Report of the

4th Common Review Mission
(17th to 22nd December 2010)

Nagaland

LIST OF ACRONYMS

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AVD	Alternate Vaccine Delivery
AYUSH	Ayurveda Yoga & Naturopathy Unani Siddha and Homeopathy
BCG	Bacille Calmette Guerin
BEmOC	Basic Emergency Obstetric Care
BPM	Block Program Manager
CEmOC	Comprehensive Emergency Obstetric care
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CRM	Common Review Mission
CT	Computerized Tomography
DAM	District Accounts Manager
DCMO	District Chief Medical Officer
DDK	Disposable Delivery Kit
DF	Deep Freezer
DGMO	General Duty Medical Officer
DH	District Hospital
DHAP	District Health Action Plan
DPM	District Program Manager
DPO	District Program Officer
DPT	Diptheria Pertussis and Tetanus
DTC	District Tuberculosis Centre
ECP	Emergency Contraceptive Pills
EmOC	Emergency Obstetric Care
F-IMNCI	Facility based Integarted Management of Newborn and Childhood Illness
FP	Family Planning
FRU	First Referral Unit
FY	Financial Year
GNM	Graduate Nurse Midwife
GOI	Government of India
HBNC	Home based Newborn care
HCMC	Health Centre Management Committee
HMIS	Health Management Information System

HMS	Hospital Management Committee
HQ	Head Quarter
ICDS	Integrated Child Development Scheme
ILR	Ice Lined Refrigerator
IMNCI	Integrated Management of Newborn and Childhood Illness
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IUCD	Intrauterine Contraceptive Device
IV	Intra venous
JSY	Janani Suraksha Yojana
LSAS	Life Saving Anesthesia Skill
MCTS	Mother & Child Tracking System
MDR	Maternal Death Review
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare
NDCP	National Disease Control Program
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NSV	No Scalpel vasectomy
NVBDCP	National Vector Born Disease Control Program
OPV	Oral Polio Vaccine
OT	Operation Theatre
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Project Implementation Plan
RCH	Reproductive & Child Health
RI	Routine Immunization
RKS	Rogi Kalyan Samiti
RNTCP	Revised national Tuberculosis Control Program
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendance
SC	Sub Centre
SHS	Sub Health Centre
SIHFW	State Institute of Health and Family Welfare

SRS	Sample Registration System
STI	Sexually Transmitted Infection
SNCU	Sick New Born Care Unit
UF	Untied Fund
UIP	Universal Immunization Program
UNICEF	United Nations Children's Fund
VHC	Village health committee
VHC	Village Health Committee
VHND	Village Health and Nutrition Day

CHAPTER ONE - BACKGROUND

The state visits under 4th Common Review Mission (CRM) started on 17th December 2010 and ended on 22nd December 2010.In two groups the team visited the districts of Mokokchung and Zunheboto. The team also visited the health facilities of Wokha district and a private hospital in Mokokchung district. During the visit a briefing and a debriefing meeting was convened on 17th & 21st December 2010. Key findings of the CRM were shared with the state officials.

The visits were comprehensive and extensive to understand the health system of the state. The team believes that the state have showcased both the good programme and weaknesses. The team received a good cooperation to obtain real picture at ground level. This report is a summary of findings of the team from both the districts and also finding regarding systematic problem that, unless corrected will affect the State in implementing the health programme, especially in long term. The findings are based on the field visits, discussion with the state, district, institutional staffs, village health committee and the beneficiaries. A detail discussion on the findings and recommendation is placed in the relevant para for the State as well to MoHFW.

COMPOSITION OF CRM TEAM

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The district selected was balanced mixed of both high and non-high focus district wherein Mokokchung is a non-high focus district and Zunheboto is a high focus district. A complete list of facilities visited by the team is given below:

Summary of health facilities in the district and visited

	Zunheboto	**Mokokchung**
Health facilities	**Number**	
District Hospital	1 (FRU)	1 (FRU)
CHC	2	3
PHC	13 (only 4 are 24x7)	14
SC	47	51
DTC	1	1 (GNM school)

	Mokokchung	**Zunheboto**	**Wokha**	**Total**
Health facilities	**Number**			
District Hospital	1 (FRU)	1 (FRU)	1	3
CHC	3	2		5
PHC	3	4	1	14
SC	4	7	1	12
DTC	1 (GNM school)	1		2
Total	12	15	3	30

Health Facilities visited				
Zunheboto				
No	Block	Location	Type of facility	Person in-charge
1	Zunheboto Block	Zunheboto	District Hospital	Dr. Ahokhe
2	Aghunato Block	Aghunato	CHC	Dr. Kiholi
4.	Satakha Block	Satakha	Block PHC	Dr. Kheshikar
5	Akuluto	Akuluto	PHC	Dr. Hokugha
6	Pughoboto Block	Poghoboto	PHC	Dr.Rupert
7.	Zunheboto Block	Sukhalu	SC	Ms.Kasheli
8	Zunheboto Block	Asukhomi	SC	Vitoli
9	Akuluto Block	Lumani	SC	Atsungla
10	Akuluto Block	Shitsumi	SC	Hutoli
		Mokokchung		
5			District Hospital	Dr. Nchomo Lotha
6	Ongpangkong	Kumlong	SC	Ms. Meya
7	Mangkolemba	Dibuia	SC	Mr.Jongto
8		Sabangya	PHC	Dr.Limanaro
9		Mangkolemba	CHC	Dr.Tiasunep
10	Changtongya	Mopongchukit	SC	Mr.Limayanger
11		Longjang	PHC	Dr.Alemwabang
12	Tuli	Yaongyimsen	SC	Mr. Odikokba
13	Changtongya	Mongsenyimti	PHC	Dr.Sentila
14		Changtongya	CHC	Dr.S.Marina
Other Institutions visited				

Wokha				
15	Wokha Sardar	DH	District Hospital	Dr.Kevingullie (MS)
16	Wozhuro -Ralan Block	Longsachung	SC	Ms.Thosano (ANM)
17	Chukitong Block	Chukaitong	PHC	Dr.Kere

