"HEALTH SERVICE SYSTEM IN NAGALAND : A SOCIO-POLITICAL ANALYSIS"

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CERTIFICATE

The work embodied in this dissertation entitled "Health Service System in Nagaland: A Socio-Political Analysis" is original to the best of my knowledge and has been carried out at the centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi. This work has not been submitted in part or full to this or any other university for any other degree or diploma.

Dated : 22.7.91

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I recommend this dissertation to be placed before the examiners for further evaluation.

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CONTENTS

INTRODUCTION

The state of Nagaland is one of the oldest states of the country - in the North Eastern Region. The region itself is not homogeneous as such, though there are overlapping similarities amongst the different communities. It is further marked by the physiographical differences with its mountains and hills, plateau and plains, the varied climatic conditions with rich flora and fauna. The region is widely known for its distinctive geographical location and the complex and yet intersesting issues and developments which have been frequent over the past decades.

The total population is close to thirty million with extraordinary diversity -- ethnic, linguistic religious and cultural. A multiplicity of languages and dialects are spoken by over a hundred tribal communities broadly under five ethnic groups and a sixth with the Indo-Aryan population within Assam and Tripura who are mostly non-tribals. The states of the region have their own distinctive political texture and cultural identities.

The area, like the rest of the country, largely came under the British colonial rule. The areas within the region came under British administration in gradual phases, subsequently strengthening their influence and dominance, but not without local resistance which were very outstanding and distinctive in their own nature.

A national level conference was also held in the early part of the century, thus introducing an organised political infrastructure in the region to thwart against the establishment of British yoke.

The present state of Meghalaya came under British rule in 1822 Khasi Hills, Garo Hills, in 1869 and Jaintia Hills in 1832. The British Rule influence came into Arunachal Pradesh in 1930s and was treated as an Excluded Area in 1934 - G. O. I. Act, with a very marginal administration. Similarly, the Mizo Hills was annexed by 1889 after a punitive expedition.

Apart from the geo-political developments, another spectacular socio-cultural phenomenon was the growth of religious adaptability. The traditional forms of worship was gradually changed. Animism and certain traditional religiousd beliefs and practices still exist, though Christianity has become the major belief of the tribal majority. There is a strong representation of other major religions such as Hinduism, Buddhism, Islam and other minorities.

The Naga Hills and Other Areas

Parts of the present state of Nagaland came into contact with the British rule as early as 1835 and came under its political control in1874. Some other areas came into contact later, but most of these did not really come under British rule directly. [1]

Unlike other parts of the country, the system by

which the British overtook these areas were of different nature - politically. There was almost no commercial developments and activities where elsewhere, the colonial rulers could form 'alliances' with the local rulers such as kingdoms. There were no organised and institutionalised political power establishments symbolised by the Maharajas, Nizams, Nawabs, princes and Zamindars through which they gained gradual control over the princely states for their politico-economic interests. There were no princely states and rulers in Naga areas, and there the nature and methods of policy approach were different. The British had to come into complete contact with the local population, as the power structure of the society was different. Therefore the means of social control was again unique in its nature and magnitude. This relates to the nature of social structure where the dynamics of democracy was strong and open to people for participation in functional matters. Though there was a collective body in most areas who represented the people in power decisions, this was not in terms of absolute. Therefore, there was no emergence and creation of 'privileged institutions' like class formation and groups, who were nurtured by the 'British Raj' for their vested interests.

There were tribal chiefs in some areas and

particularly the powerful village councils who were basically elders represented in terms of khels and clans. Thus these formations were highly democratic and their status and position were also unique which were different from the feudal lords etc. in exercising power over the people. The people were the sovereign.

Therefore it was difficult for the British to create titular heads similar to those like the Rais, Khans, Sardars, Sahibs and Bahadurs with due vested interest and importance given to them for maintaining loyalty and faithfulness, to these rulers in the Naga areas.

Creation of geo-physical boundaries and areas such as 'buffer zones', 'backward track/areas', 'inner line territories', 'tribal areas' etc. was another new development by the British under which this area also came into one of these.

Education which were job oriented and subsequent migration from rural to urban resulted in the development of differences amongst people in the overall social context. These were also further substantiated by representation and reservation for jobs etc, which also resulted in advantages and disadvantages sectorally. Opportunities in this aspect was an important issue in a

classically fragmented society like India in general.

History of "British Raj" in Nagaland

For a more specific highlight, it would be interesting to trace the roots and origins for foreign (British) contact. In 1832, the British for the first time physically entered in the Naga areas, led by Captain Jenkins in the Angami country. Thus the first contact was established. These events were not smooth sailing and there were conflicts with the local population due to the threat of occupation that they foresaw in these forces which were expeditionary in nature.

British expeditionary military posts were established in 1847 and about a dozen more expeditions occured by 1850. There were also numerous raids by the Nagas on the British by 1851, resulting in deaths and slavery. By 1854, due to constraints in the resources, expeditions were suspended by the British. Physical interventions were strongly opposed by the local people due to the 'conquering nature' of these expeditions. As a result, farther raids were yet conducted by the Nagas after the suspension of the expeditions in the subsequent years, particularly in between 1854 and 1865. These further intensified conflicts between the two.

For reasons not very specific and detail, the Inner Line Regulation was enacted in 1873. One of the impacts was that it limited the raids and encroachments of planters - tea and rubber etc. At this juncture, the missionaries actively penetrated in these areas blending with the traditional freedom and local autonomy. Taxation was imposed through administrative machinery of the British specially for meeting the needs of the controlling forces in order to physically strengthen their control. A sum of Rs. 2/- was imposed in order to meet this need. Chronologically the events of unit establishments of administrative centres started in 1878. Samaguting post (present Chumukedima) was created in that year, followed by a school, dispensary and Wokha sub-centre. In 1888, Kohima subcenter was also established. To backdate a little, almost the entire area came under British control by 1881. It was somewhere at this period 1872 that the seeds of Christianity were actively propagated in the Mokokchung sub-centre which later spread to other parts. These areas were composedly made a 'scheduled district' of Assam, in 1874 which was also similar to the "Backward Tract". In 1934-36, Government of India Act, parts of these areas were also declared "Excluded Area".

Tuensang Area: This area was declared a 'Tribal Area' in 1934, which came to be administered by the

Governor of India through the Provincial Governor of Assam in 1902. This area was the extreme most frontier. The extension of physical control commenced only in 1910, though there were contacts and encounters as early as 1890-1990 in the Yimchwnger country through Huker village bordering the Sema country[2]. This area experienced numerous 'punitive' expeditions by the British including the further interior parts, for politically resisting the advancing British forces, with casualties on both sides. No terms could be negotiated for political amicability during this period. The neighbouring Chang country also faced similar experiences.

A policy of non-interference particularly in the Tuensang area which was declared 'Tribal Areas' was enacted in 1902, by Government of India, under British Indian Law. Their influences in this area were very nominal and there was practically no form of a defined administrative system till 1948. There were towrs which were conducted into these un-administered areas prior to this period, including the famous British raid on Sangphur village in 1942, led by Adams, S.D.O (c) Mokokchung[3]. In 1952, this area was placed along with the North Eastern Frontier Agency (N.E.F.A.) under a division, i.e. after the Indian independence.

Local Formations: In 1918, the Nags Club was formed in

Kohima. It undertook responsibilities in discussing various social, cultural, political and administrative problems of the local population in general. The Naga Club of Mokokchung was also established with a co-operative society but did not function for long due to reasons not very clear. The Naga Hills District Tribal Council was formed in 1845, which later evolved into the legendary Naga National Council - N.N.C.[4] in 1946 which emphasized on more distinctive socio-cultural-political beliefs/ identities. It was more or less a political organisation which was responsible for a mass based political movements and intensified political sentiments of the locals in the late forties and throughout fifties and early sixties of the century. Its ripples still linger on in some form or other.

A Brief Social, Cultural, Economic and Political Background :

A closer look into different social factors and elements is necessary in order to develop an understanding of the people. For this purpose various issues can be subjected.

Strictly speaking, the people are not a composite nature. Different languages are spoken by the different 'communities'. Though there are significant similarities

in many ways, examples of existing differences are examples in the sahwl designs and patterns which culturally signify different temperaments, expressions and values of the different tribes. Traits of differences are also seen in the different physical features. Racially, the people extensively belong to the Mongoloid stock, yet as mentioned there are some differences in the details from one tribe to the other, or even within one tribe. Some are tall and some are short, some are fair and some are comparatively darker. Sharp features are also a common sight. Some have yellowish complexion and some brown, with hair differing from straight ones to the wavy ones. In spite of these differences, the people can be classified as Tibeto-Burman group of Mongoloid people/race. Within the population as a whole, there are various tribes or communities. Ethnically they may be broadly categorised under one group but some differential elements of these tribes are quite distinctive by culture and norms. In between these tribes, some tribes are quite akin to each other in various practices than the remaining ones. Therefore further groupings cannot be ruled out amongst the various tribal communities/groups. However, there are no acute differences, where they are rather overlapping by their approaches, which even exists within certain tribes.

Another important feature is the existence of clan system. Though the system does not play any important role in forming separate identities or create a system of hierarchy- social strata, they are important in terms of cultural factors and values. In some cases, they play a role of social relationship and mediation in the realm of social life and balances. These various clans often have their social bound duties and responsibilities by socio-cultural and political sanctions. These different clans are often associated in social practices according to traditional and customary norms of the people. which are very distinctive in most of the tribes. Marriage between members of the same clan is strictly against the norm, as these members of the same clan have same ancestral particularly in terms of parenthood. Though women do not really have as much status as men in the society, specially with reference to the various overall social role and property right etc, they are however regarded with a high esteem in the society. For further social groups, classical form of groups did not really exist, though there were individuals who constitutedly gave a shape to being a kind of people easily identified by their valours and virtues. Therefore a class type of social formation did not exist in a strict sense. Though there were differences amongst certain people in terms of norms

through Roman Scripts.Financial contributions by the local population were also received by this church for the mission programmes, which probably included mass publications of the scriptures and for other supportive activities of the church. The first Church Reported was in 1898.

By 1913-14, the Baptist Mission had established 14 schools in addition to the areas which were handed over to the government earlier. By 1931, the number of schools were 52 which had earlier recorded 42. These institutions were located in the Kohima and Mokokchung divisions respectively.

By the early part of the century, dictionaries, grammars, translations and primers, confined mainly to Christian themes in English language and the local Naga languages were written and published in Roman script, which was fast gaining momentum at a rapid pace.

Some of the tribal communities, particularly those that had come into contact with the British Colonial Administration and the Baptist Mission had the privilege for an earlier venture in this field. Subsequently they further underwent a total British subjugation.

In 1904, Rivenburg initiated Angami alphabet. The publications included the scriptures according to

st.John,& The Acts. He (Rivenburg) was an arithmetic, a hymnaland a premier. Other publications included the scriptures of St Mathew in Lotha - 1907. Dickson initiated translations and publications of St.Mark in 1908. The AO - English dictionary was also published in 1911, prior to which earlier translations have been attempted.

The Testament in Angami, Ao and lotha languages were made available in the years 1927, 1931 and 1947 respectively. [5]

Other notable developments were the extension and penetration into the hinterlands in an attempt to control the Eastern Areas. Modern system of education has gradually grown over the years, especially early after the attainment of state level in 1963, prior to which the number was much lesser and did not make much impact on the society. According to the various census taken since 1961, the growth rate in literacy is as follows: 1961 = 17%, 1977 = 27%, 1981 = 41.99%, 1991 = 61.33%, Males 66.09%, Females 55.72% [6]

Table 1: Number of educational Institutions. (1989)

Type of Institutions	1988-89 Government	Private	Total
1. University (NEHU CAMPUS)	1	-	1
2. Colleges of General Education	6	8	14
3. Higher Professional Education:			
a) Nagaland College of Education	1	-	1
b) Agriculture College	1	-	1
4. Schools for General Education:			
a) High Schools	70	50	120
b) Middle Schools	276	67	343
c) Primary Schools	1,270	1,154	1,286
5. School for Professional:			
a) Polytechnic	1	-	1
b) Basic Training Institute 9J.T.T.I)	3	1	4
c) Industrial Training Institute	3	-	3
6. Law College	-	2	2
Total	1,756	260	1776

Source : Directorate of Highe and Technical Education and School Education

Table 2 : Number of Educational Institutions (1989)

Type of Institutions	1988-89
1. University (NEHU CAMPUS)	32
2. Colleges of General Education	7,473
3. Higher Professional Educat:	
a) Nagaland College of Education	193
b) Agriculture College	244
4. Schools for General Education:	
a) High Schools	692
b) Middle Schools	691
c) Primary Schools	953
5. Schools for Professional Education:	
a) Polytechnic	278
b) Basic Training Institute(J.T.T.I)	254
c) Industrial Training Institute	358
7. Law College	308
Total	446

Source : Directorate of Higher and Technical and School Education

Table : 3

Expenditure on Educational Institutions by the State Government (Rupees in Lakhs)

Type of Institution	1988-1989
1. University	...
2. Colleges for Gen. Education	189.76
3. Higher Professional Education:	
a) Nagaland College of Education	28.17
b) Agriculture College	87.31
4. Schools for General Education:	
a) High Schools	516.33
b) Middle Schools	751.70
c) Primary Schools	1,361.12
5. Schools for Professional Education:	
a) Basic Training Institute	...
b) Industrial Training Institute and and Polytechinc	88.32
6. Law College	3.44

Source : Directorate of Higher and Technical and School Education

The Cultural Dynamics of the society also portrays a unique picture of the local social canvas on the whole.

The conceptual determinants are vast and deep ensembled in the practices of the local people.

The idea of belief and worship which on important phenomenon in the local context exists in varied forms. People were traditionally animistic to a great extend. As such, the concept of religion did not actually exist. quite in contrast, they believed in the concepts of the good and bad. There was a strong sense of morale They believed in different malevolent and benevolent spirits and to normally propitiate the spirits to cure illness and avert untoward happenings. The spirits were often offered with sacrifices and offerings. Apart from all these, the general people believed in a supreme one or being who was superior to all other forces and held Him aloft above everything from the worldy affairs. They further in building of a personal relationship with the overall Superior, which was largely through belief and faith. Much of these practices have been undertaken and replaced by Christianity which began during the British India rule through American Baptist Missionaries to a great extend. However, some sections still have these practices in many areas. The indegenous cultural traits are much more prominent and distinctive amongst these people which may be considered the authentic form of traditional culture in this respect.

Customs, traditions and customary laws of the people are widely practiced, though there are strong elements of modern influences. Customs and traditions are practiced in social givings and activities such as marriages, rituals, ownership and inheritance, made as in cultural practices of various forms, settlements of disputes such as land, boundary, and property issues, and cultural practices, where violations and or offences are committed against certain norms of the society. In this matter, the clan elders and village councillors play a vital role. In some tribes like the Konyaks, the chief usually has a powerful status.

