in Aizawl. The focus was on Health Sub Centres and Clinics in Aizawl to find out the role, functions and responsibilities, identify problems and challenges in service delivery and to find out remedial measures. The study was carried out from six Sub-Centres & Sub-centre clinics –Republic Vengthlang Sub Centre Clinic, Zonuam Sub-Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East. There exists no real difference between the Sub Centre and Sub-Centre Clinics, they basically perform the same type of functions and have similar role and responsibilities. Although, of late, it has been seen that sub centre clinics have been made to get their medical supplies from the health sub-centres like malaria test kits while previously they used to get their supplies directly from the supply centre. Also, while some sub centres are equipped with

emergency first aid like suturing materials, the sub centre clinics are not provided with such materials.[1]

The study included administration of Questionnaires among beneficiaries, health workers and doctors posted in Primary Health Care Centres within Aizawl .Personal interactions and interviews with government officials, health care providers, ASHA(Accredited Social Health Activists) covering the six health care units helped in getting information on important issues which otherwise might not be available through administering Questionnaire. The Questionnaire consisted questions on personal data of the respondents, general information regarding the Sub-Centre, availability of staff and infrastructure, availability and standard of service, availability of ASHA as well their suggestions for improvement in health care delivery at the Sub-Centre.

Due to time constraint, no systematic sample was drawn. Rather it was preferred to have random, convenience sampling. Thus, the study was carried out with a sample size of 51 beneficiaries, 6 health workers and 2 doctors. In the chapters, wherever necessary, the doctors and their viewpoints have been discussed as qualitative data in paragraphs only and not as quantitative data in tables, figures etc.,

[1] Based on a personal interview with P.C.Lalramlawma(Pa Laltea),Health Worker, Republic Vengthlang Health Sub Centre Clinic on 01.11.2018

Among the sample beneficiaries,43 were female, which accounts for 84.3 percent of the entire sample and only 8 were male, constituting a mere 15.7 percent(Table No. 4.1) .This is not surprising since the primary function and focus of health care delivery in the sub-centre is on RCH(Reproductive and Child Health).

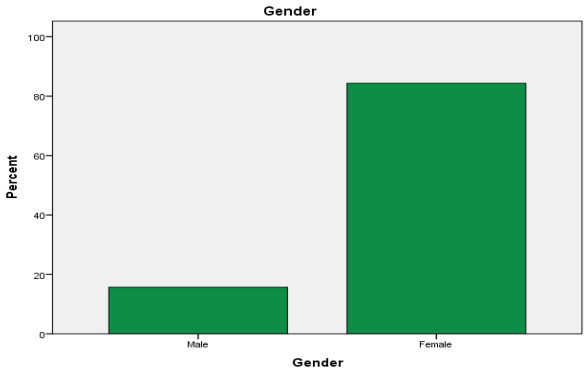
Table-No.4.1
Gender of Beneficiaries

Gender	No. of respondents	Percent
Male	8	15.7
Female	43	84.3
Total	51	100.0

Source: Field Survey,Sept-Oct, 2018

FigureNo.4.1

Gender of Beneficiaries



Majority of the beneficiaries,52.9 percent, belonged within the age bracket 25-35 years, the child bearing and productive age bracket .Only 7.8 percent were below 25 years of age,21.6 percent within the

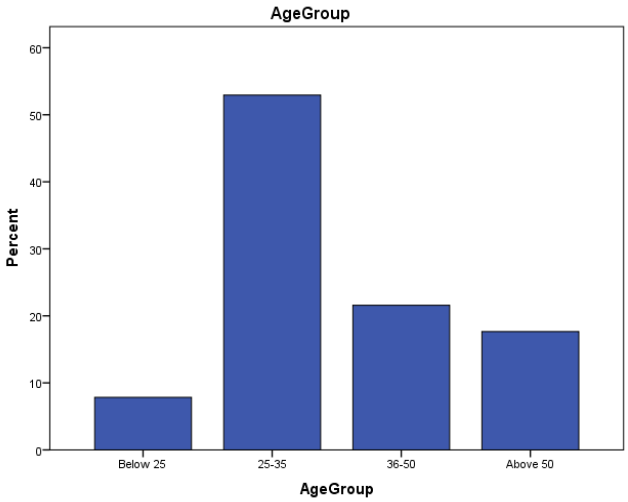
age bracket 36-50 and 17.6 percent were above 50 years of age. (Table No. 4.2)

Table No.4.2
Age Group of Beneficiaries

Age group	No. of respondents	Percent	Cumulative Percent
Below 25	4	7.8	7.8
25-35	27	52.9	60.8
36-50	11	21.6	82.4
Above 50	9	17.6	100.0
Total	51	100.0	

Source: Field Survey, Sept-Oct, 2018

Figure No.4.2
Age Group of Beneficiaries



Source: Field Survey, Sept-Oct, 2018

Table No.4.3 clearly shows that 94.1 percent of beneficiaries of the Sub Centre had educational qualifications of matriculate and above, only three persons, which constitute a mere 5.9 percent of the sample were below Cl X.27.5 of the beneficiaries were Graduate and above,37.3 percent were Cl XII pass,29.4 were CL X pass.

Table No.4.3

Educational Qualification of Beneficiaries

Educational Qualification	No. of respondents	Percent	Cumulative Percent
Graduate and Above	14	27.5	27.5
HSSLC	19	37.3	64.7
HSLC	15	29.4	94.1
Others	3	5.9	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

As regards the status of the sample beneficiaries in their respective families,9.8 percent were male heads, and a major portion of the sample,56.9 percent were female heads. The remaining 33.3 percent were sons (only 2 persons, See Table No. 4.1), daughters and daughters-in-law.(Table No.4.4)

TableNo.4.4
Status of Beneficiaries in the Family

Status in the family	No. of respondents	Percent	Cumulative Percent
Male Head	5	9.8	9.8
Female Head	29	56.9	66.7
Others - Son, Daughter,Daughter-in-law etc.	17	33.3	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

TableNo.4.5
Main Occupation and Source of income

Occupation	No. of respondents	Percent	Cumulative Percent
Farmer	3	5.9	5.9
Govt. Employee	13	25.5	31.4
Businessmen	21	41.2	72.5
Other Family Occupation	14	27.5	100
Total	51	100	

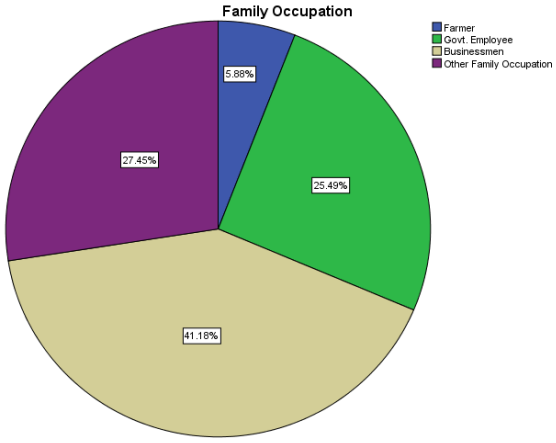
Source: Field Survey, Sept-Oct, 2018

Since the study was carried out in Aizawl, the most urbanised part of Mizoram, a small percentage of the respondents (5.9 percent) stated that their main source of income came from farming.25.5 percent were either government employees, or have government employees in their family. 41.2 percent depended on business as their

source of income and 27.5 percent of the respondents have other sources of income.(Table No. 4.3).Figure 4.3 gives a picture of family occupation of respondents, the largest portion in the pie chart is occupied by respondents who draw their source of income from business or the private sector.

Figure No.4.3

Family Occupation of Beneficiaries



Source: Field Survey, Sept-Oct, 2018

Table No. 4.6
Family Income of the Sample Beneficiaries

Income per month	No. of respondents	Percent	Cumulative Percent
<10,000	18	35.3	35.3
10,000-30,000	22	43.1	78.4
>30,000	11	21.6	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

Table 4.6 shows the family income of the respondents, 43.1 percent have an income bracket between 10,000-30,000 INR per month,35.3 percent have income below 10,000 INR and 21.6 percent of the respondents have income above 30,000 INR per month. This indicates that the services provided by the Sub Centres and Clinics benefits families across all income brackets. As regards the APL/BPL status of the families of respondents, Table No. 4.7 shows that 64.7 percent of the beneficiaries are APL families, who possess white coloured Ration Cards and 35.5 percent of the respondent beneficiaries are BPL families with blue Ration Cards.

Table No.4.7
Economic Status of the Sample Beneficiaries

Ration Card	No. of respondents	Percent	Cumulative Percent
APL	33	64.7	64.7
BPL	18	35.3	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

The study was carried out in six Sub-Centres & Sub-centre clinics –Republic Vengthlang Sub Centre Clinic, Zonuam Sub-Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-

Centre Clinics in Aizawl East. The sample size of the beneficiaries was 51,10 from Zonuam(19.6 p.c), 8 from Lawipu(15.7 p.c),6 from Venghnuai (11.8 p.c),10 from Chandmari (19.6 p.c), 9 from Thuampui (17.6 p.c) and 8 from Republic Vengthlang (15.7 p.c)(Table No.4.8 and 4.9)

Table No.4.8
Locality where Sample Beneficiaries lived

Locality	No. of respondents	Percent	Cumulative Percent
Zonuam	10	19.6	19.6
Lawipu	8	15.7	35.3
Venghnuai	6	11.8	47.1
Chanmari	10	19.6	66.7
Thuampui	9	17.6	84.3
Republic Vengthlang	8	15.7	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

Table No.4.9
Sub-Centres/Clinics

Sub-Centre/Clinic	No. of respondents	Percent	Cumulative Percent
Zonuam	10	19.6	19.6
Lawipu	8	15.7	35.3
Venghnuai	6	11.8	47.1
Chanmari	10	19.6	66.7
Thuampui	9	17.6	84.3
Republic Vengthlang	8	15.7	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

Availability of Manpower in the Sub Centre/Clinics

In order to effectively carry out the various activities and services, the Indian Public Health Standards Guidelines for Sub centres has recommended that it is essential to have One ANM and one Male Health Worker in a Type A Sub Centre.[2]In Type B Sub Centre it is essential to have two ANMs and One Male Health Worker. In Aizawl, there are no classification of Sub-Centres into Type A or B. Since Aizawl is the most urbanised area with sufficient facilities for health care at the Urban Public Health Centre, as well as at the Secondary, Tertiary and District at close proximity, all the Sub Centres fall into Type A Classification and are not equipped for conducting deliveries.

