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Challenges facing Public Health Administration in Mizoram With Special Reference to National Health Mission

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I. Introduction

In general,Public administration is the implementation of government policy and also an academic discipline that studies this implementation and prepares civil employees for working in the public service. It also serves as a field of inquiry with a diverse scope whose fundamental goal is to advance management and policies so that government can function. Some of the various definitions which have been offered for the term are: "the management of public programs"; Whilepublic health administration both as an academic discipline and a government developmental program is one among the three pillars of human developmental index which focuses in management and improvement of public health through a democratic approach, systematic planning, co-ordination and need based researches and strong and sustaining financing. In short it has its foundation of improving the administrative component of health intervention and function on the basis of POSDCoRB.

India and its varies cultures and communities has a long history of maintaining health and hygiene through various sub-disciplines based on non-allopathic system, but which has now become a major player in the health sector industry and the country's economy both in terms of service and pharmaceuticals.

In our country like most others public health assumed great importance as well as significant especially after the attainment of independence. However it cannot strive to a desired level, in terms of budgeting since the country is still in a developing state not to mention the problems of various federal units'i.e. states, UTs, autonomous district councils; whose level of progress and development is diverse just as its cultural and demographic diversity. The public healthcare system in India evolved due to a number of influences from the past 60 years, including British influence from the colonial period. The need for an efficient and effective public health system inIndia is large till today. Public health system across nations is a conglomeration of all organized activities that prevent disease, prolong life and promote health and efficiency of its people. Indian healthcare system has been historically dominated by provisioning of medical care and neglected public health.(11.9% of all maternal deaths and 18% of all infant mortality in the world occurs in India, ranking it the highest in the world. 36.6 out of 1000 children are dead by the time they reach the age of 5.62% of children are immunized. Communicable disease is the cause of death for 38% of all deaths in India (Indian context is computed by Mr.Lallianzuala, Consultant, Health and Family Welfare, Government of Mizoram).

Public health administration has now become one of the most challenging sector in the fast modern world requiring revamped and re-organization with a meticulous review of our present stand – Human Resources (HR), output and input cost efficiency index in comparison to our socio-economic standard and capacity and building upon learning from the past planning for the future and addressing the present here and now. In the words of Prof.George E Berkley *"all administration requires an organization of some shape, size or kind and all organizations carry on some measure of administrative activity"*

Country scenario and the National Health Mission

In public Health administration as an academic and governance view the health of a country or a community is measured by child survival and infant health and include of course mother's health. The development of any community or a country depends on the health status of its people especially the vulnerable populations including mothers and children. World leaders gathered at the United Nations at the beginning of the new millennium to shape a broad vision to fight poverty in its many dimensions. That vision was translated into eight Millennium Development Goals (MDGs) which has remained the development framework for the world for the past years. The MDGs goal five is to improve maternal health and since 1990, the maternal mortality ratio has declined by 45 per cent worldwide, and most of the reduction has occurred since 2000.

Maternal mortality reduction remains a priority under "Goal 3: Ensure healthy lives and promote well-being for all at all ages" in the new Sustainable Development Goals (SDGs) agenda through 2030. By 2030, its goal is to reduce global maternal mortality ratio to less than 70 per 100,000 live births. Among the indicators of maternal health, more than 71 per cent of births were assisted by skilled health personnel globally in 2014 which has increased from 59 per cent in 1990. Contraceptive prevalence among women aged 15 to 19 (married or in a union) increased from 55 per cent in 1990 worldwide to 64 per cent in 2015.

In India,

The National Rural Health Mission (NRHM) was launched in April 2005 to cover the underserved areas which later form the National Health Mission. Its basic objective was to reduce infant and maternal mortality rate, to ensure population stabilization and to control communicable and non-communicable diseases. Some of the initiatives under the National Health Mission which are directly or indirectly linked to reducing infant and maternal death are as follows:

Accredited Social Health Activists (ASHAs): Community health volunteers are engaged under the mission for establishing a link between the community and the health system; they are the first call of any health related demands of the population. Engagement of more than 8.9 lakhs Accredited Social Health Activists (ASHAs) to generate demand and facilitate accessing of health care services by the community.

RogiKalyanSamiti (RKS): The management structure that acts as a group of trustees for the hospitals and thereby manage the affairs of the hospitals.

