Chapter 1
Introduction, Scope and Methodology

Public administration existed ever since the humanity started organized living. Though public administration as a systematic study cannot claim a long history yet, its utility in the present day world is well felt and recognized. With the growing importance of governance in the wake of expanding public functions, public administration has assumed highly complex and more specialized nature. The need for better management of public affairs through scientific investigations into government working and training of public employees was voiced by practitioners and academicians alike. An essay by Woodrow Wilson published in 1887 marked the symbolic beginning of a fairly autonomous field of academic of enquiry called Public Administration. As Wilson said, “there should be a science of administration which shall seek to strengthen the paths of government, to make its business less un-business like, to strengthen and purify its organization, and to crown its duties with dutifulness”.1

An all-embracing description of public administration was given by John J. Corson and Joseph P. Harris. As they put it “public administration is decision-making, planning the work to be done, formulating objectives and goals, working with legislature and citizen organizations to gain public support and funds for government programmes, establishing and revising organizations, directing and supervising employees, providing leadership, communicating and receiving communication determining work-methods of procedures, appraising performance, exercising controls and other functions performed by the government executives and supervisors. It is the action part of government, the means by which the purposes and goals of government are realized”.2

In the words of Woodrow Wilson “public administration is detailed and systematic execution of law. Every particular application of law is an act of administration”3. An all inclusive definition was given by F. A. Nigro who said “public administration (i) is a cooperative group effort in a public setting: (ii) covers all the three branches - executive, legislative and judicial, and their inter-relationship (iii) has an important role in the formulation of public policy and is thus part of the political process: (iv) is different in significant ways from private administration: and
(v) is clearly associated with numerous private groups and individuals in providing services to the community.\textsuperscript{4}

Further more public administration can be defined from political, legal, managerial, and occupation perspective. However, its vast scope encompasses whatever the governments do. Public administration cannot exist outside of its political context. It is this context that makes it public - that makes it different from private or business administration. Public administration is what a state does. It is created by and bound by the law and is an instrument of the law. It is inherently the execution of public law. Every application of general law is necessarily an act of administration. Its legal basis allows public administration to exist, but without its management aspect, not much of public’s business would get done.

Public administration as an academic field is the study of the art and science of management applied to the public sector but it traditionally goes far beyond the concern of management and incorporates as its subjects matter all of the political, social, cultural, and legal environments that affect the running of public institutions. It is inherently cross-disciplinary, encompassing so much of other fields - from political science to sociology to business administration and law.\textsuperscript{5}

**Turning Points of Public Administration**

Regardless of instability, confusion and turbulence, today public administration as a field of systematic study and as an aspect of governmental activity had grown to a commanding stature. In course of time, many new fields have come up in the recent past which has widened the horizons of public administration. Some of the important areas are like comparative public administration, development administration, international administration, area administration, new public administration, administrative ethics, infrastructure administration, etc. Yet, the New Public Administration movement marked a turning point in the growth of the discipline in the late 60s in USA. Young American scholars pioneered a new movement in American public administration which came to be known as the ‘New Public Administration’. The scholars gathered at Minnowbrook which was also called Minnowbrook Conference held in 1968 under the patronage of Dwight Waldo and challenged the ‘givens’ of orthodox public administration and pluralist political science.\textsuperscript{6}

The features of New Public Administration included relevance, values, equity and change which were debated in the Minnowbrook Conference. The participants of
the conference wanted that public administration should be value-loaded to take care of social justice or equity and thus help the underprivileged. Organization should be design to promote loyalty and programme loyalty. It was stressed that public administration must attend to societal problems.  

However, a latest paradigm in the evolution of public administration came into being in the 1990s, known as ‘New Public Management Perspective’. The New Public Management represented the second re-invention in public administration, the first being the New Public Administration of the 1960s. The basic theme was based on 3 Es - efficiency, economy and effectiveness. It emphasized on performance-appraisal, managerial autonomy, cost-cutting, financial incentives, output targets, innovation, responsiveness, competence, accountability and market orientation.

After analyzing the definitions and meanings and the evolution and the growth that took place in the public administration one comes to conclusion that public administration basically focused on overall socio-economic development including health which emerged as most vital and important aspect of the Public Administration. As K.S. Dozie rightly said “the promotion and protection of the health of the people is essential to sustained economic and social development and contribution to a better quality of life and to world peace”. Thus, it is no exceptional that health and public administration are reciprocal and complementary. Without health, public administration can hardly flourish because the core mechanism of public administration is man, with a good health. On the other hand public administration may increase means and opportunities for better health.

Health Administration as a branch of public administration which deals with matters relating to the promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health of health manpower and the medical education and training. The purpose of public health administration is to provide total health services to the people with economy and efficiency.

Efficiency in health care administration can be achieved through proper policy formulation and its implementation. Health administration is the force which can help the health system in the formulation of sound health policy and its implementation. One of the best definitions of health administration is given by C.E.A. Winslow, define as “the science and art of preventing diseases; prolonging life, promoting health efficiency through organized community effort for the sanitation of the
environment, the control of communicable diseases, the education of the individual in personal hygiene, the organization of medical and nursing diagnoses and preventive treatment of disease, the development of social machinery to ensure to every citizen a standard of living adequate for the maintenance of health. So organizing these benefits as to enable every citizen to realize his birthright of health and longevity. Thus, public health administration is the application of administration process and methods which are used in carrying out the objectives of health in an organized community.

As a scope of health care administration, health administration is concerned with ‘what’ and ‘how’ of the health. ‘What’, is the subject matter, covering preventive, promotive, curative and rehabilitative services it also covers professional training of the health and the medical personnel and the role of the international health administration and its impact on the national health administration. It is very difficult to classify the subject matter of health administration in watertight compartment. We have to focus on the integrated philosophy of health.

The health administration studies all aspects for the delivery of health care services. In this context health administration studies the role of public, private, and voluntary efforts in meeting health challenges. Health administration also studies the structure and functioning of international health administration, government administration at all levels, private administration and voluntary administration which help the people in improving their health status.

**Health administration in India**

Health service and health administration in India on modern lines are just over a century old. Prior to the advent of the British, the modern system of medicine was not known in India but the idea of public health even in its present connotation was not absent in the country, for the concept of health is as old as the Vedas (6000 B.C.), one of its important components being Ayurveda. At this time, the causes of disease being little known or mysterious, the emphasis was on the maintenance of health and prevention of disease and so evolved one of the best treatise in hygiene ever written mainly, Manu’s laws of personal and community hygiene. These laws had the religious sanction and were, therefore, widely practiced and were handed down from generation to generation ever since. It was the Hindu philosophers who realized that for emancipation of the soul that reside in the body, both body and mind should be kept in perfect health condition. The first seed of public health administration in India was sown in 1859 when the political administration of the country was taken over.
from the East India Company by the British Crown. A high death rate among the Europeans drew the attention of the British Parliament which led to the establishment of a Royal Commission to enquire into the reasons of such heavy mortality amongst both military and civil population. These Commissions started their operations in 1864 to improve the health, primarily of the military and secondarily of the civil population.12

**Health – A concept**

Health like happiness is an elusive concept. Several definitions exist, but none is entirely satisfactory, and it is curiously difficult, for professionals and layman alike, to answer the seemingly simple questions such as what is health? Who is healthy? To the layman, health implies as “absence of disease” “a sound mind in a sound body in a soundly family, in a sound environment”. Yet, the widely accepted definition of health is that given by the World Health Organization (1948) which stated: “health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity”.13 The Webster’s Concise Dictionary defines health as “the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain”14. The Oxford English Dictionary further stated health as “Soundness of body or mind: that condition in which its functions are duly and efficiently discharged”.15 Nevertheless the Perkins English Dictionary also defined health as “a state of relative equilibrium of body and function which results from its successful dynamic adjustment interplay between body substance and forces impinging upon it but an active response of body forces working toward readjustment”.16

The First Five Year Plan, stated that “health as a positive state of well-being in which harmonious development of mental and physical capacities of the individuals lead to the enjoyment of a rich and full life... it implies adjustment of the individuals to his total environment physical and social”.17 Thus, health is clearly not the mere absence of disease. Good health confers on a person or groups’ freedom from illness and the ability to realize one’s potential. Health is therefore best understood as the indispensable basis for defining a person’s sense of well being.

**Legal aspects of health**

Health care as a right to every individual has been recognized in many countries. In 1948, the general assembly of the United Nations adopted the “Universal Declaration of Human Rights”. The declaration consists of 30 articles and recognized that “All human beings are born free and equal in dignity and rights”. The preamble to
the Constitution of WHO also sets forth the basic principle: “the enjoyment of the highest attainable standard of health is one of the fundamental of race, religion, and political belief, economic or social condition”.

Further, this right has been included in the Constitution of India in Part IV, under the “Directive Principles of State Policy”. Particularly, the Article 47 stated that “the state shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties”. These trends have resulted in a greater degree of state involvement in the management of health services; and the establishment of nation-wide system of health care services.

**Concept of health care**

Health care is an expression of concern for fellow human beings. It is defined as a “multitude of services rendered to individuals, families or communities by the agents of the health services or professionals, for the purpose of promoting, maintaining, monitoring or restoring health”. Such services might be staffed organized, administered and financed in every imaginable way, but they all have one thing in common: people are being “served”, that is, diagnosed, helped, cured, educated and rehabilitated by health personnel. In many countries, health care is completely or largely a government functions.

Health care includes “medical care”. Medical care is a subset of a health care system. The term medical care refers chiefly to those personal services that are provided directly by physicians or rendered as a result of physician’s instruction”. Health care has been characterized into; appropriateness, comprehensiveness, adequacy, availability, accessibility, affordability and feasibility.

**Levels of health care**

Health care service is divided into three levels, viz. primary, secondary and tertiary care levels. These levels represent different types of care involving varying degree of specialization and complexities.

1. **Primary care level**

   It is the first level of contact of individuals, the family and community with national health system, where “Primary Health Care” is provided. As a level of care, it is close to the people where most of their health problems can be dealt with and resolved. It is at this level that health care will be most effective within the context of the area’s needs and limitations.
2. **Secondary care level**

The next higher level of care is the secondary health care level. At this level more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals and community health centres which also served as the first referral level.

3. **Tertiary care level**

The tertiary level is a more specialized level than secondary care level and requires specific facilities and attention of highly specialized health workers. This care is provided by the regional or central level institution, e.g. medical college hospitals, all India institutes, regional hospitals, specialized hospitals and other Apex institutions.

**Primary health care (Health for All)**

The world health assembly, in May 1977, decided that the main social goal of government and WHO in the years to come should be the “attainment by all the people of the world by the year 2000 A.D of a level of health that will permit them to lead a socially and economically productive life”. This goal has come to be popularly known as “Health for All by the year 2000” (HFA). The essential principle of HFA was the concept of “Equity in Health”, i.e. all people should have an opportunity to enjoy good health.

The concept of primary health care came into lime-light in 1978 following an international conference at Alma-Ata, USSR. This approach has been described as “health by the people” and “placing people’s health in people’s hands”. Primary health care was accepted by the member countries of WHO as the key to achieve the goal of “Health for All” by the year 2000 A.D.

Primary health care was defined as “essential health care and universally accessible to all citizens and acceptable to them through the community and country can afford to maintain at every stage of their development in the spirit of self-determination”. It addresses the main health problems in the community through preventive, curative, promotive and rehabilitative medical and health services. Thus, the delivery of primary health care is the foundation of rural health care system and forms as integral part of the national health system. India is one of the very few countries that had, from the very beginning, planned health services as an integral part of general socio-economic development and health was made a part of it.²¹

The declaration of Alma-Ata stated the primary health care includes at least:
Education about prevailing health problems and methods of preventing and controlling them.

Promotion of food supply and proper nutrition.

An adequate supply of safe water and basic sanitation.

Maternal and child health care, including family planning.

Immunization against infections diseases.

Prevention and control of endemic diseases.

Appropriate treatment of common diseases and injuries.

Provision of essential drugs.

**Primary health care in India**

India, as a signatory to the Alma-Ata declaration, the government of India has been committed in achieving the goals of health for all through primary health care approach which seeks to provide universal comprehensive health care at a cost which is affordable.