To a great extent, the people were superstitutious, where it is still common in many areas. Taboos, myths, faith and healing in traditional forms thourgh worshipping normally out of fear, is a common practice till date. Beliefs and sacrifices were common methods of practices. The people were non-totemistic. Sacrifices and offerings were mainly out of fear of the concept of the existence of a 'force', failing which the 'sprits' were rather provoked to hostility. However, total fear was not submitted to this ..... underlined force. Healing from diseases and sickness, many people depended on the existences of Soothsayer, medicine-man, priests and

religious-magico practices, which was equal for dream interpretation, cures, healing rituals and for appeasing or contacting the 'spirits'.

These practices were strong cultural and traits and expressions towards their existence and well being, and their levels of perspectives and practices thereof. Food habits and diets were also part of the cultural fabric. Meat was and is taken in large quantity with various crops with rice being a stable food. Alcohol intake was generally low in the past, unlike the present trend. Besides, in the past, the alcohol intake was balanced with hard work and a disciplined timing or schedule. local drinks were gnerally brewed from rice, and other sources were of fruits and specific herbs.

Herbal foods are also quite common, particularly at times of ill-health and sickness. A kind of lycanthropy ws practiced which were supposedly blessed with the super natural forces to act as philosophers, preachers doctors, psychiatrists, mediators and medium between the common men and the spirits.

Econonmy and its capacity have great potentialities given the opportunities and the basic support. The various sources for this comes from the existing capacity in agriculture and forest resources, tea, sugar,, spices,

perfumes, dairy, poultry, piggery, fishery and the vast and rich deposits of oil and various highly valuable mineral reserves in. the state. This can be further substantiated by the untapped and unchannelised manpower resource where more relevantly required.

By and large, the major occupation of the people is agriculture particularly in the rural sectors. In the later phases, the matter can be further focussed in terms of ratio and balances corresponding to the output and consumption. Production is not in a large key scale.Terraced cultivation is fast catching, though the method is drastically handicapped due to lack of resources and managing capacity. Jhumming therefore still is major system. Traditionally this method has been skillfully balanced with the stability of the eco-system. At times, there were crop failures where harvesting was poor. The people had to face difficulties at this junctures, where they resorted to 'barter' system in meeting their daily needs and to avoid hunger and starvation. These were mainly due to drought or heavy - rainfalls and bad soil, and sometimes natural calamities. There were also the hunters which are still quite commonly practiced and basically as a form of socio-cultural milieu where their games formed part of their food habits. Blacksmith is still a very very common practice too, melting but various

tools mainly of iron, such as the ones required for cultivation, cutting of materials and also traditional weapons such as spears and sword like daos. This reflects some of the use of iron in the early stages obtained through 'barter - system' as iron was not produced locally. Weaving and pottery also forms a main portion of their economic activity, though they are not made available in large commercialized scales. The art and peices reflected in these items strongly indicates of a rich cultural heritage in these aspects. Handicraft is another area where it's creativity and talents are brilliant. Wood carving is a major element. However, is has yet to hold its place in the market. Apart from some of these economic activities which related to trade, was salt. It is also locally available with a higher quality, but very low in quantity.

Other economic resources that were of natural were forest products and resources, water supply and it's utility system, and a huge amount of unexplored raw-materials, mainly of minerals in the earth's crust.

Forest as in the past still play a major role in. the peoples economy. It is a major source for their livelihood suchas housing materials, particularly for the rural people who are overwhelmingly depended on forest resources. Their daily needs are largely supplied by

these vast and dense forests, without which their lives would be very difficult for survival.

The system of production was largely based on self-sufficiency without any major surplus. There were no organised system as such which encouraged for surplus production from the people and their land. This somewhat throws some light on the idea of their existence of egalitarianism. There were certain imbalances within the people in terms of wealth and property, but the levels did not exist to measure in terms of acute differences. These differences were in comparative terms. There were no acute and extreme cases for the same. The distribution of land was more or less balanced. There were no landless section in the society, nor was there a systems to control the dynamics of wealth and production. Land is considered an important asset and source of livelihood to all.

The cultivation of land and its production were on its basis of community participation. Meaning, that people were equal in terms of distribution of it's products, though they are minimum in comparison to the present modern development capacity and values, as enjoyed in the urban areas mostly.

Nature of ownership were both hereditary and purchasable. Hereditary was mainly through customary law, local systems and practices. Control of land and resources were mainly through barter system, which has now been mainly replaced by money economy.

Sale of land outside the local population population is strictly controlled by state law enforced after the creation of the state. Employment is a major problem. With a high literacy rate compared to most of the states with 61.2%. It is further aggravated by lack of avenues other than governmental jobs, which are usually periodical, limited.

The political aspects of the people vary, although similar to each other. The different local political institutions were to a great extent tied which suffered and underwent a comparative disintegration. The remnants of the old system however are still quite strong. The comparative disintegration was also a impact of the introduction of the New Admiistration system of the British and further even, after the Indian Independence.

Though the state is at par with the rest of the country, such as the legislative assembly and the parliament, it is worthwhile to discuss some of the political- cultural aspects, other than these

"democratically elected or represented members of the masses" in the country.

The power structure is an important issue. Each village in the past were "free and sovereign". They resembled the classical Greek city-states. The source of this powerful political structures came mainly from the people. In instances, where the tribal chiefs existed, the chieftainship symbolised the authority of the people, who presided in matters relating to power and decision makings.

In other instances, the village elders and Councillors symbolished the democratic power representation of the community in terms relating to power structure and decision making, and ocoupied a place of honour and respect for their political wisdom, guidence and culture in relation to the people.

The power structure varied from tribe to tribe in terms of the system of the democratic norms and structural capacity, and norms pertaining to the cultural aspects of the political democracy of the people.

Some therefore had democratic set ups, while few other tribes almost had autocratic set-up. The important elements in these issues gathered to the status and representations of the chiefs, village councillors and

elders who were normally represented clan wise.The numerical strength of the clan which was not really as important, warriors and their valour of experiences in decision making were mostly strategic in nature. These forms of Decision making is a highly important political land mark in the Naga society as this reflected people's opinion and participation at the helms of power and it's structure.

Nagaland after independence and state level, (in 1947 and 1963).

The state of Nagaland lies between 2506' and 2704' latitude north of equator and between the longitudinal lines 93020' E and 95015' E having an area of 16,579 sq.K.M. The topography of the state is quite severe. The attitude of the state capital Kohima is 1,463 meters above sea level. The highest altitude is the peak of Mt. Sarmati, which lies along the Patkoi range in the Yimchunger area of Tuensang District, measuring over 3840 meters. The state is bounded by Assam in the North and West, by Burma (international border) and Arunachal Pradesh in the East and North, and Manipur in the South, more or less running parallel to the left bank of the mighty Brahamaputra. The altitude varies from 194 meters (637/ft) and 3,048 meters (10,000ft), and most of the over

1 (one) thousand old villages are located 1 to 2 thousand meters high. The villages and even towwns are normally situated at high elevations. The type of forest in the state is tropical, accompanied by thick forests in some areas, With rich mineral deposits. The hilly ranges which break into wide spurs and slopes are abundant in river waters flowing from the mountain tops to the lowlands, valleys and patches of plain areas. The temperatures in the state runs between --2°C/-4°C to 20°C in winter and between 14°C to 30°C in summer. Dimapur experiences upto 34°C to 36°C in summer. Rainfall average from 177.8 cms to 317 cms.

The total population of Nagaland is provisionally as follows according to the 1991 census:

A. Population	Total	1,215,573
	Males	643,273
	Females	572.300
B. decennial Population Growth 1981-91		
	(1) Absolute	+440.643
	(2) Percentage	+56.86
C. Density of Population		73 per sq.km.
D. Sex Ratio	(1) Percentage	890 Females per 1,000 Males

E. Literacy Rate

Total	.61.30 Percent
Males	66.09 Percent
Females	55. Percent[7]

The process of the formulation of the Naga Hills district -1866 with Samaguting as it's head quarters in the West situated at the foot hills, which was later shifted to Wokka - central 1876 and finally two years later to the present state capital Kohima - 1878, the Mokokchung sub-centre and the gradual contact with the free Area (Present Tuensang and Mon Districts) of the Eastern Frontier Division gave shape to the evolution of the present state of Nagaland. Some areas lying in the present Burma and Arunachal Pradesh neighbouring the districts of the Tuensang and Mon in present state of Nagaland were out of administrative track, and politically, remained virtually free till very recently as in the case of the two mentioned districts. These two districts came under administration in 1948 only. In 1957, Tuensang Frontier Division of the North eastern Frontier Agency (N.E.F.A)was separated and joined the Naga Hills to form the popular Naga Hills Tuensong Area (N.H.T.A). In 1961. N.H.T.A. became de-facto state and the name of Nagaland with de-facto legislature and ministry. In 1963, it was made a de-jure state.

In Nagaland, Tribal Councils and Village councils regulate the social life to a great extend. This regulation of 1845 gives power to the Tribal Councils to try criminal as well as other civil cases and impose fines so long as the parties belong to the same tract. All civil suits are tried by the council. The punishment inflicted by the council is according to the customary law, though a limit has been put to avoid heavy punishments. Cases are also tried in district courts with similar power regulations and provisions.

However, in quite a number of cases the issues are manipulated and hijacked by the modern system of Judicial procedures. The traditional power structure and it's dynamics are relevant but the states functional power structure in patterned as with the rest of the other states in the country. The state enjoys a special status through Articles 371 (A)[8] of the Indian constitution.

CONCEPTUALISATION OF THE STUDY AND METHODOLOGY:

In order to carry out the health service system study in a state like Nagaland, one has to understand the integrated thinking of health and health services for the unreached masses. The magnitude and gravity of problem compounded as they are by wide-spread poverty, ignorance and lack of resources with the non-functioning of the existing health system are daunting. Nevertheless, much can be done to improve the health of the people in Nagaland if a study is carried out to evaluate and identify the key factors responsible for the failure of the existing health service system.

This present study is a humble venture in its direction and aims at examining successful or promising systems of the integrated health care in order to identify the key factors in their success and observing the effect of some of these factors in the development of health systems with the various political - social - cultural - economic and administrative variations in Nagaland.

METHODOLOGY

In the present study the investigator planned to collect all possible secondary data from the state head

quarter, Kohima. After contacting the state officials of various departments, the purpose of the study was made clear to them and their support and co-operation was solicited to bring home all possible data in relation to the health service system in Nagaland.

Periodical field trips and studies were conducted for primary source of information in certain phases for a closer inlook at the existing health service system in an integrated approach. First discussions through rapport building were exercised with some medical officials, health workers, patients, government officials and the people both from the urban and the rural.

Two PHCs each from two districts namely Medziphema and Khonoma, (Kohima Dist), Shamator and Noklak (Tuensang Dist) were chosen for the field data.

However, an overall health service system of the state was fully taken into account. From four Primary Health other centres data were collected through secondary and primary sources and a general understanding of the existing situations was also studied in detail.

Footnotes of Chapter 1

1. Robert Reid, History of the Frontier Areas Bordering Assam from 1883-1941, Government of Assam Press, Shillong, 1942, p. 205 (On the Epedition to the Naga Hills

2. Ibid, p. 223, (On fruther expedition)

3. Tour to the Un-administered Areas, Government of Assam Press, 1948, p. 75.

4. The Naga Nation 1946, p. 1-2.

5. N. Rivenburg, The Star of the Naga Hills, Philadelphia, 1991, p. 77.

6. The Nagaland State Census Report, G.O.I. 1001, p. 15

7. Ibid, p. 2

8. The Constitution of India Article 371 A

HEALTH AND HELATH SERVICES IN NAGALAND

The overall health and its status of the people was of a natural hardship, hazards which were part of the stride for social routine. An organized or institutionalised forms of measure did not exist, but enjoyed excellent physical status in majority of cases.

Diseaes and sickness like malaria, tuberculosis, STD, dysentery, cholera, etc. were largely introduced to the local areas from Assam and Manipur plain areas during the East India Company expeditions[1] Soldiers and porters from these areas along with British subjects were said to be potential carriers. The local population in these hilly areas also became vulnerable to some extent as they were unguarded against these new hazards, which spread over the years.

In the earlier periods, the local people attributed illness to the curse of evil spirits/gods who sought healing and curing by invoking them through sacrifices, offerings and prayers. Items like eggs, chicken etc. were the common offerings to dieties through village priest/which doctors/soothsayers/village healers of common ailments etc. These village healers often used to remove materials causing likely ailments and illness like stones and other particulars from the body. Blood letting was

also practiced including application of herbs. Natural herb preparations were done through professional skill and specifications best known to their experiences which is common even now. These village healers are still very common though numerically quite rare, who, treated set bone fractures and dislocation, massage pains and aches for relief etc. Apart from the existence and practices of health care in the traditional form and cultural systems, the earliest introduction of the modern medicine/ allopathy came into the Naga area during the British India rule. At various posts which were established by the British Expeditionary Forces such as Wokha, Kohima, Mokokchung, Wakching and a few more, medical units also extended facilities to the civilian population. This was closely followed by the coming of the American Baptist Mission who also set up a medical unit at Impur where its services extended far beyond. The erstwhile 'Free Area' of Tuensang Division which included the present Mon district also received modern medical facilities under the N.E.F.A. (North Eastern Frontier Agency) administration. The various manpower training for manning the health establishments were mainly based on doctors, nurses and compounders.

The earliest local doctors were qualified at the Berry White Medical School, a medical school which was

established by the British Government at Dibrugarh, Assam. (The establishment of this medical school was aimed mainly for training medical manpower for catering to the health needs of the British owned tea gardens.) This medical school was later upgraded to graduate level course - The Assam Medical College, Dibrugarh after the Indian independence in Sept. 1947.

The Berry White Medical College offered licentiate course which offered diploma -Licentiate Medical Practitioner (L.M.P.). Dr. Haralu, the earliest Naga doctor joined the Civil Hospital - Mokokchung in February 1913 as sub-assistant surgeon. This was followed by Dr. Khosa Zimju, Dr. Nielhouzhu Kire, Dr. Longri Longkumer, Dr. Uzidie, Dr. Chupulhou, Dr. Imnik Ao, Dr. Imkongliba, Dr. Motsu and Dr. (Miss) K.K. Angami and Dr. (Mrs.) I Ruby (both lady doctors).