Untied Grants for Sub-Centres: It improved the efficacy of Auxiliary Nurse Midwives (ANMs) in the field for undertaking better antenatal and other health care services.

JananiSurakshaYojana (JSY): JSY aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible women for giving birth in a government health facility.

JananiShishuSurakshaKaryakram (JSSK): JSSK provides free to and fro transport, free drugs, free diagnostics, free blood, and free diet for pregnant women who come for delivery in public health institutions and sick infants up to one year. JananiShishuSuraksha

Karyakaram (JSSK) has been launched on 1st June, 2011, which entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home.

Capacity building: Capacity building of health care providers in basic and comprehensive obstetric care is an important strategy.

Comprehensive obstetric care services: Efforts were made for perationalization of sub-centres, Primary Health Centres, Community Health Centres and District Hospitals for providing 24x7 basic and comprehensive obstetric care services.

Tracking: Name Based Web enabled Tracking of Pregnant Women to ensure antenatal, intra natal and postnatal care. This was called MTCT (Mother to Child Tracking)

MCP Card: Introduction of Mother and Child Protection Card in collaboration with the Ministry of Women and Child Development was done to monitor service delivery for mothers and children.

Supplementation: The provision of antenatal, intra natal and postnatal care by iron and folic acid supplementation to pregnant and lactating women; for prevention and treatment of anaemia.

Village Health and Nutrition Days: Observation of Village Health and Nutrition Days in the rural areas. This is an outreach activity, for provision of maternal and child health services. Health and nutrition education used to be held to promote dietary diversification, inclusion of iron and folate rich food as well as food items that promote iron absorption.

Focus on low performing districts: To sharpen the focus on the low performing districts, 184 High Priority Districts (HPDs) have been prioritized for Reproductive Maternal.

New-born Child Health+ Adolescent (RMNCH+A) interventions for achieving improved maternal and child health outcomes which was done with the aid of UN Agencies and has its impact on the health system and administration in India giving it a more ambitious goals and objectives for the MDGs on health.

Moreover the Forward linkage scheme was implemented with the sole objective of establishment of important Health service delivery point (from a Sub-centre clinic to a medical college).

The principles and systematic governance at the Union level of the government for the erstwhile National Rural Health Mission (now National Health Mission) and its up-gradation to National Health Mission is more or less the same, quite dynamic, innovative, fast paced, comprehensive and holistic. However, interaction with contractual staff (*most of these are the backbone of the Mission implementation*). Health being a concurrent subject of administration under the constitution of India we will often be comparing and contradicting between the two. Thus in short just as the problem of AIDS was seen as the United Nation and its agencies as a developmental issue, the larger dimension, Health was seen as a critical influencing determinants

of development, peace and progress. So the normal Health administration and program was found inadequate especially in the rural areas hence the Mission was launched in 2005 which focus mainly on the rural and peripheries.

As a highly motivated and ambitious project the administrative arrangement necessitate a Mission Director at the Centre headed by a Senior and competent IAS officer not below the rank of an Additional Secretary to the government of India, functioning as a secretariat for all the state and the centre having its own financial adviser.

For system strengthening and capacity building HR was enlarged with contractual staff from different technical field under its Terms of references and mission statement and visions.

Diagnosing the challenges at the State level (Mizoram)

Since inception an Letter of Undertaking/Memorandum of Understanding was signed between the Union government and the state government with a 75:25 budget sharing between the union and the state except for NE states and other backwards Union Territoriesetc. who are relaxed to a 90: 10 basis with a number of terms of references and detailed mandatory functions by both the parties. In the States and Union Territories, the states were mandated to have a State Health Society with layers of committees the highest under Chief Minister chairpersonship and a Village Health and Nutrition committee at the grass root.

The actual main functional executive was the Executive Committee Chaired by the Principal/Commissioner of Health Department at the state level the Mission Director being the Member Secretary (who should be an IAS of Supertime scale). The states were mandated to have a secretariat headed by the Mission Director with a few administrative and technical experts at his disposal. District Health Societies were to be the arms and branches of the SPMU having its own District Program Management Unit. Hence in era of advanced management and digital world we would not be directly referring to the traditional system of confirming notions, supporting ideas, and theories from Aristotle, Kautilya, Augustecomte, Woodrow Wilson, Paul Appleby etc. But rather examining the empirical facts, situational analysis.

