SOCIAL WORK JOURNAL
(BI-ANNUAL)
ISSN 0976-5484
5 (2) July–December 2014, pp. 111–122

Purview of Health Care services in Ukhrul District of Manipur

Sword Ronra Shimray & M. Tineshowri Devi

The study tries to describe the services provided by both government and private hospitals in Ukhrul district of Manipur. It further describes on the availability, accessibility and utilization of health services by people from Ukhrul district hospital (government) and private hospitals under the study area. The study is determined by sample size of 200 respondents who have utilized the health services in different departments like Women Reproductive Department, TB Department and HIV/AIDS Department of both government and private hospitals. The study discussed on the problems encountered by respondents in accessing and utilizing the services due to non-availability of health care providers, equipments, ambulance and also due to uncertain social unrest in the region.

Sword Ronra Shimray is a Research Scholar; and M. Tineshowri Devi is Associate Professor, Department of Social Work, Assam University, Silchar.

Introduction

Health is a pre-requisite for human development and is essentially concerned with the well-being of an individual as well as for integrated development of society be it cultural, economic, social or political. Societal health status is intimately related to its value system, its philosophical cultural traditions, and its social, economic and political organizations. The cultural pattern varies from tribe to tribe and region to region. Moreover, cultural setting and religious beliefs and treatment among others influence human health and health seeking behaviour. The study of health culture of a particular community is important because health problems, procedures to handle such problems, and other health practices are influenced by a complex interplay of social factors. It is difficult to implement health services without knowledge of community's traditional health culture. Thus, there is an urgent need for initiating a comprehensive study on changing health scenario.

Profile of Manipur

Manipur is a small State lying in the extreme North Eastern corner of India. It is bounded on the north by Nagaland State, on the south-east by Myanmar and on the west by Mizoram and Cachar District of Assam. The State has an area of 22,327 sq.km of which constitutes 0.7 percent of the total land surface of the country. The State has 29 Scheduled Tribes (ST) and 7 Scheduled Castes (SC) having their unique languages, tradition and culture with ethnic diversity. The state is divided into nine districts of which five are Hill districts. These are Chandel, Tamenglong, Ukhrul, Churachanpur and Senapati. The four plain districts are Imphal West, Imphal East, Thoubal and Bishnupur. According to the 2011 Census, the total population of Manipur is 2,721,756 constituting 0.22 per cent of India's population. The male population is 1,369,764 and the female population is 1,351,992. The sex ratio in Manipur is 987 for each 1000 males and has increased from 978 per 1000 males since the last census. Manipur has a literacy rate of 79.85 percent, with male literacy at 86.49 percent and female literacy at 73.17 percent.

The state has three tier administrative set up in the health care services. The state has more than 500 hundred Primary health care centres, 13 hospitals including one state level hospital (Jawaharlal Nehru Hospital) as a referral centre and seven district hospitals.

Objectives

The focus of the study was on the utilization of health services by people of Ukhrul district with regard to reproductive health, HIV/AIDS and Tuberculosis. Following were the broad objectives of the study:

(1) To assess the program/activities available in three departments (Reproductive Health, HIV/AIDS and TB) of both government and private hospitals in the district.

(2) To examine the availability, accessibility and utilization of health services by respondents in government and private hospitals under the study area.

Methodology

Area of Study

Ukhrul district was marked initially as a sub-division in the year 1919 by the British. It includes 222 villages with a population of 1, 83,115 (Census, 2011). The sex-ratio of the district is 948 females per thousand males. It covers 4,544 square kms. of area and is 2nd largest and 7th most populous district of Manipur. The Tangkhuls are the dominant tribe of the district with a population of more than 80 per cent. Other smaller tribes/communities include Kukis, Nepalese and Meiteis. Ukhrul district is considered as one of the backward districts in Manipur in terms of health care. It has one general hospital with a 50 bed capacity, and two private hospitals with 50 bed and 25 bed capacities respectively. Moreover, Ukhrul

district has highest recorded rate of HIV/AIDS in the state. According to the data given by Manipur AIDS Control Society (MACS) in 2014, there are 1285 pre-ART persons and 664 persons are alive on ART. The rate of immunization was merely 30% and the rate of institutional delivery was merely 19 per cent.