Dr. T. Ao is recorded to be the first Naga medical graduate,(M.B.B.S., (Former Indian Olympic Football Captain, 1948) from Calcutta. This was further substantiated by the earliest two medical graduates from Assam Medical College, Dibrugarh. They were Dr. Tseikhamo and Dr. Temsu Ao (Lt. Col. A.M.C.). Licentiate doctors could take up condensed course of M.B.B.S. Dr. Jona Ao and Dr. (Miss) K.K. Angami underwent this line. The other

pioneers to qualify medical post-graduate are Dr. L.M. Murry and Dr. S.I. Tushi Ao in surgery (M.S.). Both the doctors are registered as the earliest specialists in surgery from North East. [2]

Compounders / Pharmacists

The next profession in modern medicine or health service systems (allopathy) was compounder. This was short term course run at the Berry White Medical School, Dibrugarh, who were taught the principles and practices of compounding, preparation of medicines like mixtures, powders, ointments, tablets (pills) etc. This course was later upgraded to pharmacists with certificates, diplomas and degrees.

Nursing

The early educated Naga ladies under the missionary influence took up profession like dhais, midwives and nursing. They were mostly trained at the Mission Hospital, Gauhati (Barbeta) and later on in the various Tea garden hospitals and other Government Hospitals.

Medical establishments in Nagaland

The state of Nagaland was formed by consisting the Naga Hills - under Assam Administration and the Tuensang Area - under the North Eastern Frontier Agency

Administration on 1st December, 1963, which was popularly known as N.H.T.A. (Naga Hills - Tuensang Area)

1) Naga Hills: The Naga Hills comprised the present districts of Kohima, Mokokchung, Phek, Zunhehuto and Wokha. These areas were under one district in Assam.

In the British India, the Naga Hills had: a) Civil Hospital - Kohima, Mokokchung and Wokha. b) Dispensaries at Dimapur, Phek, Bhandari, Henima, Wakching and Ghukieya.

2) Tuensang Area/N.E.F.A.

The Tuensang area of the North Eastern Frontier Agency Administration comprising the present Tuensang and Mon districts was administered through District Medical Officer (D.M.O.) for the hospitals at Tuensang, Mon and Kiphire.

An interim administration set up N.H.T.A. under a commissioner in 1959. The Health / Medical set up was placed under the Inspector of the Civil Hospitals and Prisons with three districts - Kohima (present Kohima and Phek districts) Mokokchung (present Mokokchung, Wokha and Zunhehoto districts) and Tuensang (present Tuensang and Mon districts) each under a District Medical Office (D.M.O.). The Inspectors of Civil Hospitals and Prisons

(I.C.H.&.P.) were Dr. Kar followed by Dr. T. Ao. After the attainment of statehood Lt. Col. S.M. Das. was the first director of Health services, Nagaland. At the dawn of statehood, the medical units existed in the following Strenth :

1. Hospital	27
2. Primary Health Centres	33
3. Hospital beds	689

With the political instability in. the comprised areas of the state, the first 2 five years plans could not be materialised and benefited. The 3 third plan faced the same fate (1961-66).

Establishment of the various medical units at the end of the 5 yr plans from the 3rd to the 8th plans can be projected which also reflect the gradual changes.

Medical Unit Position at the end of the III five year plan (1961-66)

1.	Hospitals	27 nos
2.	T.B Hospitals	1 Nos
3.	Dispensaries and sub-centres	32 Nos.
4.	Medical Outposts	34 Nos.
5.	V.D. (STD) clinic	1 Nos.
6.	Leprosy colony	2 nos

7.	Hospital beds	638 Nos.
IV	Five year plan (1969-74)	:
1.	Hospitals	27 Nos
2.	Primary Health Centres	10 Nos

Table Contd.

3.	T.B. Hospitals	2 Nos
4.	Dispensaries/bus-centres	121 Nos
5.	Total bed strength	1091 Nos.
V.	Five year plan (1974-75 to 1979-80)	
1.	Hospitals (general)	29 Nos.
2.	T.B. Hospitals	1 Nos.
3.	Mental Hospitals	1 Nos
4.	Dispensaries	80 Nos.
5.	Upgraded P.H.C.	1 Nos.
6.	Primary Health Centres	13 Nos.
7.	Sub-centres	50 Nos.
8.	SET (survey education treatment)	30 Nos.
9.	Centre for leprosy/leprosy colony	2 Nos.
10.	Total bed strength	1205 Nos.

The disruption of the plan (5th year plan) was due to the National Emergency and the short lived Janata Government during the periods.

<u>VI Five year plan (1980-81 to 1984-85)</u>

1.	Hospitals (general)	31 Nos.
2.	T.B. Hospitals	2 Nos.
3.	Hospital (Mental)	1 Nos.
4.	Dispensaries	75 Nos.
5.	Primary Health Centres	20 Nos.
6.	Upgraded P.H.C.	1 Nos.
7.	Sub-centres	132 Nos.
8.	Subsidiary Health Centres	25 Nos.
9.	District T.B. Centres	3 Nos.
10.	Total beds	1343 Nos.

VIIth five year plan (1986- 1989-90) which includes the 500 bedded Referral Hospital at Dimapur

1.	Hospital	30 Nos.
2.	T.B. Hospital	2 Nos.
3.	Primary Health Centres	31 Nos.
4.	Upgraded P.H.C.	3 Nos.
5.	Subsidiary Health Centres	22 Nos.
6.	Dispensaries	67 Nos.
7.	Sub-centres	236 Nos.
8.	District T.B. Centres	6 Nos.
9.	STD Clinics	3 Nos.
10.	Rural F.W. Centres	15 Nos.
11.	Past Partum Centres	2 Nos.
12.	Multi Drug Therapy (MDT) centre for leprosy	1 Nos.

13. Total bed strength 1458 Nos.[3]

Apart from all these medical unit establishments, the Naga Hospital, Kohima was a gift in acknowledgment for the loyalty and services to the Allied Forces during the famous Battle of Kohima, II World War. The construction began in 1947 and was completed in June 1949, which was officially handed over to the provisional government by the engineering department of the G.O.I.

TRAINING SCHOOLS For further strenghening the medical facilities, some training institutes were established in some areas. For this purpose, a junior nursing course was started in Kohima, 1949. A batch of 6 girls were trained to meet the shortage of nursing staff.

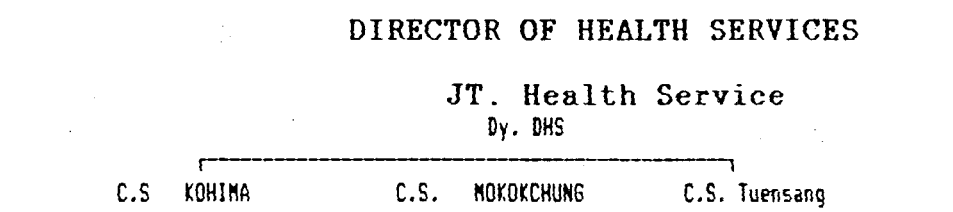
The junior nursing course was replaced by the A.N.M. (Auxiliary Nurse, cum Midwife) course in 1965 at kohima and Mokokchung hospitals

In addition, senior nursing course began at Kohima in 1973 with a batch of 5 girls. This training course is still continuing with larger number of students to meet the requirements of nurses in the state.

Further course in ANM/F.H.W. (Female Health Worker) started at Tuensang Civil Hospital, January 1983. Para Medical training Institute (P.M.T.I). For meeting the

needs of compounder/pharmacist, training was required for compounders which started at Naga Hospital, Kohima 1966, which was later upgraded to Para Medical training Institute (P.M.T.I.) in 1973, headed by a principal. This institute also trains compounders/pharmacists, laboratory assistants, sanitary inspectors and other related training as may be required by the state from time to time

V. Nagaland 1973



The new districts of Phek, ZbTo, Mon and Workha were created in but were medically administered by the S.D.M.O through the previous district under C.Ss The S.D.M.O. (sub : divisional Medical Officer) posts of Dimapur, Zunheboto, Kiphire, Mon, Wokha, Phek and S.D.M.O. (Sub - divisional Medical Officer of Health) - Peren Satakha and Shamatore were ceated in 1967-68,

SERVICE PHASE:

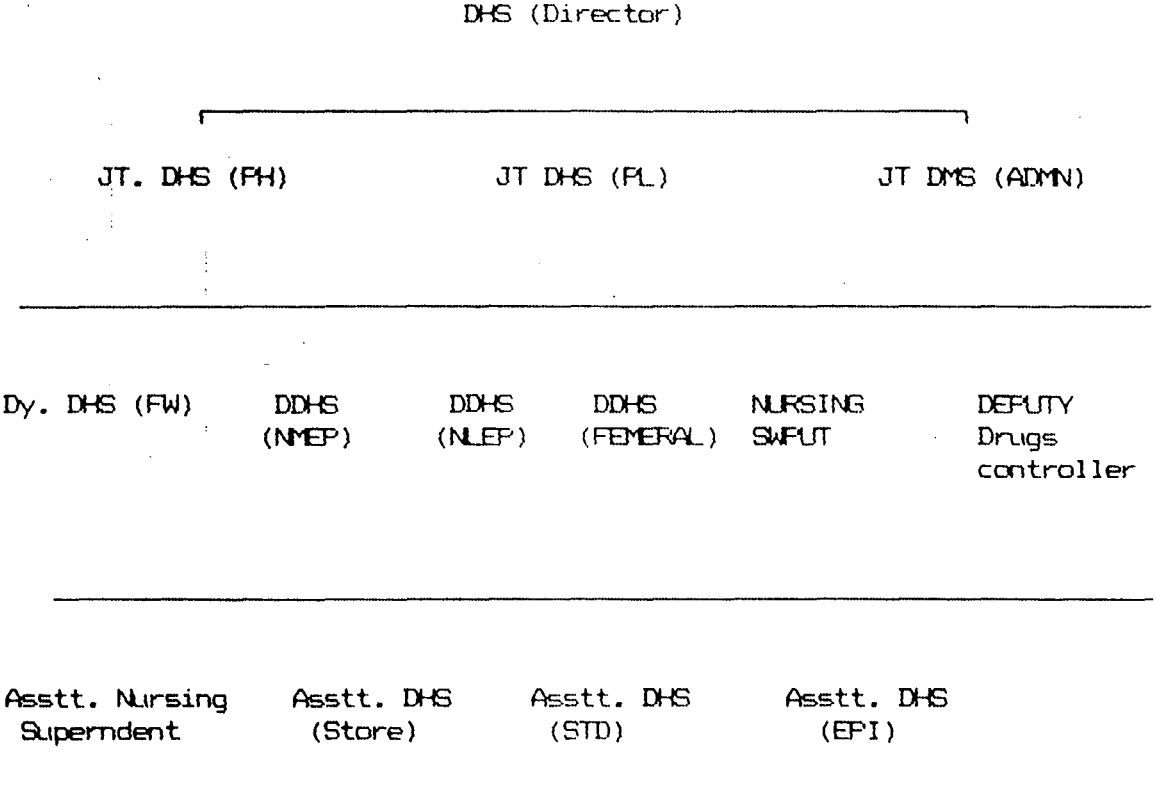
The small charitable dispensaries at known Mokokchung and Wakching in the Naga Hills were gradually upgraded to civil dispensaries and civil Hospitals.

These hospitals and Medical outposts were manned by Licentiate Medical Officer (LMP/LMF) and graduate doctor M.B. at kohima. The medicine required mostly powders and chemical making compound/mixture/pills etc. which were carried by human transporation. The treatments were mainly for minor ailments and sickness. Therefore antibiotic and chemotherapy were more essential where most of the kind of diseases and sickness were self- limiting due to the kind of socio-cultural and environmental reasons. Handicapped with lack of trained professionals, wide areas were covered by few with efforts. Civil surgeons went on visits to outpost, (medical) where operations were performed, in areas like Mkg, Wokha and Wakching from Kohima. There are recorded cases of even performing over 100 minor operations in a week Mokokchung district minor operations).

After the independence more hospitals and medical units were manned by graduate doctors. With the arrival and availability of antibiotics and chemotherapeutic agents, treatment improved with more doctors performing life-saving operations. Because of the lack of specialists in the state, the army doctor specialists were

available at times for helping out the civilian population till the sixties.

With the achievement of statehood, qualified specialists were gradually produced though limited only. They helped in the improvement of treatment of the patients which included complicated surgical operations. Some types of specialists manning the major hospitals include. General - Surgery, maternity and gynae, eye, pathologist, anaesthesiologist, psychiatrist etc. However, more specialist in number, quality and in different fields are required for overall performance in the treatment.



Health Administration set up :-

I Pre Independences ;-

Inspector General of Civil Hospitals and Prison at Shillong, (IGCH & P) Assam

Civil surgeon, Naga Hills, Kohima

c) sub-divisional medical officer Mokokchung

II Pre-statehood:

Naga Hills and Tuensang Area of NEFA.

a)(i) Inspector General of Civil Hospital & Prisons Shillong, Assam.

(ii) Civil surgeon, Kohima, Naga Hills

(iii) Sub-divisional Medical Officer, Mokokchung.

b) District Medical Officer, (DMO) at Tuensang of N.E.F.A

III N.H.T.A. (Naga Hills Tuensang Area)

Inspector of Civil Hospitals A Hospitals, Kohima

DMO (Kohima)	DMO (Mokokchung)	DMO (Tuensang)

IV New State of Nagaland (1963)

Director of Health Services, Deputy D.H.S

C.S. Kohima	C.S. Mokokchung	C.S Tuensang

ANNEXURE = 1

Comparative figures of Manpower development of Health and F.W. Department Period:-

1. Doctors :- Pre-Independence - 12

1961	- 40
1963	- 49
1973	- 89
1983	-177
1988	-218

2. Nursing staff :- Pre-independence = 4

1961	- 39
1963	- 56
1973	- 149
1983	- 526
1988	- 929

3. Compounders/Pharmacists :

Pre-Independence	- 9
1962	- 40
1963	- 105
1973	- 169
1983	- 254
1988	- 392

(Figures are approx)

(Because of the lack of specialists in the state, the army doctors specialists were available at times for helping out the civilian population till the sixties.

With the achievement of statehood, qualified specialists were gradually produced though limited only. They help in improvement of treatment of the patients which included complicated surgical operations. Some types of specialists manning the major hospitals include. Several Surgery maternity and gynae,)

Comparative figures of Medical/Arallh Units in Nagaland:

Category of units	Pre-Independence	1961	1963	1973	1983	1988
1. Hospital (Kma, Mkg, Tsg)	3	22	26	26	30	33
2. P.H.C.	-	-	-	10	18	24
3. C.H.C	-	-	-	-	-	3
4. Subsidiary	-	-	-	-	25	37
5. Sub-centres	-	-	-	31	105	214
6. Dispensaries	6	27	30	79	99	67
7.D.T.C	-	-	-	-	3	5
8. Rural F.W Centres	-	-	-	-	15	15
9. P.R.C	-	-		-	1	1
10. Bed Strength	190	427	587	921	1,248	1440

HEALTH POLICY, HEALTH INSTITUTION AND PROGRAMMES IN NINETIES

To meet the requirements of the different health service systems, the government has established an infrastructure throughout the state. This infrastructure has a uniformity for all its seven district Headquarters, but statistically differ in in terms of unit allocations pertaining to the area size, population and disease pattern as we shall come to some analysis in the later course of discussion. The suitability and necessity in comparison and in contrasts of the existing unit, proper and actual locations in terms of the intensity of needs is a primary consideration for yet another dimensional approach for situation study and acknowledegment.