Keeping in view the WHO goal of “Health for All” by 2000 AD, the government of India evolved a National Health Policy based on primary health care approach. It was approved by the parliament in 1983. The National Health Policy has laid down a plan of action for reorienting and shaping the existing rural health infrastructure with specific goals to be achieved by 1985, 1990 and 1995 within the framework of the Sixth (1980-85) and Seventh (1985-90) Five Year Plans and the 20 Point Programme. Steps were taken to implement the national health policy objectives towards achieving health for all by the year 2000 AD are described below:

1. **Village level**

To implement National Health Policy at the village level, the following schemes were in operation:

- Local Dais: An extensive programme has been undertaken, under the rural health scheme, to train all categories of local dais in the country to improve their knowledge in the elementary concepts of maternal and child health and sterilization, besides obstetric skills. They are trained for 30 days. These daises are also expected to play a vital role in propagating small-family norm since they are more acceptable to the community.

- Anganwadi worker: ‘Anga’ literally means a courtyard. Under the (ICDS) Integrated Child Development Services Scheme, there is an Anganwadi
worker for a population of 1000. There are about 100 such workers in each ICDS project. The Anganwadi workers are selected from the community and are expected to serve. They undergo training in various aspects of health, nutrition and development for 4 month. Along with village health guides, the Anganwadi workers are the community’s primary link with the health services and all other services for young children.

2. **Sub-centre level (SCs)**

The sub-centre has been the peripheral outpost of the existing health delivery system in rural areas. They are being established on the basis of one sub-centre for every 5000 population in general and one for every 3000 population in hilly, tribal and backward areas. Each sub-centre is manned by one male and one female multipurpose health worker (MPHW).

3. **Primary health centre (PHCs)**

The concept of primary health centre is not new to India. The Bhore Committee in 1946 gave the concept of a primary health centre as a basic health unit, to provide, as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The functions of the primary health centre in India cover all the “essential” elements of primary health care as outlined in the Alma-Ata declaration.

4. **Community health centre (CHCs)**

Community health centres have been established by upgrading the primary health centre, each community health centre covering a population of 80,000 to 1.20 Lakh with 30 beds and specialists in surgery, medicine, obstetrics and gynecology, and pediatrics with X-ray and laboratory facilities. The specialists at the community health centre may refer a patient directly to the state level hospital or the nearest or appropriate Medical College Hospital, as may be necessary, without the patient having to go first to the Sub-Divisional or District Hospital.

**Health programmes in India**

To improve the health of the people, the Government of India has undertaken several measures. One of the prominent measures is National Health Programmes. The purpose of this programme has been to control or eradication of communicable diseases, improvement of environment sanitation, raising the standard of nutrition, control of population and improving rural health. There are around 20 major national
health programmes launched by the Central Government. Some of these programmes which are currently in operation are given below:

1. National Malaria Eradication Programme
2. National Filaria Control Programme
3. National Leprosy “Eradication” Programme
4. National AIDS Control Programme
5. National Goitre Control Programme
6. Pulse Polio Immunization Programme
7. Reproductive and Child Health Programme
8. National Guinea-Worm Eradication Programme
9. Japanese Encephalitis Control Programme
10. National Mental Health Programme
11. National Diabetes Control Programme
12. National Family Welfare Programme
14. National Surveillance Programme for Communicable Diseases
15. Yaws Eradication Programme
16. Maternal Health
17. Dengue Fever Control Programme
18. Kala-Azar Control Programme
19. 20-Point Programme
20. Minimum needs Programme

Health planning in India

The post-independent had a significant event in the history of public health in India. But no doubt, the Alma-Ata declaration on primary health care and the National Health Policy of the government gave a new direction to health planning in India. The guide-line for National Health Planning was provided by a member of committees. The recommendations of the major committees have been given below:

**Bhore Committee, 1946**

A committee with Sir Joseph Bhore as Chairman was appointed by the Government of India in 1943, to survey the health conditions and health organization in the country, and to make recommendations for the future development, the committee submitted in 1946 with comprehensive proposals for the development of national programme of health services for the country. Some of the important
recommendations of the Bhore committee were; integration of preventive and curative services at all administrative levels, major changes in medical education which includes 3 months training in preventive and social medicines to prepare “social physicians”, the development of primary health centres in 2 stages- a) as a short-term measure with primary health centre in the rural areas centering to a population of 40,000 with a secondary health centre to serve as a supervisory, coordinating and referral institution. b) a long-term programme of setting up primary health unit with 75 bedded hospitals for each 10,000 to 20,000 population and secondary units with 650 - bedded hospitals, regionalized around district hospitals with 2,500 beds.

**Mudaliar Committee, 1962**

The Mudaliar Committee was set up by the close of Second Five Year Plan (1956-61), headed by Dr A.L. Mudaliar, to survey the progress made in the field of health since submission of the Bhore Committee’s report and to make recommendations for future development and expansion of health services. The committee suggested strengthening the primary health centre, sub-divisional and district hospitals.

**Chadah Committee, 1963**

The Chadah Committee was named after its Chairman Dr. M.S. Chadah. The Committee emphasized on strengthening and maintenance of the National Malaria Eradication Programme. They recommended the National Malaria Eradication Programme should be the responsibility of the general health services, i.e. primary health centres at the block level.

**Jungalwalla Committee, 1967**

A Committee known as “Committee on Integration of Health Services” was appointed under the Chairmanship of Dr. N. Jungalwalla. The Committee examined various problems including those of service conditions and submitted a report to the central government in the light of these considerations. The Committee recommended integration from the highest to the lowest level in the services, organization and personnel.

**Kartar Singh Committee, 1973**

A Committee was constituted in 1972 known as “The Committee on Multipurpose Workers under Health and Family Planning” under the Chairmanship of Kartar Singh. The committee was to study and make recommendation on the structure for integrated services at the peripheral and supervisory levels, feasibility of having
multipurpose workers. The committee submitted its report in September 1973. The Committee recommended having “Female Health Workers” and “Male Health Workers”, primary health centre for a population of 50,000, the doctor in charge of a primary health centre should have the overall charge of the supervisors and health workers in his area. The recommendations of the Committee were accepted by the Government of India and were implemented in a phased member during the Fifth Five Year Plan.

**Shrivastav committee, 1975**

The Government of India, Ministry of Health and Family Planning in 1974 set up a ‘group on medical education and support manpower’ popularly known as the Shrivastav Committee. This committee recommended devising a suitable curriculum for training a cadre of health assistants, to enhance the existing medical educational process, development of a referral services complex, establishment of a medical and health education commission for planning and implementing the reforms needed in health and medical education on lines of the University Grants Commission.

**Rural Health Scheme, 1977**

The basic recommendation of Shrivastav Committee was that primary health care should be provided within the community itself through some special trained workers so that the health of the people remained placed in the hands of the people themselves. It was accepted by the Government of India in 1977, which led to the launching of the Rural Health Schemes.

**Five Year Plans**

The Five Year Plans were conceived to rebuild rural India, to lay the foundations of industrial progress and to secure the balanced development of all parts of the country. Recognizing “health” as an important contributory factor in the utilization of manpower and the uplifting of the economic condition of the country, the planning commission gave considerable importance to health programmes in the Five Year Plans and the process started from the First Five Year Plan itself giving earmarked for health programmes. The BCG Vaccination Programme was launched in the country and the National Malaria Control Programme was commenced as part of the First Five Year Plan. However, during the following Five Year Plans there were many notable health programmes which were launched in the country. Smallpox was officially declared totally eradicated. Universal Immunization Programme was launched, Reproductive and Child Health Programme was launched and above all
huge amount of funds were allocated on health and family welfare. The broad objectives of the health programmes during the Five Year Plans have been: control or eradication of major communicable diseases; strengthening of the basic health services through the establishment of primary health centres and sub-centres; population control; and development of health manpower resources.

National Health Policy

The Government of India decided to have a formal National Health Policy for integrated and comprehensive development of health systems in the country. This policy was evolved keeping in view the national commitment to attain the goal of “Health for All” by the year 2000. This policy was presented to the Parliament in 1983 which adopted it and formally known as National Health Policy.

The independent commission on health in India has elaborated the tasks set out by the NHP “to attain the goal of Health for All by the year 2000 A.D.” by establishing an effective and efficient health care system for all citizens especially vulnerable groups like women, children and the under privileged”.

The initiatives taken by the Government in the public health sector have recorded some noteworthy successes. There were some diseases such as Smallpox and Guinea Worm Disease which have been eradicated from the country. Some diseases like Polio has been on the verge of being eradicated, Leprosy, Kala Azar and Filariasis in the near future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. However, the National Health Policy which was formulated in 1983 did not achieve its due objectives however there were some changes in the status of health in the country.

National Health Policy - 2002

The new National Health Policy initiated in 2002 aimed at reviving and energizing the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country. The Government of India planned to increase its contribution to the health sector from 0.9 per cent of the GDP at present to 2 per cent over the next eight years. It has also been recommended to the states to increase expenditure from 5.5 per cent to 7 per cent of their budget by 2005 and further it to 8 per cent by 2010.

The policy envisaged the setting up of an organized urban primary health structure to meet increased health needs. It suggested two-tier structure with the primary health centre providing the first and the government hospital the second tier.
The policy also laid impetus for improvement of the public health infrastructure and suggested revival of the primary health system by providing essential drugs, levying of user charges for certain secondary and tertiary public health care services for those who could afford to pay, expanding the pool of medical practitioners and simplification of the recruitment procedures for contract employment.

The policy highlighted a special role for the private sector for providing health care considering the economic restructuring under way in the country. It also emphasized on improving the ratio of nurse vis-à-vis doctors, the hospital beds and to improve the skill level of nurses. The report said the Government would work towards gradually merging all health programmes under a single field administration.

The policy focused on building up credibility for the alternative systems of medicine, by encouraging evidence-based research to determine their efficacy, safety and dosage and also encouraging certification and quality-marking of products to enable wider popular acceptance of these systems of medicine. Under the overarching umbrella of the national health framework, the alternative systems of medicine – Ayurveda, Unani, Siddha and Homoeopathy – have a substantial role.

The principal common feature covered under the National Health Policy 2002 related to the prevention and control of communicable diseases; giving priority to the containment of HIV/AIDS; the universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services and supplement of infrastructure.

The policy encouraged and to facilitate more medical research, it has suggested that government-funded medical research be increased to a level of one per cent of the total health spending by 2005 and up to 2 per cent by 2010. The policy focused medical research on therapeutic drugs/vaccines for tropical diseases, which are normally neglected by international pharmaceutical companies on account of their limited profitability potential.

Broadly speaking, NHP - 2002 focused on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities.

**Communitisation in Nagaland**

The unique scheme for involving the community was conceived under the stewardship of the then Chief Secretary of the State Shri R.S. Pandey and was launched after the passage of an Act namely Nagaland Communitisation of Public
Institutions and Services Act in 2002. Initially, the scheme focused on three very important areas: Elementary education, grass root health services and electricity management. However, the programme has been extended to three more sectors, namely, water supply, rural tourism and rural roads.

Communitisation of Health and its working in Nagaland

The goal of Communitisation of health institutions is to let the people take ownership of the health care facilities provided by the Government, through their proper management, participation and contribution of their share to make health a reality in their own villages/communities through preventive action and promotive collaboration.

Health, being a basic right of every human being the Government takes upon itself the conscientiousness of making available the health care services to the people. However, the system of function was found inadequate in many areas, particularly in terms of ownership of the welfare services and institutions that are provided for the good of the community. Since health institutions and services are owned and managed entirely by the State Government, the people do not feel any responsibility in either their proper functioning or their management, although they expect good and quality services.

Thus, the process of Communitisation for health service delivery was initiated in the State in the year 2002 under the leadership of the then Chief Secretary of Nagaland Mr. R. S. Pandey to rejuvenate the dysfunctional and deteriorated public institution and services. The concept of Communitisation was to develop a partnership between the Government and Community in which people’s participation formed the backbone of partnership. Rural health institutions were among the first to be initially taken up for Communitisation. Under this concept Village Health institution (VHC), Urban Health Committees (UBC), Common Health Sub-Centre Committee and Health Centre Management Committees (HCMC) were constituted in order to facilitate and strengthen the process of Communitisation.
Table 1.1: Status of Communitisation of Health units:

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<tr>
<th>Sl.No</th>
<th>Year</th>
<th>Health units Communitised</th>
<th>Proposed health units to be Communitised</th>
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<td>2002-2006</td>
<td>Sub-Centres 334</td>
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<td></td>
<td>PHCs 10</td>
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<td>CHCs 1</td>
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<tr>
<td>2</td>
<td>2006-2007</td>
<td>Sub-Centres 63</td>
<td></td>
<td>63</td>
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<tr>
<td>3</td>
<td>2007-2008</td>
<td>Sub-Centres 53</td>
<td>PHCs (functional) 53</td>
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<td></td>
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<td>CHCs 21</td>
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The Table 1.1 indicates the coverage of various health centres since Communitisation till 2009. In the initial year only few health centres were selected on trial basis. However, Communitisation of these few health centres has yielded good responses followed by positive result. Thus in the subsequent years maximum health centres were proposed to communited.