CHAPTER TWO - BRIEF PROFILE OF THE STATE

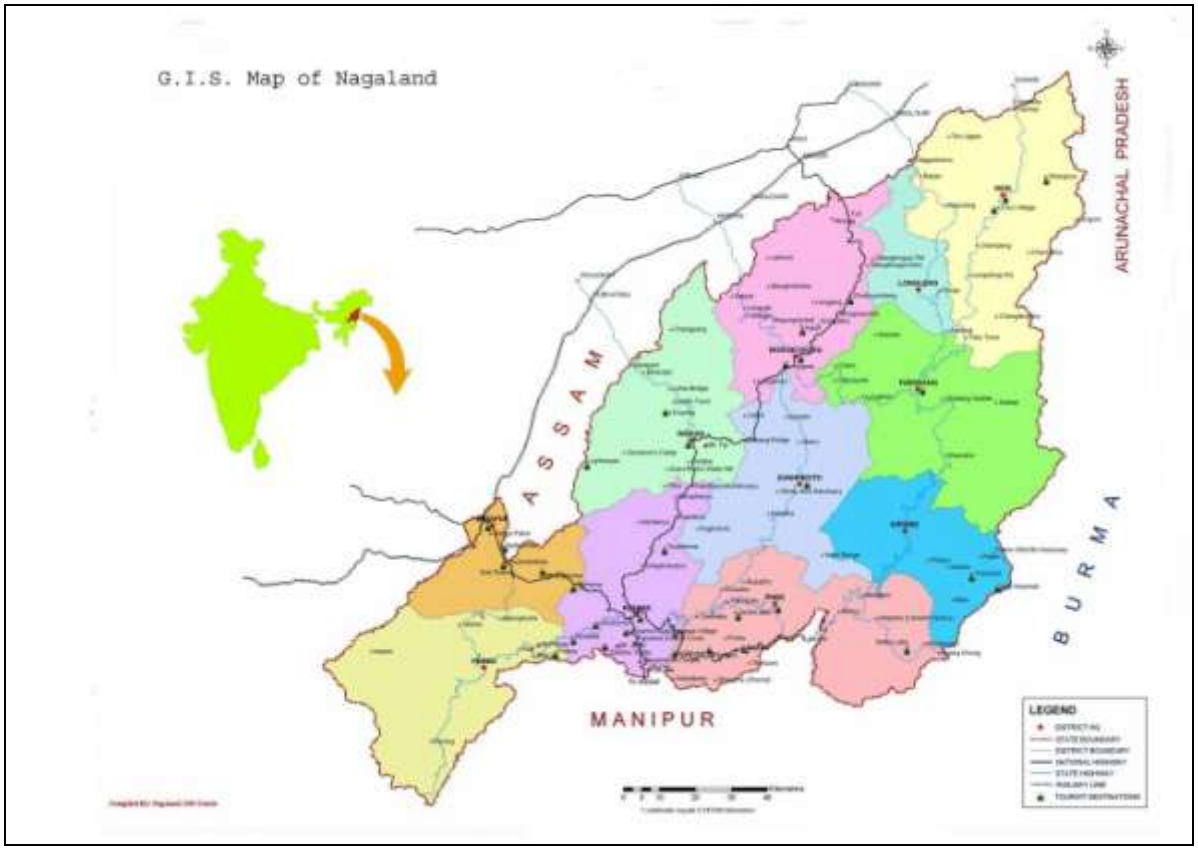
Nagaland is a state in the far north-eastern part of India. It borders the state of Assam to the west, Arunachal Pradesh and part of Assam to the north, Burma to the east and Manipur to the south. The state capital is Kohima, and the largest city is Dimapur. With a population of nearly two million people, it has a total area of 16.579 square kilometers - making it one of the smallest states of India. Statehood was officially granted to Nagaland on 1 December 1963. It is divided into eleven districts: Kohima, Phek, Mokokchung, Wokha, Zunheboto, Tuensang, Mon, Dimapur, Kiphire, Longleng and Peren. It is a largely mountainous state.

Agriculture is the most important economic activity in Nagaland, with more than 90% of the population employed in agriculture. Crops include rice, corn, millets, pulses, tobacco, oilseeds, sugarcane, potatoes, and threads. However, Nagaland still depends on the import of food supplies from other states. The widespread practice of jhum, tilling, has led to soil erosion and loss of fertility, particularly in the eastern districts. Only the Angami and Chakesang tribes in the Kohima and Phek districts use terracing techniques. And most of the Aos, Lothas, and Zeliangs in Mokokchung, Wokha, and Peren districts respectively till in the many valleys of the district. Forestry is also an important source of income. Cottage industries such as weaving, woodwork, and pottery are also an important source of revenue. Tourism is important, but largely limited due to insurgency since the last five decades.

Each of the 16 odd tribes and sub-tribes that dwell in this exotic hill State can easily be distinguished by the colourful and intricately designed costumes, jewellery and beads that they adorn. Nagaland is a land of festivals. All the tribes celebrate their distinct seasonal festivals with a pageantry of colour and a feast of music. All the tribes have their own festivals which they hold so dear. They regard their festivals sacrosanct and participation in celebration is compulsory. Most of these festivals revolve round agriculture, it being the main-stay of Naga society.

Almost all the tribes of Nagaland have their own language. Nagas speak 60 different dialects belonging to the Sino-Tibetan family of languages. The traditional languages do not have any script of their own. The Christian missionaries used Roman script for these languages. In 1967, the Nagaland Assembly proclaimed English as the official language of Nagaland and is the medium for education in Nagaland.

Christianity is the predominant religion of Nagaland. The state's population is 1.988 million, out of which 90.02% are Christians. The census of 2001 recorded the state's Christian population at 1,790,349, making it, with Meghalaya and Mizoram, one of the three Christian-majority states in India and the only state where Christians form 90% of the population.Nagaland's gross state domestic product for 2004 is estimated at $1.4 billion in current prices. In 2009-10, the gross revenues and capital receipts of Nagaland were Rs. 5,286 crore out of which Rs. 153.58 crore (2.9 %) was spent on Medical-Public Health and Family Welfare.[1]



2. BACKGROUND DATA

Table 1: District wise Population and District HQ/Towns/Villages:

No.	District	Headquarter	Population	Towns	Village
1	Kohima	Kohima	2,19,318	3	94
2	Mokokchung	Mokokchung	2,27,230	4	102
3	Tuensang	Tuensang	1,64,361	5	121
4	Phek	Phek	1,48,246	4	104

[1] Source: Annual Financial Statement, Government of Nagaland available at http://www.nagaland.nic.in/finance/main.htm accessed on 28 December 2010

No.	District	Headquarter	Population	Towns	Village
5	Mon	Mon	2,60,652	3	110
6	Wokha	Wokha	1,61,098	3	130
7	Zunheboto	Zunheboto	1,89,191	3	198
8	Dimapur	Chumukedima	3,45,237	3	216
9	Peren	Peren	97,068	3	106
10	Kiphire	Kiphire	1,27,448	2	103
11	Longleng	Longleng	1,21,581	2	40
	Total		**20,61,430**	**31**	**1,324**

Table 2: District wise distribution of Public Health Institutions as on 30.03.2010.

District	DH	CHC	PHC	SHC	BD	SC	Total
Kohima	1	3	14	0	0	40	58
Mokokchung	1	3	14	0	2	51	71
Tuensang	1	2	11	1	0	39	54
Phek	1	3	21	1	0	44	70
Mon	1	2	15	0	0	50	68
Wokha	1	2	12	0	0	37	52
Zunheboto	1	2	13	0	0	47	63
Dimapur	1	2	8	0	1	47	59
Peren	1	1	8	0	0	16	26
Kiphire	1	1	4	0	0	19	25
Longleng	1	0	3	0	0	8	12
State Total	**11**	**21**	**123**	**2**	**3**	**398**	**558**

Table 3: Health Indicators

Indicator	Nagaland	India
1. Birth rate *	17.5	22.8
2. Death rate*	4.6	7.4
3. Total Fertility rate**	3.7	2.7
4. MMR***	240	259
5. IMR*	26	53
6. Full ANC#	3.5	26.5

7. Institutional Delivery#	30.4	72.9
8. SBA#	43.8	76.2
9. Full Immunization#	27.8	61.0
10. Contraceptive Use**	30	56.3
11. Total Unmet Need**	26.3	13.2

*Source: SRS Bulletin Oct 2009; **Source: NFHS III; #Coverage Evaluation Survey 2009

*** Source: India- The State of Population 2007

Strengthening the physical infrastructure of public health institutions (since 2005-06):

S. No	Name of Work	Total Units		
		Approved	Completed	Under process
1	Sub Centre	135	85	50
2	PHC	19	6	13
3	CHC	8	5	3
4	District Hospital (Upgradation)	11	11	0
5	Staff Quarters (CHC)	19	8	11
6	Staff Quarters (CHC)	30	8	22
7	Drug Warehouse	2+3	2	3
8	Nursing School Strengthening	2	2	0
9	Nursing School Dimapur	2	2	0
10	Up Gradation Of Nursing School To College	1	1	0
11	Upgradation Of Nursing School Tuensang	1	0	1

Table 5: District wise list of 24 x 7 facilities:

Name of District	Name of Block	Name of 24x7 Facility	Category of the Facility (DH/CHC/PHC)	No of Beds (Functional)	Status (Functional / Non Functional)
Kohima	Tseminyu	Tesophenyu	PHC	6	Functional
	Viswema	Kimipfuphe,	PHC	6	Functional