(directives of N.H.P.)

As with the rest of the country, the health services infrastructure has been accordingly to a patterned. However, there may be slight variations here and there due to the given situations of the physiography -and other related issues. Data is an important issue in this respect, where 'patterning' to the felt needs is even more a priority to the overall health related problems and requirements. Standard of delivery and the systems within become immediate focal bases. Sensitivity and responses

to the call of these pulses intend to reflect the actual capability and and capacity atleast in comparative terms with the existing strength of the facilities made available to the people. Thier accessibility to benefit these provision and the rate at which it will be achieved by them is another matter of fact, where the effectiveness of the functional capacity of the service infrastructure may act as "co-relation" between the peoples and the ability of the health services. Issues like taking the system closer towards the doorstep of the target (people) and the device which is modelled for the purpose. A vast network of medical units have been undertaken by the department over the years. A gradual transformation in. the strength of the units established show the growth of the system in the state. Delivery of the services of health have been placed under various schemes and of institutions within.

An overall look at the total availability of units for delivery reveal the following figures

Position of Medical Units as on 1.4.1990

Units	Nos.
1. Hospital	28
2. T.B. Hospitals	2
3. Mental Hospital	1

Table Contd.

4.	Primary Health Centres	30
5.	Community Health Centre	3
6.	Sub-Centres	234
7.	Subsidiary Health Centres	38
8.	Big Dispensaries	16
9.	Small Dispensaries	50
10.	District T.B Centres	5
11.	D.T.D Clinics	3
12.	Urban Leprosy Centres	2
13.	Set. Centres	30
14.	Temporary Hospitalisation Ward	2
15.	Post Partum Centre	1
16.	Rural Family Welfare Centre	15
17.	District Family Welfare Bureau	3

* Annual Administrative Report, 1989-90, Directorate of and Family Welfare (KMA, NLD)

OF ECONOMICS AND STATISTICS:-

Number of hospitals, dispensaries, P.H.C., Sub-Centres and Beds - 1989.

1.	Hospital	30
2.	P.H.C.S	32
3.	S.H.C	39
4.	Dispensaries	65

Table Contd.

5.	Sub-Centres	210
6.	Beds	1,454

Of these various units, the Primary Health Centres (PHC), the sub centres and the dispensaries are aimed and targeted for catering to the needs of the rural masses in the state. They are located and patterned/the hospitals play a larger role in patients accommodation and treatment. Various given facts and situations in the rural areas are responsible for their development, in terms of manpower and medical availability and the effectiveness of the delivery and services experienced directly by them. (Treatment issues etc.)

District Wise Break-Up:-

Hospitals

1.	Kohima District	6
2.	Mokokchung	3
3.	Tuensang District	7
4.	Zunheboto District	6
5.	Wokha District	3
6.	Phek District	3
7.	Mon District	2

P.H.C.

District		Nos.
1.	Kohima District	8
2.	Mokokchung	5

Table Contd.

3.	Tuensang District	6
4.	Zunheboto District	3
5.	Wokha District	2
6.	Phek District	3
7.	Mon District	2
	Total	30

S.H.C

Districts		Nos.
1.	Kohima District	11
2.	Mokokchung District	1
3.	Tuensang District	8
4.	Zunheboto District	3
5.	Wokha District	5
6.	Phek District	7
7.	Mon District	4
	Total	39

DISPENSARIES

Districts		Nos
1.	Kohima District	21
2.	Mokokchung District	21
3.	Tuensang District	9
4.	Zunheboto District	1
5.	Wokha District	5
6.	Phek District	7

Table Contd.

7.	Mon District	1
	Total	65

SUB-CENTRES

District		Nos.
1.	Kohima District	41
2.	Mokokchung District	24
3.	Tuensang District	46
4.	Zunheboto District	29
5.	Wokha District	24
6.	Phek District	21
7.	Mon District	25
	Total	210

BEDS

Districts		Nos.
1.	Kohima District	527
2.	Mokokchung District	228
3.	Tuensang District	245
4.	Zunheboto District	136
5.	Wokha District	92
6.	Phek District	122
7.	Mon District	104
	Total	1,454

Excludes 2 TB and 1 mental hospital. They are physically

located at Kohima and Mokokchung districts (T.B) and mental hospital and Kohima. The T.B. hospital in Tuensang has not taken shape to deliver treatments inspite of lung. prevalence, mainly pulmonary.

A break up of Medical Personnel :- (District Wise) 1989

District	Particulars	Nos.
1. Kohima District	Doctors	100
2. Mokokchung District	Doctors	38
3. Tuensang District	Doctors	35
4. Zunheboto District	Doctors	20
5. Wokha District	Doctors	22
6. Phek District	Doctors	15
7. Mon District	Doctors	21
	Total	251

District	Particulars	Nos.
1. Kohima District	Compounders	99
2. Mokokchung District	Compounders	61
3. Tuensang District	Compounders	75
4. Zunheboto District	Compounders	47
5. Wokha District	Compounders	49
6. Phek District	Compounders	47
7. Mon District	Compounders	59
	Total	429

Districts	Particulars	Nos.
1. Kohima District	Nurses	279
2. Mokokchung District	Nurses	172
3. Tuensang District	Nurses	134
4. Zunheboto District	Nurses	89
5. Wokha District	Nurses	89
6. Phek District	Nurses	95
7. Mon District	Nurses	59
	Total	917

No. of T.B. Hospitals, V.C. Clinics (STD), and Mental Hospitals with beds. (1989)

T.B. Hospital:-

Districts	No.	T.B. Ward	Beds
1. Kohima District	1	...	50
2. Mokokchung District	1	...	50
3. Tuensang District	Nil		
4. Zunheboto District	Nil		
5. Wokha District	Nil		
6. Phek District	Nil		
7. Mon District	Nil		

V.D. Clinics (STD)

District		No.	Beds
1.	Kohima District	2	25
2.	Mokokchung District	1	
3.	Tuensang District	1	
4.	Zunheboto District	Nil	
5.	Wokha District	Nil	
6.	Phek District	Nil	
7.	Mon District	Nil	

Mental Hospital

District		No.	Beds
1.	Kohima District	1	25
2.	Mokokchung District	Nil	
3.	Tuensang District	Nil	
4.	Zunheboto District	Nil	
5.	Wokha District	Nil	
6.	Phek District	Nil	
7.	Mon District	Nil	

Districts with Designation :- (Dist. Wise) 1989

Particulars :-	Districts KMA	MKG	TUEN	WORKHA	PHK	ZBT	MON
1. Medical Superintendent	2	1	1	1	1	1	1
2. Civil Surgeon	1	1	1	1	1	1	1
3. Asst. Civil Surgeon	1	1	1	-	-	-	-
4. Sub-Div Medical Officer	3	1	1	1	1	1	1
5. Specialists	13	1		1	-	1	-
6. Assistant Surgeon	73	21	18	14	10	10	12
7. Dental Surgeon	3	1	1	2	1	1	1
8. Zonal Leprosy Officer	1	-	3	-	-	-	1
9. Leprosy Officer	1	1	-	-	-	-	-
10. Dist. T.B. Officer	1	1	1	-	-	-	-
11. Zonal Malaria Officer	1	1	-	-	-	-	-
	100	29	26	19	13	15	18
Total	220						

The above includes 20 doctors officers bearers, Directorate of Health

Organisation/Manipur:-

Coming down at the state level from the central level where

the Director general of Health Services (D.G.H.S.) is at the helm if the affairs, the state level is headed by the Director of Health and Family Welfare.

However, state administration is responsible in the basic principles such as it's administrative affairs and planning which are again interdependently co-related as with...

The administration of the Union Minister of Health and F.W. is headed by a secretary, who is a generalist administratror. usually belonging to the Indian Administration Service (I.A.S) who may have had a variety of assignments within the state and the Union governments, other than health. A generalist administrator such as these officers is placed at the top of the ministry because even though if he/she is not trained in technical aspects of health administration, it is felt that he/she posses the political and social skills necessary to assist the Minister in discharging his functions in the cabinet and in parliament as the political head of the ministry.

For this purpose, the secretary has available to him /her a variety of officers with specialist technical competence (specialists), headed by the Directorate - General (DH) of Health Services. The officer of the (DGHS) is called an attached office of the ministry. The responsible falls on the secretary for key functions of policy formulation, planning personnel and financial administration. It represents the view

of the Union Government. The secretariat also deals with it's counterpart in the state governments various health institutions affiliated to the ministry international agencies, foreign governments and growth and institutions. However, in the ministry of Health and Family Welfare, are two departments - the department of Health and the Department of Family Welfare and each of these departments are headed by an Additional Secretary assisted by other generalist administrators occupying different position in the hierarchy - Joint Secretaries, Directors, Deputy Directors, Under Secretary and so on. The Family Welfare does not have specialist unlike the Department of Health, where there are specialists placed under the control of additional Secretary, designated as commissioner of Family Welfare. These top specialists deal with areas such as nursing, maternal and child health services, family planning services, rural health services, programme appraisal, area projects, sale of condoms and mass communication, placed under it secretaries.

The Union Government is associated with the maintenance and development of a very wide range of community health activities in the states for which the D..B.H.S. Office is also required to have been specialists in the various areas, (including regional acknowledge).

Medical Education and other aspects of health and manpower development, hospitals and other medical care activities, health planning, health intelligence, health education, rural health

services, national programme for control and eradication of various communicable diseases, drugs control and administration of medical state department are the major areas where the D.G.of Health Services 'assists' it's counterparts in the states in the performance of their duties.

Health essentially being a state subject, the administrator are/ expected to develop their own pattern of health services to suit the conditions prevailing in individual states, failing which the state government are expected to fall back on the 'standard pattern' handed down to them by the union government. Interestingly, other than state plans, nor the 'standard pattern' suit to the matching needs in many areas ....

The Director of Health Services provides leadership to his team with assistance from Additional directors and Joint Directors. In most of the states, the priority assigned to Family Planning, a well-staffed Family Planning Bureau, usually headed by an Additional Director, is located in such state directorate to oversee the implementation of the programme. (Family Planning has been given a lesser priority in Nagaland) Deans of state financed medical colleges and superintendent of big hospitals also report to the director. He also officers of the rank of Deputy Director and Assistent Director to assist him by providing staff support in fields like malaria, tuberculosis, leprosy, blindness, prevention, extended programmes in

immunisation, hospitals and medical care, nursing, health education, health intelligence, drugs control, prevention of food adulterations, medical sores, laboratory services, vaccine production and transport. A senior officer in the directorate performs the line function of overseeing the work of district health administration which runs all levels of health services in rural areas. In big states, which have a large number of districts, there is provision for a (D.H.O). Divisional Health Officer who supervises the work of 3-5 districts.[3]

Organisation in the state of Nagaland is patterned in the following:

The Health Department and Family Welfare is usually under the charge of a Cabinet Minister and led by a Secretary who normally belongs to the civil services (I.A.S) or a senior state civil service officer who is usually a conferred I.A.S officer on seniority by the government. He is assisted by one joint secretary and one under secretary two superintendents and ministerial staff at the secretariat level.

The Directorate is headed by one Director and he is assisted by 3 Additional Directors, 2 Joint Directors, 2 Deputy Directors, 1 deputy Sub Controller, 1 Nursing Superintendent, 1 Assistant Nursing Superintendent and Programme Officers like Deputy Director (Malaria), 1 Deputy Director (Leprosy) 1 Deputy Director (F.W.), 5 Assistant Directors, 3 Medical Officers, 2

health Education Officers, 1 Senior Accounts Officer, 1 Junior Accountant Officer, 1 Registrar, 6 Superintendents and other ministerial staff. Besides, there is an Engineering cell in the Department under charge of 1 Executive Engineer, 2 Asst. Engineers and 8 Overseers and supporting staff.

There are 26 subordinate Officers located throughout the state. They function directly under the control of the Directorate of Health and Family Welfare. They are spatially located over the 7 districts of the state which also act as the agencies of the Directorate for the various schemes and programmes. [4]

For the purpose of extending the health services schemes and programmes to the people, various health channels have been established. These health channels are directly responsible for the delivery. The district hospitals, (Centres), primary health centres, community health centres, subsidiary health centres, sub-centres/dispensaries are the agencies where the programmes are made available to the people. The various of programmes have been statistically distributed in terms of geographic locations. Location priorities are and effectiveness would be more in line by looking into the disease prevalence and pattern existing in the respective locations. The nature and kind of programmes patterned to the needs of health issues have been gradually increased/ introduced and increased. The overall disease prevalence may not be as alarming comparatively (with

most other states in the country). Yet some issues in terms of comparisons within (micro level) do project variations where analysis for the cllauses table reasonable questions.

The existence of the various programmes at certain locations and at the same, the absence of such programmes in certain areas with an accountability to the magnitude of the requirement remains to be seen including the existance of the system and it's nature of functioning, appropriateness in planning and administration which would be more relevant and meaningful as claimed and projected.

Different Health Programme under the Directorate of State Health Service in Nagaland:-

1. National Malaria Eradication Programme (N.M.E.P)
   This programme has two basic types
   a) Rural Malaria b) Urban Malaria.
2. National Leprosy Eradication Programme (N.L.E.P.)
3. National Tuberculosis Control Programme
   a) New Case detection
   b) Sputum Examination at P.H.C.s
4. National Programme for Control of Blindness.
5. National Goitre Control Programme
6. Sexually Transmitted Diseases Control Programme.
7. National Mental Health Programme
8. Prevention of Food Adulteration.

9. Drugs Control Programme

   a) Drug Renewal

   b) Drug-de-addiction Programme

10. Medical Education and Training

11. Dental Health Care Programme

12. Indian systems of Medicine and Homeopathy

13. School Health Services Programmes.

14. Epidemiology and Health Intelligence

15. Information, Education Communication and Extension Education (IEC & EE)

16. Family Welfare Programme.

17. Maternity and Child Health Programme

18. Universal Immunisation Programme (UIP)

19. Health Guide Schemes

20. Oral Rehydration Theraphy (ORT)

16 F.W.P. This includes it's structure, for service delivery or availability, performance under the programme, service and supplies, training of personnel.