National Rural Health Mission (NRHM-2005)

The National Rural Health Mission have been launched on the 12th of April 2005 by Honorable Prime Minister and was operationalised from the financial year 2005-06 throughout the country, with special focus on 18 states like Bihar, Jharkhand, Madhya Pradesh, Chhatisgarh, U.P, Uttaranchal, Orissa and Rajasthan, and the 8 North-East states including Himachal Pradesh and Jammu and Kashmir.

The main aim of NRHM was to provide accessible, affordable, accountable, effective and reliable primary health care facilities, especially, to the poor and vulnerable sections of the population. It also aimed at bridging the gap in rural health care services through creation of a cadre of Accredited Social Health Activities (ASHA) and improved hospital care, decentralization of programme to district level to improve intra and inter-Sectoral convergence and effective utilization of resources. The NRHM further aimed to provide overarching umbrella to the existing programmes of health and family welfare including RCH-II, malaria, blindness, iodine deficiency, filarial, kala-azar, T.B., leprosy and integrated disease surveillance. Further, it addressed the issue of health in the context of sector-wide approach addressing sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector department i.e. AYUSH, women and child development, sanitation, elementary education, Panchayati Raj and rural development. At the district and
village level, the institutional framework of the total sanitation campaign has been integrated with the district health mission and village health and sanitation committee. The mission further sought to build greater ownership of the programme among the community through involvement of PRI, NGOs and other stakeholders at national, state, district and sub-district levels to achieve the goals of NPP 2000 and NHP.

Features of Nagaland State

Nagaland state was officially inaugurated on December 1, 1963 as the 16th state of India. Physically the state of Nagaland has been roughly triangular in shape, having an area of 16,579 kms. It is one of the North-eastern states of India, sharing an international border with the adjacent country of Myanmar on the extreme south-east. The state lies between 25° 6’N and 27° 4’N latitudes and between 95° 20 ‘E and 95° 15 ‘E longitudes. Nagaland is bounded by the states of Arunachal Pradesh on the North, Manipur on the South, Myanmar (Burma) on the East and Assam on the West.

Geopolitically, Nagaland is a sensitive state as China lies close to it in the north, Bangladesh on the west with Myanmar alongside, Thailand on the east where the valley of Bangladesh, Myanmar and Thailand merge together forming a common valley known as the ‘Golden Triangle’ which has been located on the heels of Nagaland. This valley served as the central meeting point for these three nations with their respective smuggled goods of all kinds of merchandise.

Nagaland is a hilly mountainous state with its peaks Saramati (3840 metres) in Tuensang district, Japfü (3014 metres) in Kohima district, Zanûbou (2750 metres) and Küpamedzû (2620 metres) both in Phek district. The plain area of the state is limited to Dimapur, Jalukie and adjoining areas with Assam comprising of only 8 per cent of the total area of the state. Kohima, the capital of Nagaland is situated at 1444 metres above sea level.

Nagaland has a pleasant climate. The climate of Nagaland is generally cool in winter and pleasantly warm in summer especially in the interior places and higher hills. In winter the night temperature goes down varying from 4° c to 1° c in the month of December, January, and February which are the coldest months in the year. The temperature does not rise beyond 32° c and the average summer temperature is 22° c to 27° c.

Inception and Introduction of Health Department

The history of Health and Family Welfare set up dates back to even before India’s independence during the British period. At that time there were already 3
hospitals and 6 dispensaries. In 1959 when the Naga Hills and Tuensang Area of North East Frontier Agency (NEPA) was carved out under a Commissioner, the Health Services organization was placed under the Inspector of Civil Hospitals and Prisons at Kohima, with 3 (three) District Medical Officers (DMO) positioned at Kohima, Mokokchung and Tuensang.

At the time of Nagaland attaining Statehood in 1963, a proper Directorate of Health Services was put in position with Lt. Col. S.M. Das was the first Director of Health Services, Nagaland with one Deputy Director and 3 Civil Surgeons at Kohima, Mokokchung and Tuensang. At that time there were 27 hospitals, 30 Dispensaries with total bed strength of 585.

**Status of health in Nagaland**

There are major health problems in Nagaland such as diarrhea, parasite infection and other water borne disease due to non-potable drinking water and bad sanitation. Anemia, respiratory disease, malaria, alcohol related morbidity, IV drugs abuse, HIV specifically MCH and T.B. are the main diseases and problems faced by the people of the state. Inspite of this, out reach of services is not very adequate due to the reason that many institutions have no doctors, and other supportive staff in position or staff not staying at the place of posting. Most of the health care institution were curative in nature without out-reach of PHC component. The department of Health and Family Welfare is only focusing on curative aspect of health care rather than on preventive care.

Some of the features and characteristics of Nagaland state have been discussed below.

<table>
<thead>
<tr>
<th>Table 1.2: Geographical Feature of Nagaland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total area</strong></td>
</tr>
<tr>
<td><strong>State capital</strong></td>
</tr>
<tr>
<td><strong>Population</strong></td>
</tr>
<tr>
<td><strong>Density of population</strong></td>
</tr>
<tr>
<td><strong>Sex ratio</strong></td>
</tr>
<tr>
<td><strong>Literacy</strong></td>
</tr>
<tr>
<td><strong>Sex ratio among 0-5 group</strong></td>
</tr>
<tr>
<td><strong>Population 0-1 age group</strong></td>
</tr>
</tbody>
</table>

The Table 1.2 presents some of the basic facts of Nagaland. The total area of the state is 16,579 per kilometer² with a population of 19,80,602 according to 2011 census. The density of population was 119 per kilometer² with a sex ratio of 931.
female per 1000 male and literacy rate was 80.11 per cent, where the male fare with 83.29 per cent as against female with 76.69 per cent.

Table 1.3: Health profile: A comparison of the State’s position with the National figures

<table>
<thead>
<tr>
<th>Some Key indicators</th>
<th>Nagaland</th>
<th>All India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate (TFR)</td>
<td>2.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Crude Birth Rate (CBR)</td>
<td>17.3</td>
<td>22.5</td>
</tr>
<tr>
<td>Crude Death Rate (CDR)</td>
<td>4.8</td>
<td>7.3</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>23/1000</td>
<td>47/1000</td>
</tr>
<tr>
<td>Under – five Mortality rate (children)</td>
<td>63.8</td>
<td>94.9</td>
</tr>
<tr>
<td>Maternal Mortality Rate (MMR)</td>
<td>249</td>
<td>212</td>
</tr>
<tr>
<td>Women who received Ante-natal check up</td>
<td>23.1</td>
<td>43.8</td>
</tr>
<tr>
<td>Births assisted by Health professional</td>
<td>32.8</td>
<td>42.8</td>
</tr>
<tr>
<td>Birth delivered in medical institution</td>
<td>17.8</td>
<td>33.6</td>
</tr>
<tr>
<td>Contraceptive Prevalence per cent</td>
<td>30.3</td>
<td>48.2</td>
</tr>
<tr>
<td>Unmet need of Contraceptives</td>
<td>30.2</td>
<td>15.8</td>
</tr>
<tr>
<td>Total demand for FP</td>
<td>60.5</td>
<td>64.0</td>
</tr>
<tr>
<td>Exposed to FP message</td>
<td>64.4</td>
<td>59.9</td>
</tr>
<tr>
<td>Discussed FP with husband/someone</td>
<td>65.2</td>
<td>42.4</td>
</tr>
<tr>
<td>Children who received all immunization</td>
<td>44.2</td>
<td>42.0</td>
</tr>
<tr>
<td>Women reporting a reproductive health problem</td>
<td>45.6</td>
<td>39.2</td>
</tr>
<tr>
<td>Women with any anemia</td>
<td>NA</td>
<td>25.9</td>
</tr>
<tr>
<td>Children with any anemia (6-35 months)</td>
<td>43.7</td>
<td>74.3</td>
</tr>
<tr>
<td>Household with piped/hand pump drinking water</td>
<td>40.5</td>
<td>77.9</td>
</tr>
</tbody>
</table>


The Table 1.3 indicates a health profile with a comparison of the state position and the National figures during 2010-2011. The figure shows that the status of health of the State falls below the national figure. Health need to be considerate in the state of Nagaland particularly in the area of birth rate, infant mortality, maternal care, couple protection, immunization and Family Planning.

Table 1.4: Health unit services in Nagaland

<table>
<thead>
<tr>
<th>District Hospitals</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Centres (CHCs)</td>
<td>21</td>
</tr>
<tr>
<td>Primary Health Centres (PHCs)</td>
<td>126</td>
</tr>
<tr>
<td>Sub – Centres (SCs)</td>
<td>396</td>
</tr>
<tr>
<td>TB Hospital</td>
<td>2</td>
</tr>
<tr>
<td>Mental Hospital</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Annual administrative report 2010-2011

The Table 1.4 reveals various health units in Nagaland. There are 10 district hospitals, 21 Community Health Centre (CHC), 126 Primary Health Centre (PHC), 396 Sub-centre, 1 TB hospital and 1 Mental Hospital.

National Health Programmes: Nagaland

There were some programmes in the state which have been in operation in the region due to the fact that quite a good number of patients related to that programmes were available in the state. For instance, the case of malaria, it outbreak every year in
the region, in the case of Pulse Polio Immunization, it has been in operation all over India. Similarly, Revised National Tuberculosis Programme, National AIDS Control Programme and Reproductive and Child Health Programme have been operative in the state. Some of these programmes are discussed below:

**National Malaria Eradication Programme**

The Government of India launched National Malaria Control Programme in April 1953. The programme was in operation for five years (1953-58). During this period, the programme was very successful that the case of malaria drop to 2 million cases which were 75 million just 5 years back. Witnessing the spectacular results, The Government of India, Ministry of Health changed the strategy to be more comprehensive than National Malaria Control Programme. So, National Malaria Eradication Programme was launched in 1958. The strategy was highly successful and the cases were decline to about 1 million and deaths due to malaria were eliminated by 1965-66. However, the cases of malaria mount to a peak of 6.4 million cases in 1976 due to financial and administrative constraints. In 1977, the Modified Plan of Operation (MPO) was launched with the immediate objective to prevent deaths and reduce morbidity due to malaria. The programme was integrated with primary health care delivery system.

An ample responsibility was given to the state governments for planning implementation and monitoring of the programme. The North-Eastern states have been provided cent percent support for programme implementation including operational costs. Malaria cases have declined to 1.6 million in 2003 since the implementation of Malaria Control Project in 1997. It has been found that North-East states comprises only 4 percent of the country’s population, 8 per cent of malaria, 7 per cent of Plasmodium Falciparum (PF) cases and 16 percent death due to malaria were recorded in this region of the country. In Nagaland the National Malaria Control Program has worked successfully since its inception. There were collection of blood slides, spray operations and conducting re-orientation training were the main activities. Some of the achievements made under this program are: Spray (total population covered) 13,00,000; Spray (total rooms covered) 7,00,000; 200 drug distribution centres opened; Re-Orientation training to medical Officers i.e. PHCs 25; Re-Orientation training to others, viz. Lab. Technicians and SWs/PFWs 65.
Revised National Tuberculosis Control Programme (RNTCP)

The Government of India launched Revised National Tuberculosis Control Programme on 26 March, 1997 using DOTS Strategy. The revised programme was proposed to execute throughout the country in a phase manner during the Ninth Five Year Plan period, with assistance from World Bank, DANIDA, DFID, USAID, GDF and GFATM. The RNTCP is succeeding and expanding rapidly. By mid-1999, the RNTCP became the second largest DOTS programme in the world. By early 2001, more than one-third of the country has access to the programme. Each month, there are nearly 1 million patient visits to health facilities covered by the RNTCP. Everyday, more than 10,000 Sputum examinations for tuberculosis were done in RNTCP areas and more than 1000 patients were on treatment, saving nearly 200 lives. DOTS is a community-based tuberculosis treatment and care strategy which combined the benefits of supervised treatment, and the benefits of community-based care and support. It ensures high cure rates through its three components: appropriate medical treatment, supervision and motivation by a health or non health workers, and monitoring of disease status by the health services.

The National Tuberculosis Control Programme (NTCP) was launched in the State on 1st December 2002 with twin objectives to achieve and maintain a cure rate of at least 85 per cent among newly detected infectious cases, and to achieve and maintain detection rate of at least 70 per cent of such cases in the population. Since then 2699 patients were put under treatment with 87 per cent of cure rate, 959 new sputum positive cases and 60 per cent of case detected rate.