Table 4.11 shows the availability of manpower in the localities under study which was established through field visit of individual health care units. Zonuam has one ANM, one MHW and one attendant, Lawipu has two ANMs ,one MHW and one attendant, Venghnuai has two ANMs and one attendant, Chandmari has two ANMs, Thuampui has one ANM, one MHW and one attendant and Republic Vengthlang has two ANMs, one MHW and one attendant. When beneficiaries were

[2]In view of the current highly variable situation of Sub centres in different parts of the country and even with in the same State, they have been categorized into two types - Type A and Type B. Type A Sub Centre will provide all recommended services except that the facilities for conducting delivery will not be available here. Type B will provide all recommended services including facilities for conducting deliveries at the Sub-centre itself.

asked through questionnaire the manpower in their respective Sub Centres/Clinics, the response differed even in the same Sub centre/Clinics which showed to some extent that beneficiaries were not very clear about the manpower status of the Sub Centres/Clinics that they frequented.(Table No. 4.10)

Table No.4.10
Manpower in Sub Centres/Clinics

Status	No. of respondents	Per cent	Cumulative Per cent
1 ANM Workers			
<1	2	3.9	3.9
1-2	48	94.1	98.0
3-4	1	2.0	100
Total	51	100	
2 MPW Workers			
<1	19	37.3	37.3
1-2	32	62.7	100
Total	51	100	
3 Attendant			
<1	18	35.3	35.3
1-2	31	60.8	96.1
3-4	2	3.9	100
Total	51	100	
4 Whether Workers			
Yes	42	82.4	82.4
No	9	17.6	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

Table No. 4.11
Manpower

Name of Locality	No.of ANM	No.of MHW	Attendant/Fourth Grade	Total
Zonuam	1	1	1	3
Lawipu	*2*	1	1	4
Venghnuai	*2*	0	1	3
Chanmari	*2*	0	0	2
Thuampui	*1*	1	1	3
Republic Vengthlang	*2*	1	1	4

Source: Field Survey, Sept-Oct,2018

Availability of Infrastructure

While it is desirable that a Sub-Centre should have its own building, the present study has shown that only two Sub-Centres- Zonuam Sub Centre and Venghnuai Sub Centre occupies government building, Lawipu, Chanmari and Thuampui Sub-Centres/Clinics are accommodated in NGO buildings and Republic Vengthlang Sub-Centre Clinic is set up in a private building(Table No. 4.12), the rent is not covered by the state government but paid from contributions made by families in the community, which are collected once or twice a year by the local council of the community.[3]

[3] Based on a personal interview with Miss Lalkamlovi, ASHA,Republic Vengthlang on 28.10.2018

Table No. 4.12
Ownership of Sub Centre/Clinic Buildings

Name of Locality	Owner of Sub Centre Building
Zonuam	Government
Lawipu	NGO Building
Venghnuai	Government
Chanmari	NGO Building
Thuampui	NGO Building
Republic Vengthlang	Private Building

Source: Field Survey, Sept-Oct,2018

All the Sub centres/Clinics had toilets and electricity. While 60.8 percent of respondents said there was water connection, none of them had a landline telephone connection. Regarding the availability of toilet facilities in the Sub Centres/Clinics for the beneficiaries,80.4 percent of beneficiaries said Yes, while 19.6 percent responded No. Examination tables could also been seen in all the Sub Centre/Clinics under study, though none of them had delivery beds. When the beneficiaries were asked through questionnaires the availability of these basic facilities, there were mixed responses (see Table No.4.13).

93 percent of respondents said there were B.P Apparatus in good working conditions, 86.3 percent said there were weighing scales in working conditions and 56.9 percent said disposable kits were available in the Centres. None of the Sub Centres/Clinics had sterilising instruments. All equipments were sterilised by boiling.

Table No.4.13
Availability of Infrastructure

Particulars	No. of respondents	Percent	Cumulative Percent
1 Toilet			
Yes	41	80.4	80.4
No	10	19.6	100
Total	51	100	
2 Telephone			
Yes	7	13.7	13.7
No	44	86.3	100
Total	51	100	
3 Delivery Bed			
Yes	9	17.6	17.6
No	42	82.4	100
Total	51	100	
4 Water Connection			
Yes	31	60.8	60.8
No	20	39.2	100
Total	51	100	
5 Electricity			
Yes	51	100	100
No	0	0.0	
6 BP Check			
Yes	50	98.0	98.0
No	1	2.0	100
Total	51	100	
7 Patient Bed			
Yes	49	96.1	96.1
No	2	3.9	100
Total	51	100	
8 Weighing Scale			
Yes	44	86.3	86.3
No	7	13.7	100
Total	51	100	
9 Disposable Kits			
Yes	29	56.9	56.9
No	22	43.1	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

Availability of Services

25.5 percent of respondents said that the services at the Sub Centre was available for 24 hours in a day, while 74.5 percent said that 24 hours service in a day was not available in the Sub Centre. (See Table No. 4.14).80.4 percent of beneficiaries said that doctors' visit to the Sub Centre was less than once in a month and 15.7 percent said that the doctor visited their Sub Centre once in a month. When asked whether the beneficiaries were made aware of the timings of the doctor's visit, 29.4 percent responded Yes, 56.9 responded No and 13.7 percent responded that they were sometimes made aware of the timings of the doctor's visit. When asked regarding whether Specialist doctors visited the Sub Centres, 74.5 percent responded No, while 23.5 percent responded Yes. (See Table No. 4.15).

Table No.4.14
Availability of Sub-Centre for 24 Hours

Availability	No. of Beneficiaries	Percent	Cumulative Percent
Yes	13	25.5	25.5
No	38	74.5	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

Table No. 4.15
Status of Doctor's Visit in a Month

Visiting Frequency	No. of respondents	Percent	Cumulative Percent
<1	41	80.4	80.4
1-2	8	15.7	96.1
3-4	1	2.0	98.0
> 4	1	2.0	100
Total	51	100	

Source: Field Survey, Sept-Oct, 2018

Table No. 4.16
Status of Information on Doctor's Visit

Particulars/Services	No. of respondents	Percent	Cumulative Percent
1 Information On Doctor Visit			
Yes	15	29.4	29.4
No	29	56.9	86.3
Sometimes	7	13.7	100
Total	51	100	
2 Specialist Doctor Visit			
Yes	12	23.5	23.5
No	38	74.5	98.0
Sometimes	1	2.0	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

All respondents(100 percent) agreed that all Antenatal care (Inj. T.T. IFA tablets, weight and BP check-up) as well as immunization services, as per Government Schedule were provided in the Sub centre.74.5 percent responded that emergency services in complicated cases of pregnancy was available at the Sub Centre, if the need arises.84.3 percent said medicines like Vitamin A supplements, IFA tablets/syrup, Albendazole tablets were available and provided by the sub center,86.3 percent said treatment of diarrhoea and dehydration(ORS) was available in the Sub centre, while only 31.4 percent of the respondents said the treatment for minor illness like fever, cold and cough were available in the Sub Centre/Clinic.94.1 percent responded that the facility for taking Peripheral blood smear in case of fever for detection was available in the Sub centre,92.2 percent said the facility for urine test was available in the Sub Center,94.1 percent said that contraceptive services like insertion of Copper – T, distributing Oral contraceptive pills or condoms were provided by the Sub centre.(Table No.4.17)

Table No.4.17
Status of Services Rendered by Sub-Centre

Services	No. of respondents	Percent	Cumulative Percent
1 Antenatal Care			
Yes	51	100	100
2 Emergency Service in Pregnancy			
Yes	13	25.5	25.5
No	38	74.5	100
Total	51	100	
3 Immunization			
Yes	51	100	100
4 Availability Of Medicine Vitamin A supplements, IFA tablets/syrup, Albendazole tablets			
Yes	43	84.3	84.3
No	4	7.8	92.2
Sometimes	4	7.8	100
Total	51	100	
5 ORS			
Yes	44	86.3	86.3
No	3	5.9	92.2
Sometimes	4	7.8	100
Total	51	100	
6 Medicine For Common disease			
Yes	16	31.4	31.4
No	11	21.6	52.9
Sometimes	24	47.1	100
Total	51	100	
7 Blood Test			
Yes	48	94.1	94.1
No	3	5.9	100
Total	51	100	
8 Urine Test			
Yes	47	92.2	92.2
No	4	7.8	100
Total	51	100	
9 Contraceptive Pills, condoms etc			
Yes	48	94.1	94.1
No	3	5.9	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

Standard of Service

When asked whether beneficiaries have to wait long to get treatment or services from the Sub Centre,96.1 percent responded that they did not have to wait for a long period to avail the services from the Centres and 98 percent said there are waiting areas with comfortable seating arrangements.96.1 percent said that they were not required to pay any money for services rendered by the Sub Centre,92.2 percent said that they were told their conditions by the doctor/nurse/health worker in a language that could be understood with patience and understanding.86.3 of respondents said they were provided free medicines if available in the Centre.94.1 percent of beneficiaries responded that they were satisfied with the services received from the Sub Centre.(Table No.4.18)All respondent said that depending on the nature of illness they have been referred to another health care centre, and all of them (100 percent) have been referred to Aizawl Civil Hospital, when asked the place of referral.(Table No. 4.19)

TableNo.4.18
Standard of Services Rendered by Sub-Centre-1

Services	No. of respondents	Percent	Cumulative Percent
1 Long Waiting time			
Yes	2	3.9	3.9
No	49	96.1	100
Total	51	100	
2 Place to Wait			
Yes	50	98.0	98.0
No	1	2.0	100
Total	51	100	
3 Expenditure on Check Up			
Yes	2	3.9	3.9
No	49	96.1	100
Total	51	100	
4 Understanding of Patients			
Yes	47	92.2	92.2
No	4	7.8	100
Total	51	100	
5 Service of Staff			
Yes	50	98.0	98.0
No	1	2.0	100
Total	51	100	
6 Free Medicine			
Yes	44	86.3	86.3
No	1	2.0	88.2
Sometimes	6	11.8	100
7 Satisfaction on Service			
Yes	48	94.1	94.1
No	3	5.9	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

Table No. 4.19
Standard of Services Rendered by Sub-Centre-2

Services	No. of respondents	Percent	Cumulative Percent
1 Refer			
Yes	51	100	100
2 Place Refer			
Civil Hospital	51	100	100

Source: Field Survey, Sept-Oct,2018

Role Of Accredited Social Health Activist (ASHA)

The Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005 with the core strategy was to support and strengthen the existing Primary Health Centres and Community Health Centres in terms of both infrastructure and human resources in order to achieve a number of health goals in term of reducing infant and maternal mortality as well as the prevalence of a number of communicable diseases. One key component of the NRHM is creating a band of female health volunteers, named "Accredited Social Health Activist" (ASHA) in each village to help and reduce the workload of the Auxiliary Nurse Midwife (ANM).

Table No. 4.20

ASHA Services

Services	No. of respondents	Percent	Cumulative Percent
1. ASHA			
Yes	50	98.0	98.0
Don't Know	1	2.0	100
Total	51	100	
2. Accompaniment by ASHA to hospital			
Yes	20	39.2	39.2
No	10	19.6	58.8
Sometimes	11	21.6	80.4
Don't Know	10	19.6	100
Total	51	100	
3. ASHA provided training			
Yes	30	58.8	58.8
No	1	2.0	60.8
Sometimes	3	5.9	66.7
Don't Know	17	33.3	100
Total	51	100	
4. Are medicines provided through ASHA			
Yes	21	41.2	41.2
No	2	3.9	45.1
Sometimes	28	54.9	100
Total	51	100	

Source: Field Survey, Sept-Oct,2018

When beneficiaries were asked whether ASHAs were there in their locality,98 percent answered in the affirmative. All Sub Centres/Clinics are aided in their functions by ASHAs who are selected from the locality and trained to act as an interface between the rural people and primary health centres and play a fundamental role in achieving national health goals.39.2 of beneficiaries said that ASHAs provided accompaniment for hospital deliveries,19.6 percent said that they did not know whereas 19.6 percent of respondents said ASHAs were not available for accompaniment. When asked whether medicines were supplied through ASHA,42.2 percent said medicines were provided,54.9 percent said medicines were sometimes provided.(Table No. 4.20)

ASHAs play a vital role in delivery of healthcare services to the community by establishing a link between the Sub Centres/Clinics and the citizens. Their role in RCH is particularly commendable since they act as a friend and confidante to women in the community and counselling them on birth preparedness, importance of safe delivery, breast-feeding, immunization, contraception and prevention of common infections including RTIs/STIs and care of the infant. She mobilises the community and facilitates access to health-related services available in Anganwadi, sub centre, PHCs, such as immunization, Ante Natal Check-up, Post Natal Check-up,

supplementary nutrition, sanitation and other government provided services. She is also a depot holder for essential provisions such as ORS, IFA,chloroquine, DDk,Oral Pills, Condoms and emergency pills.