Planning and Objectives of the 8th Five Year Plan

The idea and process of planning as a system in India has undertaken to shoulder the nations responsibility ever since her independence. This responsibility guarantees it's citizens of their felt needs in various multiple dimensions. Therefore the approach endures to feel the pulse (of the people) for which

systems are emphasised to respond. These systems are devised machinery organs incorporating the methods in the system which are supposedly designed basing on the call of the population. The delivery mechanisms are constituted in the various power forums for appropriate decision making and direction for a subsequent process of delivery and implementation. Various infrastructures are built upon, which act as channels to let flow of the programmes which are supposedly aimed at the 'interest' of the people. This supposedly meaningful form of democratic functioning perhaps draw attention for an analysis of the work of the functioning (actual), corresponding to the coherence of the existing 'interest' and 'felt needs' of the people (as we may subsequently discuss is given situations)

Health as a subject has been given an important priority, which has been subjected to the state governments responsibility. This approach has the full backing of the central government in terms of the needs of funds and directives of the programme implementation, which are undertaken and patterned to the subject and it's undergoing experiences.

As such, since the inception of the subject in the 1st 5 year plans, it has been given a priority which was a part of the community development programme. An instance of this is the initiative of the rural health schemes which were launched through the PHC (Primary health Centres) in 1952, the system being aimed at emphasizing in delivering the that needs of the

rural masses and as on a measure of primary health care. As emphasized before the nation's achievementof independences by the before committee (1946), health was to be treated on the basis of an overall socio-economic context of the people. Therefore 'developmental' approach to this was empahsized in an integrated forms.

Various other committees have been entrusted which emerged with various recommendations for the basic and primary issues of the heath of the people, such as the "Srivastava Committee", "Mudaliar Committee" etc.

These recommendations were influential factors in the planning process of programmes, based on the evaluation analysis and studies of the various 'findings'

Various recommendations and suggestion have emerged since then, aimed at nurturing the needs of the people.

The tall claim of the Alma Ata Declaration (Russion -1978) which called and declared programmes and packages, for basic health 'related experience' and needs'that would fulfill to the maximum "Health for all by 2000." remains a 'declared' challenge. Third would countries including India where poverty is the prime cause of ill-health and disease have been given made 'much' hope yet in despair as current situations continue to be, where development of the people is a prime socio-economic

need. This may be considered a major problem in battling against the existing situations and the systems and practices within.

In the midst of all these situations, we also have the ICMR - ICSSR committee and recommendations (1981), decades after the likes of Bhore Committee. It consisted of men and women in various fields. The main objectives were to bring about a national health policy for providing health for all by "2000 A.D". It has special emphasis for women, children and the underprivileged. It's recommendations were based on primary health care, family planning, intersectoral approach and manpower. (The outcome and nature of the various planning. (governmental) and these recommendations have various vital health related)

In the state of Nagaland, the various programmes of the first 2 five years plans and a major of the 3rd five year could not be realised due to the various socio-political developments in the state. However, the policies and developmental programme for the overall socio-economic progress have been in progress comparatively from the 4th five year plan onwards.

Being a subject and thus a responsibility of the state, health policies and programmes have been incorporated along with the other developmental plans and approaches. The state mainly 'depends' on the centre for the various programmes and the basic funds. The state is in poor her financial resources

and capacity. Central initiated and supported programmes in tracking health problems and diseases like Malaria control, Tuberculosis, Family Welfare, (maternal and child care) are emphasised.

Hospitals, dispensaries, units which (P.H.C.s etc) and maternity and child health centres have been found for the health service delivery.

Simultaneously, the principal developments in expansion of health services related to such field was water supply and sanitation, control of communicable diseases and expansion of training facilities and other infrastructures have been undertaken. The state could not avail these similar programmes in the initial stages after independence.

Health Planning

The country as a whole for the past (nearly) 50 years since independence, a serious of 'planning' has been taken place acquiring a new and quite a novel meaning. All these implies budget allocations under certain loads : hospitals and dispensaries, medical education and research, control of communicable disease; rural health programmes training programmes, indigenous system of medicine and homeopathy and other programmes' (Banerji, 1978c)

However, two important heads in overall health aspects,

namely, [1] and environmental sanitation and water supply,[2] and family planning have new been taken out of the sector. Thus health planning in the successive Five Year Plans implied no more than varying financial allocations under these heads. There are findings of serious dissatisfaction with the existing model of medical and health care services with it's emphasis on hospitals, specialisties and super-specialities and highly trained doctors which gets limited in practice mostly to urban areas and which is available of mainly by the "well-to-do" sections of the society (the privileged). It is also realised that it is this model which is depriving the rural areas and the poor people of the benefits of good health, medical services and health care whose costs go far beyond their resources, which emphasis curative rather than preventive and promotional aspects and which creates immense problems because of over-emphasis an inappropriately high level of professio- nalisation, institutionalisational and centralisation. (G.O.1. 1979). The planners of the need for evolving alternative models more relevant and appropriate to the experiences and the felt needs thererof. But the 'health plan' which resulted from this sincere and committed approach did not touch the 'existing' model of medical and health services which they had of the 'safe-state' as described by Gumas Myrdal.

The balancing (health) in Nagaland state has even formulated by taking the various constitutional accounts as

subjective and objectives for procuring plan programs. This is evident in the statements of the 8th Draft Five Year Plan - 1990-95. The plan claims emphasis on statements and declarations of the various fundamental and issues, plans and recommendations pertaining to the understanding of the 'concept' of 'health' and subsequent 'models' supposedly aimed relevently at the health service delivery cathering to the farthest and nearest of the deserving public.

The objectives have been emphasized on the following main objectives:-

- Establishing integrated network of basic health services in rural areas by opening new sub-centres, primary health centres and community health centres.

  Strengthening, modernising and expanding of the existing hospitals for an "institutionalised" treatment. In Nagaland medical facilities still not being adequate, this aspect of curative treatment has been emphasized into account.

  Integrating and consolidating of the achievements made so far by strengthening the infrastructure in this context a restructuring of the Department is to be given due emphasis. Maternity and Child Health CAre Services will be geared up.

  Training of medical and para medical personnel to be better equipped and fit into the framework. To emphasis on health

education for generating awareness about health, hygiene and sanitation.

Prior to entering and participating in the national five year developmental planning process, where the state became an active participant only from the 4th Five Year Plan. (here participation refers to receiving or getting the state allocation/funds and programmes within as planned).

Medical infrastructure was then comparatively much lower. There were 20 general hospitals, 1 TB hospital, 70 dispensaries, 3 PHCs and 725 beds in the state

The financial outlay during the fourth plan and subsequent periods (further plans) are as follows:

The IV Plan Outlay	-	145.00 Lakhs
The V Plan Outlay	-	254.00 Lakhs
The VI Plan Outlay	-	800.00 Lakhs
The VII Plan Outlay	-	1500.00 Lakhs
The VIII Plan Outlay	-	3172.00 Lakhs

A Monthly Record of Indoor/Outdoor Patients
Treated at the Medziphema PHC

Period : 1989 (Jan-Dec)

Sl. No.	Category	Treated Cases
1	Intestional infections diseases	375
2	Tuberculosis	12
3	Other Bacterial diseases	3
4	Viral diseases	20
5	Malaria	307
6	Venereal diseases	5
7	Diseases and late effects of infections and parasitic diseases	44
8	Malignant neoplasm of lymphatic and haemopoietic tissue	15
9	Malignant neoplasm of linoral cavity and pharynx	3
10	Nutritional deficiencies	5
11	Diseases of blood and blood forming organs	51
12	Mental disorder	18
13	Diseases of the nervous system	6
14	Diseases of the ear and mastoid process	24
15	Rheumatic fever and rheumatic heart diseases	6
16.	Hypertensive heart disease	11
17	Cerebrouascular diseases	1
18	Chronic diseases of tonsils and adenoids	6
19	Other diseases of the respiratory system	105

Table Contd.

20	Diseases of teeth and supporting structure	47
21	Diseases of urinary system	23
22	Diseases of the male genital organs	2
23	Diseases of the female genital organs	8
24	Normal Delivery	34
25	Diseases of skin subcutaneous tissue	24
26	Diseases of the musculoskeletal system	8
27	Certain conditions oirginating in the perinated period.	19
28.	fractures	42
29.	Dislocations, sprains and strains	12
30	Open wounds and injury to blood vessels	14
31	burns	30
32	Other injuries/early complications of trauma	9
33	Later effects of injuries to toxic effects and of other external accidents causes	1
34.	Transport accidents	9
35.	Accidental poisoning	5
36.	Accidental falls	15
37.	accidents caused by fire and flames	2
38.	Suicide and self-inflicted injury	

A Monthly Record of Indoor/Outdoor Patients
Treated at the Khonoma PHC

Period : 1989 (Jan-Dec)

Sl. No.	Category	Treated Cases
1	Intestional infections diseases	286
2	Tuberculosis	32
3	Other Bacterial diseases	9
4	Viral diseases	41
5	Malaria	65
6	Venereal diseases	8
7	Diseases and late effects of infections and parasitic diseases	
8	Malignant neoplasm of lymphatic and haemopoietic tissue	7
9	Malignant neoplasm of linoral cavity and pharynx	3
10	Nutritional deficiencies	6
11	Diseases of blood and blood forming organs	47
12	Mental disorder	4
13	Diseases of the nervous system	2
14	Diseases of the ear and mastoid process	18
15	Rheumatic fever and rheumatic heart diseases	2
16.	Hypertensive heart disease	5
17	Cerebrouascular diseases	1
18	Chronic diseases of tonsils and adenoids	2
19	Other diseases of the respiratory system	65

Table Contd.

20	Diseases of teeth and supporting structure	17
21	Diseases of urinary system	3
22	Diseases of the male genital organs	4
23	Diseases of the female genital organs	5
24	Normal Delivery	38
25	Diseases of skin subcutaneous tissue	11
26	Diseases of the musculoskeletal system	8
27	Certain conditions oirginating in the perinated period.	14
28.	fractures	15
29.	Dislocations, sprains and strains	41
30	Open wounds and injury to blood vessels	10
31	Burns	3
32	Other injuries/early complications of trauma	3
33	Later effects of injuries to toxic effects and of other external accidents causes	1
34.	Transport accidents	2
35.	Accidental poisoning	1
36.	Accidental falls	4
37.	accidents caused by fire and flames	1
38.	Suicide and self-inflicted injury	

A Monthly Record of Indoor/Outdoor Patients
Treated at the Shamatore PHC

Period : 1989 (Jan-Dec)

Sl. No.	Category	Treated Cases
1	Intestional infections diseases	285
2	Tuberculosis	85
3	Other Bacterial diseases	11
4	Viral diseases	31
5	Malaria	85
6	Venereal diseases	15
7	Diseases and late effects of infections and parasitic diseases	
8	Malignant neoplasm of lymphatic and haemopoietic tissue	
9	Malignant neoplasm of linoral cavity and pharynx	
10	Nutritional deficiencies	45
11	Diseases of blood and blood forming organs	27
12	Mental disorder	1
13	Diseases of the nervous system	
14	Diseases of the ear and mastoid process	17
15	Rheumatic fever and rheumatic heart diseases	23
16.	Hypertensive heart disease	1
17	Cerebrouascular diseases	
18	Chronic diseases of tonsils and adenoids	4
19	Other diseases of the respiratory system	21

Table Contd.

20	Diseases of teeth and supporting structure	29
21	Diseases of urinary system	
22	Diseases of the male genital organs	
23	Diseases of the female genital organs	
24	Normal Delivery	43
25	Diseases of skin subcutaneous tissue	
26	Diseases of the musculoskeletal system	
27	Certain conditions oirginating in the perinated period.	
28.	fractures	18
29.	Dislocations, sprains and strains	34
30	Open wounds and injury to blood vessels	7
31	Burns	5
32	Other injuries/early complications of trauma	
33	Later effects of injuries to toxic effects and of other external accidents causes	
34.	Transport accidents	2
35.	Accidental poisoning	
36.	Accidental falls	7
37.	accidents caused by fire and flames	4
38.	Suicide and self-inflicted injury	

A Monthly Record of Indoor/Outdoor Patients
Treated at the Ioklak PHC

Period : 1989 (Jan-Dec)

Sl. No.	Category	Treated Cases
1	Intestional infections diseases	301
2	Tuberculosis	80
3	Other Bacterial diseases	14
4	Viral diseases	2
5	Malaria	102
6	Venereal diseases	75
7	Diseases and late effects of infections and parasitic diseases	
8	Malignant neoplasm of lymphatic and haemopoietic tissue	2
9	Malignant neoplasm of linoral cavity and pharynx	
10	Nutritional deficiencies	55
11	Diseases of blood and blood forming organs	39
12	Mental disorder	4
13	Diseases of the nervous system	
14	Diseases of the ear and mastoid process	15
15	Rheumatic fever and rheumatic heart diseases	17
16.	Hypertensive heart disease	1
17	Cerebrouascular diseases	5
18	Chronic diseases of tonsils and adenoids	7
19	Other diseases of the respiratory system	18

Table Contd.

20	Diseases of teeth and supporting structure	41
21	Diseases of urinary system	11
22	Diseases of the male genital organs	12
23	Diseases of the female genital organs	33
24	Normal Delivery	60
25	Diseases of skin subcutaneous tissue	
26	Diseases of the musculoskeletal system	
27	Certain conditions oirginating in the perinated period.	
28.	Fractures	33
29.	Dislocations, sprains and strains	29
30	Open wounds and injury to blood vessels	
31	Burns	5
32	Other injuries/early complications of trauma	
33	Later effects of injuries to toxic effects and of other external accidents causes	
34.	Transport accidents	4
35.	Accidental poisoning	2
36.	Accidental falls	3
37.	accidents caused by fire and flames	1
38.	Suicide and self-inflicted injury	

Footnotes of Chpater 2

1. Dr. B.B. Ghosh, Hist of Nagaland, The Nagaland State Gazetteer, Kohima, 1981, p. 121.

2. Brief History of the Department of Health and Family Welfare: Nagaland, Directorate of Health and Family Welfare, Nagaland, Kohima, 1988, p. 2-3.

3. Prof. Debabar Banerji, Health and Family Planning Series in India. An Epidemiological, Socio-cultural and Political Analysis and a Perspective, p. 44-49.

4. Annual Administrative Report, Directorate of Health and Family Welfare, Nagaland : Kohima, 1989-90, p. 31.

MARCO-MICRO VARIATIONS IN THE EXISTING HEALTH SERVICES:

In many a situation, the approach is broad in outlook with actually a narrow knowledge of the situation. These may be in issues and cases within. Therefore the necessity for developing a better understanding and grasping of issues is a prime requirement, in order to have a better understanding of these authentic data and information. This trend may then incline towards exposing and projecting a clearer canvas of perspectives pertaining to the overall dynamics of a society.