Name of District	Name of Block	Name of 24x7 Facility	Category of the Facility (DH/CHC/PHC)	No of Beds (Functional)	Status (Functional / Non Functional)
	Chiephobozou	Botsa,	PHC	8	Functional
	Sechü	Khonoma,	PHC	6	Functional
	Tseminyu	Chunlikha	PHC	6	Functional
Mokokchung	Changtongya	Chuchuyimlang,	PHC	8	Functional
	Changtongya	Longjang,	PHC	8	Functional
	Mangkolemba	Longchem,	PHC	6	Functional
	Ongpangkong	Mangmetong,	PHC	6	Functional
	Ongpangkong	Sabangya.	PHC	6	Functional
	Changtongya	Changtongya,	CHC	25	Functional
	Tuli	Tuli	CHC	25	Functional
Tuensang	Shamator,	Shamator,	PHC	6	Functional
	Longkhim	Chare,	PHC	6	Functional
	Noksen	Noksen	PHC	6	Functional
	Longkhim	Longkhim,	CHC	25	Functional
	Noklak	Noklak	CHC	25	Functional
Mon	Tizit,	Tizit,	PHC	6	Functional
	Wakching	Wakching	PHC	6	Functional
	Chen	Aboi,	CHC	25	Functional
	Tobu	Tobu	CHC	25	Functional
Phek	Pfutsero	Chizami,	PHC	6	Functional
	Meluri	Weziho,	PHC	6	Functional
	Chozuba	Chetheba	PHC	6	Functional
	Meluri	Meluri,	CHC	25	Functional
	Chozuba	Chozuba,	CHC	25	Functional
Wokha	Wüzhuru-Ralan,	Wüzhuru-Ralan,	PHC	6	Functional
	Wüzhuru-Ralan,	Nyiro,	PHC	6	Functional

Name of District	Name of Block	Name of 24x7 Facility	Category of the Facility (DH/CHC/PHC)	No of Beds (Functional)	Status (Functional / Non Functional)
	Chukitong	Chukidong,	PHC	6	Functional
	Chukitong	Sungru	PHC	6	Functional
	Sanis-Sungro	Sanis	CHC	25	Functional
Zunheboto	Aghunato,	Aghunato,	CHC	25	Functional
	Pughoboto	Pughoboto	CHC	25	Functional
	Zunheboto	Suruhoto,	PHC	6	Functional
	Akuluto	VK,	PHC	6	Functional
	Sataka	Satoi,	PHC	6	Functional
	Sataka	Sataka	PHC	6	Functional
Dimapur	Medziphema	Medziphema,	CHC	25	Functional
	Dhansiripar	Dhansiripar	CHC	25	Functional
	Niuland	Kuhuboto,	PHC	6	Functional
	Niuland	Nuiland,	PHC	6	Functional
	Chumukedima	Chumukedima	PHC	6	Functional
Peren	Tening,	Tening,	PHC	6	Functional
	Athibung	Athibung	PHC	6	Functional
Kiphire	Seyochung/Sitimi	Seyochung	PHC	6	Functional
	Pungro	Pungro	CHC	25	Functional
Longleng	Tamlu,	Tamlu,	PHC	6	Functional
	Yongnyah	Yongnyah	PHC	6	Functional

Table 6: District wise list of First Referral Units as reported by State

Name of District	Name of FRU	Category of the Facility (DH/CHC/PHC)	No of Beds (Functional)	Status	
				(Functional /Non Functional)	Reason
Kohima	NHAK	DH	250	Functional	
Kohima	CHC	CHC	25	*Non*	Manpower

Name of District	Name of FRU	Category of the Facility (DH/CHC/ PHC)	No of Beds (Functional)	Status	
				(Functional /Non Functional)	Reason
	Cheiphobozou			*Functional*	
Kohima	CHC Viswema	CHC	25	*Non Functional*	Manpower
Kohima	CHC Tsemenyu	CHC	25	*Non Functional*	Manpower
Mokokchung	DH Mokokchung	DH	150	Functional	
Mokokchung	CHC Mangkolemba	CHC	25	*Non Functional*	Manpower
Dimapur	DH Dimapur	DH	150	Functional	
Dimapur	CHC Medziphema	CHC	25	*Non Functional*	Manpower
Peren	DH Peren	DH	50	Functional	
Peren	CHC Jalukie	CHC	25	*Non Functional*	Manpower
Wokha	DH Wokha	DH	50	Functional	
Tuensang	DH Tuensang	CHC	100	Functional	
Tuensang	CHC Noklak	CHC	100	Functional	
Phek	DH Phek	DH	75	Functional	
Mon	DH Mon	DH	50	Functional	
Longleng	DH Longleng	DH	50	Functional	
Kiphire	DH Kiphire	DH	50	Functional	
Zunheboto	DH Zunheboto*	DH	50	Functional*	

* District hospital Zunheboto cannot be considered as FRU since on verification by CRM team it was found to be lacking a blood banking facility and Special Care Newborn Unit

Table 7: Allocation of fund under NRHM:

Year	GOI Allocation	15% state Share	Amount received from GOI	Amount received from State	Amount spent
2005-06	372.00	NA	372.00	NA	372.00
2006-07	2103.00	NA	1587.00	NA	1587.00

2007-08	4753.00	553.00	4753.00	600.00	4753.00
2008-09	5511.04	826.66	5541.04	900.00	6441.00
2009-10	8552.15	1175.00	4425.00	921.77	4260.54
2010-11 till Oct 2010	9810.00	1262.00	2341.00		

CHAPTER THREE- FINDINGS OF THE 4TH CRM IN THE STATE

At the outset it will be prudent to place on record the good practices observed by the team during the field visit .Few of the noteworthy ones are listed below:

1. Village Health Committees (VHC) under communitization has been formed at village level and was seen actively participating in the affairs of health facilities in Mokokchung district.
2. VHND are regularly organized with participation of VHC member and community
3. Untied funds used for essential infrastructure development in most places that enabled and given confidence to local health care providers
4. Contribution from civil society/community for Building of health facilities, donations, materials for health facility
5. Telemedicine operationalized in the District Hospital at Mokokchung
6. Health Institutions operational- high degree of sanitation, cleanliness and well maintained even if they were located in old buildings
7. Committed and motivated staff even when they were posted at facilities located at remote locations

8. Display of vital and critical information such as citizen charter, Schedule of services and user charges, List of staff with phone numbers, etc. seen in all facilities

9. Good dental care setup in District Hospital /Community Health Care

10. AYUSH services available in Primary Health Care/ Community Health Care/District Hospital

11. Block level officers are maintaining books of accounts which can be strengthened through proper accounts training.

12. Tally ERP9 software is implemented at State and District level.

13. E-transfer started from State to District and District to CHC/PHC.

14. Concurrent Audit system is implemented at all level.

15. ASHAs are maintaining VHC cash book in proper manner.

16. Timely completion of Statutory audit report for the year 2009-10 for RCH/NRHM/RI.

CHANGES IN KEY ASPECTS OF HEALTH DELIVERY SYSTEMS

1. Infrastructure

Infrastructure is one of the major constrain observed in Nagaland. Though many important steps have been initiated to build infrastructure under NRHM in the past few years, the progress has been slow due to various reasons. Table below shows progress on civil work, since launching of NRHM in 2005-06.

S.No	Type of Institution	Total Units		
		Approved	Completed	Under Process
1	Sub Centre	135	85	50
2	Primaty Health Centre	19	6	13
3	Community Health Centre	8	5	3
4	District Hospital (upgradation)	11	11	0
5	Staff Quarters in CHC	49	16	33
6	Drug Warehouse	5	2	3

7	Nursing School Strengthening	4	4	0
8	Upgradation of Nursing School to College	1	1	0

To begin with, no population based parameters followed to construct new building for the health facilities leading to irrational construction, upgradation and random expansion of infrastructure leaving few of the health institution without building. Moreover the State does not have infrastructure development wing to manage and oversee the health infrastructure development in Nagaland.

During the visit the team found evidences wherein Zunheboto district (1) out of 47 PHCs, 2 PHCs do not have any buildings, (ii) 10 SC's are working from private buildings. Similarly in Mokokchung district, (iii) 8 SC's did not function from government building. Many of the health facilities are run from old buildings that need urgent renovation or new construction. None of the facilities visited by the team met the IPHS standards. Moreover, the District Drug Ware House is in dilapidated condition.

