REPORT OF THE
7TH COMMON REVIEW MISSION
(10TH TO 15TH NOVEMBER 2013)

NAGALAND

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Executive Summary:

7th Common Review Mission led by Dr. Pradeep Halder, Deputy Commissioner (Immunization), Ministry of Health & family Welfare and other members from Ministry of Health & Family Welfare, Development partners and civil Society visited State of Nagaland. The Mission visited 2 districts: Peren and DImapur. The key findings are summarized below:

Positives:

- ✓ Efforts made to implement the Recommendations of 4th CRM (Dec 2010)
  - ➢ Speed up construction
  - ➢ Set up NBCC
  - ➢ Blood storage at FRUs
  - ➢ Display of SOPs
  - ➢ IEC display, including patient charter
  - ➢ BMW equipment and training to be put in place
  - ➢ Strengthen referral transport system
  - ➢ Infrastructure in State is good and well maintained.
- ✓ The pace of construction in the state is very good. Almost all the works undertaken in last two years are almost completed.
- ✓ A new nursing school has been set up in Dimapur, with state-of-the-art infrastructure.
- ✓ State has a well staffed and skilled PMU at district and block level
- ✓ State has 76 level ambulances linked to 102 call centre. Ambulances are GPS fitted and vehicle tracking system in installed in them and are stationed at district and block level facilities.
- ✓ IEC material in all the facilities was displayed in local language.
- ✓ Display of SOPs on MNCH, infection control, asepsis and waste disposal in LR & OT in place
- ✓ Significant progress in setting up of facility based newborn care services, since the last CRM. There is one Sick Newborn and Child care Unit (SNCU) in Kohima, and 2 new ones have been approved this year. New born care corners were available at all visited sub-centre/ PHCs / CHC delivery points

- ✓ VHND is a good platform to deliver health services- ANC checkup, immunization, general OPD, VHCs comprising of village head, church member and others actively involved in VHND sessions.
- ✓ The process of communitisation of health services is very strong in Nagaland. ASHAs were found to be overall adequate in numbers (some gaps); training of module 6 and 7 is going on in the State, ASHA performance monitoring is being done regularly.
- ✓ HCMCs/ RKS constituted in health facilities; all facilities receiving HCMC / AMG/untied funds.
- ✓ State has initiated trainings on Biomedical Waste.
- ✓ RD Kits for malaria and ACT available at all facilities from GoI (NVBDCP) supply.
- ✓ HIV integration initiated through pooling of Lab. Techs (NRHM/DHS/NSACS), ICTC Counselors providing ARSH services; HCMC fund used for local purchase of OI drugs- CTX
- ✓ NGOs coordinating Targeted Interventions having very good coverage of vulnerable communities, not limited to the areas they receive financial support for.
- ✓ In Dimapur district, urban slum populations are well organised (have unions) and are supporting health system in some areas, by way of providing land for health facility, identification and mobilisation of target population. Community leaders were enthusiastic on launch of NUHM and ready to continue their support.
- ✓ Active involvement of churches and youth clubs in outreach activities.

Areas of concern:

- × The major gap in the Infrastructure is relative shortage of Staff quarters.
- × Due to low population coverage by facilities, utilization of services is sub-optimal in the health facilities.
- × State does not have a sanctioned strength of HR at all levels. In absence of sanctioned strength, regular posting cannot be verified.
- × DH and CHC don't have adequate complement of specialists, which is a challenge
- × Home deliveries predominant due to difficult terrain and poor referral transport mechanism
- × Maternal deaths were found unreported.
- × Under JSY, Cash payments were being made to beneficiaries and ASHAs.

- Under JSSK, Cash payment was being made to pregnant women for provision of diet and Referral Transport. The State/ district was doing cash re-imbursement of Rs 1300/- (Rs 650/- each) for Home to facility and drop back (at a flat rate irrespective of distance), Similarly for Diet, Rs 100/ day for normal delivery, and Rs 700/- for C-section was given to pregnant women. Some backlog was seen in these payments. Out of pocket expenses still being incurred on drugs, blood (for screening tests), and diagnostics. The officials and district personnel was still unaware of JSSK entitlements, despite the display of JSSK entitlements in all health facilities. There was poor awareness of free entitlements among staff at all levels, and ASHAs.
- RTI/STI and MTP services were almost not missing. IUCD insertion service quality is a concern – high (30-40%) removal rates seen in Peren District.
- Free referral transport from habitat to health facilities is still lacking in the state.
- There was a connectivity issue which hinders the communication to the health functionaries or ambulance drivers.
- Toll free number 102 was not functional.
- Lack of systematic microplanning for VHNDs/ Immunisation sessions was observed.
- There is poor awareness of open vial policy.
- Instances were noted of incorrect temperature monitoring of ILR, frozen vaccine at outreach site, vaccines submerged in water in the ILR, etc.
- No ASHA payment for full immmunisation for 12-23 months children – no incentive paid and no information.
- No dues list prepared – vaccines for VHND not always requisitioned as per requirement
- Poor counselling and follow up of missed cases
- Stock registers were not properly maintained; distribution registers were found absent
- Alternate vaccine delivery was not being used.
- Some of the essential drugs not available such as IFA syrup, Zinc Tablets, Inj. Mag. Sulph, Vitamin A.
- There were no colored poly bags available in the facilities resulting in mixing up of waste which was initially segregated.

- Record keeping was found inadequate. There was underreporting of vaccinated children in MCTS and HMIS registers.
- ASHA: While turnover is quickly addressed, new recruits are not trained systematically from the induction module – training provided in on-going (i.e. 6 & 7) modules
- Training module is not in local language
- HBNC kit not distributed in Peren; and distributed in Dimapur but not as per guidelines
- Poor knowledge and skills of danger signs for HBNC visits → indicating training gaps; evaluation and practicing of skills during training is not being done
- Training of VHC members has not been done
- VHC untied funds predominantly used for conducting VHND, including for TA/ DA and honorarium for ANM and ASHA
- LLIN has not been received by district (Peren) for last two years.
- While API shows improvement, ABER is declining.

Recommendations

- ✓ The State has a shortage of staff quarters which needs to be addressed. State may plan to first saturate High Priority districts and Delivery points.
- ✓ State must have their sanctioned staff strength.
- ✓ There is a need of rational deployment of ambulances as per their usage. State could explore alternative solution of assured referral services by tie ups with the local taxi drivers.
- ✓ State to clearly notify areas of poor/ absent banking services, where cash payments to beneficiaries and ASHAs are permitted, in order to remove any ambiguity.
- ✓ Since Nagaland has a strong communitization process, it is suggested that through the network of VHCs, ASHAs and ANMs community needs to be oriented on their entitlements of JSSK; counselling on nutrition and Family Planning; importance of institutional delivery, etc. State should put a system in place for free diet either cooked or dry food at the health facility like fruits, eggs, milk etc. or tie up with private vendor

for provision of free diet, or create in house kitchen facility from the funds available under JSSK for diet.

- ✓ Maternal Death reviews need to be strengthened.
- ✓ State needs to ensure proper microplanning for outreach sessions. Open vial policy needs to be implemented in the State. Appropriate orientation needs to be carried out at all levels. Service delivery staff needs to be urgently re-oriented on cold chain maintenance, immunisation schedule, and recordkeeping.
- ✓ State/ District to include the RTI/STI medicines in kit form within the EDL.
- ✓ Colour coded bags should be made available for waste collection. Staff needs to be made aware of waste segregation and its adherence monitored.
- ✓ State needs to plan training of VHSNC (VHC) members on their role, management of untied fund and social determinants of health on priority basis.
- ✓ VHC untied funds should be used for local needs, as per guidelines. State to consider separate budget for VHNDs.
- ✓ The selection of new ASHAs needs to be done as per Govt. of India guidelines.
- ✓ ASHAs should be made member secretary of VHC and manage VHC untied funds.
- ✓ The training modules, if in local language would be more helpful for ASHAs
- ✓ State needs to plan for 8 days training of newly selected ASHAs in induction module.
- ✓ HBNC kits should be distributed to ASHA as per guideline
- ✓ State need to map out distance of hamlet/villages or radius of hamlet/villages and select ASHA facilitators on 10-12 ASHAs as per Government of India Guideline
- ✓ There is a need of reorientation training for district and block officials on MCTS and HMIS. Handholding support is required for frontline workers for smooth implementation of MCTS and HMIS.

CHAPTER ONE – INTRODUCTION

Objectives

- Visit to Nagaland under the 7th Common Review Mission, was made from 10th to 15th November 2013 with the following objectives:
  - Review progress of National Health Mission with reference to the functioning of NHM vis-à-vis its goals and objectives – identify the changes that have occurred in the last eight years and reasons for the current state and trend.
  - Review programme implementation in terms of accessibility, equity, affordability and quality of health care services.
  - Review of progress against conditionalities and the State's response.
  - Review follow up action on recommendations of last Common Review Mission.
  - Note additional outcomes other than those envisaged under approved plans.
  - Identify constraints faced and issues related to each of the components outlined and possible solutions
  - Document best practices, success stories and institutional innovations in the states.
  - To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative. programme implementation and design.

Composition of CRM team

- The team was led by Dr Pradeep Halder, Deputy Commissioner, Immunization, MoHFW:

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Visit schedule and sample units covered

- On 10th November, the Mission Director, Dr. Khanlo Magh and his team briefed the CRM team on key areas of progress under NHM. Subsequently, the CRM team divided into two districts. A mix of both high focus (Peren) and non-high focus (Dimapur) districts were selected.

- The respective districts briefed the teams on 11th November and during 11-14th November the teams visited various health facilities at district and lower levels. A complete list of facilities visited by the team is given below:

Level	Dimapur	Peren
District	• District Hospital Dimapur • Nursing School • District Laboratory	• District Hospital Peren
CHC	• Medziphema • Dhansiripar	• Jalukie
PHC	• Molvom • Sirginijam • Neuiland • Chokodima	• Tenning • Azailong • Ahtihbung
Village/ Urban sub health centre	• S/c Tsiepama • S/c Diezephe • S/c Bade • S/c L. Vihoto • S/c Manglimukh • S/c Doyapur • VHND Aoyimiti • VHND Aoyimchen • Town health sub center - urban health post	• S/c Samzuram • S/c Mhainamtsi • S/c Punglwa • S/c Bongkolong • VHND Jalukie B • VHND Nchangram
Other facilities	• Maova – village community center • Nursing school Dimapur • District TB Hospital • AYUSH Pharmacy and Drug testing centre	• IRC centre, Jalukie
Urban areas/ slum dwelling areas	• Burma camp slums • New Market red light areas	• Marketplace near Punglwa

- Progress of NHM was reviewed on ten key parameters as laid out in the terms of reference. Key findings and recommendations were presented during the district de-briefings on 14th November and the State level de-briefing (to the Commissioner and Principal Director, Health) on 15th November.

- This report is a summary of findings of the team from both the districts. The findings are based on field visits, discussion with the state/district officials, institutional staff, village health committees, representatives of civil society and beneficiaries of various programmes.

CHAPTER TWO - BRIEF PROFILE OF THE STATE

1. Demographic Profile

Indicator	Nagaland	India
Total population (in crore) (Census 2011)	0.20	121.01
Decadal Growth (%) (Census 2011)	-0.47	17.64
Crude Birth Rate (SRS 2012)	15.6	21.6
Crude Death Rate (SRS 2012)	3.2	7
Natural Growth Rate (SRS 2011)	12.8	14.7
Sex Ratio (Census 2011)	931	940
Child Sex Ratio (Census 2011)	944	914
Schedule Caste population (in crore) (Census 2001)	Not Notified	16.67
Schedule Tribe population (in crore) (Census 2001)	0.17	8.43
Total Literacy Rate (%) (Census 2011)	80.1	74.0
Male Literacy Rate (%) (Census 2011)	83.3	82.1
Female Literacy Rate (%) (Census 2011)	76.7	65.5

2. Health infrastructure

Rural Population (In lakhs) Census 2011	14.07
Number of Districts (RHS 2012)	11
Number of Villages (RHS 2012)	1428
Number of District Hospitals	11
Number of Community Health Centres (RHS 2012)	21
Number of Primary Health Centres (RHS 2012)	126
Number of Sub Centres (RHS 2012)	396

3. Status of Health Indicators

Sl. NO	Indicators	Nagaland	India
1	Infant Mortality Rate (SRS-2012)	18	44
2	Maternal Mortality Ratio (SRS 2007-09)	NA	212
3	Total Fertility Rate (SRS 2011)	NA	2.4
4	Under-five Mortality Rate (U5MR) (SRS 2011)	NA	55

4. Progress of NRHM

Sl. No.	Activity	Status
1	24x7 PHCs	Out of 126 PHCs, 33 PHCs are functioning on 24x7 basis
2	Functioning as FRUs	11 DHs and 5 CHCs are working as FRU.
3	ASHA Selected	1854 ASHAs selected and 1700 trained up to 5th module and 1576 ASHAs are trained in round 1 & 1570 ASHAs in round 2 of 6th & 7th modules.
4	ANMs at SCs	Out of 396 SCs, 247 are functional with 2nd ANMs.
5	Contractual appointments	60 GDMOs, 234 Staff Nurses, 70 Paramedics, 347 ANMs, 39 AYUSH Doctors & 9 Specialists are positioned under NRHM.