Research design

Descriptive research design was used to describe and analyze the conditions of health care services in Ukhrul district. It focussed on three departments that include women reproductive health department, HIV/AIDS centre/department and TB centre/department from both Ukhrul District Hospital and the Private Hospitals of the district. Approximately 200 respondents were selected using simple random sampling and purposive sampling techniques. The respondents were selected from the patients who had registered in the last one year in Women Reproductive health Department, HIV/AIDS Department and TB Department. Further, data was also collected from the key informants like doctors and nurses from Ukhrul District Hospital and Private Hospitals. Two semi-structure interview schedules were used as tools for patients and for key informants.

Results

Health Structure in Ukhrul district

(a) The District government Hospital

The Ukhrul District Hospital was established on June 18 of 1976. It is 50 bedded capacities with 13 doctors, 11 nurses. Under the District Hospital, there is one Community Health Centre (CHC), eight Primary Health Centres (PHCs) and forty three Sub-centres.

(b) Private hospitals

The two private hospitals are namely: (i) **Comprehensive Health Service and Research Centre (CHSRC)** at Hamleikhong Ukhrul, which was established in 2007. It has 25 bedded capacities with 2 doctors, 14 nurses and other staff.

(ii) **Leishiphung Christian Hospital (LCH)** is situated at Meizailung, Ukhrul. It was established on March 6th, 1997. And has 50 bedded capacities with 3 doctors, 8 nurses and other staff. (It is interesting to note that both private hospitals are offering mainly composite care in Obstetrics and Gynaecology and also associating with JSY programme of National Health Mission).

Available programmes in Government District Hospital and Private Hospitals

(a) Ukhrul District Hospital

Sl. No	Program/Activities
1	Women Reproductive Health related Programmes JSY (Janani Suraksha Yojana) JSSK (Janani Shishu Suraksha Karyakram) Rashtriya Bal Swasthya Karyakram (RBSK) IUD Service
2	Revised National Tuberculosis Control Programme-DOTS Centre (Directly Observed Treatment Short-course)
3	National AIDS Control Programme- ICTC(Integrated Counselling and Testing Centres) ART (Anti-retro Treatment) CST (Care Support and Treatment)
4	Operationalization of First Referral Unit (FRU)
5	Awareness and Health education Programme

(a) In Private Hospitals

Sl. No	Program/Activities
1	At Leishiphung Christian Hospital Women Reproductive Health related Programmes: JSY (Janani Suraksha Yojana) JSSK (Janani Shishu Suraksha Karyakram) Intra Uterine Device (IUD) Service Female Sterilisation
2	At Comprehensive Health Services and Research Centre Women Reproductive Health related Programmes: JSY (Janani Suraksha Yojana) JSSK (Janani Shishu Suraksha Karyakram) Intra Uterine Device (IUD) Service Female Sterilisation

The state health department of Manipur is committed to the total health care of its people. The priority is to meet the optimum health needs of the people living in rural areas. The state health system is based upon the primary health care approach as envisaged in the National Health Policy, 1983 with the objective "Health for All" and "All for Health". The state has followed the same principle in implementing different programmes and policies such as National Health Mission, Revised National Tuberculosis Control Programme, National AIDS Control Programme, National Malaria Control Programme, Immunization Programme, etc. Likewise Ukhrul district has also envisaged the same programme. Under the National Health Mission, to fulfil the millennium development goals the district government hospital is implementing Reproductive and Child Health Programme II which helps in reducing the Maternal Mortality Rate and Infant Mortality Rate. The district hospital has implemented Janani Suraksha Yojana (JSY) but the success rate of the programme is minimal due to lack of awareness and transparency in the health system. Janani Suraksha Yojana (JSY) provides cash assistance to the mother after their deliveries and further encourages them for institutional deliveries. There is public-private partnership between the government hospital and the two private hospitals under National Health Mission (NHM) in provision of the JSY program to the respondents in

order to make the programme better and ensure the availability of services for the general population especially for women.