Table No. 4.21
Suggestions for Improvement

Sub-Centre/Clinic	Better Building	Advanced equipments or tools	More staff	Better supply of medicine	Dental Care	Opthalmic Care	Generic medicine outlet	Total
Zonuam	6	10	4	8	6	6	7	**47**
Lawipu	7	8	5	8	6	6	3	**43**
Venghnuai	6	6	6	6	6	6	6	**42**
Chanmari	3	7	7	8	5	6	4	**40**
Thuampui	5	9	7	8	8	8	7	**52**
Republic Vengthlang	5	6	2	7	2	2	3	**27**
Total	32 (62.7%)	46 (90.1%)	31 (60.8%)	45 (88.2%)	33 (64.7%)	34 (66.7%)	30 (58.8%)	**257**

Source: Field Survey, Sept-Oct,2018

When beneficiaries were asked to give suggestions for improvement of healthcare delivery through the Sub-Centre,62.7 percent respondents believed that the Sub Centre/Clinic could be accommodated in a better building and 90.1 percent desired more advanced equipments,60.8 percent believed the Sub-Centre/Clinics needed more staff,88.2 percent suggested that the function and role of Sub Centres/Clinics would be strengthened with better supply of medicine,64.7 percent desired that dental and eye care would be

included in the services provided by the Sub-centre/Clinic, and 66.7 percent desired that eye care would be included in the services provided by the Sub-centre/Clinic, 58.8 percent suggested that outlets for generic medicine at low prices should be made at the Sub Centre/Clinics so that essential medicines which are not available for free supply could be made available at affordable prices.(See Table No.4.21).

Response from Officials (Health Workers)

Questionnaires were also administered to 14 officials,9 of whom were male and 5 female. Two of the officials were between the age bracket 25-35,five between age 39-50,and seven about the age of 50 years. The official respondents were 6 ANMs ,6 MPWs and 2 Attendants.14.3 percent of the officials were qualified up to HSSLC,71.4 percent had HSLC and the remaining 14.3 percent were below HSLC.(Table No.5.1)

Table No. 5.1

Educational Qualification

Educational Qualification	No. of respondents	Percent	Cumulative Percent
HSSLC	2	14.3	14.3
HSLC	10	71.4	85.7
Others	2	14.3	100
Total	**14**	**100**	

Source: Field Survey, Sept-Oct,2018

Regarding services available at the Sub-Centre,64.3 percent of the health workers said that the services of the Sub-Centre was available for 24 hours while 35.7 percent that services was not available for 24 hours.(Table No. 5.2).71.4 percent of official respondents said that the doctors visit to the Sub Centre was less than once a month while 28.6 percent (4 respondents) said the doctors visited the Sub Centre once or twice a month. (Table No. 5.3).Information regarding the doctor's visit is not properly made known to the public(Table No. 5.4),specialists seldom/never visit the Sub Centres to conduct provide consultation or medical advice for the beneficiaries of the Sub Centre.(Table No. 5.4)

Table No.5.2
Availability of Sub-Centre for 24 Hours

Availability	No. of respondents	Percent	Cumulative Percent
Yes	5	35.7	35.7
No	9	64.3	100
Total	**14**	**100**	

Source: Field Survey, Sept-Oct,2018

Table No. 5.3
Status of Doctor's Visit in a Month

Visiting Frequency	No. of respondents	Percent	Cumulative Percent
<1	10	71.4	71.4
1-2	4	28.6	100.0
Total	14	100.0	

Source: Field Survey, Sept-Oct,2018

Table No. 5.4
Status of Information on Doctor's Visit

Particulars/Services	No. of respondents	Percent	Cumulative Percent
Yes	3	21.4	21.4
No	4	28.6	50.0
Sometimes	7	50.0	100.0
Total	14	100.0	
Specialist Doctor Visit			
Yes	1	7.1	7.1
No	13	92.9	100.0
Total	14	100.0	

Source: Field Survey, Sept-Oct,2018

Regarding the services provided in the Sub-Centre/Clinics,92.9 percent of officials said that the Sub Centres does not provide emergency care in pregnancy,100 percent said immunization service as per government schedule was provided by the Sub Centre/Clinics,78.6 percent said that medicines for antenatal care, ORS, blood test and urine tests were available.28.6 percent said medicines for common ailments were available,28.6 percent these medicines were not available while 42.9 percent said theses medicines were sometimes available for free distribution. All respondents (100 percent) agreed that Contraceptive pills were always available.(Table No. 5.5).

Regarding the Standards of Service, all official respondents (100 percent) agreed that patients did not have to wait for a long period to avail the services from the Centres ,there are waiting areas with comfortable seating arrangements, beneficiaries were not required to pay any money for services rendered by the Sub Centre and that patients were told their conditions by the doctor/nurse/health worker in a language that could be understood with patience and understanding, they were provided free medicines if available in the Centre. When asked whether health records were properly verifies by the UPHC weekly, the answer was mostly No(50 percent),21.4 percent answered

in the affirmative and the remaining 28.6 percent responded that these records were sometimes verified by the UPHC. Likewise when asked whether records were verified by the M.O as per government norms, only 28.6 percent answered in the affirmative. (Table No.5.6).All respondent said that depending on the nature of illness they have been referring patients to other health care centre, such as Civil Hospital (7.1 percent),Urban Primary Health Centre(64.3percent) and other hospitals(28.6 percent).(Table No. 5.7)

Table No.5.5
Status of Services Rendered by Sub-Centre 1

Services	No. of respondents	Per cent	Cumulative Per cent
Emergency Care in Pregnancy			
Yes	1	7.1	7.1
No	13	92.9	100.0
Total	14	100.0	
Immunization			
Yes	14	100.0	100.0
Availability Of Medicine for Ante Natal Care			
Yes	11	78.6	78.6
No	3	21.4	100.0
Total	14	100.0	
ORS			
Yes	11	78.6	78.6
No	3	21.4	100.0
Total	14	100.0	
Medicine for Common ailments			
Yes	4	28.6	28.6
No	4	28.6	57.1
Sometimes	6	42.9	100.0
Total	14	100.0	
Blood Test			
Yes	11	78.6	78.6
No	3	21.4	100.0
Total	14	100.0	
Urine Test			
Yes	11	78.6	78.6
No	3	21.4	100.0
Total	14	100.0	
Contraceptive Pills			
Yes	14	100.0	100.0

Source: Field Survey, Sept-Oct,2018

Table No.5.6

Standard of Services Rendered by Sub-Centre 2

Services	No. of respondents	Per cent	Cumulative Per cent
1. Wait time			
No	14	100.0	100.0
2.Comfortable Place to Wait			
Yes	14	100.0	100.0
3. Understanding towards Patients			
Yes	14	100.0	100.0
4. Patience and helpfulness			
Yes	14	100.0	100.0
5. Citizen Charter			
Yes	14	100.0	100.0
6.whether Health records verified by UPHC weekly			
Yes	3	21.4	21.4
No	7	50.0	71.4
Sometimes	4	28.6	100.0
Total	14	100.0	
7. whether Health records verified by M.O monthly			
Yes	4	28.6	28.6
No	5	35.7	64.3
Sometimes	5	35.7	100.0
Total	14	100.0	
8. whether VHSNC supervises the working of SC/SCC			
Yes	5	35.7	35.7
No	3	21.4	57.1
Sometimes	6	42.9	100.0
Total	14	100.0	

Source: Field Survey, Sept-Oct,2018

Regarding the Standards of Service, all official respondents (100 percent) agreed that patients did not have to wait for a long period to avail the services from the Centres ,there are waiting areas with comfortable seating arrangements, beneficiaries were not required to pay any money for services rendered by the Sub Centre and that patients were told their conditions by the doctor/nurse/health worker in a language that could be understood with patience and understanding, they were provided free medicines if available in the Centre. When asked whether health records were properly verifies by the UPHC weekly, the answer was mostly No(50 percent),21.4 percent answered in the affirmative and the remaining 28.6 percent responded that these records were sometimes verified by the UPHC. Likewise when asked whether records were verified by the M.O as per government norms, only 28.6 percent answered in the affirmative. (Table No.5.6).All respondent said that depending on the nature of illness they have been referring patients to other health care centre, such as Civil Hospital (7.1 percent),Urban Primary Health Centre(64.3percent) and other hospitals(28.6 percent).(Table No. 5.7)

Table No.5.7
Standard of Services Rendered by Sub-Centre-3

Services	No. of respondents	Per cent	Cumulative Percent
Refer			
Yes	14	100.0	100.0
Place Refer			
Civil Hospital	1	7.1	7.1
Civil Hospital/urban health centre	9	64.3	71.4
Hospital	4	28.6	100.0
Total	14	100.0	

Source: Field Survey, Sept-Oct,2018

When officials were asked to give suggestions for improvement of healthcare delivery through the Sub-Centre,100 percent official respondents believed that the Sub Centre/Clinic could be accommodated in a better building and desired more advanced equipments,42.9 percent believed the Sub-Centre/Clinics needed more staff,92.9 percent suggested that the function and role of Sub Centres/Clinics would be strengthened with better supply of medicine,57.1 percent of official respondents desired that dental and eye care would be included in the services provided by the Sub-centre/Clinic,50 percent suggested that outlets for generic medicine at low prices should be made at the Sub Centre/Clinics so that essential medicines which are not available for free supply could be made available at affordable prices.(See Table No.5.8).

Table No. 5.8
Suggestions for Improvement

Sub-Centre/ Clinic	Better Building	Advanced equipments or tools	More staff	Better supply of medicine	Dental Care	Opthalmic Care	Generic medicine outlet	Total
Zonuam	3	3	3	3	3	3	3	**21**
Lawipu	1	1		1			2	**5**
Venghnuai	2	2		2				**6**
Chanmari	2	2	2	2	2	2		**12**
Thuampui	3	3	1	2			2	**11**
Republic Vengthlang	3	3		3	3	3		**15**
Total	14 (100 %)	14 (100 %)	6 (42.9%)	13 (92.9%)	8 (57.1%)	8 (57.1%)	7 (50%)	**70**

Source: Field Survey, Sept-Oct,2018

To sum up, in this chapter, all the field data and information as collected have been compiled and analysed in the light of the present research activity. The survey of literature has been corroborated by actual field work, administering of the questionnaire, personal interview and interactions with different stakeholders whose responses have been presented.

CHAPTER V

CONCLUSION

In the previous chapter, results of the field study focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services, people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics were analysed and discussed, as well as the ideas and opinions of the officials working in the Sub Centres/Clinics as well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl.

The present chapter is divided into two parts. The first part covers summary of all the previous chapters, Chapter One, Chapter Two, Chapter Three and Chapter Four. The Second part discusses the research questions and general conclusion, highlighting the major findings of the study. And also it contains possible remedial solutions and suggested measures to be taken for effective Primary Healthcare Delivery Services in Aizawl through the working of the Health Sub-centres and Health Sub-Centre Clinics, in providing promotive, preventive and basic level of curative services to the people of Aizawl, set up and functioning in various parts of Aizawl.

PART-I

The dissertation has been divided into five chapters. The introductory chapter starts with the basic concept of health, its importance and role in the advancement and development of the nation, as well as its value, in terms of it being an asset and a resource, that ranks higher than any other factor, towards contributing to a richer and fuller life of the nation and the people. The Chapter also touches upon the role of Primary Health Care(PHC) as a vital strategy that remains the backbone of health service delivery and the importance and significance of the present study. The chapter also explains the different sources of literature that have been reviewed, statement of the problem, scope and objectives of the study ,the Research Questions, Methodology applied and Chapterization of the present study.