<table>
<tr><th>Sl. No.</th><th>Activity</th><th>Status</th></tr>
<tr><td>6</td><td>Rogi Kalyan Samiti</td><td>162 facilities (11 DH, 21 CHCs, 126 PHCs and 4 other Health facilities above SC) have been registered with RKS.</td></tr>
<tr><td>7</td><td>Village Health Sanitation & Nutrition Committees (VHSNCs)</td><td>Out of 1428 villages, 1278 VHSNCs constituted.</td></tr>
<tr><td>8</td><td>VHNDs</td><td>2450 VHNDs were held during 2013-14.</td></tr>
<tr><td>9</td><td>Infrastructure Strengthening</td><td>
<table>
<tr><th rowspan="2">Facility</th><th colspan="2">New Constructions</th><th colspan="2">Renovation/Upgradation</th></tr>
<tr><th>Sanctioned</th><th>Completed</th><th>Sanctioned</th><th>Completed</th></tr>
<tr><td>DH</td><td>-</td><td>-</td><td>2</td><td>0</td></tr>
<tr><td>CHC</td><td>4</td><td>3</td><td>-</td><td>-</td></tr>
<tr><td>PHC</td><td>19</td><td>19</td><td>-</td><td>-</td></tr>
<tr><td>SC</td><td>50</td><td>50</td><td>-</td><td>-</td></tr>
</table>
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<tr><td>10</td><td>New Born Care Units established</td><td>
<table>
<tr><td>Sick New Born Care unit (SNCU)</td><td>1</td></tr>
<tr><td>New Born Stabilization Unit (NBSU)</td><td>5</td></tr>
<tr><td>New Born Care Corner (NBCC)</td><td>120</td></tr>
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5. Reproductive and Child Health Programme (RCH)

Key indicators (***Figure in percentage***)

Year	Coverage Evaluation Survey	
	2006	2009
ANC registration		53.7
3+ANC		29.4
Full ANC		3.5
Institutional Delivery		30.4
Safe deliveries		43.8
Fully Immunized	32.5	27.8
BCG	62.5	59.0
OPV 3	40.3	35.8
DPT 3	41.0	45.9
Measles	46.1	52.2

Physical Progress of Institutional Deliveries and JSY

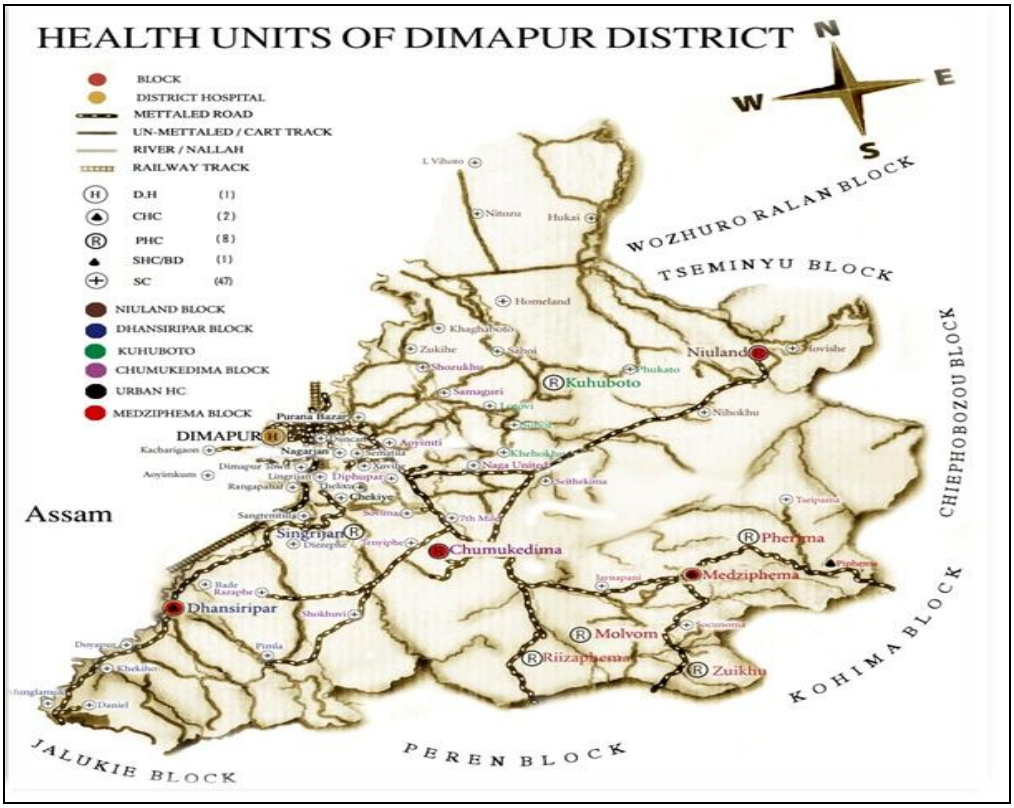
Year	Institutional Deliveries	JSY Beneficiaries
2005-06	13000	0
2006-07	1456	1301
2007-08	9000	8457
2008-09	12000	9790
2009-10	10487	22728
2010-11	11177	13291
2011-12	13145	15863
2012-13	15141	17609
2013-14 (till Oct.)	3343	2447

Services

Services	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14
Male Sterilisation	0	18	100	54	7	6	13	4
Female sterilisation	166	1257	1468	1163	1610	2158	2155	399
Full immunisation (In thousands)	NA	52	17	22	16	16	20	5

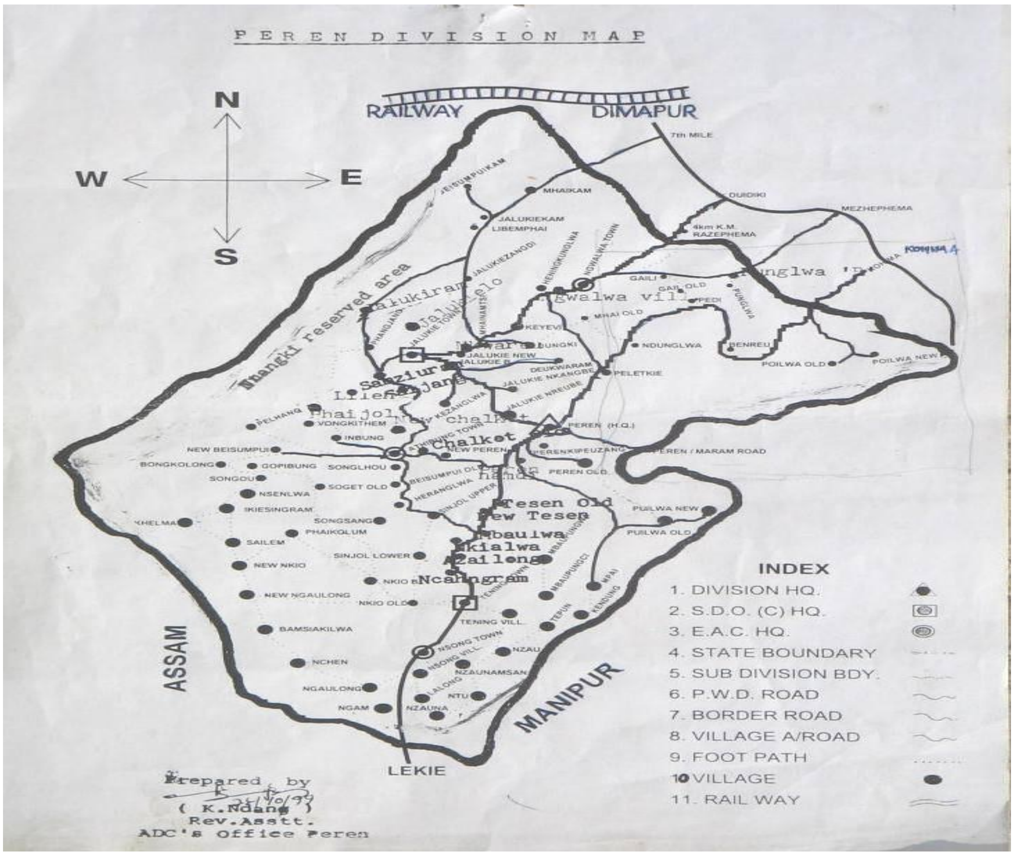
6. District Dimapur

- Total No Of Blocks : 5
- District Hospital: 1
- CHC :2
- PHC:8
- BD : 1
- SC: 47



7. District Peren:

- Total No Of Blocks : 4
- District Hospital: 1
- CHC : 1
- PHC: 8
- SC: 16



PEREN DIVISION MAP
N
S
E
W
RAILWAY
DIMAPUR
ASSAM
MANIPUR
LEKIE
INDEX
1. DIVISION HQ.
2. S.D.O. (C) HQ.
3. E.A.C. HQ.
4. STATE BOUNDARY
5. SUB DIVISION BDY.
6. P.W.D. ROAD
7. BORDER ROAD
8. VILLAGE A/ROAD
9. FOOT PATH
10 VILLAGE
11. RAIL WAY
Prepared by
(K.Ndang)
Rev.Asstt.
ADC's Office Peren

CHAPTER THREE: KEY OBSERVATIONS AND RECOMMENDATIONS

PROGRESS ON PREVIOUS CRM RECOMMENDATIONS

- State has made efforts to implement the key recommendations of the previous CRM (4th CRM, December 2010). As seen in the table below, the progress is varied:

S. No.	CRM-4 recommendation	Status
1)	Despite increase in numbers of facilities, full functionality still an issue, especially bed occupancy rates, blood bank at DH and blood storage at FRUs, and availability of Specialists/ multi -skilled Medical Officers.	• There is a constant increase in the utilization of services in term of OPD, IPD and Major services in the State over the years. • State has 8 Blood banks in 8 districts. 5 CHCs have BSUs. Dimapur DH has a model blood bank with component separator. However, 2 BSUs in Peren district have all infrastructure and equipment ready for the past two years – awaiting license.
2)	Newborn care yet to start up. Equipment should be quickly installed and staff trained	• 1 SNCU and 4 NBSUs are set up. • New Born care corner was available at all the delivery points. However, trained NSSK staff was not posted at NBCCs.
3)	Several sub-centres do not have government building. Pace of construction and renovation needs to be improved.	• Pace of construction has picked up and nearly all sanctioned works (uptil 2011-12) have been completed. • All major construction and upgradation sanctioned under NRHM in both the districts has been completed. • District Peren has all the facilities in govt. building and in District Dimapur, 35 out of 47 SHCs are in govt. building.
4)	Lack of referral transport system affects access to health services. Free referral transport from habitat to health facilities is needed.	• State has 76 ambulances. There is a centralised call centre, ambulances are GPS fitted. However, there are major gaps in service delivery. Most of the places mobile network was not available resulting in ambulance tracked by GPS but not communication. Free referral transport from habitat to health facilities is still lacking in the state.
5)	Training programmes should be planned for Village health committees for engaging them in village health planning, community mobilization and monitoring.	• Yet to be done.
6)	Bio-medical waste management system needs to be operationalised. Training of providers should be planned	• Training has been imparted to various categories of staff, but knowledge and practices were very poor. • Colour coded BMW bins are placed in all facilities. However, Colour coded bags were not available.
7)	Irrational drug supply, stock-outs are an issue. EDL needs to be followed along with the strengthening of supply chain management.	• State Drug Policy is in place. • EDL was found in place in many facilities visited. • A copy of the STG was available at the facilities, though the doctors were not aware.
8)	Micro-planning for immunization needs to be strengthened. Alternative Vaccine Delivery mechanism needs	• Microplanning is very weak. • AVD is lacking.