National AIDS Control Programme

The Government of India launched a comprehensive National AIDS Control Programme in 1987. To implement and monitor closely the various programmes, the Ministry of Health and Family Welfare set up a National AIDS Control Organization (NACO) as a separated wing in 1992. The programme implementation has been completely decentralized to States/UTs. The programme was operationalized on phase wise. The aim of the programme was to prevent further transmission of HIV, to decrease morbidity and mortality associated with HIV infection and to minimize the socio-economic impact resulting from HIV infection.

The National AIDS Control Programme phase II was officially launched on 15th December, 1999. It has been implemented by the NACO with support from World Bank, USAID and the department of International development. The objectives
of the Second phase are: (a) to reduce the spread of HIV infection; and (b) to strengthen the capacity of central/states government to respond to HIV/AIDS on a long-term basis, making people aware about services available in the public health system for the management of RTI/STD, provision of facilities for early detection and prompt treatment. In Nagaland the State AIDS Control Society is the main agency dealing with AIDS cases provided by the Government of India through the National AIDS Control Organization (NACO) where technical management and financial resources are provided to the state for the implementation of the Programme components. Under the State AIDS Control Society 17517 of HIV positive cases have been tested since January 1994 to 2004. There were 339 AIDS cases in Nagaland during 2003-2004 with 226 male and 113 female. Under the AIDS control Programme various programmes were carried out such as Family Health Awareness Campaign (FHAC), School AIDS Education Programme and Condom Promotion.

**Pulse Polio Immunization Programme**

It was launched in the year 1995. Under this programme all children of 0-5 years of age are given two doses of Oral Polio Vaccine (OPV) in December and January every year on fixed day. Ever since around 16 million children have been given polio drops in every Pulse Polio Immunization round. This led to a significant decline in the incidence of Poliomyelitis. The Polio cases have declined from 1,934 during 1998 to 268 in 2001. However in 2001, there was out break of Poliomyelitis in Uttar Pradesh and even in other states. Nevertheless with intensive activities undertaken during 2002 and 2003 Polio virus have shown a significant decline in 2003 with 225 cases reported in 2003. Since then there has been very few cases. India is committed to obtaining polio-free certification by 2007.

**Reproductive and Child Health Programme**

It was launched in 1997 which is operational in the entire country. It has been defined as “people have the ability to reproduce and regulate the fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of material and infant survival and well-being and couples are able to have sexual relations free of fear of pregnancy and of contracting disease”. The programme is mainly offered through primary health infrastructure. The RCH programme incorporates the goals to reduce maternal and infant mortality and morbidity and assure reproductive health and choice, which contributes to
stabilization of population. The programme is supported by the World Bank, European Commission, UNFPA, UNICEF and other bilateral donors.

RCH II was commenced on 1st April 2005, the main objective was to bring about changed in the three critical health indicators. Total Fertility Rate (TFR), Infant Mortality Rate (IMR), and Maternal Mortality Rate (MMR) inconsistent with the goals of enshrined in the National Population Policy 2000 and Tenth Five-Year Plan. The services under this Programme were provided on the basis of Community Needs Assessment (CNA) done at the grass-roots level.

**Phek District: An introduction**

The Phek district was formed in the year 1973 with its headquarter at Phek. The district lies in the South East of Nagaland state with Kohima in the west, Myanmar in the east, Tuensang and Zunheboto district in the North and Manipur in the south with an altitude of 1524 metres. The district is inhabited by Chakesang and Pochury tribes. The district has been subdivided into 5 (five) blocks with 14 (fourteen) administrative centres.

The status of health in Phek district has been considerably fair as compared to other districts. It is also averaging beyond the state health care. Yet, the health standard were quite laidback though there were numerous health programmes in operation such as National Malaria Eradication Programme, Revised National Tuberculosis Control Programme, National AIDS Control Programme, Pulse Polio Immunization Programme, Reproductive and Child Health Programme, National Programme for Control of Blindness, National Cancer Control Programme, National Surveillance Programme for Communicable Diseases etc. Some indicators of the profile of Phek district were illustrated in Table 5.

<table>
<thead>
<tr>
<th>Table 1.5: Basic profile of Phek district</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area</strong></td>
</tr>
<tr>
<td><strong>Total population</strong></td>
</tr>
<tr>
<td><strong>Total No. of villages</strong></td>
</tr>
<tr>
<td><strong>Total No. of R.D. Blocks</strong></td>
</tr>
<tr>
<td><strong>Total No. of household</strong></td>
</tr>
<tr>
<td><strong>Density of population</strong></td>
</tr>
<tr>
<td><strong>Sex ratio</strong></td>
</tr>
<tr>
<td><strong>Literacy rate</strong></td>
</tr>
<tr>
<td><strong>No. of villages with roads</strong></td>
</tr>
<tr>
<td><strong>All weather roads</strong></td>
</tr>
<tr>
<td><strong>Fair weather roads</strong></td>
</tr>
<tr>
<td><strong>No. of villages no Connected with roads</strong></td>
</tr>
<tr>
<td><strong>No. of villages with Water supply</strong></td>
</tr>
<tr>
<td><strong>No. of villages with electricity</strong></td>
</tr>
</tbody>
</table>

Source: Basic Health Profile of villages in Nagaland, Department of Health & Family Welfare
The above Table 1.5 indicates basic health profile of Phek district. The figure indicates that some of them are fairly better comparing with the overall state average such as number of villages with water supply is 95 per cent and number of villages with electricity 100 per cent. The area is 2025 kilometre\(^2\) with a total population of 163294 and with a total of 42,761 households.

<table>
<thead>
<tr>
<th>Table 1.6: Existing Health Units in Phek District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>District hospital</td>
</tr>
<tr>
<td>Community health centre</td>
</tr>
<tr>
<td>Primary health centre</td>
</tr>
<tr>
<td>Sub-centre</td>
</tr>
</tbody>
</table>

Source: Annual administration report 2010-2011

The District Hospital is located in Phek town which is headquarter of Phek district. There are 3 Community Health Centre (CHC), 23 Primary Health Centre (PHC) and 43 Sub-Centre.

<table>
<thead>
<tr>
<th>Table 1.7: Phek District Health Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Particular</td>
</tr>
<tr>
<td>Average family size</td>
</tr>
<tr>
<td>Crude birth size</td>
</tr>
<tr>
<td>Sex ratio</td>
</tr>
<tr>
<td>Eligible couples</td>
</tr>
<tr>
<td>Couple protection rate</td>
</tr>
<tr>
<td>Pregnant women receiving ANC</td>
</tr>
<tr>
<td>Population 0-5 age group</td>
</tr>
<tr>
<td>Sex ratio 0-5 population</td>
</tr>
<tr>
<td>Population 0-1 age group</td>
</tr>
<tr>
<td>Sex ratio 0-1 population</td>
</tr>
<tr>
<td>Children with no Immunization</td>
</tr>
<tr>
<td>Health assisted deliveries</td>
</tr>
<tr>
<td>Infant mortality rate</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
</tr>
<tr>
<td>Crude death rate</td>
</tr>
</tbody>
</table>

Source: Basic Health Profile of Villages in Nagaland, Department of Health & Family Welfare

The Table 1.7 indicates facts and figures of Phek district health indices.

Review of Literature

W. William Stoles (1953)\(^{25}\) emphasized the important of health education from the prospective of well and health of community health. He assumed that the health education integrate individual and community, it led the individual and his community through health education, the individual will learn some relative values in the art of keeping well likewise, it keeps us aware and be prepared of any outbreak of epidemic, great social and economic upheavals. The author also suggested some measures on how to deal with diseases and community health.
M. Barbara Osborn (1964) comprehensively defined the term community health and its historical development. He also states some of the health problems in the United States and the world health. In the second part of the book he deals with various organization agencies and wings which interact and meet the needs of community health.

S.C. Seal (1975) attempted a comprehensive study on health administration in India. He has meticulously explained the very aspects of health and its administration in India. An attempt has been made to describe the existing socio-economic, demographic, and environmental and mortality. He also describes the pattern of health services in India and the principles of health administration. Moreover, this book cover a numerous chapter like available treaties economics of medical care, budget allocation, local health services administration, community development project, municipal health, hospital health administration, health education etc.

S.L. Goel (1984) had published three volumes on health care administration entitle as:

2. Health care administration: Policy making and planning.
3. Health care administration: Levels and aspects.

The first book deals with the nature, scope and role of health care administration and its relationship with socio-economic development. The second book, deals with the process of policy making and planning for health care administration. It discusses the role of different agencies and stages in the formulation of health policy and plan. The third book, analyses the organizational and administrative aspects of health care administration.

A. Geiger (1985) analyzed the limit of health services and the important of social work in the health care services. He says the health services cannot penetrate and cure enormous chronic illness which cannot be cure by medical therapy alone. Moreover, medical intervention in preventive and rehabilitative measures implies a direct contact to the individual professional and personal surroundings, which is hardly possible in the current medical health system whereas so called social work follows a distinct professional ethic establishing a social and physical contact with the individuals have integrated medical health team and implies an expansion of the spectrum of interventions in the therapeutic sector and, above all , in increasing
G. Lachenmann (1985) analyzed the problem faced by the primary health care in the field of human resources development. According to the writer, human resources for primary health care must not only be developed for peripheral services, but that all categories of health personnel must be trained to support these approaches. Human resources should also not be reduced to formal categories and training for the institutional health system, but the productive resource which constitutes the patient and the population in general should be tapped for health.

J. McEwen (1985) discussed about people’s participation in the light of health care. He says that participation in health care is a process whereby a person can function on his or her own behalf in the maintenance and promotion of health, prevention, detection, treatment, care, etc. Participation can be in the form of self-help i.e. active involvement by the individual demedicalisation or deprofessionalisation and democratization, taking responsibility for decision with regard to social policy and health care provision. He further remark government, professionals and individuals to be exponents of the principle of participation but more importantly it is seen that development in participation inevitably are not comprehensively organized since they are frequently the result of individual enthusiasm or concern. If participation is to be effective we have to make full use of new education initiatives, public awareness and the professionals are to accept new responsibility and challenge to meet new needs.

D. Reprovs (1985) highlighted how health education is introduced in secondary schools of social republic of Slovenia, part of Federal Republic of Yugoslavia. The main emphasis of introducing of health education is to create healthy conscious and to be responsible towards the community health. Basing on certain principles like prevention, early detention and active cooperation of the population in treatment and rehabilitation. In secondary schools, health education is considered as a compulsory programme. Keeping in mind that health education can influence their parents and community, learn more about first aid and preventive education and hygienic lifestyle. Various health education approaches, themes and concrete programmes were imparted.

R. Senult and J.P. Deschamps (1985) edited a report by Professor Paccugnella. The report was a reality check on medical education. They view that the
doctors play a wider role in the new concept of health and at the same time the evolution of health problems towards a more psychosomatic and behavioral pathology confirmed the urgent needs for reform. Therefore, he called forth that it is must to change mentalities via medical education.

**Patrick Vaughan, Gill Walt and Anne Mills** (1985) had studied the approaches and activities of primary health care. They also consider four major management issues that all MOH staff must tackle if they are to implement PHC successfully, namely how to plan for better health, to integrate vertical and horizontal programme activities, to budget by programmes and to implement decentralized management. In conclusion they have enunciated that, the district could provide the most effective level for coordinating ‘Top Down’ and ‘Bottom Up’ planning of health services, better inter-Sectoral planning, community involvement and improved co-ordination between government and private health care.

**A.K. Hati** (1986) studied vector problems of malaria in West Bengal in certain pockets of district like Birbhum, Hoogly and Burdwan. It was found that there was reappearance of the malaria case in these areas. He opined that unless the vector problems are solved, malaria cannot be eradicated. It was also found that the larvae of certain other vectors were obtained from the perennial hilly streams, one of the reasons is because of irregular spraying of residual insecticides and development of resistance of multiple insecticides has further aggravated the problems.

**D.N. Kakar** (1988) analyzed on therapeutic of traditional medical practitioners in a community development. He also explains the role of medical practitioners playing in primary health. He also suggested that India as a vast country need to integrate the medical resources to meet primary health to all the rural population.

**Ram Kumar** (1990) published a book in two volumes dealing with various aspects of women’s health development and administration. He also acknowledge women as a key to the provision of health services in the family and society, as a central figure who provides the child care, hygiene, nutrition, and even primary health care. He had studied meticulously and presented for the welfare and development of women.