Chapter II: *Primary Health Care Delivery Services: A Conceptual Study* deals with conceptual framework and principles of Primary Health Care Delivery Services from global, national and state perspectives. It discusses elements of Primary Health Care ,the Millennium Development Goals, the Sustainable Development Goals with health related indicators, the organising and financing of health care delivery system from the national level, State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level, approaches ,strategies and the resources of health care - human,

financial, material and technological-as available or that should be available to the people at the grassroots level.

Chapter III : *Administration of Primary Health Care Services in Aizawl: Functions and Role* explains the setup of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular highlighting the role played by the Christian missionaries as well as the government. The present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system, is discussed. Sub-centres are expected to provide promotive, preventive and few curative primary health care services and lay emphasis on Reproductive and Child Health (RCH) as well as Non-Communicable Diseases related services. The Sub Centres are also expected to be involved in the implementation of National Health Programmes relating to Communicable Diseases such as National AIDS Control Programme (NACP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Eradication Programme (NLEP) and Revised National Tuberculosis Control Programme (RNTCP).

Chapter IV: *Results and Discussion* deals with results and discussions of the field study focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services ,people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics, as well as the ideas and opinions of the officials working in the Sub Centres/Clinics, suggested remedial measures as well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl-–Republic Vengthlang Sub Centre Clinic, Zonuam Sub-Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East. There exists no real difference between the Sub Centre and Sub-Centre Clinics, they basically perform the same type of functions and have similar role and responsibilities.

PART-II

From the light of the present study, it may be ascertained that no reliable study has been undertaken regarding the administration of primary health care delivery services in Aizawl: Functions and Challenges. The present study has ascertained that the Christian missionaries played a huge role in the genesis of primary health care

services in Mizoram State in general. It was the Missionaries who made ground breaking efforts in promoting modern primary healthcare concept and practices in the Mizo society. It is a generally acknowledged fact that the modern Health Care Services in Mizoram was introduced in Mizoram by the British Administration and the Christian missionaries. Until 1894 there was no real scientific health care facility in Mizoram. In the year 1890, following the second British Expeditions against the Mizo (1889-1890), the first plan for the sanction and appointment of the first Medical Officer for Mizoram was made, although there seems to be no known records of exact names and dates. Since then, Health Care Services continue to develop in Mizoram. Aizawl was the headquarters even in those days and the starting point of primary health care delivery services in the state of Mizoram.

After Mizoram attained the status of Union Territory on 21st January 1972 ,a separate Department, Health and Family Welfare Department was established, headed by Director. The Health and Family Welfare Department has been bifurcated into Directorate of Health Services (DHS) and Directorate of Hospital & Medical Education (DH &ME), each having a separate budget. Directorate of Health Services, is responsible for establishment, administration, regulation and monitoring of Medical and Health Institutions along

with handling the necessary supporting infrastructure within the state, medical education, food safety and drug control and monitoring and implementation of various programs related to public health and disease control. Directorate of Health Services, MCH&FW (Maternal and Child Health and Family Welfare) is responsible for monitoring and implementation of the centrally sponsored schemes implemented in the State to cater to the health needs of women and children. DHS look after rural health institutions i.e., Community Health Centres (CHCs), Primary Health Centres (PHCs), Sub-Centres (SCs),Sub-Centre Clinics and Rural Hospital, Tlabung. Similarly, Civil Hospital (Aizawl), Kulikawn, Hospital and all the district hospitals come under the jurisdiction of Directorate of Hospital & Medical Education.

Aizawl District has been functionally divided into Aizawl East and Aizawl West districts for health care service delivery, each headed by a CMO. At present, Health Care delivery Services in Mizoram is provided through one State Hospital (an upgraded district hospital), 7 district hospitals,1 Sub-District Hospital in Kulikawn, located in West Aizawl,1 Regional Cancer Hospital in Zemabawk and State Referral Hospital in Falkawn and a total of 18 private hospitals in the whole state,8 of which are in Aizawl. Population norms set by the Central Government need to be relaxed for Mizoram in order to reach all members of the community. Different categories of technical and non-

technical manpower work together in a coordinated effort to address the objectives and functions of Health and Family Welfare Department.

Primary Health Centres (PHC) and Health Sub centres were gradually started to provide healthcare services as close to the people as possible, even in the remotest, rural areas.In1966, there were 3 PHCs in Mizoram and the number increased to 4 in 1972.When Mizoram attained statehood in 1986,the number PHC/CHC had increased to 51 PHC/CHC and 314 sub centres. By 2013,there were 64 PHC/CHC and 367 Sub centres. At present there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state.

The first research question is : i. What are the role and functions of Primary Health Care Delivery Services in Aizawl ?.While answering this question,it was revealed that Primary health care in the Sub-Centre level in Aizawl are predominantly Reproductive And Child Health(RCH) oriented. Majority of beneficiaries are women in reproductive age group for (Antenatal Care) ANC and vaccination. The function of the Health Sub-centre/Clinic is largely preventive and promotive, but it also provides a basic level of curative care.

Primary Health Centres and its Sub-Centres are 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 present study focuses on the role of the Sub-centres as the primary, most peripheral and first contact point between the primary health care system and the community. While the primary focus of the Health Sub Centres/Clinics remains the Reproductive and Child Health(RCH) services, services relating to non-communicable diseases as well as communicable diseases have also been included, with prime focus on the promotive and preventive aspect of health care through imparting awareness and informed advice, guidance and counsel whenever and wherever suitable and required.

The Curative aspect of diseases-communicable as well as non-communicable also comes under the functions of the Health Sub-Centres to a considerable extent. It must be mentioned here that the list of services and functions performed and carried out by the Sub-Centres is rather long, extensive and fairly exhaustive.

1.Their primary role and functions center around Reproductive and child health services (RCH) which comprises of a wide array of women's health interventions, including family planning Information, Education and Communication(IEC); contraceptive counselling and provision of contraceptives, free of cost; basic screening of sexually transmitted infections; prenatal or newborn care; and breastfeeding support. The ANMs are available at the Sub-centre and the Sub-centre

remains open for providing OPD services on all working days, besides providing outreach services to the community at large.

2.The Immunization Services provided by the Sub-Centre include full Immunization of all infants and children against vaccine preventable diseases as per guidelines of Government of India and Vitamin A prophylaxis to the children as per National guidelines., prevention and control of childhood diseases like malnutrition, infections, ARI, Diarrhoea, Fever, Anaemia etc., name based tracking of all infants and children to ensure full immunization coverage and identification and follow up, referral and reporting of Adverse Events Following Immunization (AEFI).

3. School Health Services include screening, treatment of minor ailments, immunization, de-worming, prevention and management of Vitamin A and nutritional deficiency anaemia and referral services through fixed day visit of school by existing ANM/MPW4.

4.Outreach/Field Services include organising Village Health and Nutrition Day (VHND) at least once in a month in each village with the help of Medical Officer, Health Assistant Female (LHV) of PHC, HWM, HWF,ASHA, AWW and their supervisory staff, PRI, Self Help Groups etc.

5. House-to-House Surveys are done once annually with support and participation of ASHAs, Anganwadi Workers, community volunteers,

panchayat members and Village Health Sanitation and Nutrition Committee members.

6. Proper maintenance of records of services is provided at the Sub-centres as the morbidity/mortality data is necessary for assessing the health situation in the Sub-centre area. In addition, all births and deaths under the jurisdiction of sub- centre are documented and sex ratio at birth are monitored and reported**.**

7.Role and Functions of Sub Centres in relation to National Health Programmes in Communicable Disease Programme:

(1) ***National AIDS Control Programme (NACP):*** Condom promotion & distribution of condoms to the high risk groups, IEC(Information, Education and Communication) activities to enhance awareness and preventive measures about STIs and HIV/AIDS, PPTCT services and HIV-TB co-infection etc.

(2) ***National Vector Borne Disease Control Programme (NVBDCP):*** Collection of Blood slides of fever patients**,** rapid Diagnostic Tests (RDT) for diagnosis of Pf malaria in high Pf endemic areas and appropriate anti-malarial treatment.

(3) ***National Leprosy Eradication Programme (NLEP):*** Health education to community regarding signs and symptoms of leprosy, referral of suspected cases of leprosy etc.,

(4) ***Revised National Tuberculosis Control Programme (RNTCP):*** Sputum collection and referral of suspected symptomatic cases to the PHC/Microscopy centre and provision of DOTS at Sub-centre etc

8.Role of Sub Centres in relation to National Health Programmes in Non-communicable Disease (NCD) Programmes:

(1)***National Programme for Control of Blindness (NPCB):***Detection of cases of impaired vision in house to house surveys and their appropriate referral and spreading awareness regarding eye problems, early detection of decreased vision, available treatment and health care facilities for referral of such cases.

(2). ***National Programme for Prevention and Control of Deafness (NPPCD):***Detection of cases of hearing impairment and deafness during House to house survey and their appropriate referral and awareness regarding ear problems, early detection of deafness, available treatment and health care facilities for referral of such cases.

(3). ***National Mental Health Programme:*** Identification and referral of common mental illnesses for treatment and follow them up in community. IEC(Information, Education and Communication) activities for prevention and early detection of mental disorders and greater participation/role of Community for primary prevention of mental disorders.

(4) ***National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases (CVD) and Stroke:***

IEC(Information, Education and Communication) Activities to promote healthy lifestyle sensitize the community about prevention of Cancers, Diabetes, CVD and Strokes, early detection through awareness regarding warning signs and appropriate and prompt referral of suspect cases.

(5) ***National Iodine Deficiency Disorders Control:*** IEC(Information, Education and Communication) Activities to promote consumption of iodized salt by the community. Testing of salt for presence of Iodine through Salt Testing Kits by ASHAs.

(6) ***National Tobacco Control Programme:*** Spreading awareness and health education regarding ill effects of tobacco use especially in pregnant females and Non-Communicable diseases where tobacco is a risk factor e.g. Cardiovascular disease, Cancers, chronic lung diseases and displaying of mandatory signage of "No Smoking" in the Sub-centre.

(7) ***Oral Health:*** Health education on oral health and hygiene especially to antenatal and lactating mothers, school and adolescent children and providing first aid and referral services for cases with oral health problems.

(8) ***Disability Prevention:*** Health education on Prevention of Disability as well as identification of Disabled persons during annual house to house survey and their appropriate referral.

(9) ***National Programme for Health Care of Elderly:***. Counseling of Elderly persons and their family members on healthy ageing and referral of sick old persons to PHC.

Thus, the Sub-centres are fundamental, peripheral institutions for providing primary health care to the people and play a vital role in the implementation of various Health & Family Welfare programmes at the grass-root level.

At the national level, Sub-Centres with good infrastructure, adequate catchment areas and good caseload are promoted and equipped for providing intranatal services at the Sub-centre in addition to all other recommended services. Such Sub -Centres are categorized as Type B. The other type of Sub-centres (Type A) provide all recommended services except the facilities for conducting delivery is not be available here. This type of categorization is expected to result in service provision as per the need of population. The present study has established that such type of classification does not exist in the case of Aizawl, and the Sub-Centres in Aizawl are not properly equipped for providing intranatal services, the most obvious reason being that beneficiaries mostly go for institutional delivery in full fledged public and private hospitals, which are more sufficiently equipped ,and not too difficult to reach. Urban Health centres are also equipped to deal with deliveries and are more or less located in close proximity. However, it is desirable that sub centres /clinics in Aizawl

be equipped to deal with deliveries in cases of emergencies in this regard.

The 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East, as primary health care units in Aizawl play a essential role in decentralising health care services that helps to reduce morbidity and mortality through prevention and early intervention. The number of Health Sub centres as well as Sub centre clinics in Aizawl have increased significantly over the years. However, mere increase in number of healthcare services across Aizawl does not necessarily ensure sufficient facility for qualitative improvement in primary healthcare delivery services.