S. No.	CRM-4 recommendation	Status
	to be explored for improving access.	

TOR 1: SERVICE DELIVERY

Adequacy of facilities

- Nagaland has a total population of 19.81 lakhs of which rural population is 14.07 lakhs (71%). The state has 11 districts, 56 health blocks and 1324 revenue villages, as per Census 2011. The state has ***no Medical College***. There are 11 District Hospitals, 21 CHCs, 126 PHCs and 396 SHC in state.
    - As per RHS 2012, there is a shortfall of 72 SHC in the State and a surplus of 56 PHCs and 4 CHCs.
    - The major gap in both the districts is relative shortage of Staff quarters.
- There are several urban slums with lot of migratory population from nearby states; the infrastructure seems to be inadequate to provide health services in these areas.
- District Dimapur has a population of 3.79 lakhs. There are 59 facilities in the district, of which 12 SHCs are functioning in rented buildings, rest are in govt. buildings. Staff quarters are available in the DH, 2 CHCs, 3 PHCs and 3 SHCs only.
- District Peren has a population of 0.95 lakhs. There are 26 facilities, all of which are in govt. buildings.
    - Peren has 86 hard to reach villages, out of which ***25 villages are not reachable for 6 months.*** This places severe challenges on service delivery.

Utilisation of facility based services

- There is a constant increase in the utilization of services in the State over the years. Similar trends are observed in both the districts, as seen in the table below:

	OPD			IPD			Major Surgeries		
	2010-11	**2011-12**	**2012-13**	**2010-11**	**2011-12**	**2012-13**	**2010-11**	**2011-12**	**2012-13**
State	670,212	853,131	904,751	65,716	96,856	80,524	3,267	5,752	8,708
District Dimapur	210,971	274,944	328,382	23,971	43,680	34,260	698	2,928	5,136
District Peren	30,006	29,339	24,228	721	1,020	980	NA	NA	NA

- Due to low population coverage by facilities, utilization of services is sub-optimal. A very low number of normal deliveries were being conducted in SC, PHC CHC as there are only 4 delivery points each in Dimapur and Peren district.

Construction and quality of infrastructure

- The construction of facilities in is the state is taken up by PWD. The pace of construction in the state is pretty good. The summary of works undertaken by the state since inception of NRHM is as under**:**

S. No	Name of Works	No. of works Sanctioned	Works Completed	Works in Progress	Not Started
1	DH	9	9	0	0
2	CHC	9	9	0	0
3	PHC	19	19	0	0
4	SHC/SC	148	135	13	0
	Total	**185**	**172**	**13**	**0**

- The pace of construction in both the districts is also good, as seen in the tables below:

Details of Work sanctioned – District Peren	Year of sanction	Status
SHC Nkio	2007-08	completed
SHC Ikiesingram	2007-08	completed
SHC Lilen	2007-08	completed
SHC Bongkolong	2009-10	completed
SHC Mahinamtsi	2010-11	completed
Mahinamtsi construction of LR with attached toilet	2013-14	Near completion
SHC benreu	2010-11	completed
SHC Mpai	2010-11	completed
Athibung PHC	2010-11	completed
CHC Jalukie	2008-09	completed
Staff Quarter in Athibung PHC	2010-11	completed
Staff Quarter in Tening	2008-09	completed
2 Staff Quarter in DH	2010-11	completed
Drug warehouse Peren Sadar	2010-11	completed
Upgradation DH	2007-08	completed
Upgradation of CHC Jalukie	2007-08	completed

Details of Work sanctioned – District Dimapur	Year of sanction	Status
Ugradation Of DH Dimapur	2013-14	ongoing
SC Vidima	2013-14	ongoing
DH Dimapur MO Quarter	2012-13	ongoing
PHC Niuland	2012-13	ongoing
SC Suchonoma	2007-08	completed
SC Doyapur	2007-08	completed
SC Signal Angami	2007-08	completed
SC Diphuphar	2007-08	completed
SC Lingrijan	2007-08	completed
SC Bade	2007-08	completed
SC Seithekima	2009-10	completed
SC Sahoi	2009-10	completed
SC Pukhato	2010-11	completed
SC Tenyiphe	2010-11	completed
SC Tsiepama	2010-11	completed
SC Muglamukh	2010-11	completed

Details of Work sanctioned – District Dimapur	Year of sanction	Status
PHC Kuhuboto	2010-11	completed
CHC Dhansiripar	2010-11	completed

- ***Overall infrastructure in the State is quite good and well maintained.*** Sanitation was taken care of in all the facilities visited. Most of the buildings had boundary wall and one SHC was functioning in prefabricated structure. Regular water supply is a challenge in Peren district.

Range of services

AYUSH

- In both the districts, AYUSH services are co-located. The table below shows trends in utilisation of OPD services:

AYUSH OPD	2010-11	2011-12	2012-13
State	21,580	20,403	22,968
District Dimapur	5,392	2,258	2,820
District Peren	1,637	2,984	2,943

- In district Dimapur, almost all CHCs had either an Ayurvedic or a Homoeopathic MO posted in the facility. The DH had a regular Ayurvedic MO with Panchakarma training, and a contractual Homeopathic MO. These doctors serve 10-15 OPD patients/ day on average. In District Peren, there are 3 AYUSH MOs – one at DH, 1 at CHC Jaloukie and 1 in PHC Tenning. There were few health facilities in Peren which didn't have Medical Officers, and AYUSH MOs were taking care of OPD.
- In Dimapur district, all necessary drugs and supplies were available, and provided to patients free of cost. However in Peren, AYUSH drugs were in short supply and the MO AYUSH was purchasing those drugs, which got reimbursed from RKS funds.
- It was informed that an AYUSH Panchakarma clinic was coming up in Dimapur, for which infrastructure was being set up. The AYUSH MO in DH Dimapur has been given additional charge as the controlling officer, without any necessary technical and support staff or powers – though such provisions are available under AYUSH component.

Dental Services

- The OPD utilization for State and both the districts have increased over the years. The trend is as under:

Dental OPD	2010-11	2011-12	2012-13
State	17,101	31,608	38,507
District Dimapur	5,341	15,395	20,807
District Peren	1,053	1,179	1,230

- In Dimapur, all CHCs and DH visited had a functional dental clinic. CHCs had a contractual dentist posted under School Health Programme (SHP) with chair, equipments, X-ray and essential drugs. DH Dimapur had 4 dental chairs with 1 maxillofacial surgeon and 1 entodontic specialist. Though dental X-ray unit is

available in all units, it was not used except in the case of Medziphema CHC. Hence, even basic services such as Root Canal Treatment were not available at the DH, due to non-functional dental X-ray unit, even though some specialised care was available.

- In district Peren, there were dental facilities available in the DH – 2 dental MOs were posted there.

Physiotherapy

- State has 2 well equipped Physiotherapy centers in DHs in Dimapur and Kohima.
- DH Dimapur has a functional Physiotherapy centre, with a trainer and a therapist in place. They have equipment for providing different services available such as traction and therapeutic ultrasound. They have referrals from different departments of the hospital as well. The division seems to have working well.
- DH Peren has 1 Physiotherapist posted in the facility.

Blood Bank

- State has 8 Blood banks in 8 districts, and Blood Storage Units (BSUs) in 5 CHCs.
- Dimapur DH has a model blood bank with component separator. There is a van available for transport to other districts.
- There is no Blood Storage unit or Blood bank in District Peren. The State is in process of establishing 1 BSU in DH Peren and 1 in CHC Jaloukie. ***Infrastructure and equipments are in place for almost 2 years.*** The facilities are awaiting their licenses.

Diagnostic Services

- In Peren district, laboratory services are available only at DH, CHC, and 1 PHC. This is primarily due to acute shortage of lab techs (only 5 LTs). Whereas, Dimapur district has 10 LTs posted. User charges were taken from the patients for lab tests.
    - In DH Peren, there was a ***Biochemist*** posted, however there was no semi-auto analyser – hence ***no biochemistry tests*** were being done and the ***specialist was not being utilised.***
    - Excellent pooling of LTs was noted DH Peren and CHC Jaloukie (LTs from NRHM, NSACS and NVBDCP).
- DH Peren had a X-ray technician, however the unit was not functioning as the X-ray machine had not been properly installed.
- In District Dimapur, Medziphema CHC had sonography and X-ray units available, though with user fees of INR 650 and INR 100 respectively. The sonography unit was provided with computer; however any back up reports were not saved in that. The statutory messages related to sex determination and PC&PNDT Act were not displayed here.

Biomedical Waste

- The state has initiated trainings on IMEP. So far, 60 Medical Officers, 108 Nurses, 75 Lab Technicians and 92 waste handlers have been trained across the State on Biomedical Waste Management. All the facilities visited had colour coded bins. The waste was segregated in all the facilities. Almost all the facilities had hub cutters, and ANMs were using it to break the needles.
- Despite availability of colour coded bins, there were ***no coloured poly-bags***. So, all the waste which was initially segregated got mixed up. Further, the staff had very ***poor knowledge*** of waste segregation, and it was evident in the mixed up waste seen in the bins.
    - In district Peren, the sharps were segregated from other waste products in all the facilities and were sent to CHC Jaloukie where both sharps and non-sharps were burnt together, thus negating the purpose of waste segregation. Further, the collected waste is mostly burnt outside the facilities in the open, and there is no mechanism for waste collection/ incineration.

Ambulance & referral services

- State has 76 level ambulances linked to 102 call centre. The State control room is at Kohima which is adequately staffed (4 Call Centre Operators recruited since 2011). Ambulances are GPS fitted and vehicle tracking system in installed in them and are stationed at district and block level facilities.

- In district Peren, there are 4 ambulances – 1 stationed at DH and other 3 are stationed in Block PHCs. The utilisation of these ambulances is shown in table below:

Sl. No	Particulars	2010-11	2011-12	2012-13	2013 (till Oct.)
a.	Athibung Block	2	10	24	38
b.	Jalukie Block	51	40	54	71
c.	Peren Block	13	15	15	26
d.	Tening Block	2	12	31	43
	Total	**68**	**77**	**124**	**178**

- The utilisation of ambulances in District Dimapur is shown in table below:

	2010-11	2011-12	2012-13	2013-14 (till Oct.)
Total no of Patient Transported	90	431	722	309

- The average trip made is approximately 1 trip/ambulance/day. The ***software*** for tracking the vehicle is installed in the control room computer but is ***not functioning*** (due to non-maintenance of software).

- State officials informed the team that the ***toll free number 102 is not functional*** for last ***3-4 weeks***. Therefore, the phone numbers of drivers are written on MCP cards/ in facilities. There are few hard to reach areas where the ambulance takes more than 24 hours to reach.

- 102 call center is also established with 10 lines; however ***no call has been received by the State control room since 2011***. Few ***test calls*** were made, but most of them were ***not picked up by drivers*** as the numbers of drivers were ***not updated*** by call center operators.

- ***102 number*** is not functional and usually ***get connected to police control room***. Call center operators are doing duties as assigned by the referral transport nodal officer which include JSY / JSSK verification calls.
    - In Block Tening, there is one ambulance stationed at PHC Tening. The number of cases transported by ambulance in 2 in 2010-11, 14 in 2011-12, 31 in 2012-13 and 37 cases were transported in the year 2013-14. As 102 toll free number is not functional, the phone number of the driver is displayed in the facility. Log registers were not maintained properly in the facilities. The patients' details were missing and the register kept in the ambulance was not in accordance with the one present in the facility. Separate JSSK register was not maintained. The ***ambulance was being used for monitoring visits and VHND sessions***.
    - In District Dimapur, it was observed that the ambulance stationed at DH had no emergency kit, Oxygen Cylinder, Stretcher etc. in it.

Medical Mobile Units (MMUs)

- State has 11 MMUs – one in each district. These are run by the State itself. The services provided by the MMUs in the State and both the districts from April- Sept, 2013 are:

S. No.	Activity	Dimapur	Peren	Nagaland
1	No. of camps planned	77	59	625
2	No. of camps held	47	31	446
3	Total no. of patients treated	748	1065	15031
4	Average patient treated per camp	16	34	32
5	Total no. of children given immunization	0	144	1206
6	Total no. of ANC	51	27	737
7	Total no. of pregnant women administered TT inj.	57	17	571
8	Total no. of PNC	17	11	247
9	Total no. of IUCD Insertion	0	11	133
10	Total no of OCP distributed	0	3	151
11	Total no. of X-Ray performed	0	0	0
12	Total no. of USG performed	0	0	0
13	Total no. of ECG performed	0	0	0
14	Total no. of Haemoglobin estimation conducted	35	69	923
15	No of patients examined for Malaria parasite	53	66	1257
16	No of Urine Tests conducted	0	0	222
17	No. of sputum for AFB examined	0	9	92
18	No of patients referred to PHC/ CHC/ DH	3	0	101

- Peren district has 1 MMU since last 7 years. MMU team has 1 Medical Officer, 1 GNM, 1 Lab technician and 2 drivers. MMU has 2 vehicles - one is main vehicle with all the diagnostics, followed by a Gypsy. The utilization of services for last years has been average with 19 camps held in year 2011-12 where 1535 patients were treated. For 2012-13, 6 camps were held and 407 patients were treated. As seen above, services have picked up in the current year since the MO has been appointed for the first time. MMU regularly conducts medical camps in far flung villages every month now. The district has mapped down all the villages where MMU camps to be held.