**Antoine Yangni-Angate** (1991) analyzed how the French speaking countries of Africa have fair the facilities of Health for All. It was found these French speaking countries were facing inconsistent because of economic difficulties and
management problems. There was also lack of commitment personnel’s and well trained personnel’s thus, it was felt the need to introduce proper personnel planning policy, career prospects, in-service training, financial incentives and good working conditions outside the big cities in order to serve the rural areas properly.

Adele M.E. Jones (1993)\(^9\) had analyzed how the community health programmes are felt in the South Pacific countries. The author strongly supported the community health programme can be one of the most important and most available forms of education for the total community. He also outlines health programmes and health education initiatives and an approach to participatory training in the South Pacific countries.

R.P. Goyal (1994)\(^{40}\) analyzed the mortality data spurned by Sample Registration System for the period after 1970 and indicated steady and consistent all round decline in mortality level in India during the last decades. Ever since there was evident of decline in mortality rate irrespective of male and female. It was found that the current mortality level in India is high as compared to several less developed countries of the world.

Alaka Malwade Basu (1995)\(^{41}\) in his article examined some of the ways how a women’s roles can led to gender differences in health and survival in either direction. It is observed that female employment result in more equal treatment of son and daughter, it decrease the gender gap in the exposure and intensity of several diseases among adults. Nevertheless, the broad finding is that where women are economically active, not restricted to the domestic domain and not defined primarily by the number of children they bear, the gender gap in health and survival is smaller than it is for women who cut off from economic independence, cut off from the extra domestic work and independent on their reproductive success for their status.

Jack Jones, Ilona Kickbusch and Desmond O’ Byrne (1995)\(^{42}\) emphasized the importance of schools in imparting health care. They consider creating health; the school emerges as an ideal setting for action. Because schools can help young people to acquire basic skills to create health. It develops life skills which improve lifestyles, school health projects benefit the community, education improves health and health improves learning potential. Nevertheless, school health programme which provides safe and low cost health services and health education is one of the most cost-effective investments that a nation can make to improve health.
Sunita Kishor (1995)43 surveyed on gender differentials in child mortality in order to enable a comprehensive understanding of the nature of excess female mortality in India. The paper also attempted to identify the impact on excess female mortality of factors such as the level of economic development and patterns of demographic change. The study suggested that excess female mortality can be decreased, either by increasing women’s economic activity, especially where male-centred kinship arrangement predominate, or by introducing female-centred kinship arrangements where female economic participation is especially low.

A. K. Shiva Kumar (1995)44 co-related the reason of infant mortality rate in Manipur and Kerala and with other Indian states. Thought it is a customary to examine that lower level infant mortality will be associated with higher levels of incomes. But empirically high levels of incomes need not be a prerequisite for low Infant Mortality Rate. No exceptional, collective action, political awareness, active public participation and responsible for making demands on the government systems is found in the state of Manipur and Kerala. One of the reason of low Infant Mortality Rate in Manipur is the greater enjoyed by women in matter of educational, occupational and marital choices.

Mirta Roses Periago (1995)45 had written a report on health of Tupiza district of Bolivia. She said in the recent past the community of Tupiza district had well catches up with health projects and programmes which had closed the gap on health that separated them from the rest. They took up some strategic lines of action such as strengthening the health district organization, providing essential drugs and other vital materials, training health personnel in primary health care, developing the managerial capacity of the regional and district teams, making better use of resources through social security and public facilities and promoting social participation.

G. Bhaduri (1997)46 examined the ever increasing eye disease and blindness in India. His perception was because of the increasing ageing population. The last few decades has been rigorously developed in nutrition and over all health care system which had led to prolonged once life, thus, age related blindness are on the rise. The author feels that the IEC programme will help to understand current perceptions of common man about cataract, what services are available and where they can be operated. He suggested that effort should be made to improve institutional capabilities for better eye care.
Moran, N.Y. and Malone, M.P. (1997)\textsuperscript{47} cited four major areas of outcomes measurement in which home care agencies must demonstrate the ability to document success: cost/financial, clinical, functional status, and patient satisfaction. Patient satisfaction is also noted as an integral component of outcome measurement.

Shireen J. Jejeebhoy (1997)\textsuperscript{48} analyzed maternal mortality and morbidity in India. The findings have numerous reasons which are unacceptably high and largely avoidable. Socio-cultural is one of the main features, early onset of child bearing, repeated and closely placed pregnancy and without proper medical attention, women’s powerlessness in matters relating to their own lives, inadequate of medical facilities, poor roads and transportation access facilities. One of the health system weakness was safe motherhood programmes; limited outreach, lack of mobility among the young women, lack of coordination among the village health workers and professional health workers, lack of referral system to meet any emergencies. However, it was known fact that mortality levels have declined and gender differentials narrowed in the recent past. Yet, a chasm still exists in maternal health and morbidity within the Indian women. The author remarks the need of social science research on maternal health which will bring closer the gap and bring awareness of poor maternal health and no doubt the government will give more concerned and committed to its improvement.

S. Acharaya Sangmitra (1997)\textsuperscript{49} highlighted the mental shift in the changing perception of development simultaneously the concern for women’s health. The writer emphasizes the need to expand the form of women’s health concern beyond reproductive limits. The women’s vulnerability through sexual transmitted infection especially HIV/ AIDS have disused. Seeing the condition of young and adolescent girl and the mothers, the paper suggested creating awareness among them regarding like sexuality, health care in early ages, and improvement of nutrition. The writer thinks these are the various concern areas to develop and only then the reproductive health can become a meaningful concept.

Samson Rao, Madhukar Pai., A. Iyanar and Abraham Joseph (1997)\textsuperscript{50} analyzed a latrine project in Indian villages. Their finding says the project was not very successful. The reason was lack of planning, execution and mixed response on the project. They suggested to give more effort on educating the community about the value of latrines and to obtain the people’s participation because mass sanitation projects need community participation.
Fernando S. Antezana, Claire M. Chollat-Traquet and Derek Yach (1998) are of the view that the WHO staff at global, country, and regional levels have played a crucial role in supporting member states to carry out wide ranging in achieving the Health for All goals and targets. They also conducted numerous programmes and projects to explore in depth these issues. Yet, the writers feel that to develop the goals and target of Health for All the government of all member states need to support and implement policies which are coherent with the Health for All values.

P.K. Dutta (1998) examined that due to lack of career planning, proper placement and promotional opportunities, there is low moral and job dissatisfaction among different categories of health functionaries especially working in the rural areas. It is felt that there is a need to initiate clear cut action plan to improve motivation, efficiency and performance of health workers. The author feels the rural health services are far from satisfactory. To resolve this problem he urged to establish Education Commission in Health Sciences and University of Health Sciences.

Sindney Ruth Schuler (1999) analyzed two distinct approaches to gender issues into reproductive health projects and the importance of taking gender into account in order to support women’s needs. Navrongo Community Health and Family Planning Project in Ghana and Reprosalud in Peru have implemented these approaches. The men folk and the male community leaders were focused by this project to overcome men’s opposition to women using family planning, while women were visited individually in their homes. However, this approach was later modified when experience showed that gender issues could not be addressed effectively without involving women at the community level more extensively.

Anders Anell and Micheal Wills (2000) analyzed that the most frequently used bases for comparing international health care resources are health care expenditures, measured either as a fraction of Gross Domestic Products (GDP) or per capita. Widespread availability of historic expenditure figures; the attractiveness of collapsing resources data into a common unit of measurement; and the present focus among OECD member countries and other government on containing health care costs. The writer presents a simple framework for comparing data underlying health care systems. This system distinguishes measures of real resources, for example human resources medicines and medical equipment from measures of financial
resources medicines and medical equipment from measures of financial resources such as expenditures.

**Harshit Sinha (2000)** studied of leprosy at micro and macro level, focus on Vadodara district in Gujarat. His study was based on broad canvas, ranging from the casual organism its likely mode or modes of transmission, environmental influence and its spread, person to person and its communities. He illustrated how geographical view point can help in understanding the problem of leprosy and thereby provide the planners and policy makers with an inside to the problem at the grassroots level.

**D.F. Wares, T.D. Sadutshang, N.J. Beeching and P.D.O. Davies (2000)** examined the TB control programme based on the refugee-run Tibetan hospital, Dharamasala. The programme performance of the Tibetan refugee-run has been successful. The success factors are relatively stable refugee population, existence of a programme manual, regular and reliable drug supplies, motivated health workers, programme monitoring, health education to patients and general refugee population. One of the most important factors of success of the programme is funded by overseas donors. However, recently there has been new cases and followed by poor treatment. They urged to upgrade the treatment methods to overcome these problems.

**Shyam Ashtekar (2001)** emphasized the need to develop a rational curative package in the Primary Health Care (PHC) system by resurrecting Community Health Workers (CHW). Taking into account the Indian context, PHC is inseparably linked with the issue of village health workers. This is so because much of the population lives in villages, so the CHW at large is evidence of its indispensable nature. But seeing the ground realities he laments of any alternatives for effective implementation of health care. He proposed an alternative community health worker scheme, operationally managed by the people, who will also make a small financial contribution, but supported largely by the state.

**Debabar Banerji (2001)** discussed the issues concerning health and health services in India within the South Asian context. He highlighted about health development in the pre-independent period and post-independent period. He also traced the evolution of health services in India within the political historiography of the region. He located the current reforms in the disparate nature of health services and powerful policy interest of international capital that prevailed upon the political, bureaucratic and professional elite of the region.
Rama V. Baru (2001) highlighted a cogent overview of the funding of health services at the state level in India and its relationship to Sectoral Adjustment Programmes. She argues that SAPs are transferring the profitable elements of health care into the market, leaving only under-funded and poor quality essential packages for the poor.

S.L. Goel (2001) had compiled four volumes on health care system and management as it deals with:

I) Health care management organization and structure;
II) Health care policies and programmes;
III) Health care management and administration and
IV) Primary health care management.

The first volume deals with health administration organization and working of district hospital, CHCs, PHCs, and SHCs. The second volume deals upon health education and environmental sanitation. It also discussed issues, modifications and strategy of national health programmes. He also analyzes various problems encountered in the implementation of health policy. The third volume deals with the general management in policy making, planning, decision making, supervision, etc. The forth volume deals with the development and management of primary health care.

Yogesh Jain (2001) analyzed the problems and various approaches on anti-malaria therapy. He stated that given the inadequate understanding of Chloroquine and Quinine resistance in the country, the introduction of new drugs such as Efloquine and Artemisinin in the open market is irrational, which is more expensive and less efficacious drugs. He suggested Quinine to be safe and efficacious.

Renu Sobti (2001) analyzed and highlighted the enactment of the Consumer Protection Act, 1986. She reminisce that, the act was passed to create awareness among the people regarding their legal rights as consumers and to protect them against unfair trade practice. The study related to the investigation of patients perception to medical services in India. She also examines the implication of the consumer protection act, 1986 to the medical services and its fall out on patient-doctor relationship. Furthermore, the study evaluates the approach of the redress cases relating to deficiency in medical services.

Anand R. Phadke (2001) analyzed the prescribing practices with a comparison of public and private sectors. In his study conducted in Satara district of
the state of Maharashtra in India shows that the use of medicines in the private sector was more irrational and more wasteful.

**Sushma Chandra** (2002) highlighted some of the features of the National Health Policy. The National Health Policy announced recently aims at reviving the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country. Some of the features are like increase expenditure on health sectors of centre and state, a two-tier structure, funding and upgrading existing government medical colleges, fund for medical research, improving the ratio of nurse vis-à-vis doctors and infrastructure. Amidst of these all development, he also suggested to health authorities in the country to check and pay more attention on excessive drug prices and spiraling cost of health services to provide aid to a vast section of the population in the low income group when they may need these facilities.

**K. Padmaji** (2002) emphasized the importance of health of the people and note to ably the recent past achievement in Kerala state. The writer cited some of the reasons behind this achievement of healthcare in Kerala. Like the extension of primary health centers, preventive health measures against infectious diseases and stress on the expansion of medical care. Perhaps he also spotted the problem about free consultation and user fees for public health care institutions. He supported that charging fees is never a bad idea, reasonable amount may be charged from those beneficiaries who could afford to pay them. Funds raised can be used for the timely repair supplies of essential. Some amount can be set apart for extending free imposing any burden on the government.

**Renu Paruthi and P.K. Dutta** (2002) analyzed Reproductive and Child Health Programme and consider it as an integrated and comprehensive programme based on realistic decentralized and specific micro-planning tailored to meet the local needs. The paper discussed the objectives, strategies and components. It also suggested some mechanisms for the implementation, monitoring and evaluation of the programme.