Due to difficult terrain the approach roads to most of the health facilities were not proper for easy access to the people who are sick including pregnant women and children as well as the health providers. To reach the health facility in some of the areas the health providers[2] have to walk for 4 to 5 kms to reach the health facilities to provide outpatient services.

The concern mentioned in the above para about traveling of the health providers is related to non-availability of residential accommodation in all the health facilities visited. There is acute shortage of staff quarters. Staffs had to look for decent accommodation in nearby habitations that is nearest to health facility but it is not available. This was one of the important factor for low motivation in hard to reach areas.

One of the basic criteria for operationalizing a health institution is to provide electric supply but it was observed that electricity connection is not available in few of the health institutions including Community Health Centres. Moreover, the facilities that have electric connection have to undergo long durations of power disruption due to non-availability of generator. Basic facilities like running water were also deficient in many health facilities. Presently, there is no system of in-house repair of equipment in timely manner. Lot of equipments is lying none utilized, e.g. equipment for new born care corner is not installed, X- ray machine of Zunheboto DH not functional.

[2] Mangnetong PHC is an example

It is seen that GNM training school is being ignored. The school does not have adequate infrastructure such as class rooms, hostel and teaching aids. The fund approved for strengthening of nursing school is not being utilized till date.

Though it is beyond the purview of NRHM still the team would like to document that Chief Medical Officer (CMO) of both the district does not have offices. The offices of programme officers of various programme are spread across the district (either in rented building or attached to some government offices) due to which coordination between the CMO and its programme officers is a major problem.

Recommendation

1. The State should have an Infrastructure Development Wing to plan, implement and monitor the civil work. It should develop a master plan for infrastructure development based on the gap analysis done by facility survey. Along with the plan for the health facilities it should also have a map for road up gradation and new construction to facilitate access of the health services by the distant population.

2. The approved civil works under different heads should be expedite and completed at the earliest.

3. The shortage of staff quarters may be addressed and to be planned in the State PIP for the coming years. While planning the State should analyze the requirements and then phase it out, at the initial stage it may think of constructing quarters for the staffs of FRUs and 24x7 PHCs.

2. Human Resource Planning

Like any other states in India, Nagaland is also facing shortage of manpower in the public health facilities; table below depicts the manpower shortage even after contractual appointments. About one third of the staff positions are vacant. NRHM funding has allowed State to recruit contractual staff and fill the human resources gap. However, still the gap remains. There is a severe shortage of specialist doctors at District Hospital and CHCs. It is appreciable that in most of the PHC/CHC Ayurvedic and homeopathy doctors were available and drugs were available for both of them.

Further due to poor payment scales the physicians are reluctant to come forward and work in the public sector. For instance 16 contractual medical officers have resigned and joined

private hospitals because there the monthly remuneration ranges from 30, 000 to 45,000 or more and under NRHM they receive a fixed pay of Rs. 20,000 per month. It was informed that the state has plans to enhance the salary structure in line with the 6th Pay Commission recommendation.

Discipline	Required	In Position	Gap
Medicine	19	9	**10**
Surgery	19	10	**9**
OBG/GYN	42	15	**27**
Anaesthesiology	42	12	**30**
Paediatric	40	9	**31**
Ophthalmology	12	12	**0**
ENT	12	7	**5**
Orthopaedics	9	6	**3**
Dermatology	8	1	**7**
Radiology	11	3	**8**
Path/Micro/Biochemistry	11/3/7	9/2/5	**2/1/2**
GDMO	435	253	**182**
AYUSH	171	21	**150**
GNM	1612	419	**1193**
PHN	149	48	**101**
ANM	1295	1133	**162**
Lab Technician	364	148	**216**
Pharmacist	601	409	**192**

Human Resource (HR) remains the critical determinants of availability of health services and the issues related to HR can be addressed by the state on priority to operationalize the health facilities as per the standards.

2.1 Rationalizing Human Resource:

The state has dearth of adequate professional HR but the available HR are not being deployed rationally in the health facilities. Many a times, the manpower (doctors, nurses, ANM, LTs) deployment at the health institutions does not match with the case load. In few of the health facilities (excluding District Hospital) visited it is seen that more then 5 doctors were posted and the patient examined by each doctor is one per day. Similarly in two of the CHCs and one PHC, 4- 6 laboratory technicians were posted and the laboratory test done is

1 to 6 in a month. It is also seen that MBBS doctors[3] were posted in a facilities that is catering to a population of 1500 and is providing only out patient services. The ANM of that area can also cater to this population.

During discussion with the district officials and doctors it has come out that the majority of the providers both physician and paramedics' staffs are posted in Mokokchung district.

Pharmacists have been posted at all SC against the IPHS norm.

2.2 Incentivizing the physicians and paramedics & Capacity Building

The state does not have a plan for incentivizing the doctors and paramedics (both regular and contractual) posted in the rural/ difficult areas.

The team has also observed lack of opportunity for the doctors in accessing new knowledge through Continous Medical Education (CME), medical conference etc. It has been felt that the medical work of the doctors are limited to the routine work and are deprived of current practices and knowledge.

2.3 Skill quality of Human Resource

In-service training institution such as SIHFW is not available both at the state and district. Although the state have identified 3 District Hospital of Mokokchung, Kohima and Dimapur for RCH training programme – SBA, IMNCI etc. The State has unable to capitalize the existing GNM and ANM training centres for in service training of the ANMs and nurses.

To address the shortage of specialist, GoI emphasizes on multiskilling of doctors in CEmOC and LSAS and have provided support to the states but in case of Nagaland the scenario is pity. Presently the State does have acute shortage of specialist; in this situation multiskilling of MBBS doctors is the need of the hour. However the progress so far in training of doctors in CEmOC too slow, till now only 2 doctors have been trained in CEmOC. Similarly slow progress in training on IMNCI and also few of the other training such as SBA, F-IMNCI is yet to be started. The team felt that most of the staff requires skill based trainings as envisaged under RCH/NRHM on a priority basis such as SBA, LSAS, EmOC, BEmONC, CEmONC, IMNCI. Most ANMs had not received the trainings on SBA, IMNCI, and alternate methodology for IUCD insertion. The duration of trainings such as F-IMNCI has been reduced to 5 days from the recommended 11 days.

Only about 50% of the trained staff has been placed in the proper facilities as per their acquired skills. There was no post training follow-up.

[3] Mokosongyimti PHC

The MOs who have undergone trainings in F-IMNCI, CEmONC and LSAS have not all been placed at the facilities their training skills could be fully utilized for patient care.

Capacity Building at State level:

Type of Training	**Trained Till Dec. 2009**	**Training Load 2010-11**
1. Mini Lap	28 MO	24 MOs
2. Lap		24 MOs
3. NSV	66	30 MOs
4. RTI/STI	60	90 MOs
5. HMIS	11 DPMs/45 BPMs/11 DEOs/21 SMOs	ToT/District level/Block level
6. ARSH	22 MOs	21 MOs
	16 Nurses	21 Nurses
	8 Counselors	21 Counselors
7. Capacity Building for DCMOs, DPOs, DPM/BPM	DCMOs, DPOs, DPM/BPM	DCMOs, DPOs, DPM/BPM
8. Orientation ASHA Coordinators	40 ASHA Coordinators	40 ASHA Coordinators
9. ASHAs	1700 ASHAs	1700 ASHAs 6th Modules/ HBNC
10. Immunization Trainings		
11. IMNCI	298*	8

* 5 day IMNCI training being carried out in Nagaland (instead of 8 days) is not as per GoI guidelines

Recommendation

- Establishment of State Training Centre, (like SIHFW in the other States). Need to rationalise training management at all levels. Successive reviews show lack of comprehensive planning, including trainee selection, post training placement, linking with facility operationalisation, monitoring of training and post training supervision of skills

- Re-deployment of manpower between facilities: rationalization according to population served and level of the facility. Staff with special qualification should not be allowed to languish at PHC level.