- In Dimapur, there is one MMU in the district which is adequately staffed, (1 MO, 1 SN, 1 LT, 1 Driver and 1 RCH ANM of respective area). Quarterly work plan is prepared on an average, 12-14 days field deployment plan especially for remote and hard to reach areas.
    - The log book of MMU was not available and meter was not functional. The MMU required periodic maintenance.
    - MMU had most of the drugs available during the time of visit which was recently provided. MO informed the team that there was shortage of drugs in last few months. The MMU has lab facilities and microscope.
    - For immunization services, the ANM of local area remains associated with MMU. MMU work plan is synchronized with VHNDs. The vaccine which was used for immunization session at MMU was not properly stored. The vials were submerged into water and labels were not readable of vaccines and diluents. Moreover, the vaccine was kept in bio medical waste bag instead of zip lock bag.

IEC/BCC

- State has an IEC Bureau that is headed by a Jt. Director level officer, and supported by State IEC and Publicity consultants.
    - For the year 2013-14, Health Melas were conducted in the 4 high priority Districts of Wokha, Mon, Tuensang and Kiphire.
    - Translation and printing of leaflets in 8 more local dialects are being carried out.
    - 2 TV programmes on RNTCP & AYUSH & 13 TV spots on ARSH, Family Planning, Child Health, Maternal health, AYUSH, NLEP, and IDSP were produced and telecast through DD Kohima.
    - 52 radio programmes were produced in Nagamese on NRHM, RCH and Vertical Programmes and broadcast on AIR Kohima & FM Mokokchung**.**
    - Jingles were recorded on Polio sent to 2,20,000 BSNL subscribers during 2nd phase IPPI in March 2013.

- District Peren has an IEC bureau headed by the DMEIO and supported by the District Media Officer.
    - There was good display of IEC material in all the facilities visited. Hoardings of full immunization and JSSK were widely displayed. However, the officials and district personnel was still unaware of JSSK entitlements.

- Citizen charter and user charges on lab investigations were displayed in the facilities.
- The phone numbers of drivers of ambulances were displayed in facilities and are stamped at MCP cards.
- However, there were very few hoardings in the local dialect.

- Dimapur district has an IEC bureau staffed by District IC officer and District Mass Media Officer. State specific posters on different thematic areas and disease control programme and RCH are adequately displayed in all the facilities. Citizen Charter, IEC and BCC activities in all facilities are well maintained.

Convergence with National Aids Control Programme

National AIDS Control Programme (NACP) has made steady progress towards its goal to reverse and halt the epidemic by end of 2015. Sincere efforts have been made by Government of India and Department of AIDS Control to intensify and consolidate the efforts by scaling up prevention of new infections among high risk groups and the general population, and increase care, support and treatment of People Living with HIV (PLHA) in all HIV burden states including Nagaland.

According to the latest HIV data, the state of Nagaland has demonstrated an overall improvement in key indicators – reduction in estimated adult HIV prevalence from *1.27%* in 2005 to *0.*73% in 2011; decline in new adult HIV infection from *667* in 2007 to *560* in 2011; and decline in AIDS-related mortality from 839 in 2007 to 581 in 2011. However, the HIV prevalence rates among high risk groups (HRG) are still high, with an HIV prevalence of 2.21% among injecting drugs users (IDU), 13.58% among men having sex with men (MSM) and 3.21% among female sex workers (FSW).

Integrated Counselling and Testing (ICTC), & Prevention of Parent to Child Transmission (PPTCT)

Scale up of ICTC Services: In Nagaland, ICTC services are available in DHs, CHCs, select 24x7 PHCs, and few private institutions. Currently, 120 ICTCs are operational in Nagaland covering 11 districts. With the annual target of 95,000 general clients (excluding pregnant women) for HIV testing; a total of 35,000 clients were tested during April - September 2013. It was noted that the state is making progress in establishment of facility-integrated ICTCs at 24x7 PHC level, in convergence with NRHM. With the annual target of 45 F-ICTCs to be made operational, total of 37 F-ICTCs were functional by end of September 2013.

Scale up of PPTCT Services: PPTCT Services are provided through 120 ICTCs at various service delivery levels in the state. As per NSACS, the programme performance for the period April to September 2013 is as follows:

- 28% of the estimated pregnant women were tested for HIV (of the estimated 34,383 pregnancies per year; 9,800 pregnant women were tested for HIV).
- Of these, 0.63% were detected HIV positive (62 positive out of 9,800 tested).

- 56% of the mother-baby pairs received single-dose Nevirapine prophylaxis
- Only 40% of HIV positive pregnant women underwent CD4 count; of which 20% of eligible pregnant women commenced on ART.

In addition, CRM also acknowledged the initiatives underway by the state government towards NACP and NRHM convergence and the progress is as follows:

- Universal screening of HIV by ANM has been rolled out in all the 11 districts covering 37 facility-integrated ICTCs during the current financial year. The rapid whole blood test kits are procured by state NRHM and training of ANMs was undertaken in partnership with NSACS.
- At the facility level, in addition to HIV Counselling, ICTC Counsellors are trained in Adolescent Reproductive and Sexual Health (ARSH) and providing services to adolescents accessing the ARSH clinics.
- At the facility level, LTs from NRHM, DHS and NSACS have been pooled together to provide round the clock lab services.
- Some health facilities mobilized Rogi Kalyan Samitis funds to procure drugs for opportunistic infections (OIs) for PLHAs accessing HIV treatment services.

Issues and Challenges

- Quality of counselling and follow up of HIV infected pregnant women and exposed children still offer room for improvement. The outreach worker (ORW) component would address the issue of lost to follow up cases and tracking of mothers; however, the component needs further strengthening through better coordination with the state agency (Infrastructure Leasing and Financial Services Ltd.) and supportive monitoring and mentoring of the contracted NGOs.
- While local initiatives focusing on NACP and NRHM convergence would pave the way for increasing coverage for mothers and children in need of HIV services, ensuring quality of services and respect of confidentiality remains a challenge to be addressed if universal screening of pregnant women is to be achieved.

RECOMMENDATIONS

- ✓ The State has a shortage of staff quarters which needs to be addressed. State may plan to first saturate High Priority districts and Delivery points.
- ✓ Necessary steps should be taken by the State to make toll free no '102' and the call centre fully functional. There is a need of rational deployment of ambulances as per their usage. State could explore alternative solution of assured referral services by tie ups with the local taxi drivers.
- ✓ Monitoring mechanism needs to be established for MMUs.
- ✓ Colour coded bags should be made available for waste collection. Staff needs to be made aware of waste segregation and its adherence monitored.
- ✓ There is a team of dentists available in the state and a potential high risk of oral health problems. State can consider launching oral health/ community dentistry initiatives.

✓ In the health institutions with sub-optimal workload, the role ICTC counsellors may be considered for expansion to include counselling on comprehensive RMNCH+A. The quality of counselling may be ensured through joint supportive supervision of the centres by state NRHM and NSACS.

TOR 2: REPRODUCTIVE & CHILD HEALTH

Maternal Health

- A total of 11 facilities in the state provide C-section services. Out of these 9 are DHs and 2 are CHC- FRUs. With regard to availability of specialists, the State has a total of 19 Anaesthetists (18 R + 1 C), 17 Gynaecologists (14 R + 3 C) and 14 Paediatricians (11 R + 3C). Besides these, State has trained 9 LSAS doctors and 8 EmOC doctors but their utilization is not appropriate.

- State has around 280 ANMs/ SNs / LHVs trained as SBA, 49 MOs have been trained in MTPs and around 330 MOs/ SNs have been trained in RTI/STI services but during visit to the Districts of Dimapur and Peren, CRM Team observed that ***most of the PHCs and CHCs do not have a provision of either MTP services or RTI/STI services***. Besides this, ***SBA trained Staff were not posted at the LR*** and in some facilities where they were posted, they had ***a lack of knowledge*** of Eclampsia, AMTSL, plotting of Partograph, PPH management, new born resuscitation etc.

Delivery Points

Out of a total of 545 Health Facilities in the State, ***20 delivery points*** are currently functioning in the Govt. Sector.

- Out of 398 Sub centres, 5 SCs conduct >2 deliveries per month
- Out of 33 no. of 24X7 PHCs, 7 are functional as delivery points.
- Among 5 FRUs (CHC and other FRUs excluding DH), 1 conducts >20 deliveries per month while 2 conduct C-Sections.
- Of the 11 DHs, 7 conduct >50 deliveries per month and 9 conduct C-Sections.
- Out of 17 accredited private health facilities, 9 conduct >10 deliveries per month and are also conducting C sections.
- In Dimapur district, only the DH is providing C-section services, while in Peren district, the DH and a CHC are conducting C-sections.

Quality of ANC, INC and PNC

- While outreach sessions are well staffed (at least 2 ANMs, MO, ASHAs), full complement of ANC services are not available.

- In most of the facilities ANMs and GNMs were not able to give reply on simple queries like how to measure Hb, BP, critical steps of conducting ANC etc.

- There was no maintenance of any record for line listing of severely anaemic pregnant women and mothers at SCs and PHCs for follow up.

- During interview with beneficiaries, none of them received Safe Motherhood Booklet which is an IEC tools which tells about women rights DO's and DONT's during pregnancy and child birth. MCP Card was not to be found completely filled in by ANMs particularly PNC and essential lab investigations.

- GNMs/ SNs lack knowledge and skills on key quality protocols like AMTSL, PPH management etc. Partographs are not being maintained during progress of labour.

Janani Suraksha Yojana (JSY) Janani Shishu Suraksha Karyakram (JSSK)

- Earlier JSY payments were made to beneficiaries and ASHAs by cash. After the change in the GoI requirement of payment by A/c payee cheque, delays are seen in payment to beneficiaries. Even ASHA payments are delayed as they are to be paid directly into their bank account (account opening is still under process).
    - State has recently issued an order that in the areas where banking services are not available, cash payments can be made under JSY to the beneficiaries and ASHAs. However, this has been left up to the districts and there is no clear demarcation of such areas.

- State launched JSSK in September 2012. State and District Nodal Officers are in place and notification has been issued for all free entitlements under JSSK including exemption of all user charges for PW and sick new-borns and empowerment of MO-in-charge to make emergency purchases of drugs/ investigations.

- The State has a total network of 76 ambulances with 102 Centralized call centre and GPS fitted ambulances. As discussed in the previous section, there were issues of functionality and utilisation of this service. Lack of assured Referral Transport is one of the major reasons of increased home deliveries, as facilities are far from the habitation.
- Based on JSSK reports for the 1st and 2nd quarter of 2013-14, the achievement of the State under JSSK for PW on a pro-rata basis is as under:
    - Free Drug-26%; Free Diet-35%; Free Diagnostic-26%; Free RT-33%; Free Drop back-31%

- The State/ district have misunderstood it to be a cash reimbursement scheme instead of free entitlement. ***Cash is being given to Pregnant Women for provision of diet and RT*** instead of making available these entitlements.
    - With respect to Referral transport, the State/ district is giving cash re-imbursement of Rs 1300/- (Rs 650/- each) for Home to facility and drop back (***at a flat rate irrespective of distance***), which is not permitted under JSSK. Similarly for Diet,

Rs 100/day for normal delivery, and Rs 700/- for C-section are given to Pregnant Women in cash. Some backlog was seen in these payments.

- A good practice was seen in Ahtihbung PHC in Peren district. A member of the local community had constructed a small community kitchen near the PHC, and another member provided free firewood. With the cash provided for diet, the family members of the PW would cook in the community kitchen.

- ***Out of pocket expenses*** still being incurred on drugs, blood (for screening tests), and diagnostics. There was ***poor awareness of free entitlements among staff*** at all levels, and ASHAs.

- JSSK entitlements display is seen at all health facilities, which is a good step, however the ***telephone numbers of the nodal officers*** have ***not*** been ***printed*** making grievance redressal difficult. A complaint box has been put in most of the facilities, however no complaints have been reported.

Comprehensive Abortion Care (CAC)

- State has around 49 MOs trained in MTP, however essential MTP drugs like Mifepristone and Misoprostol were not available.