**Abusaleh Shariff and Geeta Singh** (2002) discussed the issues associated with the demand and supply of the five measures of maternity care-antenatal care, blood pressure check up, place of delivery, use of trained help at all time of delivery and postnatal care. Econometric analyses is undertaken to find out the determinants of the use of reproductive health care services among rural Indian households. Analysis
shows that the education and information variables significantly increase the utilization rates for prenatal, child delivery and postnatal health care.

**S. Srinivasa** (2002) acknowledged health as an essential input for the development of human resources and the quality of life and in turn the social and economic development of the nation, for which he considered primary health care service as an important component in rural India. He also explains the meaning and objectives of primary health care, programmes and policy, health financing, achievements and limitation. Regardless of all the shortcoming and limitation in the recent years, he suggested that to make rural health care services more meaningful to the rural community, it is must to bring about fundamental changes in the focus and approach to the entire health care delivery system in general and rural health care, in particular.

**H. Peters David, K. Sujitha Rao and Robert Fryatt** (2003) felt that India’s health system was designed in a different era, when expectations of the public and private sectors were quite different. They are of the view that all together the India’s population is undergoing transactions in all the aspects of health. The health care, life expectancy, disease and finically has been rampant with disparities. They suggested that with the change of time the content of National Health Policy needs to be more dynamic and diverse for meeting the needs of all the states and districts. They also suggested ‘Splitting’ of India’s health policy at the state level would better address their health problems and would open the way to innovation and local accountability, ‘Lumping’ of policy issues at the central level is also needed, but not how it was in the past. They also suggested focusing on the ever growing disparities on health and tackling growing challenges to health such as the HIV epidemic.

**F. James Levinson, Sucheta Mehra and Dorothy Levinson,** (2003) studied a follow-up 30 years after a classic study carried out in 1971 in Punjab villages indicating changes in nutritional status, mortality, gender discrimination and malnutrition causality which had taken place over this period of rapid economic growth. The findings was laudable seeing improvement as observed over the 30 year period in nutritional status among these young children and the marked reduction in gender disparity with malnutrition among young girls falling to a quarter of earlier levels.

**R.D. Sharma and Hardeep Chahal** (2003) studied dealing with the patient’s satisfaction in the rural area of Jammu district. The various factors
determining consumer satisfaction in rural health service among the outdoor and indoor patients have been empirically studied. For assessing the satisfaction of consumers it has been drawn from three main domains namely staff behavior, physical condition and infrastructure and administrative work. The study shows low patient satisfaction in rural health. They suggested that the patient satisfaction can increase if the health care facilities are efficiently managed and effectively delivered.

Mamata Swain (2003) found that, rural drinking water supply is a public utility delivering a basic service and an essential consumer good’s to the community. So, it is imperative that the ushers should participate in the planning, design, maintenance, construction and operation of the system. The system should be such that demand-oriented focus on what ushers want and are willing to pay for. Keeping in mind the cost recovery aspect of water services has been emphasized for sustainability.

Mohanty Bijoyini (2004) discussed the scope and extent of problems related to health administration in Orissa where the paucity of funds to run government health centre and dispensaries has brought the medical services to a dismal state. Seeing the pathetic condition of health care system the author found it worthy of study. The author also highlighted the health administration in Orissa and its desirability of health sector and health care infrastructure. He also highlighted certain critical issues in medical administration like, inadequate public healthcare system maintenance of qualitative healthcare institution; medical treatment other then public medical institutions and new drugs were beyond scope of provision the state exchequer. He concluded by suggesting some measures for improved healthcare.

Jacob John (2004) highlighted how holistic health practices promote a lifestyle that help to control and manage stress, which is a major cause of most cardiac diseases. They analyzed the case from three angles, namely, preventing disease, promoting health and complementing cure. It was evident from the case studies and the discussion, that holistic approach to health brings about wellness through self-responsibility and self-awareness, because the holistic approach touches the inner core. This gives joy, peace and tranquility which in turn give energy to face the realities of daily life and also to remain healthy.

Monica Munjhal and Poonam Kaushik (2004) analyzed the case of abortions in Punjab based on the data RCH surveyed separately for urban and rural areas. They analyzed intensively for which abortions are seeking, district wise, social-
cultural and demographic variables. In their findings, it was the rural areas who seek more abortion and no exceptional with the other general caste and schedule caste couples. The reason was accessibility, availability, awareness and economic conditions that influenced the decision to continue with pregnancy or to terminate.

K. R. Nayar (2004)\textsuperscript{76} asserted the rural health mission as absence of mission or absence of vision. The country’s public sector health system stands discredited by constant neglect and lack of effective and efficient governance. Added to these cut backs, preferential treatment for the private sector and the lack of epidemiological vision for rural health have added to the misery of public sector services. Thus, in its present form, the proposed rural health mission adds to the confusion about the country’s approach to health care.

Piroska Ostilin, Gita Sen and Asha George (2004)\textsuperscript{77} stated that little research has been done on the social causes of ill-health inspite of disparity in health and poverty. Rather health researchers have focused on Biomedical Research which is very individualistic. The researchers have used two factors – poverty and gender. They feel that there is a systematic imbalance in the medical journals: research into diseases that predominate in the poorest regions of the world is less likely to be published. In addition, the slow recognition of women and men’s health, and the dearth of information on how gender interacts with other social determinants continue to limit the content of health research. These linked into biases against researcher. Researchers from high-income countries benefit from better funding and infrastructure. Their publications dominate journals and citations, and these researchers also dominate advisory boards. Thus, the author finds it’s a high time to correct biases against poverty and gender which he think it is a key to a better life and moving forward.

P. Palani, S. Basha and Ajit Mullasari (2004)\textsuperscript{78} discussed deliberately on the hazard of air pollution which cause chronic diseases specially that air pollution affects the digestive system and liver; and thus reduces high density lipoproteins cholesterol, thereby increasing the risk of coronary artery diseases. He suggested citizen support for clean air programs can help counter industrial pressure to weaken the clean air Act.

Suneetha Kadiyala and Tony Barnrtt (2004)\textsuperscript{79} explained how the epidemic HIV/AIDS had been responded in India. It was found that the medical community has been one of the worst offenders routinely violating confidentiality, stigmatizing and
refusing to treat those tested HIV positive. There was a paucity of research in these issues and were of the view that the politicians, civil servants, the educated, businessman and the community to promote the right of the vulnerable and lead the fight against HIV/AIDS.

Ajit K. Dalai and Subha Ray (2005) highlighted the place of social science in control, treatment and betterment of health in the context of significant research contributions. They also provided an overview of the state of social science literature, particularly in reference to India social context, and bring out some of the factors critical to improving health status and a sense of well-being. They also segmented four sectors that cover most of the areas and disciplines of social sciences such as socio-economic concomitants of health, health services and systems, health care practices and health attitudes and perceptions.

Kenneth H. Cohn (2005) has examined the relationship between the physician and the administrators. The author viewed that better communication for better care provides fresh tools and ideas for overcoming the training, outlook, and culture issues that have plagued physician-administrator relationships. Conflict is inevitable in rapidly changing environments. Recognizing the inherent differences between physicians and executives, he clearly outlines specific tools and methodologies for building stronger relationships. It points out the common ground that will allow both groups to form alliances.

Rajib Dasgupta and Imrana Qadeer (2005) analyzed the concept of the National Rural Health Mission including the role of the Common Minimum Programme and the structural Adjustment Programme. They also examine some of the main features of the NRHM from the perspective of theoretical frameworks of decentralization, integration of programmes, primary health care, community health workers and standards.

Kuldip Kaur and B. K. Pattanaik (2005) had discussed about a case study which they carried out in about 30 villages (Saharanpur district in UP). The study covered extensively in the field of the reproductive, child and community health aspects, also reveals the socio-economic conditions of the schedule caste and backward caste among the Hindus and Muslims in the project area. The authors also studied to ensure the participation of representative of the community in generating awareness about the health and related information, capacity building of the
functionaries of Panchayati Raj Institutions and the district administration on the other.

**B. Hema Malini** (2005) highlighted the importance of spatial data analyses in understanding the distribution patterns of various natural and cultural phenomena and their cause and effect relation and consequent environment implications. The findings for the cause of Goiter was consequence of the non-availability of iodine from the ground water and it was largely influenced by physical factors such as relief, soils, climates, etc. of the region.

**Barun Mukhopadhya** (2005) studied the changing socio-cultural environmental milieu in the eastern Himalayas, specifically in the Sikkim-Darjeeling Himalayan region that bring forth changing community health profile. He addressed that the changing scenario of health needs to be addressed through appropriate health care delivery systems, for which reorientation of primary health care strategy may be necessary.

**Deoki Nandan** (2005) was of the opinion that the NRHM holds a great hope and promises to serve the deprived and underserved communities of the rural areas. He feels that ASHA will play a great role inspite of socio-cultural clusters in the community, which is a novel concept to melt the ice among the various cluster community groups. Regardless of constraints faced by the ASHA and success of cluster community approach in UNICEF supported community bases Maternal Child Health and Nutrition (MCHN) project, it is quit reasonable to state that inclusion of community mobilisers (Bal Parivar Mitra) from within the cluster community group might well be an asset to the programme, who may actually bring about the task of spreading the spirit of NRHM. No doubt, it will at least bring about the feeling of community participation and ownership.

**Snehalata Panda** (2005) focused some health issues faced by the tribal women of Orissa. She assumed that inadequate medical facilities is not only the reason for dismal health condition of tribal women but there are many related problems, such as, socio-cultural factors, nutritional and hygienic awareness, economic reasons etc.

**M.V.S.S. Prakasa Rao** (2005) studied about health care and health services in tribal areas. He assimilated the problems and conditions of health care and health services in tribal areas. Despite the great advances in medical science and technology, and various health programmes, the changes in tribal are less visible rather many
health problems had been pop up in recent past. Realizing these situations, he suggested to select and utilized health technology and the provision of health services. This will make more relevant and appropriate to the needs of the community and the health care system.

A.K. Sharma (2005) analyzed various perspectives on health, illness and well-being. He considered the subject of health was contextualized and subjective which leads to overlapping and multiple perspectives. The author detailed some of the major perspectives such as biomedical or provider’s perspective, people’s perspectives, women’s perspectives, perspective of the sick, health workers perspective etc. He also suggested the need to look at health resources and health ideas from different perspectives because this will provide a fresh insight into the issues related to health and make health management in society more effective.

Bharati Sharma (2005) analyzed the rural health care system of the rural India villages. He says despite numerous programmes and policies initiated by the government of India, there are still disparity and inadequacy in the rural health care system. Thus, to bring changes in the rural health care scenario he found that, cohesive action and participation by all concerned is needed. Without which no reforms in health sector, any policy or programme to improve rural health will have the desire outcome.

R.K. Sharma (2005) conducted a study to find out the level of patient satisfaction at the zonal hospital, Mandi (HP). It was observed that indoor as well as outdoor patients were dissatisfied with most of amenities, cleanliness and behaviour of the staff. Whereas, they were satisfied with behaviour and attention given by doctors to them. The researcher opined that frequent patient satisfaction survey is very essential to know the shortcomings of services provided and to make improvements on the basis of the opinions and suggestions given by patients. Then only it is possible to have a healthy society, which will in turn work for development of the nation.

Abhay Shukla (2005) examined the programme National Rural Health Mission which was declared recently. He was of the view that the programme was a significant move taken by the Government of India. It will enable the public health systems in the rural India to function which have been long overdue and strengthen the weak link. He also assumed it will empowered community to be involved in the planning and utility of health systems. However, Jan Swasthya Abhiyan (JSA) has been involved in analyzing various aspects of the mission.
Sanjanna Bhardwaj (2006)93 highlighted the outbreak of HIV epidemic among the adolescent and young people in India in recent years. The indication of surveillance data reveal that young people are the centre of HIV epidemic, with 50 per cent of all new infections who are below 29 years and 22 per cent in adolescent age between 10-19. Unmet education in inadequate health services, cultural norms and taboos, lack of knowledge, low status of women and girls, lack of supporting environment in the family and community context and absent of enabling and supportive environment are considered some of the vulnerability factors of HIV(epidemic) infection among the (young India) youth. The columnist also discussed some programmes and policies undertaking for preventive measures against HIV infection and also suggested some measures and strategies based on the Right to know communication initiative.

Ramesh Bhat and Nishant Jain (2006)94 examined the relationship between public and private healthcare expenditures in India. A comparison has been drawn between public healthcare expenditure and private healthcare expenditure as per the current status. The finding states that the ratio of healthcare expenditure to GDP increased as countries developed economically and industrially.