- Develop a plan to increase the pay scales of both regular and contractual doctors with better working condition for the staffs. The state should study various models of other

states on HR policy especially for the physicians and paramedics. Initiatives could be undertaken such as - additional difficult area allowance, performance based incentives, in-service skill development to upgrade their efficiency and supportive supervisory visits by State.

- Trainings should be speeded up specifically on: District planning, SBA, IMNCI, F-IMNCI, NSSK, EmONC & LSAS and Immunization. The State should take technical support from RRC – NE especially on district planning and Immunization or any other need based training programme. It should also plan capacity building programme for the MO (I/C), DPMU/BPMU (other than district planning).In coordination with RRC-NE visit to other states can be arranged to gain knowledge of good practices.

- The Ayurevedic doctor posted in PHC/CHC may be trained on SBA and F-IMNCI

- Nagaland needs a lot of technical support for rapid progress and implementation of NRHM programme. State should request for technical assistance from International and national level Development Partners and NGOs. MoHFW can facilitate the technical assistance from Development Partners.

- Professional public health cadre/ specialist are required for program management specifically at the State and district level. The State should plan for developing capacity of the middle level Medical Officers/ District officials on public health management. It should also have a plan to deploy them in posting them in right place; they should not be randomly picked and trained. A channelize career path should be in place for these trained officials.

- Recruitment of contractual doctors and nurses through NRHM should be facility specific to fill the gaps in manpower and not for general purposes.

- The state may plan for a medical college to address the shortage of physician and one more GNM training school.

3. Health Care Service Delivery – Quantity and Quality

It is evident from the data on service delivery that NRHM is impelling institutional deliveries. However, as per the data available there is not much increase in the OPD and IPD case load. This was evident during the field visit, in the District Hospital of Mokokchung on the day of the team's visit the OPD load was only 40. It was told to the team that due to festive season the people of the state do not prefer to visit hospitals until and unless it is an emergency. Similar trend was observed in bed occupancy rates, as throughout the year it

varies in the range 10-40%. In Zuhneboto DH and CHCs, about 10% beds were found occupied.

Over the years the trend in service deliveries is given below:

Year	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10 (Apr-Oct)**
1. Patient Turnover					
Out-patient Load	226957	295963	478078	523090	316544
In-patient Load	18500	29158	34460	63805	54532
2. Maternal Health					
Institutional Delivery	1182	5696	9943	12606	10765
3. Child health					
BGG	35024	52450	49917	26799	Data not available
DPT3	29912	60257	50441	23717	
OPV3	30614	62653	52904	24586	
Measles	27876	50180	51618	23157	
Full immunization	-	50180	51618	23157	

3.1 Preparedness of health facilities for patient care

In Zuhneboto district, the DH did not have obstetrician and medical specialist.In both the districts none of the CHCs including visited have any specialist doctor.

Ambulance with drivers were available but not in all the PHCs and CHCs. Blood Storage Unit were not available in the FRUs. Emergency room at all the places needs management needs better management especially Wokha District Hospital- the patients were seen in the corridor of the hospital and a small room was designated as emergency room. Oxygen Cylinder and emergency drugs were not observed in the emergency rooms.

At many places laboratory technicians were more than sufficient but the laboratory services were underutilized. In all the places reagents were not supplied and it is being procured by the hospital from untied fund.

3.2 Reproductive and Child Health (RCH) Services

There is lot of scope for improvement in the quality of care and service delivery. Massive demand generation is required since community is not availing the services even if provided to them.

As per the Coverage Evaluation Survey (CES) done by UNICEF, 53.7 percent women have received at least one ANC but only 3.5 percent have received full ANC. Similar trend was observed during the field visit, no micro birth planning & follow up being done by the ANM. Moreover it was also observed that IFA tablet is not consumed by the pregnant especially those which were available in the public health institutions and they prefer to buy it from the chemist shop. This fact is known to all the district officials but no where an effort to generate awareness about IFA consumption and its initial affect is seen; no IEC campaign or discussion during VHND.

The institutional deliveries have remained stagnant at lower level of 31% as per CES 2009. During discussion with the community and the health providers the teams were told that the women prefer to deliver at home and when cross checked with the delivery register it was found to be true. Most of the deliveries were home deliveries (7 out of 10 were home deliveries) but they have been assisted by ANM (as mentioned in the registers).Like the problem of IFA this fact is also known to all the health officials but plan of action to address this issue. It seems the state have not even thought or planned to address these issues.

Disposable Delivery Kits were not supplied anywhere in the Sate to any of the health facilities. Standard Treatment Protocols were also not available.

After a threadbare discussion among the team members and observation during the field visit, following reasons for low institutional delivery were found:

- No delivery room is there at SCs, hence there is no delivery work. The state apparently does not insist on SC deliveries at this stage fearing possible over reporting of institutional deliveries.

- The health providers do not stay in the hospital premises due to non availability of the quarters. Even if a pregnant woman comes for delivery she is not sure whether the doctors or nurses will be available or not.

- Referral transport mechanism is non existent and there is shortage of public transport as well as it has difficult terrain. Generally the people will have to hire a vehicle and that will cost them more than what they will receive from JSY scheme.

- Below District Hospital there is no provision of food for the inpatient including pregnant women.
- At the health facilities ambulance is available but user money is being charged from all the patients availing its facility including the pregnant women.
- Under JSY ASHA gets cash incentive of Rs. 600/- while in 90% of the cases the transportation cost to health facilities is much higher than what she receive.

In the labour room partogram were not being used. New born care corner were seen along with the labour room but utilization of these corners is questionable. In some of the facilities it is kept unpacked or waiting to be installed and in few the staffs does not know how to use it. Training to the staffs is required.

It was good to see that male and female wards were separate in all the health facilities but most of them were not having curtains or bed sheets. Most of the beds needs to be replaced (e.g. Wokha District Hospital). All the health facilities were clean including toilets except Chantungya CHC and Wokha District Hospitals where in the patient's toilet were not clean. The Mokokchung District Hospital has outsourced cleaning of the toilets to a local person. It is an initiative worth mentioning and a minimal user fee of Rs. 2/- is being charged from every body including the patient. It is being suggested that no money to be taken from the patient as it should be a part of service delivery.

IMNCI program has not been implemented yet. The trainings have not been completed yet and necessary forms and formats have not been printed and supplied. IMNCI program should be planned and managed at the State level and it should include training, supply of forms & formats, supervision and monitoring

Family planning service provision is inadequate and a huge gap exists between demand and supply. During discussion with the state and district officials the team was told that the community prefers more than 2 children because they feel secured. However during the field visit it was observed that more than 2 children norm is true still there is a huge demand of family planning. In the Family Planning register of Yaongyisem SC of Mokokchung district it was seen in last one month that all the women registered for ANC and who have delivered a child have accepted family planning services; many of them have undergone tubectomy and few of them have accepted IUCD insertion and OCP. The ANM informed that she counsels that women and if they show interest than she send them to District Hospital for sterilization. She also informed that they want to limit there children and there husband's to agree with them but they themselves will never go for sterilization, male sterilization is very poor.

It will be imperative to mention that demand for family planning is there in the community but due to no supply in terms of awareness generation, well equipped facility with trained providers. Family welfare services such as oral pills, IUCD, ECP and Nishchay were available up to the level of SC. Most of the CHC is not equipped to handle sterilization cases. The districts do not have a nodal officer for family planning. It does not have its plan for awareness generation or fixed day strategy. Till now 66 & 28 MOs have been trained in NSV and Minilap but performance in terms of people trained is negligible. In Mokokchung district the Gynaecologist of the District Hospital plans the camp and whenever she gets time from her hospital she along with her team conducts camps in coordination with the CHC.