- None of the health institutions at CHC and PHC level are providing safe abortion services.
  - There are ***cases of incomplete abortions coming to DHs*** observed from MTP registers, which suggest that abortions services are absent in periphery and being performed by quacks / untrained providers.

Maternal Death Review (MDR)

- There is only 1 maternal death reported and reviewed in District Dimapur. on checking of records, it was found that there have been 8 maternal deaths in District Hospital, Dimapur between January-October 2013 - 2 maternal deaths due to severe anaemia, 2 due to septic abortion, 1 due to eclampsia, and 3 due to other medical causes. However, only 1 maternal death , out of the 8 was reported and the facility based review has not been conducted for them.

- No deaths reported in the district from community, despite the incentive being available for ASHA / any informer for reporting maternal deaths.

Management of RTI/STI

- In Nagaland, 12 designated RTI/STI Clinics have been established at 11 district hospitals and one referral hospital to provide a standardized package of services. The pace of decentralization of STI services below sub-district level has been sluggish, however State has trained nearly 200 MOs, nurses, LTs and counsellors in FY 2012-13 who are not optimally placed / utilized. Drug kits were not available in both the districts visited.

- Sub-optimal cross referral between ICTC, Targeted Interventions (TIs) and STI designated clinics due to lack of tacking and monitoring mechanism at facility level.

- The partner's notification and follow-up remains to be a challenge. Concerns around partner notification include possible discrimination, violence or other harm due to partner reactions, and relationship termination or risks of breaching confidentiality.

Newborn and Child Health

Facility Based Newborn Care

- There has been ***significant progress*** in setting up of facility based newborn care services, since the last CRM. There is one Sick Newborn and Child care Unit (SNCU) in Kohima, and 2 new ones have been approved this year. Additionally, 5 FRUs have newborn stabilisation units (NBSUs), 4 NBSUs are being set up, and 4 new have been approved this year[1]. Additionally, newborn care corners (NBCCs) have been set up at 120 LRs and OTs, including all delivery points.
    - In District Dimapur, 2 bedded NBSU was available at the DH. However, the NBSU was not appropriately located as it was almost 500 feet from the labour room. The registers were available with details. There was NBCC in labour room but not in Gynae OT. The NBCC and NBSU were not properly functional as the resuscitators, laryngoscope, mucus extractors were not readily available (locked in almirah), electric suction machine was out of order and foot operated suction not available. The staff nurses posted at Paediatric Ward were also handling NBSU and labour room (no dedicated and F-IMNCI trained SNs posted), and were not aware of the components of essential and emergency new born care. There was no size 1 mask; and the resuscitators were neither being used or autoclaved.

- New born care corners were available at all visited sub-centre/ PHCs / CHC delivery points. The protocols of new born resuscitation were available at all the health facilities visited, however staff posted were not aware of new born resuscitation, and some even did not know how to operate radiant warmer and use of bag and mask. Most of the staff posted in the LRs was not SBA and NSSK trained. Hence, essential new born care including resuscitation protocols, are not being practiced by the staff.

- Many ANMs were not aware of use of 102 Referral Transport services in case of sick new born / infant, even though the JSSK guidelines were displayed in the facility.

- ORS was available in all facilities; however, Zinc was not available in any facility. The ANMs and ASHAs were not aware about use and correct dose of Zinc and its bundling with ORS.

- Cotrimoxazole tablets and syrup and injection gentamycin were available at most of the facilities. However, the ANMs and SNs were not able to tell the signs of pneumonia. IMNCI related implementation protocol booklets, formats, charts etc. were not available at any of the facility.

[1] In 2010, there were no SNCUs or NBSUs in the State, and only 42 NBCCs were in place.

Malnutrition

- The identification of malnourished children is lacking, as growth charting and weight recording were not being done in most of the units visited. There is no referral mechanism of severely underweight and SAM children. There is no Nutritional Rehabilitation Centre (NRC) in the State.

- Bi-annual round for Vitamin-A and micronutrients is not initiated in the State. The coverage of all doses of Vitamin-A is very low. Many ANMs do not know correct doses and are not aware about 9 doses of Vitamin-A.

- Iron plus guidelines were not disseminated in the field, and iron syrup was not available in any health facility visited. ANMs, ASHAs and MOs were not aware of use of liquid iron in under-5 children.

Rashtriya Bal Swasthya Karyakram (RBSK)

- RBSK has not yet begun in the State. The State Nodal Officer was undergoing training in Mumbai at the time of the visit.

Immunisation

Service provision

- There is lack of systematic microplanning for VHNDs/ Immunisation sessions - only rudimentary microplans are prepared.

- AVD mechanism is not in place – ANMs / Health workers from the SC are coming to PHCs to collect the vaccines.

- Zero dose polio, birth dose Hep-B and BCG was given in most of the institutional deliveries, however, not given on Sundays and Gazetted holidays – hence missed at times. There is no mechanism for follow up through outreach sessions. Tickler bags were available at all facilities visited, however their use was limited as dues list are not prepared. There was poor counselling and follow up of missed cases.

- Vaccines for VHND were not always requisitioned as per requirement.

- Most ANMs were not aware of correct immunization schedule and measles second dose and JE second dose are not given to children in most of the facilities visited. Some ANMs were not aware of correct site for administration, and route of vaccine, indicating need of refresher training.

- Village wise MCH registers are printed. The registers are very thick not taken into account that these registers should have to be for 1 year. Detailed mother and child information is filled in those registers for 4-5 years which makes these registers

bulkier and difficult to be carried to session sites. In the registers, there is one page to write the summary of session. Ideally, there should be 12 such pages. So that every session is summarised every month.

- These registers were printed and distributed without any proper training. Hence, they were kept unused at almost all the facilities.
- Head count of children vaccinated and the one entered in MCTS were not in accordance with each other. There is an underreporting of number of children who were vaccinated as they were found to be more in number than the children who were reported in MCTS registers.
-
- There are 5 urban sub centres providing outreach immunization services in the city, however, many of the areas including slums like Burma Bazar, no vaccination outreach camps has been conducted for several months.

- ASHA incentive for full immunisation for 12-23 months children is yet to be implemented in the State.

Cold Chain maintenance

- In Dimapur, District vaccine store is in the CMO office campus. The equipment is inadequate in terms of capacity to cater the requirement of vaccine of the district and to maintain the buffer stock. At the time of visit, there was practically stockout of most of the vaccines.
    - The vaccines which were available were not placed as per guidelines i.e., TT Vaccine kept at the bottom of ILR despite availability of ample quantity of baskets lying unused. All ILR and DFSs were attached to functional voltage stabilizers but the placement was not correct.
    - The ice packs and cold boxes were inadequate, the ice packs used for packing the vaccine sent by manufacturer were used in ILR and DFSs. The physical stock of vaccines and AD syringes was not matching with the stock books as stock book was not updated for the last one month in District Vaccine Store.
    - District has new vaccine van allotted since July as per records but district has not initiated vaccine distribution to PHCs by using vaccine van. The referral transport vehicles of PHCs were used for getting the vaccine from district vaccine store many times.
    - There is poor awareness of open vial policy. Hence, it is not followed at any facility visited.
    - Vaccine carriers were made available in all health facilities visited except District Hospital which is the highest delivery load facility.
- Similar issues were also seen in Peren district. Additionally, instances were noted of incorrect temperature monitoring of ILR, frozen vaccine at outreach site, vaccines submerged in water in the ILR, etc.

Recordkeeping and reporting

- There was no record of batch no., expiry date, VVM status in the vouchers issued from state and further, to the PHCs and were not mentioned in stock book and distribution register in any facility visited.

- There was no record for diluent of BCG, measles and JE in stock books, distribution register and vouchers.

- Registers not maintained at session sites. Hence, when the data was transferred to the registers at the facility, often after a time lag, there was often data loss during transfer to registers. Additionally, there were data mismatches between HMIS and MCTS registers.

Family Planning

- Family Planning Service availability and uptake was very poor in the State.
    - In both the districts, there are no fixed day services for sterilization and IUCDs.
    - Distribution of contraceptives by ASHA at the doorsteps has not picked up momentum - ASHA awareness is limited.

- Condoms are available in drug kits with ASHAs, however ECPs are not available. ECPs are not available in any facility in Peren District, however it was available in some of the facilities in Dimapur.

- Overall, weak counselling services were seen for FP - not done as per need, e.g. multi-para woman not counselled for limiting methods or for IUCD, but just given OCPs.

- PPIUCD has started only recently in Nagaland, with 3 persons trained in Guwahati.

- IUCD insertion service quality is a concern – high (30-40%) removal rates seen in Peren District. In Dimapur, IUCD services were not found below DH level.

- ICTC Counsellors are trained in ARSH and FP Counselling but the services they provide indicate weaker training in ARSH and FP which requires attention.

Adolescent Health

Adolescent Friendly Health Clinics

- ARSH Clinics are functioning in all 11 DHs, in 20 CHCs, 1 PHC and 2 accredited private facilities. Services are provided by the designated/ trained MO and ICTC counsellor. The table below shows utilisation of these clinics:

Indicators	2011-12 (One Qrtr)	2012-13	2013-14 (April to Sept)
No. of adolescent clients registered	315	3366	2292
Clinical Services provided	207	2433	1916

Counselling services provided	137	1853	881
No. of clients referred	76	859	462

- All OPD cases below 19 yr. are referred to the ARSH Clinic - however these are mostly general cases of fever/cough/diarrhoea etc.; few RTI/STI cases are reported.
- No IEC materials targeting adolescents was seen at the facilities.
- In Dimapur district, high HIV case load for ICTC counsellor leading to lesser attention on ARSH issues

School Health

- There are nearly 2200 public schools in the State, with nearly 1.80 lakh students enrolled.
- Each district has a SHP team has an MO, a GNM, an ANM, and one SHP coordinator. It covers 7-8 schools in one month and they teach problems related to anaemia, dental, worm infection, fever, eye problems and refer the cases to the facilities for treatment. The table below shows service provision under SHP:

Indicators	2011-12	2012-13	2013-14 (April till Sept)
No. of schools covered	688	1,654	931
No. of students screened	50,080	42,318	71,419
No. of Disease, Deficiency, Disability cases identified	17,214	14,184	18,690
No. of students referred	1,105	1,440	1,823

RECOMMENDATIONS:

- ✓ Carry out a gap analysis of all delivery points (Level 1, 2 and 3 facilities) and prepare an action plan for the identified gaps.
- ✓ Baseline competency of ANMs to be assessed by the State/ District to identify key gaps in providing quality ANC, and accordingly conduct a short training program for addressing the gaps.
- ✓ State needs to ensure posting of SBA and NSSK trained staff in Labour rooms.
- ✓ Proper filling of MCP Card and distribution for Safe Motherhood Booklet to be done on priority.
- ✓ An order needs to be issued to block MOs and programme officers by MD, NRHM and District CMOs for monitoring the line listing and follow up of severely anaemic PW and mothers. Compliance on this should be reported to GOI.

- ✓ State should clearly notify areas of poor/ absent banking services, where cash payments to beneficiaries and ASHAs are permitted, in order to remove any ambiguity.
- ✓ State should put a system in place for free diet either cooked or dry food at the health facility like fruits, eggs, milk etc. or tie up with private vendor for provision of free diet, or create in house kitchen facility from the funds available under JSSK for diet.
- ✓ State should place JSSK registers in all their facilities for proper physical and financial reporting under JSSK. Quarterly reports under JSSK to be submitted timely with an analysis by the State. JSSK reviews with districts and blocks to be done quarterly.
- ✓ Since Nagaland has a strong communitization process, it is suggested that through the network of VHCs, ASHAs and ANMs community needs to be oriented on their entitlements of JSSK; counseling on nutrition and Family Planning; importance of institutional delivery, etc.
- ✓ State to revisit the MTP trained providers, map them out, and place them rationally in facilities where it intends to initiate 1st trimester MTP services. MTP training also needs to be revisited. Training load to be prepared for all delivery points from PHC upwards (by mapping trained MOs, SNs including training and reorientation requirements),
- ✓ Maternal Death reviews need to be strengthened. Sensitization of MS and other officials needs to be undertaken and completed on priority. Mission Director/ CMOs of the district should review every quarter the MDR reporting and action points taken.
- ✓ State/ District to include the RTI/STI medicines in kit form within the EDL.
- ✓ In the health institutions with sub-optimal client load, NACO and NSACS may consider to integrate ICTC and STI designated clinics to provide comprehensive services for improving early identification and management of STI cases.
- ✓ NSACS and NRHM need to accelerate convergence between the two programmes at state and district level on a priority basis. Joint monitoring and mentoring visits may be undertaken to strengthen the quality of services at local level.
- ✓ State needs to ensure proper microplanning for outreach sessions, microplans should be comprehensive consisting of Alternate cold chain plans, mobilizers etc. It should include processes put in place for any vaccine stockouts, etc.
- ✓ Open vial policy needs to be implemented in the State. Appropriate orientation needs to be carried out at all levels.
- ✓ Service delivery staff needs to be urgently re-oriented on cold chain maintenance, immunisation schedule, and recordkeeping.