In 2005 Mizoram also oathed and commenced the NRHM with a poor administrative policy of human resource. The post of Mission Director was given to the Joint Director of Health Services (Family welfare) and through assessment we can see from the following points that such deliberation against the Memorandum of Understanding was quite a negative start. Hardly was the government/department aware that the Mission Director would be calling the District collector/Commissioner at least twice or thrice in a year. Now gathering a few facts and finding as mentioned:

i) The state government was not aware from head to tail of its mandatory obligation and function of NRHM before signing the Memorandum of Understanding with the Centre

ii) The state did not strive enough to put IAS officers to the Mission Director post much to the liking of the Mizoram Health services.

iii) However, there was already Public Health specialist among the medical fraternity, already in the state for whom post could be allotted.

iv) This fourth point should have come in the first in terms of priority that is the state or any governing political party has a robust, dynamic and SMART(Specific, Measurable, Attainable, Relevant, Time Bound) Health policy therefore till date besides just following the central guidelines, this small tribal state can have its own

v) Public Health policy which could be synergized and converged with the National Health policy and the mandates under the NRHM/NHM

vi) The success or failure or achievement of the NRHM/NHM was quite dependent on individuals rather than system.

vii) Both at the National and state level many ideal connotation and terms were repeatedly used as an indispensable task such utopian terms as ‘convergence’, inter-sectoral collaboration etc. lie unpracticed in the so called no modus operandi, note sheets and in meetings.

viii) At the state level the SPMU functions like an implementing agency and decentralization was not properly administered as envisaged. It took decades to follow the PFMS in financial administration and procurement, recruitment etc.

ix) The declining performance across most of the states came when funding pattern which was earlier directly credited to the Society was shifted to the state government through finance department. This resulted in delayed implementation of activities, all or most of the NRHM/NHM staff (contractual) was delayed on salaries, TA/DA reimbursement, procurement delay, civil works etc.

x) Public Health cadre was/is not made lucrative and till date it has ‘miles to go’ especially on the posting and transfer norms, training & capacity building norms. While clinical PG courses remained the aspirations of most of the general duty medical officers, as they could earn hugely from their private clinic.

xi) Mizoram is fortunate to have at least 2-3% of its GDP on Health but this is not judiciously and strategically planned or utilized most of it goes to salaries and HR it is almost totally dependent on NHM now.
xii) Absence of bottom up approach in planning, M&E learning and documentation
xiii) Lack of convergence among the different key technical groups even within the health administration such as nursing, food and drugs control, AYUSH, paramedical etc.

II. Conclusion

Although the public administration and governance has undergone a series of positive changes, reforms thriving towards progress and development and multisectoral advancement, alleviating the poor, improvement in public health, increase in GSDP, revival of our Nations, unity in diversity and digital revolution yet, Pandemics such as Covid-19 starkly remind us that public health systems and administration are core social institutions in any society and that our investment and budgeting in short revitalization of our public health administration need to be among the top agenda of our MDGs.

The government has made several efforts to address the shortfall in the public health system through the schemes like the National Medical Commission (NMC) Act, 2019, PradhanMantriBhartiyaJanaushadhiPariyojana, PradhanMantri - Jan ArogyaYojana etc. and the state having their own healthcare system and assurance, the need of the hour is an adequate investment, for creating a health system that can withstand any kind of public health emergencies, deliver universal health coverage and meet the targets of the Sustainable Development Goals. Therefore, unlike many other journal papers lets wind up with the following points so that pragmatic steps can be taken in the interest of public service on public health administration:

i) State specific Health policy development in consultation with a variety of stakeholder (a multi-disciplinary approach) and have it legislated
ii) Review of the current status and challenges presented herewith which is not exhaustive with development partners from Ministry of Health and Family Welfare, World Health Organisation, and representative from s/n 1
iii) Strengthening of Public Health Cadre – Recruitment rules, post allotment/reservation, creation
iv) Robust Public Health workers induction program – outsourced with National Institute of Health and Family Welfare etc.
v) Establishment of a Legislator forum for the objective.

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