One of the key components of Primary Health Care at the sub Centre level are the Accredited Social Health Activists(ASHAs) who are female community health activists selected from the village and trained to act as an interface between the community and public health system. These ASHAs play a commendable role in Aizawl in educating, providing information and creating awareness on health determinants such as nutrition, basic sanitation and hygiene, existing health services provided by the sub centre/clinic and promoting immunization, referral and escort services for RCH and other health care programmes.

The Second research question is: ii. What are the problems and challenges of Primary Care Delivery Services in Aizawl?. It is pertinent to mention here that when service delivery points, such as the Sub-Centres, are at such close proximity to the people, there are scores of challenges because it is at the cutting edge of administration and touches the lives of the people so much more.

Some of the challenges faced by primary health care centres in Aizawl are;

(i)Unavailability of sufficient infrastructure for efficient delivery of health care services. Among the six Sub Centres/Clinics under study, only Venghnuai Sub-Centre is accommodated in a government building, four of them-Thuampui Sub Centre Clinic, Lawipu Sub Centre Clinic, Zonuam Sub-Centre and Chandmari Sub-Centre Clinic are accommodated in NGO/Local Body buildings. Republic Vengthlang Sub-Centre Clinic is accommodated in a private building, and the rent money of which is not borne by the government but by families in the community who contribute money to meet the rent. This creates some problems in the functioning of the Sub Centre/Clinics, especially when they are accommodated in private buildings.

(ii)The Sub Centres/Clinics face some challenges/problems due to unavailability or of basic facilities like LPG and water connection, and insufficient or inadequate supply of resources and critical and essential

medicines which hamper their smooth functioning in the delivery of services to the people. Since the six Sub Centres/Clinics do not have sterilising instrument, they have to sterilise their instruments by boiling, which requires an LPG connection. Also, these health units are not provided with fridge/freezer which is sometimes required to store vaccines, vitamins and medicines. Sufficient storage facilities and furnitures like cupboards, almirah etc. are also not provided to these health units. Some communities like the Republic Vengthlang have very helpful and concerned Local Council who have donated essential facilities like fridge and almirah to their Sub Centre Clinic.[1]There are also instances where diabetes test strips are purchased from the local market by the health workers and the patients have to pay for use of these strips since they are not available on supply from the government.[2]

(iii)Unavailability of emergency first aid materials for care of injury (stitches, suturing ,dressing and allergies etc.) is another challenge faced by the Sub Centre/Clinics. While some Sub Centres have emergency first aid materials for care of injury, the Sub Centre Clinics are not provided with such materials. Local bodies and NGOs in some

[1] Based on a personal interview with Miss Lalkamlovi,ASHA,Republic Vengthlang on 28.10.2018.
[2] Based on a personal interview with P.C.Lalramlawma,Health Worker,,Republic Vengthlang on 01.11.2018.

communities purchase these emergency first aid materials for stitches, suturing and dressing etc. and donate them to the Clinics.[3]

(iv) ASHAs(Accredited Social Health Activists) ASHAs play a praiseworthy role in different communities in educating, providing information and creating awareness on health determinants such as nutrition, basic sanitation and hygiene, existing health services provided by the sub centre/clinic and promoting immunization, referral and escort services for RCH and other health care programmes. While these ASHAs share very good working relationship with the health workers and participate in all programmes of the Sub Centre/Clinic including taking an active part in the Nutrition Day, they operate under some level of stress because the incentives provided to them are not commensurate with their workload.[4]

The last research question is: iii. What are the remedial measures for effective delivery of Primary Health Care Services in Aizawl? Suggestions based on the findings are:

(i)All Health Sub-Centres/clinics be accommodated in government buildings so that these health units do not have to rely on contributions

[3] Based on a personal interview with P.C.Lalramlawma,Health Worker,,Republic Vengthlang on 01.11.2018.

[4] Based on personal interviews with ASHAs in Venghnuai, Republic Vengthlang and Lawipu on 28.10.2018 and 30.10.2018 respectively.

made by the community to meet their rent money. While contributions from the community to meet the rent money in a show of solidarity and community participation is well and good, it is also the bounden duty of the government to take charge in this regard since the government is expected to provide the basic infrastructural set up to provide primary health care services to the people.

(ii) The Sub Centres may also be provided with basic facilities like LPG, water connection and good toilet both for the health works and patients who come to the Sub-Centre/Clinic to avail of the services provided. Maybe further down the road, the Sub-Centres/Clinics may be provided with staff quarters. Since it may be difficult, rather irrational to expect the Sub-Centres/Clinics to remain open 24X7, it would be beneficial for the families in the community if the staff of the Sub Centre/Clinic reside nearby and are easily accessible for medical advice and consultation especially in cases of medical emergencies.

(iii)It is also desirable to equip the Sub Centres/Clinics with modern, more advanced instruments in good working conditions to enable to provide better services for the community they serve.

(ii) the government should ,at the least, ensure sufficient supply of essential and critical drugs in adequate amounts in appropriate dosage forms with assured quality and adequate information. While all medicines should be administered in a timely manner, there are some (drugs for TB, Malaria, Emergency pills) that must not be omitted or their administration delayed as this can potentially cause harm since adherence is key to effective treatment.

(iii) It could be highly beneficial if efforts be made by concerned authorities to make medicines which are not available in supply for free such as medicines for minor ailments like fever, diarrhoea, ARI, worm infestation, First Aid etc, more affordable and accessible by opening outlets in the Sub Centre to sell high-quality generic medicines at low prices.

(iii) ASHAs, who are the strongest grassroots linkage in the chain to provide quality primary health care to the community, are expected to function in different communities as the first port of call for any health

related demands of deprived sections of the population, especially women and children, who find it difficult to access health services, have a lot of responsibilities to fulfil in the community. She is expected to mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centres, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government. Besides, she also acts as a depot older for essential provisions being made available to all community like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. Working as ASHA is a full time job leaving no time to search for alternate source of income .These ASHAs receive performance based incentives for the services they render, which are somewhat meagre and not commensurate with their job and responsibilities. It is desirable if their honorarium be increased, as this will boost their morale and help promote and improve the delivery of primary health care services to the people.

(iii) Paper-based reporting and recording process in the Sub Centre may be replaced by computer based records. There are instances where

Report Forms are not available with the Sub centres in sufficient amount and the Health workers have to make photocopies of the forms.

(iv) It may be mentioned that the doctors need to be attached to or be in charge of specific Sub Centres without being shifted frequently so that they may be available to visit the Sub centres/clinics at least once in a month and attend to their positions without any breaks.

(v)The Health and Family Welfare Department may have a more clear and sound policy of posting, transfer or, if more convenient, rotation policy in regard to the doctors.

The present study has a few limitations such as limited span of time for completion of the research work; small area of study i.e., a few areas in Aizawl City; and lack of scope for generalisation and general conclusion. However, these limitations can be overcome in case of future studies with more time, broad area such as the entire state of Mizoram and wider consultation with the stakeholders, study materials and field data to conduct a more meaningful study and arriving at general conclusions with broad based suggestions concerning primary health care services in Mizoram.

Appendix No.I

Ref:Beneficiaries/Patients

Format-I
Department of Public Administration,Mizoram University
Questionnaire

This Questionnaire has been prepared in connection with data collection for completing M.Phil research Work in the Department of Public Administration,Mizoram University.The data and information collected will be used only for academic purposes and will not be used in any manner by which privacy of the respondents will be revealed.

Sd/- Marie Zodinpuii,

Part I : Date : _____

1. Name of the locality_____
2. Name of Health Sub-center_____
3.Total population covered by the Sub-centre:_____
4.Whether the Sub-center functions for 24 hours Yes/No_____
5.Distance (in KM) between Sub center/Sub Center Clinic from the PHC_____
6.Name of PHC_____
7.Number of female Health Worker-(ANM) - _____
8.Number of male Health Worker- (MPW) - _____
9.Number of Attendant/Fourth Grade_____
10.Others_____
11.Designated government building available for the Subcentre? Yes/ No
12.Type of building? Pucca /Semi-Pucca?Kutchha
13.Are toilets available? Yes/No
14.Is Telephone connection available ? Yes/No
15.Is there a Delivery Bed? Yes/No
16.Is Water Connection available Yes/No
17.Is Regular Electricity Connection Available Yes/No
18.The Blood pressure apparatus is in working condition in the Subcentre? Yes/No
19.Is the Examination table in working condition in the Sub centre? Yes/No
20.Is there sterilizer instrument in working condition in the Sub centre?

Yes/No/Instruments are sterilized by boiling

21.Is the weighing machine in working condition in the Sub centre?
Yes/No

22.Are the disposable delivery kits available in the Sub centre?
Yes/No

23.Does the Doctor visit the Sub centre ? Yes/No

24.If yes,how many visits in a week/month?_____

25.Are the residents of the village aware of the timings of the doctor's visit?
Yes /No

26.Do other Specialist doctors visit the Sub Centre Yes/No

27.Is the Antenatal care (Inj. T.T. IFA tablets, weight and BP checkup) provided by those in the Sub centre? Yes No

28.Is the facility for referral of complicated cases of pregnancy / delivery available at Sub centre for 24 hours? Yes No

29.Are the immunization services as per government schedule provided by the Sub centre? Yes No

30.Are Vitamin A supplements,IFA tablets/syrup,Albendazole tablets provided by the sub center? Yes/No

31.Is the treatment of diarrhea and dehydration available in the Sub centre?
Yes/ No

32.Is the treatment of minor illness like fever, cough, cold etc. available in the Sub centre? Yes /No

33.Is the facility for taking Peripheral blood smear in case of fever for detection available in the Sub centre? Yes /No

34.Is the facility for urine test available in the Sub Center?Yes/No

35.Are the contraceptive services like insertion of Copper – T, distributing Oral contraceptive pills or condoms provided by the Sub centre? Yes No

36.Did you have to wait long to get treatment? Yes/No

37.Are there comfortable waiting areas with seating arrangements? Yes/No

38.Did you have to pay any money to the doctor/nurse/healthworker ? Yes/No

39.Were you told your condition by the doctor/nurse/healthworker ,in a language you can understand? Yes/No

40.How was the behavior of the doctor/nurse/healthworker towards you
Nice/Bad/Ok

41.Did you have to pay for the medicines you received in the center?
Yes/No

42.Depending on the nature of illness,have you ever been referred to another health care center? Yes/No/Does not arise

43.If referred to another health care facility,specify where?_____

44.Are you satisfied with the services received from the sub center?
Yes/No/Cannot Say

45. If Satisfied,tick(below) reasons for satisfaction
(i)Cleanliness
(ii)Respect and good handling
(iii)Technical competencies of staff
(iv)Good Services
(v)Others(Pl.Specify_____

_____

_____

_____

_____

_____

46. Patient's suggestions to improve PHC service(Tick)
(i)Better Building
(ii)Provide more advanced equipments
(iii)Increase the number of staff
(iv)Supply of adequate medicines
(v)Provide dental care
(vi)Provide eye care
(vii)Others(Pl.Specify)_____

_____

_____

_____

_____

_____

Part II.Personal Data (Personal Data is never to be shared nor revealed even in research writing)

1.Name of the Respondent(Optional) : _____

2.Gender : Male/Female_____

3.Age Group (Tick) :

(i)Below 25
(ii)25-35
(iii)36-50
(iv)Above 50

4.Educational Qualification :

(i)Graduate or more
(ii)HSSLC
(iii)HSC
(iv) Any other(Pl.Specify)_____

5.Main Source of Income :

(i)Agriculture
(ii)Service
(iii)Business
(iv)Any other(Pl.Specify)_____

6.Monthly Income(Tick)

(i)5000-10,000
(ii)10,000-30,000
(iii)Above 30,000

7.Position in the family : _____

8.Ration Card : APL/BPL/AAY

Appendix No.II

Ref:Beneficiaries/Patients

Format-I
Department of Public Administration, Mizoram University
Questionnaire

He Questionaire hi Department of Public Administration, Mizoram University hnuaia M.Phil zirlai-research work atan chauha buatsaih a ni a. I chhanna hi thup tlat a ni ang. Khawngaih takin dik tak leh a kim thei ang bera min chhansak turin kan ngen a che.