TOR 3: DISEASE CONTROL PROGRAMMES

National Vector Borne Diseases Control Programme (NVBDCP)

- Vector borne diseases are a major public health problem in the state:
  - Malaria is endemic in **all 11** districts

- Japanese Encephalitis (JE) is confirmed in **8** districts viz. Dimapur, Kohima, Peren, Mokokchung, Zunheboto, Longleng, Tuensang, Wokha.
- Dengue is endemic in 1 districts viz; Dimapur.
- Recently **Scrub typhus** outbreaks have been seen in **all 11** districts

Indicator	National / State	Target for 2011	Achievement in 2011	Target for 2012	Achievement in 2012	Target for 2013	12TH Plan Target (2012-17)
Annual Blood Examination Rate (ABER)	National	>10%	8.6%	>10%			>10%
	State	>10%	10.4%	11%	10.8%	11% ABER may be sustained as per last year	To sustain the national target of >10% at both State & district level
Annual Parasite Incidence (API) Malaria cases per 1000 population annually	National		1.06	<1			<1
	State	1.89	1.69	1.3	1.46	<1	<1

- The State is able to achieve the national target of Annual Blood Examination Rate (ABER) of 10% in 2011 and as the ABER almost sustained from 10.4% in 2011 to 10.8% in 2012. However, UMS Dimapur continues to record ABER below the target. The State has set a target of 11% ABER for 2012 and aims to sustain the national target of maintaining >10% ABER during the 12th five year plan.

- Annual Parasite Incidence (API) has reduced from 1.69 cases/1000 population in 2011 to 1.46 in 2012. To enter the pre-elimination phase, the State has set a target of API of <1% during the 12th Five Year Plan.

- In addition unlike Peren District, **Urban Malaria Scheme (UMS), Dimapur** covers a population of 1.97 lakhs (Census, 2011) in urban areas of Dimapur town. UMS, Dimapur records a high percentage of falciparum cases with 77.4% of cases detected during 2011 being falciparum malaria.

		2011				2012				2013 till Sept			
Malaria	Population as per 2011	Malaria Cases	ABER	API	Malaria Death	Malaria Cases	ABER	API	Malaria Death	Malaria Cases	ABER	API	Malaria Death
State	1980597	3363	10.37	169		2891	10.85	1.46			11% exp	< 1	
Dimapur	223621	666	12.62	2.98	0	506	11.39	2.26	0	243	-	-	0
Peren	94954	15	14.28	0.19	1	13	11.73	0.12	0				0
		No of cases		Death		No of Cases		Death		No of cases		Death	
Japanese Encephalitis (JE)													
State		36		6		21		2		5		0	
Dimapur		30		5		17		2		3		0	
Peren		2		0		3		0		1		0	
Dengue													

		2011		2012		2013 till Sept	
State		3	0	0	0	0	0
Dimapur		NA	NA	6	NA	7	
Peren		3	0	0		0	

- As per table above, the prevalence of all three vector borne diseases (Malaria, JE and Dengue) are declining from year 2011 to 2013. On an average 11 % ABER maintained in both the district, although ***API*** is < 1 in Peren district while ***2.26 in Dimapur district*** which is higher than state goal.

Integrated Vector Management

- On an average state is covering 70% households and rooms in first phase and 60% in second phase. Similar coverage is present in both districts. Surveillance and monitoring need to be improved.
  - In Dimapur, IRS in the village area and fogging in the town area is carried out as per guidelines, although the pace of IRS is slow.
- State reported distribution of nearly 4.03 lakh larvivorous fish seeds upto September 2013. No distribution of LLINs was done in 2012 and 2013 by the state. District Dimapur reported distribution of LLIN and its high acceptability in community, while LLIN were not available in facilities in Peren district.

Facilities for illness Management for vector borne diseases

- Management and diagnostics kits e.g. RDS kits etc were available in all facilities in District Dimapur.
- In Peren district, vector borne cases reported only at IRC center at CHC Jalukie, and not at any other facility; but reported at all facilities in Dimapur district

Key issues

- Training of manpower under NVBDCP programme is not done as per guideline.
- LLIN has not been received by district (Peren) for last two years.
- While API shows improvement, ABER is declining.
- No review of staff position and vacancies is being done, especially MTS.
- Vector borne cases are not reported in Peren district in the DH, CMO office, SHC, and PHC, except IRC centre at CHC Jaloukie.

Recommendations

- ✓ State need to increase surveillance and monitoring and other preventive measures.
- ✓ Training of the lab technicians, ASHAs and MTS should be reoriented as per changing scenario.
- ✓ LLIN supplies need to be ensured to all facilities.

Revised National Tuberculosis Control Programme (RNTCP)

- There are total 9721 patients in state undergoing treatment, of which 3395 are new sputum positives. Out of total, 1949 completed their treatment and 3372 patient got cured till date. Thus 92% cure rate and 78% case detection rate was reported to team.

- In Dimapur district, RNTCP has been implemented since 2004. District is covered by 2 Tuberculosis units, 90 DOTs centres that include 47 sub-centres and NGOs. DOTs plus was launched in Dimapur district in February 2012 and till date 34 patients have registered under the programme. MDR suspects' samples are collected at DTC and tested at Gene Expert testing on free of cost.
    - The programme achieved most of the targets except training programme in the second quarter of current year, due to delayed release of fund. In addition, 59% achievement was recorded in Nikshay (compulsory notification of TB cases).
        - In 2012, ACDR (Annual Case Detection Rate) was 87 (116%) and success rate is 86%.
        - In 2013 in the third quarter, ACDR is 97%, default rate is 9%, and failure rate is 8%.
        - Sputum conversion rate is 90%.
        - 90% of TB cases referred to ICTC, and 10.1% were found HIV positive
- In Peren district, the prevalence of TB cases has declined.
    - 25 patients under NSP were reported in year 2011 which come down to 20 patient till date.
    - There is also failure of 3 cases in year 2011 and 2012. No failure is reported in the current year till September, 2013.

National Tobacco Control Programme (NTCP)

- COTPA Act 2003 has been implemented in the State, and 80300 tobacco products have been destroyed. NTCP in Dimapur district has started recently. There are seventy schools covered under the programme. District Tobacco Control Cell has been formed and training for enforcement officers, District level anti-tobacco squad personnel, school teachers, students and church leaders, dental surgeons, MOs, and SNs has been organised. In addition, Tobacco cessation Centre has started in the DH.
    - Till date, challan booklets were issued to enforcement officers, awareness programme conducted in 27 schools, district level coordination committee has formed and awareness campaign and anti-tobacco pledge taken during different social and political activities.
    - The programme is monitoring 25 hostels and 21 schools, and has penalised 39 shops for violation of section 6 (b) of COTPA.

National Programme for Control of Blindness (NPCB)

	Dimapur District	Peren District

Activities	2010-2011	2011-2012	2012-2013	2013-2014 Till Sept.	2010-2011	2011-2012	2012-2013	2013-2014 Till Sept.
Cataract Operation	297	420	386	177	105	38	58	11
IOL Implantation	173	411	386	176	89	38	58	3
Cataract Surgery Camp Held								
Total Surgeries	82	202	30	0	NA	NA	NA	NA
SIS with IOL	72	132	29	0	NA	NA	NA	NA
SICS	10	70	1	0	NA	NA	NA	NA
School Eye Screening								
Students Screened	2320	2110	2413	625	NA	NA	NA	NA
Refractive error detected	541	581	617	748	NA	NA	NA	NA
Free Spectacles	132	96	50	0	42	19	1	7
Teachers trained	24	0	0	0				

National Leprosy Eradication Programme (NLEP)

- In Dimapur district, 29 multi-bacillary and 6 pauci-bacillary cases were identified in current year till October. No reconstruction surgery has been conducted. The new cases of grill disability increased from 17 to 24 in last three years in district. Contact survey of all MB cases of past three years as well as healthy contact survey is going on.

- In Peren district, only 1 case (of a defaulter) was reported.

National Iodine Deficiency Disorders Control Programme (NIDDCP)

- In Dimapur district, the first meeting of NIDDCP was held in June 2011 followed by Iodine Deficiency Disorder survey in rural area of district.
    - Awareness building programme has been organized in different schools, academic organizations and Nursing school. IDDP days have been observed for past three years in DH and Senior Secondary School regularly.
    - ASHAs of three blocks have been trained in STK.

- In Peren, district level sensitisation was only recently carried out (in October 2013) and block level sensitisation is planned in December. ASHAs have been trained and are regularly doing salt testing.

Other Programmes

- Under National Mental Health Programme, drug de-addiction programme is going on but no rehabilitation centre has been established yet.

- Few cases of Thalassemia have been detected while Sickle cell Anaemia is very rare in the area.

- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS) has only started recently in the State.

TOR 4: HUMAN RESOURCES AND TRAINING

Generation of human resources

- As already mentioned earlier, there is no medical college in the State. Doctors in the state undergo medical training outside.

- A new nursing school has come up in Dimapur with state of the art infrastructure. A GNM school was started in Kohima last year, and two new ones are planned (for Mon and Wokha districts) for the current year.

HR Policies

- The state has a service rule book for regular employee and there is no HR policy for NRHM employees. The regular cadre is appointed by State Public Service Commission and for appointment under NRHM, gap analysis is done at facility level and hiring is done by State Programme Management Unit.

- Under NRHM, there is a provision of incentivising the Medical Officers and specialists. State has categorized difficult areas in A, B, C and D parts. Salaries of MOs and specialists in these difficult areas are:

Difficult area category	MO salary (Rs. per month)	Specialist salary (Rs. per month)
A	27,000	35,000
B	33,000	43,000
C	47,000	61,000
D	64,000	70,000

- For regular specialist, any MO who enters the speciality gets an advance increment depending upon the number of years he has put in for that specialization, e.g. an MBBS MO gets Rs 17,000 as a basic pay and gets increment of Rs 2000 every year. If an MO goes for Diploma, he would get Rs 21,000 (Rs. 17, 000 + Rs. 2000 + Rs. 2000).

Saturation at delivery points

- In Nagaland, there are 11 DHs of which 7 are delivery points.
    - Only 4 out of these 7 delivery points have a full team of Gynaecologist, Anaesthetist and Paediatrician.
    - DH Peren has 1 Gynaecologist, 1 Paediatrician, 1 Eye surgeon, 1 Biochemist, 2 MBBS MO, 2 Dental Surgeons, 1 AYUSH MO, 8 GNMs, 8 ANMs, 2 Lab Techs and 1 Pharmacist. The Ob/Gyn administers spinal anaesthesia for conducting C-sections.
    - In DH Dimapur, there are 3 Gynaecologists, 1 paediatrician, 2 Anaesthetists, 2 surgeons, 5 other Specialists, 5 MBBS MOs, 4 Dental MOs, 2 AYUSH MOs, 43 GNMs, 24 ANMs, 8 Lab Technicians, and 6 Pharmacists.

- State has 5 FRUs at sub-district level, of which only CHC Jalouki is a delivery point. It has 1 Paediatrician, 1 Surgeon, 3 MBBS MOs, 1 AYUSH MO, 10 GNMs, 6 ANMs, 2 LTs, and 1 Pharmacist. One of the MOs received some multi-skill training in CMC Vellore and provides anaesthesia, while the surgeon conducts the C-sections.

- State has 16 Non FRU CHCs, out of which 5 CHCs are Delivery Points. In these facilities, there is no Gynaecologist, Anaesthetist, Paediatrician and Physician posted. There are 2-3 MBBS MOs and 1 AYUSH MO posted in these facilities.

- There are 33 24*7 PHCs in the State, out of which 7 are Delivery Points. There are 1-2 MOs posted in these PHCs. There are 94 non 24*7 PHCs. Out pf this 54 PHCs have MBBS MO and 1 PHC has AYUSH MO. 42 PHCs have no MO posted. There are 396 SHC, out of which only around 18 SHC are without ANMs.

- The state ***does not have a list of sanctioned strengths*** at various levels, hence it is difficult to undertake a systematic gap analysis. In absence of sanctioned strength, regular posting cannot be verified. In the State, No of sanctioned staff is taken as sanctioned staff. The requirement of contractual staff is made on arbitrary basis.