Recommendation

- The FRUs should be operationalized by positioning with specialist/ MOs trained in CEmOC/LSAS. Blood Storage Unit to be made functional at the earliest.
- Referral transport system to bring the patient from village to health institution and back to village. No charges to be taken from the pregnant women and new born.
- Emphasize on microbirth planning and follow up of the registered women for ANC & PNC by the ANM. New born care corner should be operationalized; staffs should be trained on operationalizing the equipments.
- ASHAs to be trained on identification of high risk pregnancies. It seems even after completion of 5^{th} module they are not clear about importance of institutional deliveries etc (Detail explanation on ASHA is given under communitization).
- The health facilities should be well equipped to welcome the pregnant women and her attendant. It should have adequate number of bed sheets/blankets; the toilet should be attached to the ward, clean drinking water and free food for her and one attendant.
- Regular supply of drugs and medicines.
- MoHFW to take decision on revisiting the cash incentive for ASHAs from hilly and terrain areas especially the transportation cost.

Looking the at accessibility problem the State can plan for birth waiting room in the identified MCH centres so that the pregnant women and one attendant can come and stay few days ahead of delivery date. It has to be ensured that it should be free for them

4. Universal Immunization Programme

In comparison to rest of the country the immunization coverage is lowest in Nagaland. The reasons for low performance were evident during the facility visits, which are discussed below:

4.1 To have universal coverage SCs and PHCs should have microplan for immunizing the infants of their areas but in most of the health facilities it was not available. Though in few of the health facilities microplan were found but it needs to be strengthen. Moreover it was informed that the districts have not printed registers for microplanning, those who are doing this are maintaining it in loose papers.

4.2 There is lack of understanding in maintain the immunization register. The register is used to list the beneficiaries coming for immunization on that particular day along with the vaccine given. The names of the children were written again and again every time they came for immunization. This way it will be difficult to follow immunization status of children, and find number of beneficiaries & drop-outs.

4.3 Tickler /Tracking bags were found in all the health facilities but they are not being used to monitor left-out and drop-out.

4.4 It is seen that at each level from District to PHC cold chain maintenance was poor. Everyday temperatures of both Deep Freezers and ILR were checked but they don't know the appropriate temperature for both the equipment. In Longjang PHC of Mokokchung district the temperature maintained for ILR is -2^0C to -8^0C (it is worth mentioning that ANM is regularly checking and recording the temperature. Similar problem was observed in district cold chain, the person who is maintaining the cold chain do not know the correct temperature for ILR and Deep Freezers, he does not know where to keep the icepacks one they are ready.

4.5 Vaccine storage practices not up to suggested standards

- Vaccines were not stored in baskets, the baskets were missing from most of the ILR
- No temperature recording were observed since thermometers were not supplied
- Bottom storage of vaccines was observed in many places that may lead to freezing of vaccines
- In one place vaccine were stored in deep freezer
- Many other medicines, drugs and lab test kits such as Insulin, HIV test kits, were found to be stored in ILR (which was against the guidelines) along with vaccine providing ample opportunity for program errors leading to adverse events.

4.6 The district cold chain office does not have power back up and same is the case at peripheries.

4.7 The district officials are not aware of policies regarding condemning the obsolete equipment. When discussed with the state officials about this they very firmly informed that they do have a policy but no one was having clear knowledge about it.

4.8 At all levels there is a need of training on routine immunization staring on cold chain maintenance, microplan etc. The people are doing the way they think is correct and this is due to no supervision/ handholding by the district/state. Vaccine handler's trainings not started yet.

4.9 Alternate vaccine delivery (AVD) system has not been operationalized though it was an activity mentioned in the State/District PIP. There is enough scope for employing a person with a 2 wheeler to deliver the vaccines to the outreach session site. Staff requires training on AVD.

Recommendation

- The state should plan a concrete training on routine immunization to address the issues mentioned above. Two separate training plan (i) for ANMs on micro plan and maintaining tickler bags (ii) on cold chain maintenance at district and health facilities.
- All the health facilities should be provided with printed registers
- Regular review and monitoring by the district officials especially District/State Immunization Officer and the State Cold Chain Officer.
- ASHAs to be utilized for tracking the left outs and drop-outs.

5. Village Health & Nutrition Day (VHND)

VHNDs are being implemented regularly – every month in each village but not in Anganwadi Centres. The team could visit only one VHND wherein it was observed that the village health committee was actively participating during VHND. However, it was seen that AWWs were not involved in VHNDs. ICDS was not at all associated with VHND planning.

In terms of service delivery it is limited to immunization and health education.

Recommendation

- VHND is a platform for intersectoral convergence; hence the state should involve other departments such as ICDS, PHED (TSC), NSACS etc. Each month a discussion on various topics may be initiated by the ANM. For this the district can provide IEC materials to her.

- The basket of services during VHND to be expanded. It should cater to ANC/PNC etc. Village Health Committee to be given responsibility to procure basic instruments for VHND in discussion with ANM and keep it in there custody. During VHND she can use instruments, this way the ANM will not have to carry BP instruments etc.

- A detail awareness generation plan needs to be developed.

6. Biomedical Waste Management/Infection Control Practices

Biomedical Waste Management is a concern in the State. The observation made by the team during the field visit is given below:

6.1 Training on Biomedical Waste Management is not being imparted to any of the health providers due to which in none of the health institutions color coded bins were seen. The State have not supplied consumables related to Biomedical Waste Management

The team would like to document that the Medical Officer of the Tuli CHC have taken her own initiative to download the BMW guideline from Ministry's website and circulated it to her staffs. Similarly, the ANM of Mopungchuket SC have procured bins and kept it in her SC. When asked how she knew about it, she informed that it was written in the checklist. However in both the health institution segregation is a concern but there effort is being appreciated.

6.2 All the health institutions burn the waste generated including expiry medicines, which is a concern

6.3 The Mokokchung District Hospital and TB hospital have a locally made incinerator where they burn the biomedical waste

6.4 Infection control practices such as needle destruction and sterilization of equipment were practiced in all the facilities

Recommendation

- The state should plan training of health providers (both physicians and paramedics). If the state does not have expertise then they can take the help of external agencies for training. RRC- NE may be asked to provide the models tries in the neighboring state of Assam and Tripura.

- In the PIP the state should plan procurement of color coded bins and bags, needle destroyer etc and distribute them to the health facilities. For disposal of waste at CHC, PHC and SC deep burial and sharp pit to be used. For District Hospital Incinerator should be procured as per the Environmental Ministry's act which will be available with the State Pollution Control Board.

- The state should issue an order not to use the locally made incinerators.

7. Mobile Medical Unit (MMU)

The MMU at Mokokchung district is not properly functional due to political pressure. Moreover, the MMU does not have monthly plan for outreach services (as told by district hospital), the X-ray machine is not working. It is not providing services that are meant from MMU.

The vehicle needs repairing and renovation.

8. Logistics and drug supply

Drugs were available in the health institutions but the supply is not regular. It was informed to the team that sometimes the drug supplies are irrational i.e. drugs were over and above the recommended essential drug list for that level of health facility. In none of the health facilities essential drug list was displayed.

Similar to UIP, printed stock registers were not available in the health facilities (e.g. PHC V.K. District Zonheboto).

The state should strengthen the supply chain management. It seems at the district there are more than one drug depot, i.e. from the state some of the drugs are sent to District Drug Ware House (DDWH), District Hospital and District Immunization Office. Mechanism to dispose-off expired medicines and obsolete equipment was not clear to staff. The DDWH does not have a stock of all the medicines received by the district.

At the same time it was found that Village Health Committee are also procuring drugs for SCs, which is again a concern because they are not aware of drugs that are required in Sub Centre. It was told to the team that in discussion with pharmacist of the SC[4]. In PHC V. K. many non-essential medicines with short expiry dates were purchased in large number even thogh is catered to a small population With so many agencies involved in drug procurement still following essential medicines and supplies were not available in most of the health facilities

[4] In Nagaland all the SC have one pharmacist, which is against the norms

1. Disposable Delivery Kits (DDK) Essential since most of the deliveries take place at home in Nagaland.
2. Zinc tablet (if available, staff not aware how to use for diarrhea)
3. Misoprostol
4. Vitamin A
5. Haemaccel IV fluids

Recommendation

- The State should provide Essential Drug list to the districts and it should be displayed in all the health institutions.
- The DDWH should be the focal depot to receive all the medicines from the State and they will be charge of keeping a stock and distributing it in the peripheries.
- The State should have a regular supply of medicines and to keep a stock of it Drug Ware House (both at State and District) should be computerized and bar code system may be introduced.