This may suggest of a calling need from the aspects of one corner to the other or from one form to the other. Every form of differences and their existence are interlinked with certain causes and factors. A pyramidic outlook and an inlook may perhaps provide a frame for a comparative view in both ways. For the purpose, a brief macro --> micro = micro --> macro may provide a data source for talking views on given issues.

MACRO VARIATION

A macro variation in terms of underlying regional experiences and conditions may throw a focus for a

variable understanding. The North East with a particular references to the state of Nagaland is comparatively weak and dependant on external source for the management of sustainence of the population, mainly from the centre. Yet, although this may be the case, the population in general possess the capacity and the potentiality for the basic requirements in terms of both human and material resources. Although the literacy rates are again comparatively high in the region, the area is much less developed. Rather, emphasis has been placed more on the side of the national security, where in the process, localised and a broad based development has failed to grow, owing to disadvantages and discontantment amongst the population, in addition to the in famous attitude of - these 'remote' and 'far-flung' areas of the country.

The Region has an area of 2.55 lakh km and a population of a little over 26.37 million (roughly 30 million). Remoteness co-relating to the underdevelopment of any area is a national perspective. Further, within the area or region itself, inaccessibility and poor development are the common features. This, may be consdered as an indication of intra - regional variations within. The percentage of rural population is estimated to be as high as 90%. Density of population is as high as s

421 per sq. km in some areas and as low as only 2 in some areas. The tribal population is almost 55% of the region's population, as against roughly 8% of the total Indian population The region presents a paradoxical picture of being poor in the midst of plenty. Inspite of the agro-climatic conditions, (predominantly agricultural population) the region has to depend on import of food grain upto almost 10 lakh. M.T. (Metric Tonnes) per year.

The region has a heavy reserve for generating hydel power capacity which is estimated to be about 30,000 M.W. + and 23 million cubic wts. The region as a whole has 2998 million tonnes of limestone deposit, about 928 million tonnes of coal and is rich in agriculture and forest section. Inspite of this, the industrial output of the region is low - only Rs. 554.86 crores against the all India figure of Rs. 3409065[1] crores. A further indication may be noted of the gap between these differences and also the potential and the actual, If these natural resources are emphasised with local managerial capacity training, the region's socio - economic situation would make a tremendous improvement.

However, random and generalising methods prove to be extremely inappropriate in many issues and cases. Within a

certain area in total as such a composed macro outlook may prove to be inadequate while there is great deal of need for a fragmented penetration for a closer inlook to attain a deeper and richer understanding in correspondence with the existing conditions. For this purpose some issues in the following phases indicate the specifications to some degree.The socio economic structure in Nagaland has been undergoing transformations from traditional to the present system, though its conditions are unique. Relatively a socio-cultural form of equalitarianism exists within the society. Besides the contact with the British Colonial Administration, the American Baptist Mission, dispatching or a continent of labour corps to France in the Ist World War and finally the World War II in which the present state of Nagaland had to bear the brunt of being the last and main battle field between the advancing Emperial Japanese forces and the allied forces (The battle of Kohima)[3]. The British did not really emphasize on real socio-economic development and a systematic political administration suited to local advantage, where and commerce was never really established. As a result, when the British left, the local population and areas were still comparatively at a great disadvantage and socio-economically in a position of being very underdeveloped and "backward".

In the fifties a sum of Rs. 500,000 was the total revenue. Only over 1,237 persons were employed through trade and commerce. The urban population in the three districts was roughly 19,157. Only 10&% (20,500) were employed through various programmes.

The rest 90% of the work force were engaged in agriculture, who were rural based.

Limited and self-gathering army oreinted developments took place, mainly medium communication and transport means, garrison and contonments withh limited health service system were bought in. Other than these, were the small health service schemes of the Christian Missionaries which was also very limited. (Presently a mission Hospital is situated In Impur - Mokokchung District). This was probably the first time that the locals were exposed to the modern allopathic medical system. However further, at the state's a composition.

Agriculture still remains to be the main source of livelihood. About 75% of the total population are engaged in agriculture. They are mainly rural and are in a stage of traditional society. Their level of output per capita is low, which more or less remain constant over a period of time. The techniques of high production are low with an

absence of market orientation[2] cultivation in production where the terrains are also not too conducive. Industrialisation is almost nil, with pockets of small scale and semi large industries. They often fail to generate revenues to the state treasury.

The growth rate of population is the highest in the country with 50% through influx from the neighbouring states (particularly from Assam) are heavy. They occur mainly in the plain areas. Among the locals, the normal practices is 4-5 in a family. The procreation standards is mainly based on socio-cultural norms. The numerical standards differ from community to community, though not very strictly. The density of population is almost 73% per[5] sq. km. (91 census). About 80% of the total state population live in the rural areas. Rural population in Nagaland is almost 10,54;711, as against 2,31,031 living in urban areas.

Total Workers constituted about 50.75% of the total population. It is comparatively higher in Mokokchung and Tuensang districts, with the former being mostly of office job holders with the later in contrast is overwhelmingly agricultural through complusions.

In a further breakup, 84% of the population are

scheduled tribes (ST). The rest are constituted by Hindus, Muslims, Sikhs Buddhists and other minor groups. The majority of the tribal population are Christians with some of the local with no religion as such (traditional). The migration pattern within the state is hard to define in strict terms, particularly as recorded from 1901-1991. The movement has been mainly based on natural resource form of economy.

In the age structure, which is important for occupation and profession of work force, the population is mainly composed of children and the young The young and older are gradually reportedly increasing in number.

In variation terms, Tuensang district has 65% of the population as a work force which is highest[3]. The main reason for this is largely negligence, receiving little attention for the socio-economic progress and development inspite of having being declared an "underdeveloped" area, generally referred to as "backward areas", by the government. The district lacks good and standard educational system with weak and low quality of manpower for the management. Emphasis on primary level of education is a highly important baseline in this regard, for qualitative input and product. People feel deprived, exploited, sidelined where avenues comparatively become

very limited. This is a major reason for drawing the larger protion of the districts population to the hard, simple and somewhat typical rural form of agricultural life, and therefore schooling and educationsl opportunities are deprived to the children of this district. Naturally, the stagnancy is more prominent in the field of socio -economic development, particularly among the tribal communities bordering Bruma in the exterme east of the state

In general, the overall health of the state's population enjoys a good status in comparison with the rest of the country, although this should not 'facilitate' the purpose of having poor of low and weak health infrastructure in comparative terms.

In comparison there are differences in terms of health status of the people, the efficiency of the management of the health service system and it's infrastructure, the distributional pattern and location, quality efficiency etc, in coherence with the socio-economic status of the people, within the paradigm of the state and it's the capacity of fundamental management. A general focus can also be thrown at the periphery level and the managerial level, for evaluating a more co-efficient and relevant system of management to the core. The state has comparatively made a significant progress

over the year, through it's infrastructure for the delivery system. However, the disparity exists between the infrastructure and the service delivery to the people in the overall context. For developing an avenue of critical analysis, a base on socio economic criteria and the perspectives of the socio-political system within the people are crucial for understanding the integrated health dynamics.

THE INTERIORS

The health status of the population are strongly determined by factors like food-intake, both quality and quantity, water supply system, sanitation, housing, income, education, employment and the availability and accessibility to all these, including the health care facilities. Policy making and decisions in harmony with these key factors are important in the process, particularly where emphasis must be thrusted in term of priorities and more of a need based. Traquenled approach to the context.

Inspite of the indicated figures of progress in the earlier chapters, the health care delivery system both in the its rural and urban section, a sound achievement for

the health of the people is still a prime issue and demand. With the rapid increasing number in the population, there is a requirement for sound and integrated system in the health sector of the state with a timing and calculation. The planning process therefore requires this need to pattern programmes accordingly and appropriately in the subsequent plans.

In the light of the statements so far, a closer look to familiarise some of the actual existing state of affairs and their causes would perhaps help understand more of the realities and their determinant factors.

Though there are bound to be some differences with ups and downs in any farm of a given developmental situation as such, it would be grossly limited and drastically shortcoming to dimiss and assume by generally categorising these existing differences or disparities merely on the grounds of these so-called "bound-to-be".

The determinant factors require analysis and then to focus on the facts of the situation as they exist, while some of these shortcomings in, the state may be based on hard ground which may prove to be of some difficulties to the socio-economic developmental process of the people,

there are other equally hard factors which are intentions and deliberate, directly responsible for the given situations.

No doubt, the new or modern economic and politico administrative systems have provided the state's population with a change and motivation - of new values and norms, such as the growth more and changes with skilled and advanced techniques, modern educational facilities and the capacity related within, producing professionals and other qualified manpower. They have been responsible too a considerable extend for the overall improvement, in the standard of living and management of the state affairs and the changes within.. By and large, 5 yearly Plans (central) have in a sense benefitted the people to a great extent. But interestingly, these benefits have been marginal in most cases and very uneven, inspite of the small size population of the state. These differences can be further analysed by looking into the different districts of the states and their overall state of affairs and conditions as they exist. The inter-district imbalances in Nagaland vary from one to the other, though the difficult experiences are similar to all. 3(three)out and of the 7(seven) districts have seen declared as "backward," by the state

and has been well notified to the central government for the 'resources' that are required to improve and develop these declared areas, in addition to their share and the overall state budget allocations. Yet, ever since the attainment of the statehood, the given situation in many of these declared backward" areas have more or less been the same, while in contrast, the "advanced" districts continue to receive and benefit the bulk of the overall development and thus making the disparity situation much more wider than ever was. The 'comparative difference' is thus ever widening. These wide development differences among the districts and the comparative capacities of the people are mainly in terms of socio-economic conditions, and a manipulated political representation grossly imbalanced formation of the state government and the machinery.

As mentioned, regional disparities in economic development and social structure, are but natural. However, the efficiency and the nature of plan formulation and implementation to the context of the state in an overall paradigm provide justifications in raising questions which are unavoidable in the circumstances.

For instance, all the areas are 'tribal' as such and geographical conditions are but the same. Therefore

then, the conduciveness is almost in uniformity be it in terms of the possibility to deliver and achieve the plans so as to provide the needs of the people, or for that matter of the difficulties for the developmental process. Given this situation, there is not much reason to agree with the wide differences in the socio-economic developmental context between these districts. The declared areas as "backward" are Tuensang district, Mon district, Meluri block and in Phek district, and one or two blocks under Zunheboto districts bordering Tuensang district, and the Peren division of Kohima district. Of these, Tuensang in the most backward' followed by other Mon district.[4]

The Tuensang district is relatively in a more "disadvantage" position. It is located it in the interior, bordering Burma with rugged physiography. The other districts are comparatively in a better "advantage", having a closer physical proximity with the plain areas of Assam where developmental changes took place earlier." It is a fact that regular administration was earlier in these "advanced districts" with Tuensang and Mon districts undergoing the system much later. But over four decades almost towards after the nation's independence and almost 30 years of the statehood,it is not statistically and

factually not convincing for the "backwardness" of these districts. It is rather an indication of mismanagement and inefficiency of the state governments. The backwardness is rather an outcome of neglegience and failure.

The system of distribution and allocation of development is not in harmony with the socio-economic conditions of the of these districts. Many of the rural villages and it's population under these areas are yet to experience the same programmes of basic developments which were introduced since the independence and the statehood, unlike the areas of the advanced areas. This long period since then, do not justify the existing- district imbalances on flimsy pretensions that these areas are 'interior', `educationally low` and are therefore 'backward`. Resources and capacity of the people are comparatively very low in these areas . Suitable and relevant policies have hardly been given the effort to these areas, for which the developmental imbalances and disparities exist in the state. Overall these status projects a backwardness of the state itself as a whole.

There are almost 100 odd villages in Tuensang district, 40 odd villages in Mon district, 20 odd in Phek district, all situated along Burma which are again in extreme 'backward' condition.

For a deeper understanding of the health status of the state, a look at the infant mortality rate (IMR) according to the survey conducted in 1981 may reveal certain rate of figures.

The recent study still reveals the existence of the variations in a break . Brief studies were conducted to evaluate and analyse the functioning of four selected Primary Health Centres (P.H.C.) in the state. The centres were chosen from Kohima and Tuensang districts.

1) Kohima District - a)Medziphema, P.H.C.
   b) Khonoma, P.H.C.

2) Tuensang District - a) Shamatore, P.H.C.
   b) Noklak, P.H.C.

Child Mortality Rates of Nagaland by District Wise

Name of the State and Head District	TR	Q(1)			Q(2)			Q(3)			Q (4)		
Nagaland	U	P	M	F	P	M	F	P	M	F	P	M	F
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Nagaland	T	68	76	58	76	82	61	82	86	79	100	104	16
	R	73	86	57	81	89	72	70	94	87	109	112	106
	U	55 (45)	48	64 (41)	63	63 (48)	63	53 (68)	56	50	63	71	54
Kohima	T	57	63	50	72	79	64	73	77	68	92	97	86
	R	54 (64)	72	33 (54)	71	84	57	78	83	74	100	104	96

Table Contd.