- The current staff also needs to be rationally placed.

- Status of HR is as under:

Sr. No	Specialty	Regular	Contractual	TOTAL
1.	O & G	14	4	18
2.	Paediatrician	11	2	13
3.	Anaesthetist	16	1	17
4.	Physician	9	1	10
5.	Surgeon	9	1	10
6.	Other specialists	55	0	55
7.	GDMO	126	54	179
8.	Dental Surgeon	26	20	46
9.	AYUSH MO	2	38	41

- In addition, each district has a MMU which is staffed by 1 MO, 1 GNM, 1 LT, and 2 drivers. Only two posts of MOs are vacant, rest all positions are filled.

- Also, each district has a team of 1 MO and 2 GNMs under the School Health Programme. Only 1 position of GNM is vacant, rest all positions are filled.

RECOMMENDATIONS

- ✓ State must have sanctioned strength of HR so that the additional requirement in terms of provision of Contractual staff under NRHM can be used as flexibility for state.
- ✓ State needs to undertake a gap analysis of the delivery points and ensure rational posting of available human resources.

- ✓ Skill lab may be considered for set up at the new nursing school, and also a nursing in-service training centre may be developed.

TOR 5: COMMUNITY PROCESSES AND CONVERGENCE

Village Health Sanitation & Nutrition Committee (VHSNC)

- The process of communitisation of health services is very strong in Nagaland. The process was started much before the inception of NRHM with the promulgation of Communitisation Act namely 'the Nagaland Communitisation of Public Institutions and Service Ordinance 2002'. As a result, Village Health Committees (VHCs) were formed at village level and health centre management committees (HCMCs) were formed at Sub-Centre, CHC, and PHC levels. Their role was primarily to support and monitor the health facilities and their services. The committee includes its members from various walks of life including Village Council (Panchayat) and concerned health facilities.

- With the inception of NRHM, the VHC has incorporated the role of VHSNC as proposed under NRHM. Presently, VHC comprises of Chairman, Secretary and 10-12 members depending upon the availability of social organizations. The members include women of village, church pastor, 4 members from village council and self-help groups (if present).

- There are 1324 VHSNCs functional in state as per target. The chairman and members of the committee are elected by villagers/ community, and elders of villages are mostly elected as Chairman of the committee. ASHAs are involved as active members and sometimes as Secretary (not in all VHCs).
    - In district Peren, there are 86 revenue villages and VHCs are constituted in 74 villages. In a few VHCs, ASHA is a Member Secretary of VHC. If VHC is in the Sub Centre village, the Member Secretary is either ANM or pharmacist.

- Certain powers and responsibilities of management (e.g. check attendance of staff, disburse their salaries, grant them casual leave, maintaining building etc.) are shouldered by the VHC. In addition, members of VHC also help in organising VHND in the village, facilitating to meet emergency needs and cleanliness of village.
    - VHC members need to be trained for utilizing funds on the village level activities as in Peren, it was observed that the majority of the untied funds are utilised for paying the incentives to ASHA for VHND meetings, and refreshment for VHND.

- The level of documentation of VHC meetings varies. There are some VHCs found in Chokodima PHC of Dimapur district maintaining documentation properly including minutes of meeting while this is not case with VHC of Aoymiti and other villages of Nuiland PHC in same district.

- Funds to VHCs are routed through the DHS, which transfers funds to block and from block it is transferred into village account. The funds are not transferred to the VHC until

it provides SOE for the last year's utilization, which is a good practise as it ensures SOEs on time.

- All VHCs have opened bank account. Most of the VHCs had received fund for the current year. However, VHC members reported (and bank passbooks verified) that there were delays in receiving untied fund, sometimes as late as the last quarter of financial year.

Village Health & Nutrition Day (VHND)

- VHND is synchronous with Immunisation day and is organised on monthly basis in each village. Although there is no fixed day, it is either 1st Thursday or 1st Friday or market days. In the current year, 5449 VHNDs had been organised against a target of 15888 covering 1324 villages.

- As an outcome of communitisation and regular support from VHC members, VHNDs are organised regularly in villages, although it is being organised as per convenience of health staff as well as community. ASHAs are being informed on mobile phone about the date of VHND in a month, and it is not necessarily planned in advance. However, network connectivity in State is an issue. At times there is no network connectivity for months.

  In PHC Tenning, it was observed that ANMs went for an outreach session with all the vaccines and ASHAs were not communicated about the session because of no netwok. This results in wastage of vaccines and day. State needs to have a microplan for outreach sessions which is fixed and doesnot require to be communicated on phone.

- To reach the marginalised population, State has issued a GO in October 2013 for integrating the vertical programmes by engaging a MO for VHND on fixed days (generally market days) in the districts which is a good practise as it provides range of services under one roof. Medical Officer does the routine OPD and checkup and ANMs do the immunization sessions and ANC checkup.

- Since overall there are access issues to the health facilities, such sessions provide a good platform of service provision and improving access.
  - In VHND Nchangram, few beneficiaries informed the team that most of the women prefer home deliveries in nearby village. However, they attend the VHND sessions for ANC checkup.

- Most of the services provided in VHND are ANC checkup, registration of pregnant women, immunisation of children, and display of IEC material.

- There is a strong coordination between ASHA, ANM and VHC member during VHNDs observed by the team. Members of VHC monitored the regularity, services provided and availability of health staff in VHND.

ASHA Training and Performance

- Till date 1854 ASHAs have been selected in state as per target. Selection is done as per community processes guidelines for selection of ASHA as reported by state. However, a few unmarried women were selected as ASHAs, resulting in high attrition rate, after they get married. ASHAs are generally nominated by the villagers and then the VHC recommends their name to CMO for approval. 87% (1624) ASHAs have completed training till Round 3 of ASHA Module 6 and 7. The necessary books and equipment kit were distributed among ASHAs.

    - There are 135 ASHAs in district Peren and 4 ASHA coordinators at block level. These ASHA coordinators are mentoring an average of 35 ASHAs each (range is 18-49 ASHAs per coordinator).

    - In both the districts, the newly selected ASHAs were not provided with the training of 1 to 5 modules or induction training of 5 modules. They are straightway trained in the module that is going on in the state (module 6 & 7).

    - ASHAs' education level varies from Standard 2 to Graduation. ASHA training module is in English language and most of the ASHAs who were met during the visits were not very comfortable with the language. The modules in the local language, which varies from block to block, would be more beneficial to ASHAs.

Table: No of ASHA Selected, drop out and Training status

No.	Districts	No. of ASHA selected	No of ASHA Drop out		Status of ASHA Training (Module wise)							
										Module 6 and 7		
			2012-13	2013-14	Module 1	Module 2	Module 3	Module 4	Module 5	Round I	Round II	Round III
1	Kohima	120	01	05	98	98	98	98	110	94	92	96
2	Mokokchung	180	03	00	171	171	171	171	171	161	171	136
3	Tuensang	176	01	00	144	144	144	144	153	144	129	139
4	Phek	142	01	00	69	132	132	132	132	116	130	120
5	Mon	277	00	00	210	210	210	210	210	207	210	228
6	Wokha	163	14	08	45	45	45	95	160	144	151	135
7	Zunheboto	194	00	14	175	175	175	175	194	183	171	182
8	Dimapur	255	02	00	242	242	242	242	242	232	245	255
9	Peren	131	00	04	130	130	130	130	130	130	120	117
10	Kiphire	110	**10**	**04**	**103**	**103**	**103**	**103**	**103**	**96**	**78**	**110**
11	Longleng	106	**07**	**00**	**85**	**85**	**85**	**85**	**85**	**69**	**73**	**106**
		1854	**39**	**35**	**1507**	**1570**	**1538**	**1588**	**1690**	**1576**	**1570**	**1624**
		%			**100**	**100**	**100**	**100**	**100**	**92.71**	**92.35**	**87.12**

Performance Monitoring of ASHAs

- Performance Monitoring has been instituted as per Govt. of India guidelines. Out of 11 districts, 10 are graded A in ASHA Performance on all ten indicators.

- Both the districts, Dimapur and Peren, have consolidation of ASHA performance at Block as well as District Level. Although training has completed upto Round III of Module 6 and 7 in Dimapur district and is on-going in Peren district, and both the districts have "A" grade.
    - ASHAs are active in attending VHND/ supporting immunisation and institutional delivery and management of childhood illness mainly diarrhoea.
    - ASHA performance is poor in HBNC home visit.
    - In addition, ASHAs were found more active in RNTCP programme- referring TB cases to District centre of RNTCP in Dimapur district, helping in organising VHND and also meeting of VHC.

- ASHAs are active in caring of marginalized population as they were aware of migratory population and unreached population in their villages, even though their orientation in "reaching the unreached" is yet to be conducted.

- ASHAs and ASHA coordinators (except in Athibung block) are unaware of the JSSK entitlements provided to pregnant women and infants in both the districts. They were aware of the cash payment given under JSSK to the pregnant women and children upto 1 month of age (not aware that entitlements have been extended upto one year).

ASHA Incentive and Support Systems

- ASHA programme in state is being supported by one ASHA Nodal officer, One State ASHA coordinator, 11 District Community Mobilisers and 66 Block ASHA Coordinators covering 56 health blocks. ASHA support staff has been oriented in Performance Monitoring, Supportive Supervision and Reaching the Unreached guidelines. Block ASHA coordinators are meeting with ASHAs during monthly meeting held at PHCs and during VHND while they visit VHND with PHC MO.

- Although state has provision of providing incentive to ASHAs for different range of services (JSY, HBNC, VHND, counselling women for spacing between birth of first child to second child, identification and motivation for surgery of cataract cases and reporting of all deaths and births), on an average ASHA receives minimum Rs 700 and maximum Rs 2200 in a month as an incentive for her tasks. CRM team was informed that not all ASHAs have bank accounts yet; therefore, there is a reduction in ASHA receiving incentives. To avoid the backlog, State has recently issued a GO that cash payments may be made till the time ASHAs get their accounts opened. In the debriefing session, Secretary Health for the State of Nagaland was briefed on the issue. He directed the state officials that payment would be made through checks as per the guidelines laid down by GoI.
    - Incentive is being paid in cash as well as cheque. No ASHA in Peren district reported receiving cheque payment of their incentives. However ASHAs of Neuiland PHC of Dimapur district reported the receiving cheque for JSY incentive from facility itself.
    - It was also reported that ASHAs are facing problems in encashment of cheques, as they need to visit nearby town and market to deposit cheque in her account which

involved travel cost (especially for ASHAs residing in difficult terrain and hard to reach area).

- ASHAs have received drug kits. In Peren, the drug kits were refilled by ASHA Coordinators, who get the drugs from facilities, during training or monthly meetings. However, mechanism of refilling of drug kits in Dimapur was weak.
  - ASHAs in district Peren didn't have HBNC drug kits and in Dimapur they had drug kits but few commodities like thermometer and blanket were missing.

- 102 ambulance driver's number is available with ASHA. However it is sometimes difficult for ASHA to call ambulance because of non-availability of network in mobile. Due to scattered nature of households and distance of facility from some of the hamlets, ambulance is not being utilised by ASHAs in case of emergency for JSY / JSSK and other services. Many ASHA also reported long duration taken by ambulance to reach after placing call. This is also one of the causes of preference given by community to home delivery. The case load of JSY with ASHA is minimum in such area where travel cost is much higher for escorting pregnant women to health facilities since JSY incentive for beneficiaries as well as ASHA are much less than the cost involved in travelling to facilities, although VHC does support sometimes.

Community Monitoring

- Communitisation process in state proved as a boon in making accessible health services to the community. As part of communitisation process, committees were formed at various levels, from sub-centre to CHC.
  - Common Health Sub Center Committee – a federation of constituent VHCs that come under a common health sub-center. For Town/Urban based sub Center, Urban Health Committee wase constituted with VHC-like membership to take control and management of all urban based Health Sub-Centres in the state.
  - At the CHC/PHC level, Health Centre Management Committee was constituted with representative of VHCs and Village Councils of constituent villages and towns failing within the respective CHC/PHC areas In all these Committees the Chairman is selected/ elected by the Community, while the Member Secretary is the senior most health worker of the health centers, and in case of CHC/PHC it is the Medical Officer.

- These committees play an important role in management of health centres (administrative, technical and financial management), promote preventive health (through education and action), popularise/ encourage traditional medicine and its practitioners (through identifying genuine ones, encouraging them to practice at the health centre, documenting their practices, honouring them etc.), checking attendance of staff, disburse their salaries, grant them casual leave, maintain the buildings, and monitor the availability of services and performance of facilities.

Key Issues

– The training of VHC members is still due, as recommended in the 4th CRM.