Ashish Bose (2006)95 reviewed the first results of NFHS-3 as announce in New Delhi. He pointed out it was impressive still than there was a significant drawback of NFHS due lack of district wise data which does not represent the diverse state of India. While the fall in the total fertility rate in the five states for which NFHS-3 results have been released is to be welcomed, but one cannot draw any general conclusion until the data for the BIMARU states come in. The data on anemia prevalence among women and children however is disturbing.

Meine Pieter Van Dijk and Christine Siljbesma (2006)96 overviewed the conditions and policies on domestic water supply, sanitation and water resources management in a wider context. They analyzed experiences with implementation of sector reforms in India based on research of government and non-governmental projects and programmes, and make comparisons with integrated water resources management development in the E.U. they have shown where progress has been made and where constraints and challenges continue. They also identify which further research can help achieve the millennium development goals for the sector: halving by 2015, the proportions of those who now have no safe water and sanitation and ensuring that the services and programmes become sustainable.
Hallelohim Ghonglam (2006) comprehensively studied over the problems of HIV/AIDS and substance abuses in North-Eastern section of India and also suggested a possible ways of eliminating the problems. He suggested trained professionals in the region, planning, facilities for testing, counseling and church playing a big role. The author was well aware of the HIV/AIDS as more than a medical problem and it is also affecting the whole society from all angles.

Indrani Gupta and Trivid, Mayur (2006) analyzed the health insurance which has been currently discussed in a variety of forums to explore the possibilities of wider coverage for the citizens of the country. They also highlighted some of the recent initiatives for health coverage, central initiatives as well as state initiatives for health insurance. They suggested the necessary to plan the spread of health insurance on a national scale, so that all the initiatives currently in place in a disjointed fashion can actually become part of the same system.

R Jaishankar and C.P. Jhonson (2006) felt that the geomatic technology has tremendous potential to address public-health issues particularly under the present circumstances of global climate change and climate or technology induced human migration, which results in the geographical extent and re-emergence of vector borne diseases. They also presented an overview of the science of geomatic, describe the potential impacts of climate change on vector borne diseases and review the application of remote sensing for disease vector surveillance.

T. Jacob John (2006) analyzed the crippling diseases, polio, which was trying to eradicate the diseases for a decade-long. However, there was still this controversy about the route of transmission which had a critical bearing on the choice of vaccine. He also writes up on advantages of OPV. He visualized the major flaw in the eradication plan of action that needs rectification which lack organizational set-up commensurate with the enormity of the task. Thus, he suggested improving operational, economic and technical inputs, particularly regarding the need for Injectable Polio Vaccine; a National Commission on Polio Eradication is a necessity.

Neeti Malhotra (2006) discussed how the dominant world view of women being subservient to men has also translated into HIV/AIDS prevention programmes where women are largely seen as carriers or vectors of the diseases. Also of the view that Gender-sensitive and gender-transformative interventions are needed to make more effective strategies in preventing HIV/AIDS. Training of personnel’s particularly social workers is very important for preventing AIDS since it posses a
formidable challenge for them in terms of what can be done on behalf of clients and also how to respond professionally.

Rabinnora Nath Ojha (2006) stated health, as a prerequisite for all round development. He also highlighted some of the objectives and suggested how to streamline National Rural Health Mission in the process. He considered community participation forms the cornerstone of the concept of primary healthcare to achieve the goal of ‘health for all’.

K. Srinath Reddy and Kavita Sivaramakrishnan (2006) discussed the importance of PHFI’s objective seeking to infuse greater public health expertise into the health services and to make the policy developed and do research more responsive to public health needs. They states that PHFI’s is emerging as a new and innovative models to address the challenges in public health education through appropriate training in the precept and practice of public health education, by enhancing the capacity of public health functionaries and by fostering linkages and partnership with existing academic institutions in India and abroad.

M. Gopinath Reddy (2006) elucidated the health sector reforms based on the study of primary health care delivery system in tribal areas of Andhra Pradesh. He stressed on the context of health sector which was rampant by corruption, accountability failure, significant referral problem, and tremendous logistical problem and politicized. He also emphasized on the key problems in the health sector delivery, health sector reforms and vision 2020 in tribal areas of Andhra Pradesh. He viewed the reforms in the health sector in the last decade had failed to addressed the problems faced by the people in the rural tribal and backward areas. It was inadequate quantitatively as well as qualitatively.

C. Sathyamala (2006) explained the setting up of the Public Health foundation in India which was to be modeled on the national academy of sciences in the US. The foundation plans to set up five “world class” institutes to provide training and conduct research in prioritized, “high impact” areas of public health as an extension of American interest. It was to be governed by technocrats/ bureaucrats and nominated NGOs and will be subjected to little or no accountability/ scrutiny by the Indian polity.

M. Gopina Threddy, K. Jayalakshmi and Anne-Marie Goetz (2006) studied the health sector in Andhra Pradesh especially the primary health care system in tribal areas of Vishakapatnam. The article focused on the ‘chain of referral’ from
community health workers. The study also consider how the local political dynamics shaped by competition between parties and between authorities representing the tribals. However the credibility for poor health care in tribal areas was due to poor state machinery and health officials.

**Anand Zachariah** (2006) had featured a programme which aims to provide universal access to HIV care i.e. Anti Retroviral Therapy (ART) a part of the WHO’s “3 by 5 initiative”. He further cited two nation Brazil and Thailand which was very successful and responsive in access to HIV care. The crucial to these achievements have been the legal demand of access to healthcare as a basic right under the constitution. Thus, the writer here he urged, if quality and expensive care can be provided for one disease like HIV, than the same should be achievable for common diseases which require less expensive treatment.

**Sunil Amrith** (2007) discussed a historical perspective on the political culture of public health in India. He examined the genesis of the state’s commitment to provide for the health of the people, but argues the original commitment laid numerous contradictions and fractures which have failed in many ways in the field of public health. The dept of ambition for public health was unmatched by infrastructure and resources. The paper also examined the malaria eradication programme as a case-study which reveals the limitation and weakness of the approach, the ultimate failure of malaria eradication left a huge dent in the state’s commitment to public health.

**A. K. Shiva Kumar** (2007) analyzed the case of child malnutrition with reference from third National Health Survey. He found the NFHS- 3 clearly shows limited progress in insuring universal health services and care for children less than three year of age and to mothers and women. He also observed the continuing neglected on health care services, the failure of strategies to reach newborn children and those under three years and administrative weakness to assure children their right to adequate nutrition and health.

**Jai Pal Majra and Das Acharya** (2009) have deliberately studied about climate change and its significant and emerging threat to public health and to meet the challenge, health systems require qualified staff. A majority of medical interns are aware about the causes and health impacts of climate change, but their knowledge regarding health protection measures is limited. This may be due to the insufficient space assigned to the subject in the medical curriculum. Therefore, it is recommended
that learning resource materials on the subject are developed and inducted into the medical curriculum.

Kapil Yadav, Prashant Jarhyan, Vivek Gupta and Chandrakant S. Pandav (2009) have analysed the state of rural health care delivery in India. They found that the rural health system of India is plagued by serious resource shortfall and underdevelopment of infrastructure leading to deficient health care for a majority of India. The rural population of India still does not get the basic quality of primary health care as stated in Alma-Ata conference attended by governments of 134 countries and many voluntary organizations in 1978. Indian health system is stagnated today and it requires out of box thinking, a jump start to revitalize itself. It is high time to recognize and integrate RHP with existing health care delivery system in rural areas can be the solution for tackling this shortfall in healthcare delivery personnel.

Darryl D'Monte (2009) has studied Animal farming practices that pay little heed to the welfare of domestic animals which invariably lead to public health threats for humans. He was of the view that swine flu can spread with lightning speed and cause havoc. Thus, it serves as a wake-up call to all countries to take a second hard look at farming practices as well as urban growth and return to more ecological ways in both sectors.

Bhawati Prasad and M.S Turan (2009) analysed Yashaswini cooperative Rural Health care Scheme which is considered a landmark initiative and a great boon to the farmers in Karnataka. In spite of having the best of doctors and facilities in place, the rural masses lacked the capacity to pay for speciality care. Thus, the healthcare scheme for the rural masses was launched to access quality healthcare at a nominal of Rs. Five per month. The author state the Yashwini Scheme has brought quality health care and bridge the poor desperate farmers and their need to live a healthy life in order to survive.

Kannan Kasturi (2010) has analysed the healthcare policy and indicates the main culprit for the low standards of medical education and the credibility of the regulator is government policy itself, which has consistently placed a low priority on healthcare. Moreover corruption is certainly considered a major issue that affects the standards of medical education and the credibility of the regulator.

Freny Manecksha (2010) conducted a pilot project in community-based monitoring under the National Rural Health Mission in three districts of Jharkhand provides encouraging results. It showed how with heightened awareness demands for
ante-natal care and for the monetary incentives given under the JSY (maternity benefit scheme) had increased. One of the cheering aspects has been the Civil Surgeon's active and dedicated participation from its very inception and the proactive approach of the District Programme Manager and the District Nodal Officer.

Kannan Kasturi (2010)\textsuperscript{116} has analysed the healthcare policy and indicates the main culprit for the low standards of medical education and the credibility of the regulator is government policy itself, which has consistently placed a low priority on healthcare. Moreover corrosion is certainly considered a major issue that affects the standards of medical education and the credibility of the regulator.

Freny Manecksha (2010)\textsuperscript{117} examined the Growing focus on palliative care particularly the State of Kerala's palliative care movement shows health services can go well beyond the biomedical model of health and be seen as an affirmative act of living with dignity. Kerala's community-led initiative has provided home-based palliative care has grown into a genuine people's movement and is hailed as a model that can be replicated in other states.

Anupam Hazra (2010)\textsuperscript{118} has critically analysed the state of health in India. The author has cited clearly the figures of accessibility and availability of health services in India. He also highlighted the recent achievement such as over 5 lakh trained ASHAs/community workers working actively in the field to connect households with health facilities, the significant achievements in the North Eastern states. He also opined some challenges and constraints such as 5 per cent of GDP is not enough considering the health problems, shortages of funds, gender disparities, there were sub optimal utilization of health centres, improving nutrition, number of doctors, nurses and other paramedical workers per 1000 population is low. He was of the view that the health scenario in India is full of contrasts.

S. Vineeth (2010)\textsuperscript{119} studied NRHM and its objectives. He put forth some of the issues and challenges faced by the NRHM programmes and the road ahead. The author believe in India' vision that is to attain the level of health that will enable every individual to lead a social and economically productive life. Thus, it is the NRHM that launched in 12\textsuperscript{th} April 2005 is a right initiative in this direction.

V. Mohan Rao (2010)\textsuperscript{120} has very positive view about the impact of ICDS taking care of nutritional needs of children. The scheme provides an integrated approach for converging basic services through community based workers and helpers. The services are provided at Anganwadis. As under ICDS scheme, children
are provided pre-school education, besides supplementary nutrition, health-checkup and immunization. He also stated that considering the importance of ICDS, the government has given very high priority to the scheme.

Anju Kuruvilla and K.S. Jacob (2010)\textsuperscript{121} has pointed out that mental health aspects of reproductive health are a sorely neglected topic, and there is a significant interplay between these two areas, an absence of awareness of the extent and effects of poor mental health on reproductive health, inadequate research and consequently, no appropriate policies. The article seeks to raise awareness on the significant intersection between mental health and reproductive health and emphasize its public health significance.

Valley Dolma Chankapa, Ranabir Pal and Dechenla Tsering (2010)\textsuperscript{122} have assessed the impact of men's perceptions on reproductive health decisions has weakened reproductive health care programmes. They evaluated husbands' knowledge and practices with regard to the use of conventional contraceptives as manifested through reproductive health and sexual decisions. The study was conducted in a rural setting of Sang PHC and Pakyong PHC area in Sikkim. The research found that awareness and prevalence of contraceptive use among married men in a rural community in the East District of Sikkim were quite high. Nevertheless, female contraceptive methods continue to be the dominant method used in the community.