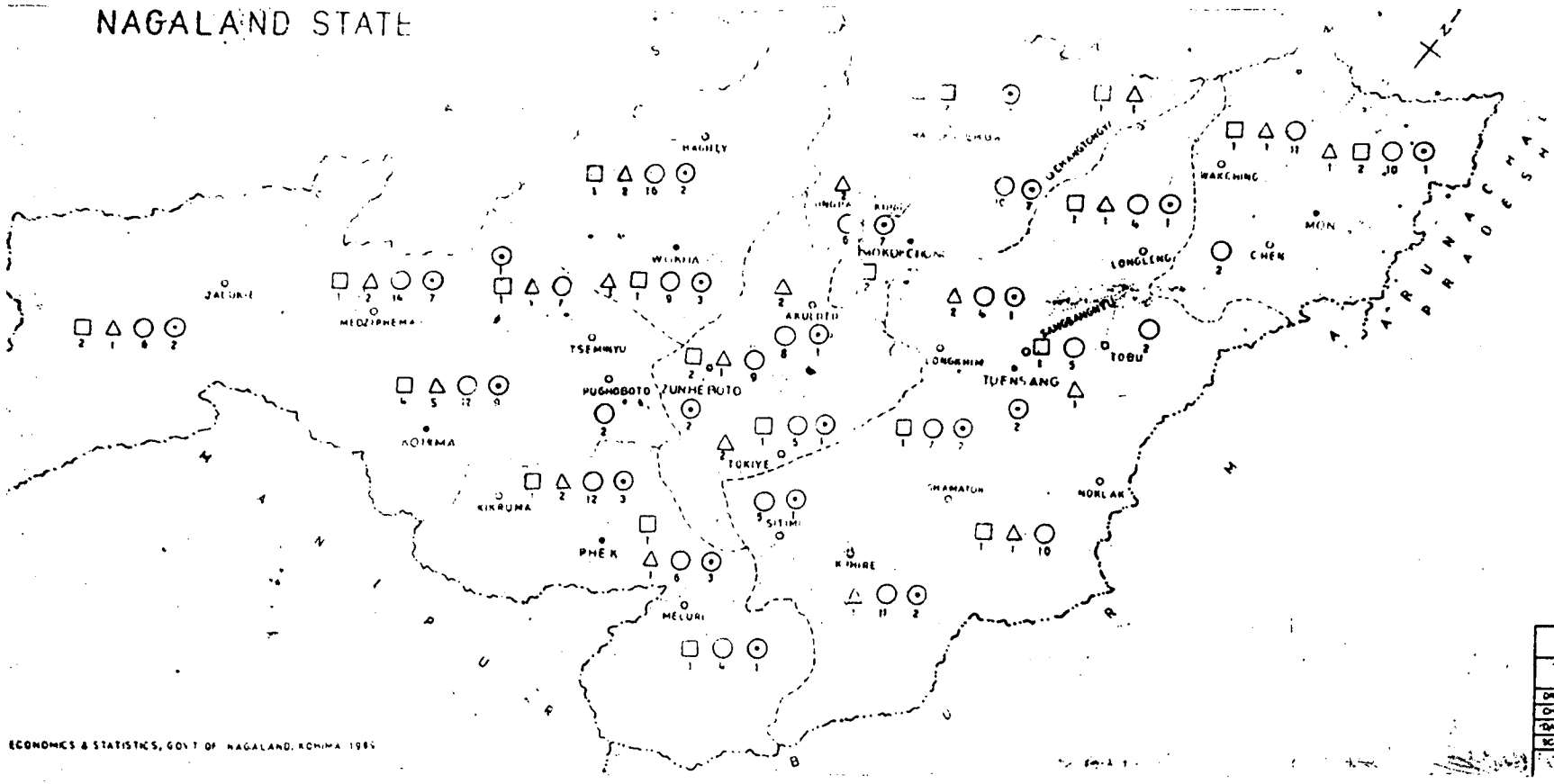
	U	63	46	85	72	72	73	61	65	57	72	82	61
		(51)	(60)	(46)	(69)		(54)		(77)				
Phek	R	33	50	19	54	66	42	75	76	74	95	87	102
			(72)		(72)	(73)							
Mokha	T	34	66	-	44	44	44	56	57	55	62	65	59
	R	52	90	-	56	59	52	62	65	80	70	73	68
		(52)											
@	U	-	-	-	8	-	16	31	25	38	20	28	11
Zunheboto	T	51	50	53	66	75	56	104	96	113	115	126	104
					(96)		(96)						(118)
	R	76	69	85	75	87	62	116	110	123	124	134	114
		(85)			(103)		(104)						(128)
	U	-	-	-	39	38	39	48	28	69	61	71	86
Mokokchung	U	34	28	40	52	64	41	56	57	54	68	64	67
		(47)	(53)						(67)				
	R	30	32	23	57	76	38	58	59	57	75	76	74
		(50)	(60)						(76)				
	U	-	-	69	41	35	47	49	52	46	42	441	41
		(35)	(32)					(42)	(39)				
Tuensang	T	107	116	95	91	108	103	108	97	127	128	125	
		(83)	(81)	(86)	(108)	(95)	(122)	(113)	(117)				
	R	121	125	114	108	95	122	113	117	108	113	134	131
		(87)	(85)							(127)			
	U	49	69	31	63	72	55	35	45	25	68	72	64
								(66)	72)	(59)		(80)	
Mon	T	159	179	137	121	136	105	126	135	115	138	146	128
		(93)	(99)	(85)		(123)							
	R	170	188	148	133	152	114	134	149	129	147	154	131
		(99)	(105)	(92)	(124)	(132)							
	U	106	130	77	76	80	72	56	65	46	72	92	52
		(45)	(66)	(39)	(51)		(45)		(86)				

From the above figures, statements can be drawn where the rates of child mortality are higher in the backward areas of the state. However the mortality does not necessarily indicate the overall status of health in district. The rates can also be conducted according groups and the level of education etc. For that matter. For instance, it is lower in among the educated mothers, particularly in the urban areas.

MICRO VARIATION:

In the process of understanding the health service system of a state a detailed analysis cannot be worked out on the basis of the macro variations, unless one delays into the micro variations existing at different levels in the functioning of the health service system. In a state like Nagaland inspite of macro variations and diversities the acute micro variations in relation to functions of the health organisation have provided us a detailed data regarding the key factors in relation to determining the health culture of the various communities in the developed and less developed districts. The/the investigator has attempted to collect data from four PHCs in two districts, namely Kkohima district and Tuensang districts to analyse the detail micro variations.

NAGALAND STATE



LEGEND

1. DISTRICT H.Q.	●
2. BLOCK H.Q.	⊙
3. INTERNATIONAL BOUNDARY	
4. STATE BOUNDARY	
5. DISTRICT BOUNDARY	
6. BLOCK BOUNDARY	
7. HOSPITAL	△
8. P.H.C.	□
9. P.H.C. SUB-CENTRE	○
10. DISPENSARY	⊙

SCALE 0 5 10 15 20 Km.

FIGHTH FIVE YEAR PLAN OF NAGALAND

INFRASTRUCTURE AND H.R.D

BLOCKWISE MEDICAL INSTITUTIONS IN NAGALAND STATE.

DRAWN BY RAMESHWARI

CHECKED BY Dr. A. SINGH

DATE 16.10.85

SCALE - 1 CM = 5 Km. V.

DRG. NO XIX-1

HASK CONSULTANTS
(A Consortium of Techno-Economic Consultants)

ECONOMICS & STATISTICS, GOVT OF NAGALAND, KOHIMA 1985

1) Kohima District :

a) The Medziphema P.H.C. is located almost 60 km from Kohima, which is situated alongside the National Highway No. 39. 1 it is comparatively a equipped centre, in terms of efficiency and delivery of the health services. The community population are comparatively more responsive with a higher rate of mobility, which also is in terms of resource capacity in the context.

The centre is managed by a local M.O. (Medical Officer) with 20 beds. The P.H.C. is well represented in terms of manpower, trained for their respective responsibilities in. the centre, which mainly deals with curative medical work and partly public health in the comminity, which has almost 20,000 population with a regular flow of basic amenities. The area is furthered supported by subcentres which are managed mainly by pharmacists and supportive manpower such as the village health guides whose works are basically oriented towards community health.

However, the centre does lack some basic facilities such as constant stand-by vechile for the M.O., ambulance for patients. Timely supply of medicines, and further

requires strengthening of the housing facilities for the staff. After a brief review and analysis, the P.H.C. was chosen relating to the objectives, structures, functioning and data. The analysis tend to identify successful conduct of the programmes and as well as to identify problems for references and discussions. some of the approaches were based on training, working methods, location, (physical proximity) density, (population coverage) basic facilities, co-ordination, people's relations, suitable schemes and programme that may exist or be required at the centre.

b) The Khonoma P.H.C.

The Khonoma is situated about 20 km from Kohima. The PHC is situated is conveniently for health services to the nearby community. The centre, comparatively being near the state capital is not handicapped as much as the other centres in the far flung areas. Although there are cases where the efficiency must also be emphasized, the awareness of the people require some educational approach, to reduce the intensity of the community health problem. By and large, the people are healthy but preventive aspect is required other than simply curative oriented. Means of transport for the centre and the patients are required in cases of urgency, which is

lacking most of the time. Emergency medical supplies such as life-saving drugs are sometimes almost absent in the store, which makes it more difficult for the needy patients. The normal flow of out door patients ranges from 50-100 in a day. The periphery of this centre needs strengthening in order to develop a better co-ordination in terms of health treatment and administration. The local population see of a need to post M.O even at sub-centres, which are quite evident from the requirements of the situations. Vaccination process are not being followed systematically. Ignorance of the people is one strong reason which is a hinderance for a better health status where even the existence of such facilities are not known. The environment, relating to the hygiene of the community in Khonoma and neighbouring villages is poor, which includes cleanliness and sanitation which requires an improvement in the community, as well as in the health service centres. There is a need for orientation and training of staff at the P.H.C., which should also involve the community people. It can develop a follow up model at the periphery level in regard to health education. Common diseases are malaria, gastroenteritis, skin diseases, T.B.

The Khonoma PHC is comparatively strong in its

infrastructure. The PHC has 5 sub-centres, which are basically SHCs (sub health-centre) and dispensaries.

The Jotsoma dispensary has an M.O, supported by other para-medical staff. The other centres such as Pedoucha and Palwa are manned by an M.O. and a pharmacist, along with the other para-medical staff as may be sanctioned to the full.

The Seeuma and Mezoma subsidiary health centres (SHCs) are also manned by an MO each along with para-medical workers. The only village which does not have a centre is Dzulake. However, inspite of this comparatively strong infrastructure both at the central and the periphery level, the efficiency of the health services and delivery require improvement. Immunisation was reportedly in a better situation in 1988-89, having covered well over 80% of the target. This achievement however needs to be maintained. Other programmes like medical education, malaria eradication programme, family planning (Maternal and child health) are common.

PHC on the other hand as it exists, needs strengthening. Example, indication shows that inspite of the strong peripheral infrastructure, most of the Malaria patients and T.B. patients came to the PHC. The flow of such patients are heavy. This causes difficulties at the

centre, in terms of manpower capacity in handling the patients systematically. As a result, the patients are not given the proper treatment in many cases. Emphasis on the efficiency of the PHC is therefore more necessary for the time being unless the services are improved at the periphery.

Tuensang District

The Shamatore [13] P.H.C. (12 bedded)

The centre is located almost 60 km from Tuensang and is one of the centres which actively handles well over 25,000 population. Nearby block population often come for treatment due to acute lack of medical facilities both the infrastructures and the manpower. There are over 20 villages which are covered along with 4 sub-centres, which are also severely handicapped due to non existence of some of the centres and of acute lack of medicines and the manpower too. Patients are further compelled to even go to Kohima for treatment, who are basically the the rural areas with poor income and capacity. In many cases, patients die due to absence of the M.O., the other staff and even live-saving drugs. These drugs are stored are again situated at the faraway district head quarters much in addition to their hardships.

There are no A.N.Ms serving presently, inspite of the posts having been assigned to the sub-centres. This is a level pahramacist stationed at sub-centre, which has only one small building with no staff quarter as yet.

The earlier ones have been phased out, and are still lying vacant without having been strengthened.

The Mangkho sub-centre does not have any building or other infrastructures facilities, for quite some time. The pharmacits and other manpower are existing in a vacuum. The transportation services are poor with only footpath in most cases. The electrification in the block has been connected the power supply in most cases is low and irregular. The water supply system is poor, requiring a better system of management. The Chassir-Melangchur dispensary has been sanctioned but the infrastructure is yet to shape up. The common diseases particularly in the villages are tuberculosis, diahorreal diseases, malaria, malnutrition and goitre in some limited areas. The delay out patients (OPD) ranges from 50-130, with an average of almost 50-70.

The P.H.C. building is old and situated in the centre of the town, which needs to be relocated some where convenient in all aspects. The M.O of the P.H.C.

has been absent even for 3 to 4 months without any replacement. Even otherwise, the M.O is mostly out of station, inspite of the services required. As a result the patients are compelled to go a nearby army doctor in a small contonment area, which also run dispensary for themselves.

Inspite of the high T.B. incedental rate, case, there is no islolation ward and therefore treatment is even more difficult. They often refuse to go to other centres for treatment. In addition, the district T.B. centre does not exists, which has been sanctioned for long. Infact, the supposed T.B. Hospital is `still` under construction. Poverty and lack of financial capacity for meeting the basic requirements, which are not made available to them either at the P.H.C. or at the sub-centres. Again, in many cases, the mortality is comparatively high due to diarrhoeal diseases and malnutrition. Parents are usually handicapped to even purchase or spend a small amount of money for meeting this problems, in which as a result acute and collective health problems, occur. Above all, ignorance reason for which literacy and health education is systematically required.

Immunisation is yet to pick up through basic health eduction and publicity. Infrastructural managerial

capacity is important in this regard. In the centre, there are other basic shortcomings, such as the M.O.s quarter which is old and badly needs reconstruction, including an ambulance, which has been also pointed out as a basic requirement in other centres. The remoteness and being out-post by administration justify these demands.

Manpower needs strengthening much more, with more emphasis in health education in the villages, where the centre should directly initiate responsibility, which is ironically lacking. In one instance the post of a pharmacist was "temporarily" replaced by a" lab" technician, for "Diagnosis" and "Treatment" of patients.

Noklak PHC (12 bedded)

The Noklak PHC has been upgraded to 30 bedded rural hospital. Presently, the hospital is maintained with 12 (twelve) bed and is yet to receive the basic amenities of the 30 bed capacity.

The Noklak PHC is situated 58 kms away from the district head quarter. The centre covers an area with a population of about 14,000 (fourteen thousand) there are 18 (eighteen) villages under its health service jurisdiction, with 6(six) sub-centres or dispensaries.

Out of these only two have ANMs with the other staff and 3(three) pharmacists only. The supply of medicine is very poor including life saving drugs. As a result, the village population depending on the sub-centres are worst suffers, where the health status is low.

Means of communication are poor, except the rural footpaths connecting and leading to the villages. They are often crude and gets very inhospitable during rainy season. Water supply system and electrification are poor, and the difficulties are daunting. Hygiene is low where even water-boiling is not very common, specially during certain seasons.

The common disease are Helmenthesis, malnutrition, diarrhoeal diseases, tuberculosis. Goiter fairly common in some of the villages skin infection, STD specially syphillis etc. are also quite common. The socio-economic conditions of the overall population is poor which is a probable major factor and reasons for multiple poverty related diseases, accompanied by igorance of the population in health and related issues.

Inspite of the governments approval for a 30 (thirty) bedded hospital, only one hospital building along with some other smaller buildings (Type III and Type V) exist.

These structures are old without any repair.

The centre handles about 40-130, with an average of OPD (outdoor patient department) patients of almost 50 to 60. There is therefore a great need for more doctors and paramedical workers for both the centre and the periphery. Tuberculosis (pulmonary) and Helmethesis are fairly common. Treatment is often difficult, special without the separate T.B. ward and Another common and a major problem in the centre similar to the other health centres in the district is the lack of basic curative medicine, further handicapped by their (patients) socio-economic limitations. They are often compelled to purchase the medicine normally from the far away district head quarter. Health education is another requirement. The purpose and need for immunisation are yet to become aware among the rural masses.

The centre is further handicapped by lack of a vehicle for M.O and an ambulance for the patients, which is presently necessary by the existence of health standard inspite of the high rate T.B. incidences, bone fractures and other diseases, the centre lacks an X-ray facility. The centre further requires a staff nurse, which has been going without one.