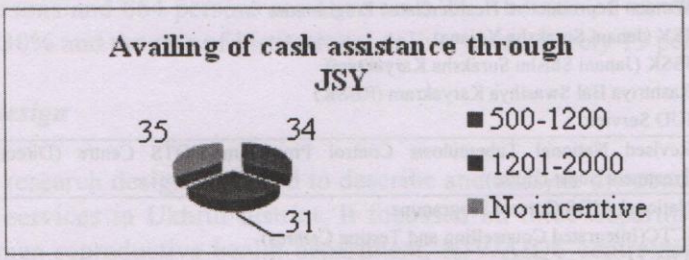

Fig. 1: Cash assistance availed through JSY

Fig. 1 shows the cash assistance which was availed under the JSY programme. The JSY programme states that a pregnant mother (belonging to a BPL household) receives at least 3 ante-natal checkups during pregnancy both in rural and urban areas for availing cash assistance (Park, 2013). It is seen that respondents who have availed incentives, the amount ranges from rupees 500–1200 and rupees 1201–2000. Here 35% of the respondents did not get any incentive both before and after delivery. They claimed that even after they had fulfilled the criteria, no assistance was provided from the government. They further expressed that they asked the Ukhrul district hospital staff for the assistance, but they were being asked to come along with the ASHA worker. Since they were unaware of the presence of ASHA worker as they had not received any facilities from her, they did not get the incentives. While 34% of respondents expressed that they received rupees 500–1200 as cash assistance through JSY after they delivered their babies in the government or private hospitals, followed by 31% who received a sum of rupees 1201–2000 from government or private hospitals. It is interesting to note that majority of the respondents who delivered at private hospital received cash incentives through JSY. It is further seen that majority of the respondents preferred private hospital than the government hospital not only for getting cash incentives but because of positive attitude of health care providers and timely availability of doctors. Thus, availability of health care facilities within the vicinity helps to receive services in time (Prakasam & Raju, 2006). According to respondents, although Janani Shishu Suraksha Karyakram (JSSK) and Rashtriya Bal Swasthya Karyakram (RBSK) were a part of the programme, it has not implemented in the region.

In Ukhrul District Hospital, Revised National Tuberculosis Control Programme – DOTS Centre has been introduced since 2005 onwards. They provide sputum testing examination and provide multidrug therapy to TB patients. Likewise the hospital has also implemented National AIDS Control Programme in collaboration with NGOs but the implementation of ART services started only in 2005. They provide services like (i) Integrated Counselling and Testing Centres (ICTC), (ii) Anti-retro Treatment (ART), (iii) Care Support and Treatment (CST), (iv) Operationalization of First Referral Unit (FRU), and (v) Awareness and Health education Programme.

But in both the private hospitals, the programmes like Revised National

Tuberculosis Control Programme and National AIDS Control programme are not implemented and they focus more on generic health services.

Availability, Accessibility and Utilization of health care services

Utilization of health care services is indirectly inter-linked with the availability and accessibility of health care services like, the programmes, schemes, materials, facilities, equipments and other services from the health care centres. The easy accessibility and availability of treatment from the health centres are indicated by provision of good services by the health care providers and establishing a good relationship between the health care providers and the patients.

(a) Availability of medicines in different departments/centres

Medicine brings relief and improvement to people particularly to respondents who seek services from health care providers. Timely availability of medicine in hospitals will make it easy to provide adequate medicines and will also increase satisfaction levels of respondents who avail services from different departments.

Table: 1 Availing and accessing of medicines from the hospitals

Women reproductive health		**HIV/AIDS**		**TB**	
Tetanus Injections	71	ART and Counselling	100	DOTS	100
Iron Folic Acid Tablets, etc	29				
Total	**100**	**Total**	**100**	**Total**	**100**

Table 1 shows the provision of medicines in different departments (Women Reproductive Centre, TB Centre and HIV/AIDS centre) in Ukhrul district hospital. 71 per cent of women availed only Tetanus injections from the district hospital (government) whereas 29 per cent of the respondents availed medicines like Iron Folic Acid Tablets, calcium, etc. free of cost. It is seen that due to shortage of medicines in the government hospital, the essential drugs are not available, which is a serious lapse in the health system. Thus, the respondents were asked by the health care providers to buy the medicines. At times the patients had to buy expensive medicines from the market. Many poor patients were to buy expensive medicines had to be contented with the cheaper drugs (Advani, 1980). It is more than evident that the government's initiative to provide free medicines to the rural poor who cannot afford the escalating costs of medications on the market has miserably failed to deliver the goods in Ukhrul district. They invariably fail to provide even one out of 4–5 medicines prescribed by doctors of the District Hospital. Instead, one has to buy all the medicines from the Chemist thereby incurring huge expenses even as free medicines provision is officially in place.