9. HMIS/ Monitoring & Evaluation

Monitoring and Evaluation is a concern in the State. At each level the team has felt the absence of supportive supervision. The district officials including CMO have shown there concern and they have informed that they are short of fund/ vehicle. In this financial year the State have given them fund for monitoring i.e for SC Rs. 100 per village, for PHC Rs. 300 per SC and for District Rs. 500 per village. Looking at the distance and shortage of public transport the team felt that the money is too less.

In addition to field visit it was also seen that review meeting at the districts/ block is not being conducted regularly. No one at the state/district analyses the data fed in the HMIS web portal. It seems uploading of data is just following the order by ministry. These data are not being used during review meetings

Name Based Tracking System (NBITS) / Mother & Child Tracking System (MCTS) were yet to be implemented. The training is completed for district trainers for MCTS, nodal officers at district and state identified and notified, designing and printing of MCTS registers and formats completed and dissemination to districts underway. NBITS/MCTS program is yet to be operationalized by State.

Recommendation

- The State should provide mobility support to the district and block officials. The checklist for field visit is given to all the district by the state and now it is to be ensured that they visit as per the plan
- HMIS data to be used during review meetings.
- Implementation NBITS/MCTS and Maternal Death Review needs to be expedite

10.Programme Planning and Management

District planning is the key decentralization strategy under the NRHM. However, In Nagaland the district health officials need to understand the concept of district planning, budgeting, monitoring and implementation. A good DHAP that should have all key activities along with the budgets and the timeline was missing at the district level. In 2009-10, Zonheboto district prepared a satisfactory somewhat DHAP with the annual budget of Rs. 2,68,73,400 out of which Rs. 1,18,40,990 was disbursed to them. Thus only 44% of the budgeted funds were available to district to implement the DHAP. These funds came 'earmarked' for salary of contractual staff, untied funds and the YSY. Due to lack of funds and understanding of concept of 'flexipool' funds, the district could not use the money available to them for the planned activities in the DHAP. Needless to say, the planned activities were not carried out. Many planned trainings could not be organized. In year 2010-11, as a retrograde step, the DHAP of the Zonheboto listed only the activities but did not budget for them or proposed a timeline for implementation.

DHAP once prepared was not consulted either to implement the plan or to monitor the implementation. There was no state level monitoring of the DHAP implementation either.

DPMU staffs (CMO, CMHO, Contractual staff and officials of other dept) need to be supported through:

- Promoting the concept of District Planning and Implementation Team that should meet regularly to oversee the district planning and implementation
- Trainings on district planning and monitoring
- Inculcating belongingness that they are part of the team
- Difficult area allowance and pay parity with other contractual staff
- Transport for field visit to provide close monitoring and supervision
- Pay parity of all contractual staff and difficult area allowance

11.Communitization

Prior to launching of NRHM in Nagaland, the enactment of the Communitisation of Public Institutions and Services Act in 2002 ushered decentralized management of various health units by the constitution of Village Health Committees (VHC) in SC, Health Centre Management Committee (HCMC) in PHC & CHC to promote public participation and ownership. Under NRHM, the level of Communitisation was taken to all recognised villages and to the District Hospital by constituting Village Health Committees and Hospital Management Society (HMS) respectively. HMS functions as RKS.

In many places VHC have constructed beautiful sub-centres from their own funds and contributed in cash and kind to the health facilities.

CRM team found that the VHC and HMC were very strong and active at their respective levels. However, they have not been properly sensitized about their roles and responsibilities. As a result the demand for health care services and community participation has not increased in the recent years. Village health plans have not been developed. Trainings of the VHC members specifically on NRHM and their role in village health planning, demand generation for services available at health facilities, monitoring, utilization of untied funds and VHNDs have not taken place. VHC have not been able to bring ICDS and departments to contribute to village health programs such as VHND.

Recommendation

- VHC's/HCMC can be a catalyst to motivate the community on various health and related issues. The state can plan orientation programme for them on various health issues and ways to address them. At present there role confined to infrastructure development and maintenance of the health facilities.

12.ASHA programme

There were 1700 ASHAs working in the State and have been trained in module 5.

District-wise number of ASHA

Sl. No.	District	No. of ASHA
1	Mon	210
2	Dimapur	242
3	Zunheboto	194
4	Mokokchung	171
5	Wokha	160
6	Tuensang	153
7	Phek	132
8	Peren	130
9	Kiphire	103

Sl. No.	District	No. of ASHA
10	Kohima	120
11	Longleng	85
		1700

Following initiatives taken by the state to strengthen ASHA programme :

1. Development of ASHA diary completed and distributed to all ASHAs.
2. ASHA Coordinators appointed in 48 blocks to give handholding support to ASHAs.
3. Regular monthly thematic meeting initiated in most of the blocks by ASHA Coordinators.
4. Radio sets provided to all the ASHAs.
5. Translation of ASHA Reading Materials into 3 major local dialects viz. Ao, Tenydie and Phom completed.
6. ASHA Drug Kit was given to the ASHAs.Hand Weighing machines and thermometers procured for ASHAs.
7. State Trainer for modules 6 and 7 trained at SEARCH, Gadchiroli, Maharashtra.
8. Training of District/ Block Trainers on 6th and 7th Modules completed.

Training status of ASHAs

Status of ASHA trainings

Sl. No.	District	Total ASHAs trained (module wise)				
		Mod 1	**Mod 2**	**Mod 3**	**Mod 4**	**Mod 5**
1	Mon	210	210	210	210	210
2	Dimapur	242	242	242	242	242
3	Zunheboto	175	175	175	175	194
4	Mokokchung	171	171	171	171	171
5	Wokha	45	45	45	95	160
6	Tuensang	144	144	144	144	153
7	Phek	69	132	132	132	132
8	Peren	130	130	130	130	130
9	Kiphire	103	103	103	103	103
10	Kohima	98	98	98	98	110
11	Longleng	85	85	85	85	85
		1507	**1570**	**1538**	**1588**	**1690**

The average continuation duration of ASHA is 4 years and only 10% drop-out rate have been noted in the State. Most of the ASHA vacancies have been filled but their training is yet to be completed.

the team felt that lot of quality initiatives need to be taken to strengthen ASHA programmme.

12.1 As per the above table ASHAs have been trained in the entire 5 module and the state is preparing to train them on 6th and 7th module but during the field visit it was found that there knowledge on basic health issues is not clear.

12.2 If further analyzed than number of ASHAs trained in 1st module is lesser than the 5th module. It seems approximately 183 ASHAs have not received 1st module but they have been trained on 5th module. Henceforth it is suggested that emphasis should be given on quality and not quantity.

12.3 The State does not have ASHA support system. They do not have ASHA Resource Centre. At the block level they do have ASHA Facilitator in the ratio of 1 per 30 ASHAs (1:30). Apparently these facilitators have very less knowledge on health and related issues. It was told to the team that training has been imparted to ASHA Facilitators but the quality and duration of the training is a concern. The State should remember that the ASHAs are in the field for more than 3 years and will have better understanding of the system than the ASHA Facilitators. Hence to handhold the ASHAs they should be prepared thoroughly with robust trainings and reviewing

12.4 Diaries have been provided to the ASHAs but they are not using it. When asked they informed that do not understand many of the terms written in the diary (e.g. RTI/STI) and it is too cumbersome.

12.5 ASHAs are mainly contributing to VHNDs and the JSY incentives are not big enough for them to support institutional deliveries.