Perspectives of the Eight Plan

There are findings of serious dissatisfaction with the existing model of medical and health care services with it's emphasis on hospitals, specialities and super-specialities and in practice usually to urban areas and which is availed of mainly by the "well-to-do" sections of the society (the privileged) it is also realised that it is their model which is depriving the rural areas and the power people of the benefits of good health and medical services and health care exists so far beyond our resources, while emphasis curative rather than prevention and promotional aspects and which creator immunise problems because of over-emphasis an inappropriately high level of professionalisation, institutionalisation and centrali-sation. (7.0.1, 1979)

It was also emphasised by planners of the need for evolving other native models more relevant and appropriate to the experiences and the felt needs thereof. But the 'health plan' which resulted from this sincere and committed approach did not touch the 'existing' model of medical and health services which they had disapproved of so categorically - further widened of the 'safe-state' as described by Gunnar Myrdal.

The planning (health) in Nagaland state has been

formulated by taking the various constitutional accounts as subjactive and objectives for procuring plan programmes. This is evident in statements of the 8th draft 5 Year Plan - 1990-95. The plan claims emphasize on statements and declaring if the various fundamental guarantees and issues, plans and recommendations pertaining to the understanding of the concept of 'health' and subsequent' models' supposedly aimed vehemently at the health service delivery benefitting the farthest and neediest of the most deserving people.

Footnotes of Chapter III

1. Seminar, The North East, 1989, p. 4.

2. Swabeva Islam Saleh, Nagaland's Economy in Transition since 1964, p. 70

3. Ibid, p. 11

4. The Nagaland State Gazetteer Kohima, 1981, (December).

DISCUSSION

Health is defined as not merely an absence of disease or infirmity but it means complete physical, mental and social wellbeing. Health therefore embraces the whole spectrum of an individual and its activities. The constitution of India envisaged a new social order based on equality, freedom justice and the dignity of the individual - a where poverty, ignorance and ill-health is to be eliminated. The states were entrusted to deliver an optimum health care services and ensure health of every citizen with emphasis on mother and child. A healthy society is the state's best resource and potential for development. It is therefore relevant to regard expenditure in health sector not as an output but an input towards resource development.

For a critical appraisal of health policies, process and programmes in a complex border state like Nagaland conceptually as well as methodologically one has to develop the interdisciplinary exercise. Health service system of a state is an epidemiological, socio-cultural and political process rooted in its history and its changing ecological and demographic setting. However, after Nagaland gained statehood, while the political leadership continues to renew their commitment in the

lofty egalitarian pronouncements made during the anticolonial struggle, they essentially used the same machinery which was handed over to them by the colonial rulers to ensure the fruits of independence and statehood. This benifitted them most by perpetuating their hold on the state government apparatus.

Thus a noteworthy feature of health services development in Nagaland is that, throughout the past decades of the statehood, it has been influenced by the powerful forces pulling it in different directions: the colonial values and practices, which continued to be nurtured by the privileged class, pulling in one direction, and the anticolonial struggle which after independence took the form of struggle for democratisation pulling in another direction. To sum up, this is the trend in the political economy of functioning of health services system in Nagaland.

CONSTRAINT AND CONTRADICTIONS IN THE HEALTH SERVICE DEVELOPMENT:

With the achievements, the department has been able to improve the health care facilities mainly in the rural ares and thereby improved the health status of the people of the state, but due to non availability of technical manpower a number of sub-centres and community health

centres could not be provided with essential categories like the ANMs and specialists, etc. Thus shortage of trained manpower i.e. doctors, nurses, ANMs and other paramedical officers have been a major constraint in delivering the health services to the community inhabited areas especially in interior villages of the state. Although Nagaland as compared to other states in North Eastern region is better placed for medical coverage to the rural areas, the far flung villages of state are yet to be provided health care centres equipped with trained manpower, transportation, medicines and materials like infrastructure.

The non availability of buildings under construction or non-completion of buildings have also jeopardised the functioning of different health programmes and schemes. Depending upon other states for medical education and inadequate facilities for training of medical and paramedical in the state have added to the shortage of medical personnel and trained para-medical staff essential to run the health institutions i.e., SCs SHCs, PHCs, CNCs, dispensaries, 'hospitals' etc.

Financially, huge expenditures on education and training of medical and para-medical personnel in sponsoring local boys and girls outside state ia a major

problem.

For the purpose of providing medical care to serious patients a Referral Hospital under establishment is yet to be completed and properly equipped. These patients are often referred to outside the state and in most cases timely treatment are not given.

For the implementation of the different health schemes effectively and to attain better health status, involvement of community and optimum participation of people at grass-root level is very essential. In this direction, training and posting of village Health Guides (VHGs) or multi-purpose Workers (MPWs) in this field is essential for the restructuring of health units. But the scheme has not made desired impact as the training and posting of these peripheral workers were not materialised at an optimum level.

Epedemiological call at the state level and district level were perhaps not carrying out the regular surveys on the pattern of diseases prevalent in the state.

On health education, corner stone of all health schemes has not given due empahsis so far. The urgent need of teachers training about the utility of school health services have been comparatively nominal. This is

required to bring about the awareness of health in the community. The awareness of health play a vital role in presenting and promoting health status of the society. There have some efforts at certain peripheral levels (i.e PHCs) through a co-ordinated approach but further needs more emphasis through the district levels with a more effective and systematic organisation.

The high incidence of tuberculosis, malaria, leprosy not eradicated, entire children and pregnant women population not covered under immunization and low couple, protection rate (CPR) reveal low health status of population in Nagaland. These core areas of health should have been the consensus of planners and policy formulators not only to reduce the mortality and morbidity drastically but to achieve health for all by 2000 A.D. (Alma Ata Declaration 1978, Russia)

The basic facilities of other systems of medicine except homeopathy are not made available. The potentialities of traditional and herbal medicine are yet to be explored in Nagaland, which has been abundant and popular.

Another major factor for the existing health problems in the state is the dependence of the population solely on governmental medical centres in absence of any private or

voluntary medical units. However, it might perhaps make the existing infrastructure and the programmes more meaningful to the people with emphasis based on the priorities of the overall needs and expieriences of the people.

Developmentla policy in Nagaland

The state of Nagaland remains backward economically inspite of allocation of Plan funds since the attainment of statehood in 1963 Physical achievements on the ground are far from satisfactory. There are strong evidences of imbalanced developments and economic disparities among the different constitutuents of the state. Such lopsided economic development and disparities are, to a great extent, result of complete centralised process of planning being adopted in the state. The formulation and implementation of the Plan Programmes are done at the state level without making proper assessment of the local needs, and the common people especially at the grass root level, do not enjoy the fruits of economic development. The benefits of development do not trickle down to the most deserving sections of the people.

Planning and development process plan of the state so far has remained centralised in the state level. Some recommendations for schemes did come from the district

level but very few of them were actually accommodated while finalising the schemes at the state level by the different departments. This has led to the acute lop sided development in certain areas. There is no uniformity in development level which can be compared to any reasonable extent even between the the different districts. Since the entire planning process is centralised at the state level it has led to a lot of measures from their assembly representatives for inclusion of their schemes in their areas in each departments. As a result, very small amounts are allocated for different developmental projects such as communication means like road,water supply schemes or other developmental projects that are deserving by the demand.

Therefore, with a view to overcome the prevailing loopholes,lapses and lacunae and with a renewed objective to filter down the benefits of economic development to the grass root level a new programme of "compact and development" has been evolved and will be implemented with effect.1.4.1991

However, like all other developmental plans and programmes, the efficiency and the positive outcome of the plan will be important for a focus and evaluation, particularly in the context of the given socio-economic

condition of the state. The organisation of Nagaland remain essentially unchallenged because its structure reflects the interest of the ruling class for e.g., an article in the 'Weekly Journal', a local publication news publication released by the Nagaland doctors association (N.D.A.),Quoted that " facilities of 'outside' the state treatment at government's expense can be availed by the privileged few people only and the majority of the people who are too poor too go outside Nagaland at their own expenses for treatment continue to suffer. The 'medical model' of health as a model of disease causation focuses almost exclusively on the individual as opposed to the social determinants of diseases in Nagaland. The control factors determining the ill health in Nagaland is because of might system which is the legitimation from liberal developmental model which in a sense even the de ss a welfare' approach to social problem. When apptu to issues of health care, the solutions prepared for over and legitimise a technical, often dependency creating framework for action.

Thus the problems associated with the expansion of the western health care model in Nagaland had been examined in the context of values assumptions and contradictions within the existing sociopolitical structure of Nagaland.

The liberal developmental approach in Nagaland in its basic welfare approach to societal problems is inadequate the to overall social development viz a good health. This approach is the source of underdevelopment and perpetuate poverty by not attaching the transforming existing exploitative social structure and vast rural-urban differences.

This study, taking the lead from liberal developmental theroy has analysed more deeply of the provisions of basic needs, concept and the nature of under development in Nagaland

CONTRADICTIONS WITHIN THE MODEL

Compared to the urban living, living in villages have major disadvantages in Nagaland. A big city enjoys many social, economic, and political benefits that are not available to the population of rural areas. The dependence of the villages on the cities make them more vulnerable to exploitations and controlled by city based political leaders, traders, bureaucratics, and intellectuals. For example when a person living in a non -PHC village becomes severely ill, at most he has access to a PHC situated some 10-15kms away on an average. The PHCs facilities being rather, limited, the patients are often tken to a nearby town or city to avail more

sophisticated investigations and treatment.

This and treatment is his unjust order aggravates further when the limited PHCs facilities gets blocked, often in the absence of the MOs in the far-flung areas. The macro diversities discussed in the chapter III has clearly brought out a strengthened exploitation of the masses in the rural areas. contaminated source of drinking water, dust, dirt and infestation by various kinds of insects, other pests and parasites, extensive poverty, grossly sub-standard housing, poor drainage and sanitation and extremely poor hygiene are some of the factors in a village setting. These have created an ecological condition highly conducive to wide spread prevalence of various kinds of communicable disease, T.B., Malaria, leprosy, STD etc. and malnutrition and high rates of morbidity and mortality. Obversely the health hazards in the rural areas are much greater than what is found in urban areas of Nagaland.

In most of the underdeveloped districts (bordering Burma), in Nagaland, the people of rural area suffer deprivations because of their being more poorer, lower rate of literacy and less scope of meeting their basic needs. Not having the proper scope for social justice, the exploitation process get enlarged. Thus the

geographical, social, economic and political 'conditions' rural communities greatly influence its growth and development. The data collected from the various PHCs have provided ample evidence for the extensive prevalence of poverty and exploitation, and the denial of basic health services and the facilities.

Infact, to understand the fundamental measures as to why the rural people of Nagaland are unhealthy and die unnecessarily, it is required to analyse and assess the present developmental model. The failure of the present developmental strategy has recently led to a greater empahsis on community participation. In truth, within the existing soico-economic political order, it has been found that there can be little genuine participation by the "community" because this is no "one" community, but rather there are "communities."

Qadeer likewise, observed that within the semi feudal values of social relation in most Indian villages, "giving for th poor", earns for the richer sections, the right to exploit the poor and strengthen their own social dominance. Developmental projects and model schemes, then, are irrelevant to the ultimate problems of ill-health, no matter what the technical innovation expertise, unless they clearly lead to empowering the poor and healthless to confront their dependency not only with

the regard to the existing, system but more importantly within the entire social order There is a need to confront the reality of the present gross mal distributions of health and economic resources and the powers that continue to legitimate and tolerate such injustices. Developmental efforts which do not start at the basic level of analysis and action are irrelevant to the struggle for health in Nagaland. Even worse they contribute to the obscuring of the central issue i.e. the question of why is maldistribution exist in practice. For example AIDS Programmes in Nagaland ignoring the basic health programmes.

It is still more important to understand why the galring underdevelopment is still perpetuated in Nagalnd inspite of a lot of developmental measures which have been initiated since 1963. Nagalands economy is, inspite of some major public services and infrastructural state enterprises and market economy, the ownership of the means of production is primarily private or individual. Because of this market economy the above imbalances in development in the health sector has been fund. The exploitative soico-economic relations between the classes has perpetuated. Low allocation to the rural health sector in Nagaland. This warrants a more decentralisation

of policy in the health planing of Nagaland to give more attention to the acute health problems seen in the districts and PHCs of the underdeveloped districts. The best alternatives health strategy is to give primacy to the basic needs of the masses, seeing health needs as part of the total overall needs. To fight this ill health in Nagaland is to fight the unjust socio economic power structure, and to minimise the macro , micro diversities and inequalities existing betwen the class and the masses.

SUMMARY AND CONCLUSION

Nagaland from the colonial past attained it's statehood on 1 Dec 1963 from the Naga Hills and Tuensang Area of the North Eastern Frontier Agency (N.G.T.A.). Having it's socio-economic and geographic diversities has embarked to deliver good health services to the Naga of Nagaland through it's health service system spread in the different areas in the national pattern.

Health and human development form integral components of overall socio-economic development of the state. Both go hand in hand and help in making the human life healthy and happy. This very objective was followed by the department of health and family welfare. This department is responsible for providing basic medical cover to the entire population of the state and also to control the various communicable disease; to take effective measures at the time of epidemic due to natural calamities. Further the department is making all-out efforts to provide basic medical care to the far flung areas of the state by opening community health centre. Primary Health, subsidiary health care and the sub-centres.

The present study was aimed at analysing holistically the health service system of Nagaland keeping in view the diversities found at the level of socio-economic and

political structures. This study has brought out the major problems with regards to the building up of health infra structure in major geographical areas of Nagaland. In Nagaland the health service system is based on the basis of the unjust distribution of the resources and allocations of the funds mainly in favour of the urban areas and in which mostly the elite class who politically dominating is benefited most.

At the PHC level from a detail and systematic investigations it was found out that the mere institution were there without adequate staff, medicine and other basic infrastructure. This has resulted a great problems to the people of rural Nagaland who are the deprived most. Very high prevalence of diseases like tuberculosis, malaria and leprosy has provided the evidence that the availability of the basic health services has perpetuated a heavy morbidity and sufferings among the lowest of the law socio-economic groups of the districts like Tuensang and Mon.

It has been seen that the people of Nagaland have approached the health institutions in search of basic health services wherever they have faced different kinds of ailments and diseases, but the health service system and viz-a-viz the personnels are not tuned to this feltneed which has resulted a vacuum in the government health services and provided the privitisation of health services

an Nagaland. This amply demonstrate that the elite oriented health structure has been grown out of imbalanced planning as well as maldistribution of resource in the state.

The democratisation process has not been mobilised in the masses as a result of which a small elite section are ruling the state monpolising the state power structure since statehood. This very nature of the power structure of Nagaland is required to be changed if Nagaland is launching the policy of health for all by 2000 AD" by minimising the glaring macro and micro differences existing in the health service system.

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