In case of HIV/AIDS and TB patients, all the respondents have availed ART

and Multi-drug therapy through DOTS from the government hospital. It is evident that Manipur government is trying to curb the problem of HIV/AIDS and TB by providing all the necessary medicines to patients in Ukhrul district. Further, 52.4 per cent of the HIV/AIDS respondents have received the ART services for more than 2 years, followed by 27.6 per cent who availed the services/facilities for 1 to 2 years, while 10.8% and 9.2% have availed it for 6–11 months and 1–5 months respectively. 51.5 per cent of the TB respondents had availed DOTS for 6–8 months from the centre, followed by 34.3 per cent who availed it for 3–5 months, while 8.6 per cent and 5.6 per cent availed the services for more than 8 months and 1–2 months respectively.

(b) Availability of doctors and equipments in hospitals

Hospital is considered here as a social system and the doctors and patients are the sole occupants who mutually interact to form relationship directed by their specific goals and the general goals of the system (Advani, 1980). Availability of doctors and equipment is a must and necessary to run effective health institution. Thus availability of doctors and equipments should always go hand in hand in order to provide good services to the people.

The health care institutions in the study area has still shortage of manpower, poor working conditions and lack of transparency in posting especially in rural areas makes people unsatisfactory with the government hospital (Misra *et al.*, 2003). Many of the women reproductive health respondents have complained that there is no specialised doctor in women reproductive health (Gynaecology) department. One specialised doctor from plain areas who is posted in the department (Gynaecology) never came for her duty this made patients face difficulties in availing the services from the government hospital. The hospital is functioning with six junior doctors or medical officers (MOs), 14 staff nurses against the actual sanction of 29. Thus, they mostly tend to avail the services from private hospitals. Likewise respondents from HIV/AIDS and TB departments complained that doctors who are posted from plain areas hardly come to the department. Even if they come, they do so only for five to six days in a month, this makes the respondents face difficulties in consulting the doctors resulting in helpless situations for them.

Regarding equipments available in the hospital, women respondents revealed that ultra sound machine and ECG have been installed in the hospital, however the machine lie unused due to shortage of staff. So they need to consult expensive private hospitals for check-up. Further the respondents from TB and HIV/AIDS department expressed, there is still lack of equipments like (X-ray, Liver Functioning Test, Kidney Functioning Test and CD4 count) in government hospital. Often such equipments are damaged or non-functional. According to Grant (1941) hospital facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in

hospitals is both insufficient and precarious, especially for services to people who cannot pay for the cost of the care they need.

(a) Accessibility of health care services

In developed countries, there is not much problem for travelling to centres of medical excellence in larger towns and cities. But in poorer countries most of the people live in the rural areas where communications are difficult, expensive, and sometimes non-existent (Muriel & Katherine, 1978) due to lack of accessibility.

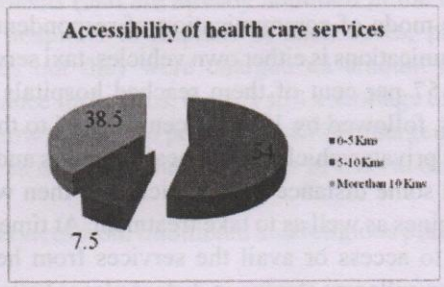

Fig. 2: Accessibility of health care services

Fig. 2 highlights the accessibility of health care services by the respondents. It is seen that majority of the respondents are living at a distance of 0-5 Kilometres from the hospitals. They are mainly from the main town and neighbouring villages of the health centres. 7.5 per cent of the respondents stay within a distance of 5 to 10 kilometres from the health centres. However, a significant number (38.5 per cent) of respondents are staying at a distance of more than 10 kilometres from the hospitals. It is important to note that the landscape of the Ukhrul District is totally hilly. It is very difficult for the respondents to avail the services of hospitals not only due to distance but also by difficult geographical terrain and poor road conditions. The situation becomes worse during rainy seasons.