Recommendation

- Revisit Role of ASHA specifically for tracking of women and children for maternal newborn care, immunization, beneficiaries for VHNDs. The state should look into:
  - Job responsibility
  - Trainings
  - Work out-put to be defined
  - Focus on beneficiary tracking

- The State should establish ASHA Resource Centre to support ASHA program. The plan for training of ASHAs needs to be robust. The state can plan refresher training for ASHAs may be for a duration of 1 to 2 days.
- The state may think of giving uniform to ASHAs and increase the number of ASHA Facilitators from 1 per 30 ASHAs to 1 per 10 ASHAs
- Train ASHA facilitators too for better supervision of ASHAs

13.National Disease Control Programme

NDCP was well integrated in NRHM. Funds are available for implementing the programs.

13.1 RNTCP

RNTCP Infrastructure

For 2010	11 District TB Centre (DTC)
	13 TB Unit
	43 Designated Microscopy Centre (DMC)

RNTCP Performance

Year	Cure Rate	Case Detection Rate
2005	90%	61%
2006	87%	61%
2007	90%	72%
2008	89%	72%
2009	90%	80%
2010	91%	85%

National target: Cure rate- 85%, Case Detection Rate- 70%

In Zuhneboto district, there were 113 patients detected in 2010 for DOTS

13.2 NVBDCP

NVBDCP Human Resources

Sl. No.	Health facility	Sanction/ Required	In place	Trained as per new Malaria guidelines
1	DMO (Full Time)	11/11	10	5
2	DVBDC Consultant	Nil/11	Nil	Nil
3	AMO	10/11	10	10
4	CHC-MO	42/84	42	177
5	PHC -MO	82/125	82	
6	Other MO	272	272	
7	Lab. Technician (regular)	29	29	19
8	Lab. Technician (contractual)*	11/33	11	11
9	Health Supervisors (M)	81	81	81
10	Health Supervisors (F)	Nil	Nil	Nil
11	MPW (M)/ SW	290+57	290+57	290+57
12	MPW (M) (contractual)#	132	132	132
13	MPW (F) (contractual)#	68	68	68
14	Malaria Technical Supervisor – MTS contractual)*	10/39	10	10
15	ASHA	1700	1541	1195

State PMU (GFATM)	In Place
Project Director/Programme Officer	1
Consultant M&E	1
Finance Consultant	1
Data entry operator	1
Secretarial Assistant	1

13.3 Malaria: State Epidemiological Situation

Year	Population	BSC/ BSE	ABER	Total cases	Pf cases	API	SPR	SFR	Deaths
2005	1805263	66751	3.69	2524	100	1.39	3.78	0.14	-
2006	1805263	89253	4.94	3361	506	1.86	3.76	0.56	75
2007	1805263	125933	6.97	4978	806	2.75	3.95	0.64	26
2008	1980597	135910	6.87	5078	835	2.56	3.73	0.61	19
2009	1980597	156259	7.88	8489	2893	4.28	5.43	1.85	35
2010 (Jan-Oct)	1980597	143541	7.24	4180	1477	2.11	2.91	1.02	13

In Zuhneboto, 20,326 blood smears were collected out of which 112 slides were positive for P. vivax and 20 were positive for P falciparum API was 0.81 and ABER was 12.2. PHC Akuloto was reported as malaria endemic with SPR of 4%.

14.Financial Management

Key observations at State/District level:

1. Post of Director Finance is vacant at State level.
2. Positions of District Accounts Managers are vacant in Zunheboto and Mokokchung Districts.
3. No separate Government Order (GO) is issued for Delegation of Financial Powers.
4. E-banking not properly implemented in Nagaland.
5. Funds are transferred activities wise from State level to District Health Society.
6. Tally ERP9 is implemented at State Level.
7. No proper age wise advance monitoring from State level.
8. Summary of Concurrent Audit report is not being sent to GOI, Ministry of Health on quarterly basis.
9. State organized only 2 Accounts Training for DAM.
10. Books of Accounts maintained at District level both on manual basis and Tally ERP9 software basis.
11. Lack of understanding of double entry system District level.

12. Up to 2008-09 DHS transferred the funds to facility through cash withdrawal from bank and from 2009-10 DHS started the funds transferred through e-transfer from SBI.
13. Accounts Training was not provided to CHC/PHC officer at District level.
14. Lack of communication amongst the District and Block level officer.
15. E-banking not properly implemented in District level.
16. No proper advance control and monitoring system exists in District level.
17. Advances under AMG, RKS, UF treated as expenditure in District level.
18. No integration of all NDCPs programme under NRHM.
19. Districts were not uploading the FMR on HMIS portal.
20. Lake of monitoring of funds transferred to CHC/PHC/SHC/VHSC level.
21. No proper books of accounts maintained.
22. Lack of understanding of double entry system.
23. JSY payment register is not maintained.
24. Most of expenses made through cash withdrawals.
25. RKS funds are not being audited by the chartered Accountants firm.
26. No Bank Reconciliation statement prepared.

Key Findings from CHC /PHC/SHC Level:

27. Books of Accounts are not properly maintained at CHC/PHC/SHC level.
28. No JSY payment register is being maintained at CHC/PHC/SHC level.
29. Lack of understanding of double entry system at CHC/PHC level officers.
30. Original Vouchers of payment have been sent to DHS without keeping the photocopy of the voucher in the records of Pughoboto CHC.
31. No bank reconciliation statement is prepared at CHC/PHC level. Pass books are also not updated on weekly basis.
32. Accounts Training has not been provided to Block level Officers.
33. Lack of co-ordination between the Block and SHC Level .
34. Substantial delay in payment of JSY at Akuluto PHC. There are 80 cases of JSY payment pending at Akuloto CHC and the payment of JSY is not being recorded in cash book.
35. RKS funds have been misused at V.K.Town PHC.
36. Payment receipts have not been obtained from the suppliers of medicine/equipment by pharmacist at Asukhomi Sub-Centre.

Summary of recommendations

A. State

- Meeting of State Health Mission should be held regularly to oversee the implementation of the NRHM. A team should be constituted for setting agenda and important decisions expected out of the meeting.
- Inter-sectoral Convergence with the other line departments – ICDS, education etc. should be strengthened specifically in the area of village health planning, VHND and community mobilization.
- A guideline/ decision for uniformity in the user fees for the services rendered by the health institutions should be taken by state government
- Despite increase in numbers of facilities, full functionality still an issue, especially blood bank at DH & blood storage at FRUs, and availability of specialists / multi-skilled MOs. Newborn care equipment should be quickly installed and staff trained.
- Infrastructure plan for Sub Centres may be relooked in terms of speed of implementation, budgeting and timeline.
- Construction of Health Institutions should be based on the population norms.
- Public Private Partnership: Involve community based organization in NRHM planning, implementation and monitoring
- Civil work to be expedite and pending works to be completed
- Equipment maintenance is one of the key area requiring attention:
    - State action plan for equipment maintenance
    - Dedicated trained staff at district level
    - Annual Maintenance Contract for equipment
    - Purchase equipment with in-built 3 to 5 year maintenance contract
- Procurement and supply chain management system should be established
    - Centralized state level procurement (Tamil Nadu model could be copied)
    - Monitoring stocks at all level (use HMIS to the extent possible0
- Review meetings to be held every quarter **at State and district level**:
    - Systemic program review
    - Monitoring of program
    - Resolving bottlenecks
    - Update on new initiatives & guidelines
- Cross learning trips to other states should be organized. Many states have demonstrated good models of facility and community based care and health system development. These trips will broaden the vision and horizon of the staff in Nagaland.

- Quality assurance committee need to be established at least at District/DH/CHC level

National

- Non availability of blood storage units is a major barrier in operationalisation of FRUs, Ministry may need to work together with NACO for time-bound establishment of Blood Storage Centres (BSCs).

- The Nagaland team is very keen to take the ongoing work forward to its logical conclusion. However they are challenged by systemic weakness and capacity. CRM team strongly felt that if a stronger Development Partners presence is there in Nagaland to handhold the State and provide need specific Technical Assistance then the State can achieve better health outcomes

- Handholding of the state by supportive visit by the officials from the Ministry to help them in better understanding and implementation of the programme.