Sd/- Marie Zodinpuii,

Part-I Date : _____

1. Veng hming :_____
2. Health Sub-centre hming : _____
3. Sub-centre huam chhunga mihring cheng zat :_____
4. Sub-centre hi darkar 24 chhungin mamawhtu tan a dawr theih em ? : Aw/Aih
5. PHC atanga Sub-centre hlat zawng : KM _____
6. PHC Hming : _____
7. Hmeichhe Health Worker(ANM) engzat nge thawk ? : _____
8. Mipa Health Worker(MPW) engzat nge thawk ? :_____
9. Attendant/Fourth Grade engzat nge thawk ? :_____
10. Heng bakah hian thawktu dang an awm em ? :_____
11. Sub-center Building hi tu ta nge ? : Sawrkar/Mimal In /NGO Building
12. Eng ang Building nge ? : Cement In/Cement ban/Thing In
13. Inthiarna a awm em ? : Awm/Awmlo
14. Telephone connection a awm em ? : Awm/Awmlo
15. Nau neihna khum a awm em ? : Awm/Awmlo
16. Tui connection a awm em ? : Awm/Awmlo
17. Current a awm tha em ? : Tha/Tha lo
18. Blood Pressure(B.P) check-na hman tlak a awm em ? : Awm/Awm lo
19. Damlo mutna-Examination Table hman tlak a awm em ? : Awm/Awmlo
20. Hmanraw tih thianghlimna- Sterilizer Instrument hman tlak a awm em ? : Awm/Awmlo/hmanrua te chhum thianghlim thin anni

21. In bukna-Weighing Scale
hman tlak a awm em ? : Awm/Awmlo
22. Disposable delivery Kits-Kutkawr, Syringe, etc. a awm em ? :
Awm/Awmlo
23. Doctor a lo kal thin em ? : Kal thin/Kal ngailo/Kal zeuh zeuh
24. Kar khatah vawi engzat nge
Doctor a lo kal thin ? : _____
25. Doctor lo kal hun tur hi mipui
hriattir an ni em ? : Hriattir/Hriattir lo/A changin hriattir
26. Thiambikna nei- Doctor Specialist
dang an lo kal thin em ? : Kal thin/Kal thin lo
27. Raipuar tan B.P leh Taksa rih lam endikin
Tetanus(T.T) injection, Vitamins-IFA Tablets, etc.
te pek thin a ni em ? : Pe thin/Pe ngailo
28. Rikrum thulhah naupai lama harsatna nei tan englai pawhin zan lamah pawh
tanpuitu tur/rawn tur/nau chhar tur leh nau neihna tur a awm em ?
: Awm/Awmlo
29. Hri danna-Immunization-te hi a hun takah
Sub-center hian a pe thin em? : Pe thin/Pe lo/a hun tak nilo ah a pe thin
30. Vitamin A supplements, IFA Tablets/Syrup, Albendazole, etc.
lak tur a awm em? : Awm/Awmlo /a changin awm
31. Kawthalo enkawlna-ORS hi Sub-centre-ah
lak tur a awm em ? : Awm/Awmlo /a changin awm
32. Natna tlanglawn-Hritlang, Khuh, Khawsik te tan damdawi lak tur a awm em ?
: Awm/Awm lo/A changing awm
33. Thisen Test-na a awm em ? : Awm/Awmlo
34. Zun Test-na a awm em ? : Awm/Awmlo
35. Indanna heng-Copper–T, Oral Contraceptive Pills leh Condoms te a awm em ?
: Awm/Awmlo
36. In entir turin nghah rei a ngai em ? : Ngai/ngai lo
37. Nghah chhunga thutna tur a awm em ? : Awm/Awmlo
38. In entir man chawi a ngai em ? : Ngai/Ngailo
39. Uluk takin damlote hriatthiam theih turin natna dinhmun hrilhfiah a ni em ?
: Ni e/Ni lo
40. Thawktu te biak an nuam em ? : Nuam/Nuamlo
41. Damdawi a thlawnin in dawng thin em ?
: dawng thin/dawng ngailo/a changin
42. Damlo nat dan a zirin hmun dangah
an refer thin em ? : Thin/Thinlo
43. An refer chuan khawiah nge an refer ? : _____

44. ASHA(Acredited Social Health Activist)in vengah a awm em ?

: Awm e/Awm lo/Ka hre lo

45. ASHA an awm chuan nau nei turin ASHA in damdawiinah a hruai thin em ?

: Thin e/Thin lo/ A changin hruai thin/Ka hre lo

46. ASHA-te hi hnathawh kalphung in hrilh hriatna leh training pek thin an ni em ?

: Ni e/Ni lo/A chang changin/Ka hre lo

47. PHC/Sub-centre-in ASHA kal tlangin damlo leh mamawhtu te tan damdawi a thlawna pek chhuah tur a awm em ? : Awm e/Awm lo/A chang changin

48. Citizens' Charter hi Sub-centre-ah damlo te chhiar theih turin Mizotawnga ziak a awm em ? Awm e/Awm lo

49. Sub-center hnathawhah i lungawi em ? : Lungawi/Lungawilo

50. I lungawi chuan, engah hian nge i lungawi (Thai rawh) :

(i)Thianghlimna kawngah
(ii)Thawktute lo dawnsawn danah che
(iii)Thawktute thiamna leh theihnaah
(iv) An service that vangin
(v) Lungawina chhan dang :

_____

_____

_____

51. Sub-center hmasawn nan engte nge pawimawh a i hriat (I duh zat zat thai rawh) :

i) Building tha zawk
ii) Hmanraw changkang zawk dah belh
iii) Thawktu dang dah belh
iv) Damdawi lak tur dah belh
v) Ha entirna dah
vi) Mit entirna dah
vii) Jan Aushadhi Store-Generic medicines zawrhna dah
(Sawrkar approved damdawi tha mantlawm si zawrhna)
viii) Hmasawnna atan i ngaihpawimawh dang te:

_____

_____

Part-II : Zawhna chhangtu mimal nihna hi tumah hriat tir an ni loh mai bakah Research ah hian ziah lan a ni lo vang)

1. Chhangtu hming : _____
   (Chhangtu duh leh duh loh a thuin ziah lan nise)
2. Mipa/Hmeichhia : _____
3. Kum zat : (Thai rawh)
   i) Kum 25 hnuai lam
   ii) Kum 25-35 inkar
   iii) Kum 36-50 inkar
   iv)Kum 50 chunglam
4. Lehkha zir san lam : (Thai rawh)
   i) Graduate leh a chunglam
   ii) HSSLC
   iii) HSLC/Matriculate
   iv) A dangte (sawi chian nise)_____
5. Chhungkaw eizawnna : (Thai rawh)
   i) Loneimi
   ii) Sawrkar hnathawk
   iii) Sumdawng
   iv) Adangte: _____
6. Thlatina Chhungkaw Sum lakluh : (Thai rawh)
   i) 5,000-10,000 inkar
   ii) 10,000-30,000 inkar
   iii) 30,000 chunglam
7. In chhungkua a i dinhmun : _____

In Ration Card Rawng *(Thai Rawh)* : a Var/a Pawl/a Eng

Appendix No.III

Ref:Officials/Health Workers,etc.,

Format-2
Department of Public Administration,Mizoram University
Questionnaire

This Questionnaire has been prepared in connection with data collection for completing M.Phil research Work in the Department of Public Administration,Mizoram University.The data and information collected will be used only for academic purposes and will not be used in any manner by which privacy of the respondents will be revealed.

Sd/- Marie Zodinpuii,

Part I. Date_____

1.Name of the locality : _____
2.Health Sub-center : _____
3.Total population covered by the Sub Centre:_____
4.Whether the Sub Center functions for 24 hours Yes/No_____
5.Distance (in KM) between Sub center/Sub Center Clinic from the PHC_____
6.Name of the PHC_____
7.Number of female Health Worker-(ANM) - _____
8.Number of male Health Worker- (MPW) - _____
9.Number of Attendant/Fourth Grade_____
10.Others_____
11.Designated government building available for the Subcentre? Yes/ No
12.Type of building? Pucca /Semi-Pucca/Kutchha
13.Are toilets available? Yes/No
14.Is Telephone connection available ? Yes/No
15.Is there a Delivery Bed? Yes/No
16.Is Water Connection available Yes/No
17.Is Regular Electricity Connection Available Yes/No
18.The Blood pressure apparatus is in working condition in the Subcentre? Yes/No

19.Is the Examination table in working condition in the Sub centre?
Yes/No
20.Is there sterilizer instrument in working condition in the Sub centre?
Yes/No/Instruments are sterilized by boiling
21.Is the weighing machine in working condition in the Sub centre?
Yes/No
22.Are the disposable delivery kits available in the Sub centre?
Yes/No
23.Does the Doctor visit the Sub centre ? Yes/No
24.If yes,how many visits in a week/month?_____
25.Are the residents of the village aware of the timings of the doctor's visit?
Yes /No
26.Do other Specialist doctors visit the Sub Centre Yes/No

27.Is the Antenatal care (Inj. T.T. IFA tablets, weight and BP checkup) provided by those in the Sub centre? Yes No
28.Is the facility for referral of complicated cases of pregnancy / delivery available at Sub centre for 24 hours? Yes No
29.Are the immunization services as per government schedule provided by the Sub centre? Yes No
30.Are Vitamin A supplements,IFA tablets/syrup,Albendazole tablets provided by the sub center? Yes/No
31.Is the treatment of diarrhea and dehydration available in the Sub centre?
Yes/ No
32. Is the treatment of minor illness like fever, cough, cold etc. available in the Sub centre? Yes /No
33. Is the facility for taking Peripheral blood smear in case of fever for detection available in the Sub centre? Yes /No
34.Is the facility for urine test available in the Sub Center?Yes/No
35. Are the contraceptive services like insertion of Copper – T, distributing Oral contraceptive pills or condoms provided by the Sub centre? Yes No
36. Do patients have to wait long to get treatment? Yes/No
37. Are there comfortable waiting areas with seating arrangements? Yes/No
38. Do you sufficiently explain and communicate the health condition of the patient,with patience and empathy in a language he/she can understand? Yes/No
39. Do you think it is important to be kind,courteous,attentive and supportive to the patients,as far as possible? Yes/No
40. Depending on the nature of illness,have patients been referred to another health care center? Yes/No/Does not arise

41. If referred to another health care facility,specify where?_____

42. Suggestions to improve PHC Service(Tick)

(i)Better Building
(ii)Provide more advanced equipments
(iii)Increase the number of staff
(iv)Supply of adequate medicines
(v)Provide dental care
(vi)Provide eye care
(vii)Others(Pl.Specify)_____ _____

_____ ____

_____

_____

_____

_____

Part II.Personal Data (Personal Data is never to be shared nor revealed even in research writing)

1.Name of the Respondent(Optional) : _____

2.Designation of the Respondent(Tick)

(i)ANM
(ii)Health Worker(Male)
(iii)Other_____

3.Gender : Male/Female_____

4.Age Group (Tick)
(i)Below 25
(ii)25-35
(iii)36-50
(iv)Above 50

5.Educational Qualification_____

6. Years of Service:

(i)0-1
(ii)2-5
(iii)More than 5 years

7.Year of joining in the present Sub-Center : _____

8.Position in the family_____

Appendix No.IV

Ref:Officials/Health Workers, etc

Format-2
Department of Public Administration, Mizoram University
Questionnaire

He Questionaire hi Department of Public Administration, Mizoram University hnuaia M.Phil zirlai-research work atan chauha buatsaih a ni a. I chhanna hi thup tlat a ni ang. Khawngaih takin dik tak leh a kim thei ang bera min chhansak turin ka ngen a che.