Health centres and family medicine schemes are supposed to serve as the first point of contact. However, the provisions for ART and DOTS were not available at Primary Health Centre (PHCs), Community Health Centre (CHC) and the two private hospitals in the district. Thus, the respondents who are suffering from TB and HIV face maximum challenges in accessing the services from hospitals.

(d) Mode of Communication

The transport systems for the patients are extremely significant to reach the hospitals for treatment. In certain cases, due to long distance and transportation problems, the patients could not reach hospitals on time for their treatment and therefore, the patients went into critical conditions.

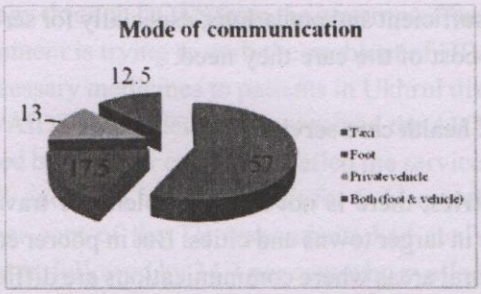

Fig. 3: Mode of Communication

Fig. 3 highlights the mode of communication of respondents to health centres. Their mode of communications is either own vehicles, taxi services, by foot or both (Vehicle and Foot). 57 per cent of them reached hospitals from their villages through taxi services, followed by 17.5 per cent walked to the health centres. 13 per cent went in their private vehicles to the health centres and 12.5 per cent of the respondents covered some distance on a vehicle and then walked to access the immunization, medicines as well as to take treatment. At times it became difficult for the respondents to access or avail the services from health centres due to heavy rains. Moreover, villagers staying in distant places have no access to vehicle services for around two to three months as the condition of the roads get worsened during rainy season.

Respondents who are accessing the services are mostly from the villages where their profession is farming in the paddy field. In the Tangkhul society, farmer's live in the villages whereas employees and business people are mostly resided and live in town. Thus, farmers have to travel for more than 10 kilometres for accessing, availing and utilizing the services from the health care institutions.

(e) Provisions of Ambulance services for women (reproductive health)

Ambulance services are provided for emergency cases. In case of emergency, ambulance service is crucial for taking the patients to health centres. Thus, availability of ambulance services 24X7 is necessary for dealing with emergency cases.

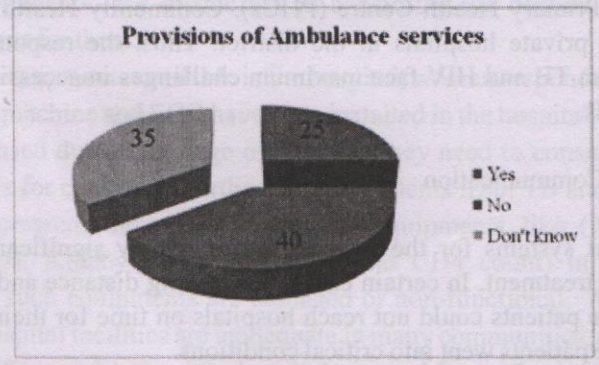

Fig. 4: Provisions of Ambulance services

Fig. 4 highlights the availability of free ambulance services for the respondents in both government and private health institutions. It shows that majority did not avail ambulance services from both government and private hospitals. 40 per cent of the respondents said that there is no free provision ambulance service for the community from both government and private hospitals. 35 per cent of the respondents were not even aware that there is any provision of free ambulance services for pregnant mothers. While 29 per cent of the respondents said that there is provision of free ambulance services by both government and private hospitals. Provision of ambulance services is subject to the health conditions of the patients. For example, ambulance services are provided when the patients have serious health problems (and are already admitted in the hospitals) need further referral to better hospitals in Imphal. In such cases, patients were provided ambulance services but they were charged an amount of Rs. 1500–2000 for refilling the ambulance fuel. Thus, there is still a shortage of ambulance services in the district. Until now there is no provision of 108 emergency ambulance services in the government as well as private hospitals of Ukhrul district.

(f) Utilization of services from traditional and religious practitioners

According to Kalla & Joshai (2004), to understand the meaning of tribal health, it is important to understand the people themselves their social, economic and cultural aspects and also their indigenous medicines. The health status of the tribal is marked by poverty, illiteracy, malnutrition, lack of personal hygiene, poor sanitation, poor mother and child health services, absence of health education, lack of national programmes, and lack of available health services.