R.K. Sharma, Raj Rani, Bikar Singh and Raghav Khanna (2011)\textsuperscript{123} studied to find out the level of patient satisfaction regarding the behaviour of health care deliveries of outdoor patients in selected primary health care institutions i.e. CHCs and PHCs. The study was conducted in the district Nawansahar of Punjab. It was found that the poor patients were more satisfied with the behaviour of the staff and the treatment given to them. Some of the Doctors and staff were found missing during the working hour. Satisfaction level to be high in female as compared to male patients. It was deciphered that the majority of the outdoor patients were found satisfied with the behaviour of the health care deliveries in select block of the study.
Sudesh Kumar Chawla (1999) in his study of primary health care administration in Himachal Pradesh found that the Minister of Health and the Health Secretary as the head of the Department and head of Health Administration respectively had failed to develop the health of the state. He found the health administration was not operating smoothly. He also found the health funds and Programmes were not spending in their proper channel. Nevertheless, there was discrepancy in equipments and supply of medicines in the state and lack of community participation.

Rajnesh Goel (2000) critically analyzed primary health care administration in Karnataka. It was found that over all the primary health care administration was pathetic. There was lack of reliability on the health providers, lack of cooperation between the health personnel’s, lack of health equipment in the rural areas and infrastructure wise it was not enough to run a health centre in the rural areas. It was also found that there were no proper transport facilities for the patients as well as for the health workers. The Panchayati Raj Institution which was supposed to be the pivotal in providing and managing the health care in the rural area was not effective at all. He suggested there is a need of drastic change in health administrative system to bring a better health in the rural areas.

Ravinder Kumar (2002) critically analyzed the organization and working of Health and Family Welfare administration in Himachal Pradesh. He found that the link between the district and state health administration is very weak. The fact was that the Chief Medical Officer (CMO) was the only link between the district and the health administration. He suggested improving the district and health administration linkages. However, he also spotted the district health administration working in isolation, lack of coordination between the officials and non-officials, moreover there was just two official to supervised the entire health care administration. There was also lack of community participation which has failed to mobilize various health programmes in the state.

Sarwan Singh (2005) in his study, it was found that the patients were displeasure over the system for making them to wait for long to see the doctors. The in-patients were also not satisfied the way how they were treated and taken care during their stay in the wards. There was lack of inter personal relationship between the patients and the health personnel. However, the doctors found that the patients
were not following their prescription properly. The researcher also found that there was lack of proper channel in monitoring health and administration. There were also no proper records as well. The researcher suggested rising up the standard of infrastructure, maintaining proper records and filling up adequate experience staff to be employed.

Raj Rani (2012)\textsuperscript{128} has studied the performance of Rural Health Care in relation to Select National Health Care Programme in Faridkot District of Punjab. The study has brought forth several findings and concluded with satisfactory performance of some select Programmes in the District. It was found the Rural Health Care not only lacks in basic infrastructure but there was inadequacy of the material as well. The supportive services were absent much to the dismay of the patients. To add to all these woes and worries of rural life and healthcare there were inadequacies in terms of infrastructures, healthcare facilities, healthcare providers and life saving drugs and equipments so to say that the supply of healthcare providers was inadequate in rural than urban areas.

**Inference drawn from the review of literature**

- In many tribal and rural areas the health sector is rampant by corruption, accountability failures, significant referral problem, and tremendous logistical problems and politicized. There is disparity and inadequacy in the rural health care system. It is also found that the paucity of funds led to problem in health administration which failed to run government health centres and dispensaries. However, unarguably the satisfactions of the patients are very low in rural and tribal areas. The reason is lack of facilities, staff behavior and administrative failure.

- The survey of literature shows that the post-independent period has been all together sweeping leap in the health care system. Numerous literatures on health were published, apart from this many research work on health have taken place, many health programme have launched and many innovative health project have carried out. But seeing the health status from every perspective, the literature clearly reveals that the standard is not upto the mark. The health care system in India has still a wide chasm to meet the goal of ‘Health for all’.

- The survey of literature shows that participation in health care led to maintenance and promotion of health, prevention, detection, treatment
care, etc. in the form of self-help. It is also found that health education play a vital role in keeping oneself healthy. It create healthy conscious and to be responsible towards the community health.

- Many literatures have discussed about health and health problems. Many researchers have done research on health and suggested upgrading the referral system and proper management of health personnel and administrative system. But the importance of primary health care has been overlooked in the recent past which is the bottom-line in health care system though it is the key to well being of a community.

- It is found that many research studies and survey on health have been doing time and again in a very extensive and intensive manner in almost all the states like Punjab, Haryana, Himachal Pradesh, Kerala, Andhra Pradesh, Orissa, Karnataka, Gujarat etc. But least research studies were done in north east states of India and Nagaland is no exception in this case. Thus, this provides an ample opportunity to explore and harness challenges to health care in Nagaland in general and Phek district in particular.

**Scope of the study**

The study comprehensively analyzed the delivery of Primary Health Care and Health Care Administration in tribal areas of the Nagaland state while making case study of Phek district of Nagaland.

**Objectives of the Study**

1. To study and comprehend the existing organisational structure engaged in the delivery of Primary Health Care in Nagaland

2. To assess the adequacy of Primary Health Care infrastructure and Health facilities available at Community Health Centres, Primary Health Centres and Sub-Centres level.

3. To study the job satisfaction among the Doctors having direct interface with the patients in delivering Primary Health Care services at the level of Community Health Centres and Primary Health Centres.

4. To assess the job satisfaction among the Nurses having direct interface with the patients in the challenging task of delivering Primary Health Care services at Community Health Centres and Primary Health Centres.
5. To analyse the satisfaction among the outdoor patients of Primary Health Care services at Community Health Centres and Primary Health Centres
6. To identify the main obstacles in provision and deliverance of Primary Health Care services and to suggest suitable remedial interventions.

**Hypotheses of the present study**

1. The organisational structure engaged in the delivery of Primary Health Care services in the state is adequate in terms of structural requirements as per the national norms.

2. Primary health care infrastructure and the health care facilities available at District Hospital, Community Health Centres, Primary Health Centres and Sub-Centres are adequate.

3. The Doctors who are providing primary health care are satisfied with their job, further,
   a) Higher the age of the Doctors higher is the job satisfaction.
   b) Longer the length of service higher is the job satisfaction.

4. The Nurses who were providing primary health care were satisfied with their job, further,
   a) Higher the age of the nurses lower is the job satisfaction.
   b) Longer the length of service lower is the job satisfaction level.

5. The patients are satisfied with the delivery of primary health care, further,
   a) Male patients are more satisfied vis-à-vis the female patients.
   b) Lower is the income of the patients higher is satisfaction level.

**Research Methodology**

The present study has been conducted in Phak district of Nagaland. The study has been conducted in all the 5 blocks of the districts. Out of the 5 blocks, 4 blocks has been dominated by one community i.e. Chakesang and 1 block has been dominated by another community namely, Pochury. These two communities have distinct cultures, taboos, dialects and practices. There has been often an outbreak of seasonal diseases which have been encountered by these two communities for many decades despite the fact that various programmes were operating in the area.

Both primary and secondary data has collected as regard for the study. For primary data three interview schedules has been prepared i.e. one each of health providers which included Doctors and Nurses, and health seekers i.e. only outdoor patients. The interview schedules were prepared in English. As regards the primary
data, the District Hospital, a census sample of all the Community Health Centres and 8 Primary Health Centres was taken. There have been 3 Community Health Centres and 23 Primary Health Centres in the district. There have been 43 Sub-Centres in the district however, only 20 Sub-centres have been selected on the basis of the population covered by them out of these 10 Sub-Centres were taken with maximum population and 10 Sub-Centres with minimum population. A census sample of Doctors and Nurses was taken since the number of health providers was usually less and for that reason no statistically inference could have been possibly drawn from the small selected sample. As regards the health care seekers, a sample of 500 health care seekers (outdoor patients) were selected i.e. 80 from District Hospital Phek, 40 samples each from 3 Community Health Centres and 30 samples each from 10 Primary Health Centres. The Sample of health care seekers was not selected from the Sub-Centres since the study focused on the outdoor patients. However, 20 Sub-Centres were selected as has been mentioned above were critically analysed and studied the administration system and health care facilities available in the SCs.

The secondary data was collected from various books, journals and newspapers. Publications, Statistical Abstracts, Guidelines of the Programmes and Policies of both the Central and the State Government were used. Publication of WHO, Annual Reports of the Department of Health and Family Welfare, Acts various Five Years Plans etc. were used. The secondary data wherever used were supported by the reference from where it has been obtained.

**Development of Research Instruments**

There were three (3) set of interview schedules i.e.

i) Interview schedule to find out the job satisfaction among the Doctors

ii) Interview schedule to find out the job satisfaction among the Nurses.

iii) Interview schedule to find out the Patient satisfaction.

The respondents were asked to rate each statement on five point Likert Scale i.e. Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree and to each rating 5,4,3,2,1, score were given respectively. All these interview schedules were developed by searching relevant literature on the subjects and by consulting the experts in the fields of Public administration, Health Administration and allied disciplines.
The Interview Schedule so prepared was assessed for its validity and reliability using the ‘Karl Pearson’s Split-Half Method’ and the Coefficient i.e. \( r_{n} \) was 0.70, thus the scale was considered as reliable. The following formula was used for calculating the Reliability Coefficient Rate:

\[
(r_{n}) = \frac{2 \times r}{1 + r^{2}}
\]

Where \( r = \frac{\sum x y}{\sqrt{\sum x^2 \sum y^2}} \)

Secondary data was collected from the records available at Regional Offices and Head Office, which included Service Manuals, Annual Reports, Policy Guidelines, Books, Magazines, Journals and other Publications for education.

Assumptions and Limitation for the analysis of primary data

1. Proportion of response

<table>
<thead>
<tr>
<th>Range of Percentage</th>
<th>Proportion of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-40</td>
<td>Fairly</td>
</tr>
<tr>
<td>41-50</td>
<td>Moderately</td>
</tr>
<tr>
<td>51-60</td>
<td>Simple Majority</td>
</tr>
<tr>
<td>61-70</td>
<td>Fair Majority</td>
</tr>
<tr>
<td>71-80</td>
<td>High Majority</td>
</tr>
<tr>
<td>81-90</td>
<td>Significant Majority</td>
</tr>
<tr>
<td>91-100</td>
<td>Highly Significant Majority</td>
</tr>
</tbody>
</table>

The assumptions considered while analysing the primary data given in the Tables.

Pearson’s R and approximate significance

<table>
<thead>
<tr>
<th>Value of R is positive</th>
<th>Approximate positive significance</th>
<th>Value of R is negative</th>
<th>Approximate negative significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>No relationship</td>
<td>(-) 0.0</td>
<td>No relationship</td>
</tr>
<tr>
<td>Below 0.4</td>
<td>Low relationship</td>
<td>Below (-) 0.4</td>
<td>Low relationship</td>
</tr>
<tr>
<td>0.5 to 0.7</td>
<td>Moderate relationship</td>
<td>(-) 0.5 to (-) 0.7</td>
<td>Moderate relationship</td>
</tr>
<tr>
<td>0.8 to 0.9</td>
<td>High relationship</td>
<td>(-) 0.8 to (-) 0.9</td>
<td>High relationship</td>
</tr>
<tr>
<td>0.9 to 0.99</td>
<td>Significantly high relationship</td>
<td>(-) 0.9 to (-) 0.99</td>
<td>Significantly high relationship</td>
</tr>
<tr>
<td>1</td>
<td>Perfect positive relationship</td>
<td>(-) 1</td>
<td>Perfect positive relationship</td>
</tr>
</tbody>
</table>

The assumptions considered while analysing the primary data given in the Tables. Positive and negative values will be taken to indicate the direction of the relationship between the variables.

Chi Square Test

<table>
<thead>
<tr>
<th>Value of Chi Square</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00 to 0.01</td>
<td>Highly significant</td>
</tr>
<tr>
<td>Above 0.02 up to 0.05</td>
<td>Significant</td>
</tr>
</tbody>
</table>

Source: The assumptions considered while analysing the primary data given in the Table.
Data Analysis and Interpretation

The primary data so collected has been analyzed using cross tabulation with the help of the statistical package SPSS using relevant statistical techniques like chi-square test, Karl Pearson’s correlation to support the findings. The data analyzed has been presented neatly in the tabular form for easy comprehension.

Scheme of Chapterization

Chapter I - Introduction, scope and methodology.
Chapter II - Administration of primary health care in the State of Nagaland: Organizational Structure and Infrastructure
Chapter III - Job satisfaction among Doctors in the deliverance of Primary Health Care.
Chapter IV - Job satisfaction among Nurses in the deliverance of Primary Health Care.
Chapter V - Patient’s Satisfaction towards the delivery of Primary Health Care.
Chapter VI - Conclusions and Recommendations.
References:

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15. Ibid. p. 12.
16. Ibid. p. 12.

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K. Padmaj, “user fees for public health care institutions”, Yojana, July 2002, pp. 31-34.


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