Sd/- Marie Zodinpuii,

Part-I Date : _____

1. Veng hming :_____
2. Health Sub-centre hming : _____
3. Sub-centre huam chhunga mihring cheng zat :_____
4. Sub-centre hi darkar 24 chhungin mamawhtu tan a dawr theih em ? : Aw/Aih
5. PHC atanga Sub-centre hlat zawng : KM _____
6. PHC hming : _____
7. Hmeichhe Health Worker(ANM) engzat nge thawk ? : _____
8. Mipa Health Worker(MPW) engzat nge thawk ? :_____
9. Attendant/Fourth Grade engzat nge thawk ? :_____
10. Heng bakah hian thawktu dang an awm em ? :_____
11. Sub-center Building hi tu ta nge ? : Sawrkar/Mimal In /NGO Building
12. Eng ang Building/In nge ? : Cement In/Cement ban/Thing In
13. Inthiarna a awm em ? : Awm/Awmlo
14. Telephone connection a awm em ? : Awm/Awmlo
15. Nauneihna khum a awm em ? : Awm/Awmlo
16. Tui connection a awm em ? : Awm/Awmlo
17. Current a awm tha em ? : Awm tha/Awm tha lo
18. Blood Pressure(B.P) check-na hman tlak a awm em ? : Awm/Awm lo

19. Damlo mutna-Examination Table
hman tlak a awm em ? : Awm/Awmlo
20. Hmanraw tih thianghlimna Sterilizer Instrument hman tlak
a awm em ? : Awm/Awmlo

21. In bukna-Weighing Scale
Hman tlak a awm em ? : Awm/Awmlo
22. Disposable delivery Kits-
Kutkawr, Syringe, etc. a awm em ? : Awm/Awmlo
23. Doctor a lo kal thin em ? : Kal thin/Kal ngailo/Kal zeuh zeuh
24. Kar khatah vawi engzat nge
Doctor a lo kal thin ? : _____
25. Doctor lo kal hun tur hi mipui
hriattir an ni em ? : Hriattir/Hriattir lo/A changin hriattir
26. Thiambikna nei- Doctor Specialist
dang an lo kal thin em ? : Kal thin/Kal thin lo
27. Raipuar tan B.P leh Taksa rih lam endikin
Tetanus(T.T) injection, Vitamins-IFA Tablets, etc.
te pek thin a ni em ? : Pe thin/Pe ngailo
28. Rikrum thulhah naupai lama harsatna nei tan englai pawhin zan lamah pawh
tanpuitu tur emaw nau neihna tur a awm em ? : Awm/Awmlo
29. Hri danna-Immunization-te hi a hun takah
Sub-center hian a pe thin em? : Pe thin/Pe lo/a hun tak nilo ah a pe thin
30. Vitamin-A supplements, IFA Tablets/Syrup, Albendazole, etc.
lak tur a awm em? : Awm/Awmlo /a changin awm
31. Kawthalo enkawlna-ORS hi Sub-centre-ah
lak tur a awm em ? : Awm/Awmlo /a changin awm
32. Hritlang, Khuh, Khawsik leh Natna tlanglawn
damdawi lak tur a awm em ? : Awm/Awm lo/A changin awm
33. Thisen Test-na a awm em ? : Awm/Awmlo
34. Zun Test-na a awm em ? : Awm/Awmlo
35. Indanna heng-Insertion of Copper–T, Distributing Oral Contraceptive Pills
leh Condoms te a awm em ? : Awm/Awmlo
36. In entir turin nghah rei a ngai em ? : Ngai/ngai lo
37. Nghah chhunga thutna tur a awm em ? : Awm/Awmlo
38. Uluk takin damlote hriatthiam theih turin natna dinhmun hrilhfiah a ni em ?
: Ni e/Ni lo
39. Thawktu ten damlo inentir te tha taka an lo dawn sawn hian damlote tan a
tangkaiin I hria em ? : Hria e/Hrelem lo
40. Damlo nat dan a zirin hmun dangah

an Refer thin em ? : Thin/Thinlo

41. Refer chuan khawiah nge refer an nih ? : _____

44. ASHA(Acredited Social Health Activist)in vengah a awm em ?

: Awm e/Awm lo/Ka hre lo

45. ASHA an awm chuan nau nei turin ASHA in damdawiinah a hruai thin em ?

: Thin e/Thin lo/ A changing hruai thin/Ka hre lo

46. ASHA-te hi hnathawh kalphung in hrilh hriatna leh training pek thin an ni em ?

: Ni e/Ni lo/A chang changing/Ka hre lo

47. PHC/Sub-centre-in ASHA kal tlangin damlo leh mamawhtu te tan damdawi a thlawna pek chhuah tur a awm em ? : Awm e/Awm lo/A chang changin

48. Citizens' Charter hi Sub-centre-ah damlo te chhiar theih turin Mizotawnga ziak a awm em ? Awm e/Awm lo

49. Sub-centre-a Health record siam hi PHC atangin Kar tin an rawn endik pui thin em ? : Thin e/Thinlo/A chhangin

50. Sub-centre-a Health record in siam hi Medical Officer/Doctor-in Thla tin an rawn endik pui thin em ? : Thin e/Thinlo/A chhangin

51. Local/Village Health Sanitation and Nutrition Committee ten Sub-centre hnathawh an enpui thin em ? : Enpui thin e/Enpui lo/A chang changing enpui thin

52. Sub-center hmasawn nan engte nge pawimawh a i hriat (I duh zat zat thai rawh) :

i) Building tha zawk
ii) Hmanraw changkang zawk dah belh
iii) Thawktu dang dah belh
iv) Damdawi lak tur dah belh
v) Ha entirna dah
vi) Mit entirna dah
vii) Jan Aushadhi Store-Generic medicines Zawrhna dah
(Sawrkar approved damdawi tha mantlawm si zawrhna)
viii) A dang te: _____

_____

_____

_____

_____

_____

_____

Part-II : Zawhna chhangtu mimal nihna hi tumah hriat tir an ni loh mai bakah Research-ah hian ziah lan a ni lo vang.

1. Chhangtu hming : _____
   (Chhangtu duh leh duh loh a thuin ziah lan nise)
2. Nihna/Designation : Thai rawh
   i) ANM
   ii) MPW
   iii) A dangte(sawi chian nise) _____
3. Mipa/Hmeichhia : _____
4. Kum zat : (Thai rawh)
   i) Kum 25 hnuai lam
   ii) Kum 25-35 inkar
   iii) Kum 36-50 inkar
   iv)Kum 50 chung lam
5. Lehkha zir : (Thai rawh)
   i) Graduate emaw a chung lam
   ii) HSSLC
   iii) HSLC
   iv) A dangte(eng ang chiah nge sawifiah nise)_____
6. Service Kum : (Thai rawh)
   i) Kum 0-1
   ii) Kum 2 atanga kum 5
   iii)) Kum 5 aia rei
7. Hemi Sub-centre i thawh tan kum : _____
8. In chhungkua a i dinhmun : _____

BIO-DATA OF THE CANDIDATE

Name of the candidate	:	MARIE ZODINPUII
Degree	:	M.Phil
Department	:	Public Administration
Title of the Dissertation	:	Primary Health Care Delivery Services in Aizawl : Functions and Challenges.
Date of Admission	:	10.08.2017
Commencement of the Dissertation	:	03.05.2018
Approval of the Research Proposal		
1.B.o.S in P.A	:	20.04.2018
2.S.S.S Board	:	03.05.2018
Registration No.&Date	:	Regn.No:MZU/M.Phil/468 of 03.05.2018
Due Date of Submission	:	12.12.2018
Extension(if any)	:	NIL

(Prof.SRINIBAS PATHI)

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PRIMARY HEALTH CARE DELIVERY SERVICES IN AIZAWL: FUNCTIONS AND CHALLENGES

ABSTRACT

M.Phil Dissertation

Submitted by

Marie Zodinpuii

Regn.No:**MZU/M.Phil/468 of 03.05.2018**

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Prof. Srinibas Pathi

Professor of Public Administration

DEPARTMENT OF PUBLIC ADMINISTRATION

School of Social Sciences

MIZORAM UNIVERSITY

Aizawl, Mizoram

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Introduction

Health is of crucial importance for the advancement and development of a nation since, development, in its ultimate analysis is about improving the well being of the people and opening out opportunities to them for a richer, happier,healthier and more varied life. Of the many factors that contributes towards a richer, happier and fuller life, health ranks very high. In terms of resources, nothing can be of higher value to a nation than the health and well-being of the people.In this context the report of the Commission on Macroeconomics and Health(MCH)[1] published by the WHO established the link between health and wealth by arguing that healthy people generate wealth,and ill health and disease significantly impact the growth momentum.In an ageing world,India's 40 percent young and productive population can be,and is,an enviable advantage,but only if they are healthy.Sick people do not produce wealth.[2]

Healthcare covers a broad spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis and treatment and rehabilitation. The term health services imply organisation, delivery, staffing, regulatory and quality control [3].Primary Health Care is the first and foremost level of contact of individual, family and community with the health system of the state. It forms the base of all health care delivery services in a country and is most effective and closest to the people Primary health care (PHC) is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford.

[1]JeffreyD.Sachs,'*Macroeconomics and Health: Investing in Health for Economic Development*'(Geneva:WHO,2001)
[2]K.S. Rao (2017), ' *Do we care? India's Health Care System*', New Delhi, Oxford University Press.preface x.
[3] B.Thangdailova (2003) '*Modernization of Health Care Services in Mizoram*' in R.N Prasad and A.K.Aggarwal (ed.). Modernization of Mizo Society, Mittal Publications, New Delhi,p.30

Primary healthcare is a vital strategy that remains the backbone of health care service delivery.

India was one of the first countries to recognize the value and importance of primary healthcare approach. Long before the Declaration of Alma-Ata of 1978,India adopted a primary healthcare model based on the principle that incapacity to pay should not prevent people from access to health care services. The recommendations of the Health Survey and Development Committee(Also and more commonly known and referred to as The Bhore Committee) Report 1946, gave importance to social orientation of health care services and gave priority to community participation in public health care delivery mechanisms . Community Development Programme was launched in 1952 when first five year plan formulation (1951-1955) was started and health care planning in India was started in a systematic manner. It was envisioned as a multipurpose program covering health and sanitation through establishment of primary health centres (PHCs) and sub-centres to provide health care services nearest to the people, in a manner that could be acceptable and most friendly for them, with their full participation, that could be affordable to them and to the country, at every stage of their development while at the same time respecting their spirit of self-reliance, self-determination and free-will.