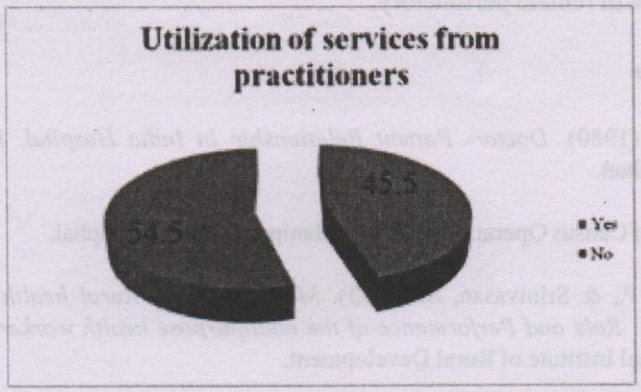

Fig. 5: Utilization of services from the practitioners

Fig. 5 highlights the utilization of services from traditional and religious practitioners by the women reproductive health, HIV/AIDS and TB respondents. However, the practice of older beliefs during times of sickness has reduced with the discoveries of science and changing of medical knowledge and treatment of disease (Lenore, 1996). It is seen that 54.5 per cent did not consult traditional and religious practitioners believing that some sicknesses like HIV/AIDS and TB

need to be treated by doctors only. Whereas 45.5 per cent of the respondents mostly women reproductive health and few respondents from HIV/AIDS and TB have consulted the traditional and religious practitioners for treatment purposes. They have the perception that treatment can be sought from traditional and religious practitioners for both minor and major health related problems!

Conclusion

Hospital is the most important institution for improvement of health conditions. There is a fundamental incompatibility between supply of resources for modern health care and the demands for them. There is ambiguity surrounding the contribution of health services to social well-being (Wall, 1996). Preventive health services for the nation as a whole are grossly insufficient. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay for the cost of the care they need (Grant, 1941).

The private sector has been playing a crucial role in curative health care in Ukhrul district of Manipur as compared to other districts of the state. It is not secure for patients to go for treatment, since there is no availability of doctors, and non-availability of equipments. Thus, it is necessary for state government to join hands with community people to take up necessary steps for betterment of hospitals. Also, they need to enquire about issues such as the negligent behaviour of doctors and non-availability of equipments. Thus, they should increase the recruitment of doctors and other staff in health centres otherwise the health institutions will remain perfunctory.

References

Advani, M. (1980). *Doctor- Patient Relationship in India Hospital*. Jaipur: Sanghi Prakashan.

Directorate of Census Operations. (2011). Manipur Porompat, Imphal.

Duraprasad, P., & Srinivasan, S. (1993). *Management of Rural health care delivery system: Role and Performance of the multipurpose health workers*. Hyderabad: National Institute of Rural Development.

Gupta, R. (2007). *Popular Manipur General Knowledge*. New Delhi: Ramesh Publishing House.

Grant, B. J. (1941). *Public health as a social service*. Calcutta: University of Calcutta.

Kalla, K. A., & Joshai, P. C. (2004). *Tribal Health and Medicines*. New Delhi: Concept Publishing company.

Manderson, L. (1996). *Sickness and the state*. New York: Cambridge University Press.

Mclachlan, G. (1968). *Problems and Progress in Medical Care*. London. Null field provincial hospitals trust by Oxford University Press.

Park, K. (2013). *Park's Textbook of Preventive and Social Medicine, 22nd Edition*. Jabalpur (M.P): M/S Banarsidas Bhanot Publishers.

Prakasam, P. C. & Raju, S. (2006). *Adolescents Reproductive Health Perspectives*. Delhi: B.R. Publishing Corporation.

Ramasubbhan, R., & Jejeebhoy, J. S. (2000). *Women's Reproductive Health in India*. New Delhi: Rawat publication.

Rout, S. H. (2011). *Health care system: A global survey*. New Delhi. New century publication.

Skeet, M., & Elloitt, K. (1978). *Health Auxiliaries and the Health Team*. London: Croom Helm

Wall, A. (1996). *Health Care Systems in Liberal Democracies*. New York: Routledge on birth of congress cataloguing in publication data.