With this approach, the country seeks to achieve more meaningful and more equitable distribution of health services. Also it recognises the fact that the people and the community themselves are the makers of their health, because many decisions on health matters are and should be taken by individuals and the family members; and this is particularly significant in the context of India where family bonds are still strong. But to enable them to take correct and sensible decisions in matters of health, individuals in community, and the community itself, as a whole, need to be equipped with knowledge and skills which will help them make informed decisions and exercise their responsibilities for a healthy individual and community

life. Primary Health Care offers a composite package of services through health institutions, health workers, groups and community.[4]

Providing as well as maintaining quality primary health care to large, diverse populations is immensely difficult, and that is certainly true in the case in India. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies, even after six decades of independence, continue to be persistent leading causes of deaths, non communicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are also on the rise .Mental health disorders are also on the increase taking a considerable toll of human lives. The health issues related to elderly population are common due to increase in life expectancy. India has been witnessing rapid urbanization particularly in recent decades. Currently one-fourth of the urban population lives in slums with severely compromised health and sanitary conditions. While the primary healthcare system is struggling to provide services, there is an emerging need for addressing the above mentioned issues. This presents huge challenge to the current primary healthcare delivery services in India.

Primary Health Care in India has been a great challenge because of its diversity and disparity. The current status of Primary Health care (PHC) in India is very grim. Besides low rates of institutionalised delivery and immunization coverage, high maternal and infant mortality rate which is definitely a concern and priority, availability of formal primary care in urban and rural areas particularly is low. Public health System is rigid, appallingly underfunded and inadequate to cater to health-care demands of 1.28 billion population of India. There are gross shortages of skilled health-care workers at primary care level. Whatever little resources are available, they are either overburdened or underutilized.

[4] A.B.Hiramani (2016), '*Health Education in Primary Health Care*', New Delhi,B.R. Publishing Corporation.p.1

Mizoram is one of the states of the Indian Union, which is a participant of the Alma Ata Declaration of 1978. Primary Health Centres and Community Health Centres were started in Mizoram as early as 1966 when there were 3 PHC/CHC in the state, one more was added by year 1972 when it became a Union Territory and over the past, its numbers has steadily increased to meet the increasing demand for primary healthcare services.

After attaining statehood the emphasis was on the increasing and extension of the healthcare establishment. By 2013, there were 64 PHC/CHC and 367 Subcentres. At present there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state.

In Mizoram, the growth of healthcare facilities in the state has been slow. There were two pioneering agencies that started and carried on the health care delivery services in Mizoram; one under the Christian missionaries as charity services and another under the government. Both these agencies have continued to work side by side. The contributions of early Christian missionaries were commendable for the growth and development of modern healthcare system in Mizoram. Dispensaries, which started earlier were gradually replaced by Primary health centre and Community health centre. People living in remote rural areas were provided with simple modern healthcare system like Sub-centre & Sub-Centre Clinics only after Mizoram attained statehood in 1986.

There are 22 rural development blocks in Mizoram. Most of the block headquarters in Mizoram have Primary Health Centre (PHC) or Community Health Centre (CHC).The pattern in the growth of healthcare facilities, reveals a strong urban bias particularly in Aizawl district. Nearly one-third of all health institutions are concentrated in the district. This is mostly attributed to the enormous concentration of population in Aizawl district compared

with the other districts. It must be mentioned here that mere availability of health institutions is not a guarantee of quality healthcare.

There is a need to study, in depth the nature, role and status of primary healthcare delivery services in Aizawl, problems and challenges in primary healthcare delivery mechanism. Therefore, the present study has tried provide an overview of primary healthcare delivery services in Aizawl, identify the problems and challenges encountered and fetch possible suggestions that may contribute towards solutions of the problems and meet the challenges so identified.

Objectives

At this backdrop, the broad objectives of the present research are:

i.to examine the role and functions of Primary Health Care Delivery Services in Aizawl.

ii.to identify the problems and challenges of Primary Health Care Delivery Services in Aizawl.

iii. to suggest remedial measures for effective delivery of Primary Health Care Services in Aizawl .

Scope of the Study

The present study attempts to provide a conceptual overview of primary healthcare delivery services in Aizawl. Efforts were made to study the growth and development of primary healthcare delivery system in Mizoram. For the purpose of health administration and delivery of health services, Aizawl District has been divided into East and West Aizawl District. At present, there are 9 Community Health Centres, 57 Primary Health Centres and 372 Sub- centres & 149 Clinics spreading across the state. In Aizawl, at present, there are 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-

Centre Clinics in Aizawl East. The main focus of the present study is on the administration of primary healthcare delivery services in selected Sub Centres/Clinics as the most peripheral and first contact point between the primary health care system and the community with the objective of exploring their role and functions. The study has further highlighted the problems and challenges concerning the Health Sub-Centres and Clinics in Aizawl and has attempted to provide suggestions arising out of the study. While studying the Primary Health Care Delivery Services in Aizawl, particularly in the selected areas and health units, the indicators and dimensions have been analysed as representatives of the situations in different districts and also in the state of Mizoram, in general. The present study has indicated any kinds of gaps or otherwise which has been looked into with a view to providing possible suggestions for remedial measures as primary health care delivery services contributes to the general well-being of the citizens.

Research Questions

Given the context and the broad objectives of the research, following research questions have been placed for obtaining an adequate answer:

i. What are the role and functions of Primary Health Care Delivery Services in Aizawl?

ii. What are the problems and challenges of Primary Care Delivery Services in Aizawl?

iii. What are the remedial measures for effective delivery of Primary Health Care Services in Aizawl?

Methodology

The present study is an analytical and descriptive study of Primary Health Care Delivery Services in Aizawl. Both Primary and Secondary data has been used. The primary data has been collected from six Sub-Centres & Sub-Centre clinics –Republic Vengthlang Sub Centre Clinic, Zonuam Sub Centre ,Venghnuai Sub Centre, Thuampui Sub Centre, Lawipu Sub Centre Clinic and Chandmari Sub Centre - out of the 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East with the help of Questionaire along with personal interactions with government officials, health care providers, ASHA(Accredited Social Health Activists) and fifty one beneficiaries covering the six health care units. Convenience sampling has been used to represent the functionaries and beneficiaries. The total size of the sample is 69. The secondary data has been collected from published and unpublished works on the related topics, books, articles, journals, publications of the World Health Organisation, Government of India and Government of Mizoram, Web sources also formed an important source of secondary information.

Chapterization

The present dissertation is organised into five chapters.

Chapter I : Introduction

The introductory chapter deals with a brief introduction on the topic, the concept of health and primary health care, importance and significance of the study, a review of different sources of literature, statement of the problem, scope and objectives of the stud ,the Research Questions, Methodology applied and Chapterization of the present study.

Chapter II : Primary Health Care Delivery Services: A Conceptual Study

Chapter II deals with conceptual framework and principles of Primary Health Care Delivery Services from global,national and state perspectives. It discusses elements of Primary Health Care ,the Millenium Development Goals, the Sustainable Development Goals with health related indicators, organising and financing of health care delivery system from the national level, State, Regional, District, Sub-Divisional, Community, Primary and Sub Centre Level, approaches ,strategies and the resourses- human, financial, material and technological-as available or that should be available to the people at the grassroots level.

Chapter III : Administration of Primary Health Care Services in Aizawl: Functions and Role

Chapter III explains the set up of primary health care delivery services in Aizawl, with some information about the genesis and evolution of primary health care in Mizoram in general, and Aizawl in particular highlighting the role played by the Christian missionaries as well as the government. The present status of primary health care delivery service with respect to the essential as well as desirable role and functions performed by the Sub Centres/Clinics existing in Aizawl, as the first point of contact between the people and the health system, is discussed.

Chapter IV : Results and Discussion

Chapter IV deals with results and discussions of the field study focussing on respondents characteristics, manpower availability, availability of infrastructure and facilities, availability of services, standard of services, people's awareness, opinion and satisfaction about the function and role of the Sub Centre/Clinics, as well as the ideas and opinions of the officials

working in the Sub Centres/Clinics, suggested remedial measures as well as the role of ASHAs in service delivery, covering six Health Sub Centres/Clinics in Aizawl.

Chapter V : Conclusion

Chapter V is divided into two parts. The first part covers summary of all the previous chapters- I,II,III and IV. The second part presents a summary of conclusions and attempt has been made to give suggestions regarding primary health care delivery system based on the research findings.

Findings and Conclusions

Field investigation undertaken in six sub centres/clinics located in Aizawl led to the following conclusions:

The Christian missionaries played a huge role in the genesis of primary health care services in Mizoram State in general. It was the Missionaries who made groundbreaking efforts in promoting modern primary healthcare concept and practices in the Mizo society,

The 41 Sub Centres and 33 Sub-Centre Clinics in Aizawl West and 55 Sub-Centres and 35 Sub-Centre Clinics in Aizawl East, as primary health care units in Aizawl play a essential role in decentralising health care services that helps to reduce morbidity and mortality through prevention and early intervention. The number of Health Sub centres as well as Sub centre clinics in Aizawl have increased significantly over the years. However, mere increase in number of healthcare services across Aizawl does not necessarily ensure sufficient facility for qualitative improvement in primary healthcare delivery services.

Primary health care in the Sub-Centre level are predominantly Reproductive And Child Health(RCH) oriented. Majority of beneficiaries are women in reproductive age group

for (Antenatal Care) ANC and vaccination. The function of the Health Sub-centre/Clinic is largely preventive and promotive, but it also provides a basic level of curative care.

One of the key components of Primary Health Care at the sub Centre level are the Accredited Social Health Activists(ASHAs) who are female community health activists selected from the village and trained to act as an interface between the community and public health system. These ASHAs play a commendable role in Aizawl in educating, providing information and creating awareness on health determinants such as nutrition, basic sanitation and hygiene, existing health services provided by the sub centre/clinic and promoting immunization, referral and escort services for RCH and other health care programmes.

Some of the challenges faced by primary health care centres in Aizawl are;

(i)Unavailability of sufficient infrastructure for efficient delivery of health care services.

(ii)Unavailability of basic facilities like LPG and water connection, and insufficient supply of resourses, critical and essential medicines etc.,

(iii)Unavailability of emergency first aid medical services and materials for care of injury (stitches, suturing ,dressing and allergies etc.)

(iv)ASHAs(Acredited Social Health Activists) operate under some level of stress because the incentives provided to them are not commensurate with their workload.

Suggestions based on the findings are also discussed, some of which include:

(i)accommodating Health Sub-Centres in government buildings so that these health units do not have to rely on contributions made by the community to meet their rent money. The Sub Centres may also be provided with basic facilities like LPG and water connection,good toilet, staff quarters etc and with modern, more advanced instruments in good working conditions.

(ii)the government should ,at the least, ensure sufficient supply of essential and critical drugs in adequate amounts in appropriate dosage forms with assured quality and adequate information. While all medicines should be administered in a timely manner, there are some

(drugs for TB, Malaria, Emergency pills) that must not be omitted or their administration delayed as this can potentially cause harm since adherence is key to effective treatment.

(iii) efforts to make medicines(for minor ailments like fever, diarrhoea, ARI, worm infestation, First Aid etc) more affordable and accessible by opening outlets in the Sub Centre to sell high-quality generic medicines at low prices.

(iii) Paper-based reporting and recording process in the Sub Centre may be replaced by computer based records. There are instances where Report Forms are not available with the Sub centres in sufficient amount and the Health workers have to make photocopies of the forms.

(iv)It may be mentioned that the doctors need to be attached to or be in charge of specific Sub Centres without being shifted frequently so that they may be available to visit the Sub centres/clinics at least once in a month and attend to their positions without any breaks.

(v)The Health and Family Welfare Department may have a more clear and sound policy of posting, transfer or, if more convenient, rotation policy in regard to the doctors.

The present study has a few limitations such as limited span of time for completion of the research work; small area of study i.e., a few areas in Aizawl City; and lack of scope for generalisation and general conclusion. However, these limitations can be overcome in case of future studies with more time, broad area such as the entire state of Mizoram and wider consultation with the stakeholders, study materials and field data to conduct a more meaningful study and arriving at general conclusions with broad based suggestions concerning primary health care services in Mizoram.

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