- Documentation and details of untied fund utilisation is poorly maintained. Some of the VHCs in both the district did not have any record.
- 8 to 12% ASHA drop out was reported by State, and training gaps were identified by the team.
- ASHAs are not selected as per Community Processes guideline in Peren district. 25% ASHA are unmarried and can lead to attrition in future and wastage of resources for selection of new ASHAs.
- No induction training is planned for newly selected ASHAs, who are directly trained in any on-going round of Module 6 and 7, resulting in poor knowledge and skill level.
- Evaluation, as required with roll out of Module 6 and 7 training to strengthen the knowledge and skill of ASHAs, is not being conducted during ASHA training. The training quality observed was very poor. ASHAs were not able to tell about the home visits required under HBNC programme. As per interaction with ASHAs it was found that neither they are providing any health education to mother during pregnancy nor they were conducting first examination of newborn in home delivery.
- ASHA Modules have been distributed in English, which all ASHAs do not adequately understand. No translation in local dialects has been done.
- Equipment kit has been distributed but it is not as per specification. Mercury thermometer was provided in ASHA kit while they are trained in digital thermometer. ASHAs of Tsiepama village reported that weighing machine provided by state is not comfortable for newborn. They are facing problem in weighing the baby in given weighing scale.
- Drug kits are available but state doesn't have any mechanism of replenishment. The quantity of drugs available in drug kits shows low utilisation of all drugs except pain killer. Co-trimoxazole was not available in ASHA drug kit
- The position of District Community Mobiliser is vacant in Dimapur district since last month. No District Data Assistant (ASHA) has been placed in any district of the state.
- HBNC – the training under Module 6 and 7 is completed upto 3 rounds in the districts. However, ASHAs are not doing complete 6/7 visits for HBNC. Most of the ASHAs are doing 2-3 visits only as per their convenience. The reporting and recording formats were not made available to the CRM team in any facility.
- Most of the ASHAs were not aware of all danger signs of new born and unaware of when and where to refer. They also did not know about use of 102 referral transport service in case of sick newborns.
- Block and District ASHA coordinators are not monitoring HBNC implementation.
- ASHA coordinators have been placed in all blocks of state, but no ASHA facilitators have been deployed so far at sector level. The coverage under one Block ASHA Facilitator varies from 25-50 ASHAs, making it difficult for them to conduct performance monitoring and handholding and support to each ASHA every month.
- State doesn't have any operational mechanism for ASHA rest room in facilities. Although ASHA rest room was found at DH Dimapur and CHC Medziphema, there was no toilet facility. No ASHAs were seen in the rest rooms.

- ASHAs in the field reported various problems being faced by them. However, State doesn't have ASHA grievance redressal cell as per Govt. of India guidelines.
- Database of ASHAs at block and district level does not incorporate training status, data on dropouts, new selection and incentives being provided in different programs.
- The work being done by ASHAs has not been reflected in the database in Dimapur District. District has endemic area of TB, Malaria and HIV cases. ASHAs are referring TB cases to District RNTCP centre (minimum 6-7 cases every week) and also receiving incentive for it but it has neither reflected in performance monitoring report of last quarter nor in district database.

RECOMMENDATIONS

- ✓ State needs to plan training of VHSNC (VHC) members on their role, management of untied fund and social determinants of health on priority basis. This is also recommendation of 4th CRM.
- ✓ VHC untied funds should be used for local needs, as per guidelines. State to consider separate budget for VHNDs.
- ✓ The selection of new ASHAs needs to be done as per Govt. of India guidelines.
- ✓ ASHAs should be made member secretary of VHC and manage VHC untied funds.
- ✓ The training modules, if in local language would be more helpful for ASHAs
- ✓ State needs to plan for 8 days training of newly selected ASHAs in induction module.
- ✓ HBNC kits should be distributed as per guideline.
- ✓ Mechanism to replenish drug kits should be regularized.
- ✓ State need to map out distance of hamlet/villages or radius of hamlet/villages and select ASHA facilitators on 10-12 ASHAs as per Government of India Guideline
- ✓ Grievance Redressal Mechanism for ASHA needs to be set up at district level and publicised. All grievances should be documented, with action taken report as per GOI guidelines.
- ✓ District Community Mobiliser needs to be appointed in Dimapur district and ASHA data base at District and Block level should be strengthened.
- ✓ Evaluation of ASHA and ASHA Trainers during training need to be conducted to ensure the training quality.
- ✓ For conducting VHNDs, there has to be a microplan, State needs to fix calendar for next year wherein 1 or 2 days are mandatory for conducting VHNDs.

TOR 6: INFORMATION & KNOWLEDGE

HMIS (Health Management Information System)

- All the facilities are reporting on HMIS in the state. All 79 facilities in District Dimapur and 36 facilities in district Peren are reporting on HMIS portal. However, due to lack of internet connectivity in district Peren, the HMIS data is collected manually from all the facilities and uploaded by the DPMU every month.

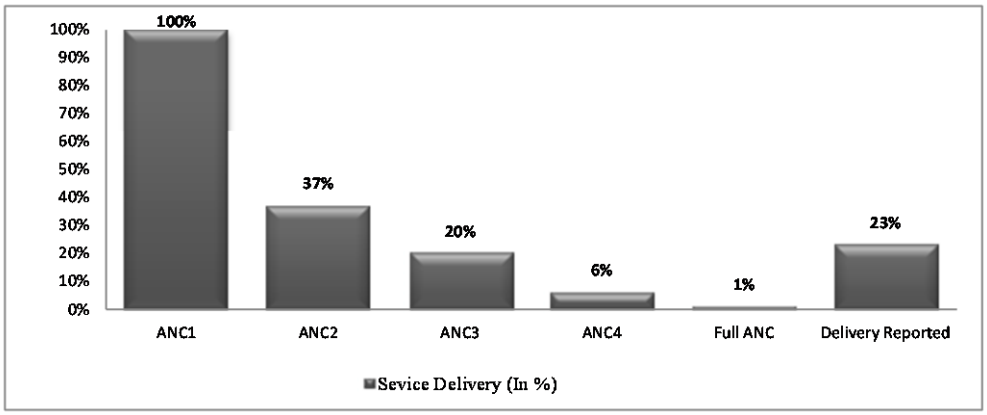
- There is a ***discrepancy in the figures*** which State has committed to national portal and those presented in State briefing. The table below is data captured by the national HMIS portal, wherein total number of pregnant women registered for ANC and Number of Pregnant women registered within first trimester for the year 2012-13 is 25,945 and 10,667 respectively whereas in State's briefing, it was 51,969 and 19,835 respectively.

	State		Dimapur		Peren	
	2013-14 (upto Oct)	2012-13	2013-14 (upto Oct)	2012-13	2013-14 (upto Oct)	2012-13
PW registered for ANC	25,087	**25945**	10726	10,000	960	1014
PW registered in 1st trimester	8602	10667	3923	5701	503	538
PW received 3 ANC checkups	7461	4112	164	162	238	194
Institutional deliveries (Public Insts.+Pvt. Insts.)	7278	**7349**	2911	2783	320	347
Home deliveries	2532	**2952**	538	258	102	125

- In district Peren, it was observed that data is being captured for both IUCD Insertion and IUCD removal. The IUCD insertion in the year 2012-13 is 184 and removal is 61. In 2011-12, IUCD Insertion and removal was 169 and 69 respectively. The ***facilities / providers with high removal rate were not identified for any corrective measures***.

Mother and Child Tracking System (MCTS)

- The district Peren has no internet connectivity. MCTS data is collected manually from all the facilities, and is uploaded from either Kohima or Dimapur. DPMU Dimapur is tracking the information from all the facilities of their jurisdiction and updated the data online. The mobile numbers given by beneficiaries were called individually and verified.
    - **Pregnant women:** A Total of 15,494 PW have been registered in MCTS for the year 2012-13 which is 42.2%. The rate of registration of PW in 2013-14 till October is 33.7%. In Dimapur, it is 21.2% in the year 2012-13 and 20% in the year 2013-14 till October, 2013. In Peren district, it is 63% in 2012-13 and 33.6% in the year 2013-14 till October. The data entered into MCTS by the State shows a sharp decline in services delivered to the PW as follows:



Services provided to the Pregnant Women with LMP in **November,** 2012

- **Children:** A Total of 19,024 children have been registered in MCTS for the year 2012-13 which is 57.0%. The rate of registration of PW in 2013-14 till October is 31.6%. In Dimapur, it is 19.6% in the year 2012-13 and 5% in the year 2013-14 till October, 2013. In Peren district, it is 103% in 2012-13 and 18.37% in the year 2013-14 till October. Total 1,705 live births were reported in **September,** 2012.
    - BCG, Measles and Full Immunization services delivered to the children with DoB in September, 2012 is as follows:

S. No.	Services	No. of Children received services	% of Children received services
1	BCG	1,107	64.9%
2	Measles	487	28.6%
3	Full Immunization	234	13.7%

    - There is a sharp decline in service delivery from BCG (64.93%) to Measles (28.6%) services. Further only 13.7% of children registered in MCTS with DoB in September 2012 are fully immunized.
    - This was observed in the field as well where in most facilities (except PHC Ahtihbung), there was coverage data mismatch between corresponding DPT and OPV doses. All the children given DPT dose were not given OPV, and vice versa.
    - In DH Peren, there were dropout cases in DPT sessions every month. The defaulters were not tracked or followed up by the DH.
    - Similarly in District Dimapur, for children registered under MCTS, with date of birth in September to October 2012, all the vaccinations received have not been tracked. ANC record for pregnant women is also not upto the mark. The mechanism of work plan generation and providing to ANMs, their updation and data entry need lot of improvement.

- The data is not analysed properly at both district and state level and hence not being used for corrective actions. For example, in year 2013-14 there is a difference in the number of children given OPV 1, HEP 1 and DPT 1 dose (should be given together). The details of children vaccinated, as captured by MCTS portal in 2013-14 are as under:

2013-14	OPV1	HEP 1	DPT 1
Nagaland	3074	2457	3096

- In MCTS registers, the column for capturing unique IDs of mothers was not filled.

Key Issues

- HMIS data shows that out of total 25,945 pregnant women registered in 2012-13, 2911 have come to institutes for deliveries and 2952 cases are of home delivery. Nearly 60% deliveries are not captured in the HMIS.
- The total number of pregnant women registered for ANC in 2012-13 is 25,945 in HMIS whereas the same is 15,494 in MCTS portal. This was observed in the field as well, where almost at all the facilities there were data inconsistencies in MCTS and HMIS registers.
- **There is no clarity in how is MCTS data being transferred in MCTS portal which results in parallel entry in another register. This leads to duplication of work.**
- ANMs were maintaining so many registers for data reporting. For example, for an Immunization session, an ANM records the details on rough page at the first place, than it is filled on Immunization register and then on the MCTS register. Huge discrepancy in the data filling was noticed at almost all the health institutions. The same data is entered in MCTS registers after time lag. This leads to the loss of data and inconsistency in the data of Immunization register and MCTS register.
- Work plans for ANMs were not being generated in both the districts.

RECOMMENDATIONS

- ✓ There is a need of reorientation training for district and block officials on MCTS and HMIS. Handholding support is required for frontline workers for smooth implementation of MCTS and HMIS.
    - State to ensure that services delivery data is regularly entered in MCTS from all health facilities, sub-facilities (sub-centers) every month.
    - The registration status of the beneficiaries on MCTS portal is not up to the mark. State needs to improve to achieve 100% registration.
- ✓ Call centre at State level needs to be set up.
- ✓ The data entered in MCTS needs to be utilized for generating work plans for ANMs.
- ✓ ANMs should be trained before they are given new MCTS and village registers.

TOR 7. FINANCIAL MANAGEMENT

HR availability and capacity building for Finance & Accounts

- The following F&A staff are in place at the State level:
    - Finance Controller : 1
    - Finance Manager: 1
    - Finance Consultant: 2
    - Asst. Finance Consultant: 1
    - Accounts Manager: 2
    - Asst. Accounts Manager: 1
    - Accountant: 3

- Each of the 11 districts has a District Accounts Manager and an Accountant in place. Block Accounts Managers (BAMs) have been appointed for the first time under NRHM, in November, 2012. Currently, 52 out of 56 blocks in the State have BAMs in place.

- ***Overall availability of F&A staff is good.*** At SHS level, the posts of 1 Asst. Accounts Manager & 2 Accountants are vacant since August, 2013, while 4 BAM posts are vacant in the blocks.
- In the past year, the following FM training has been carried out:
    - NRHM Finance Division, MoHFW, GoI undertook a State level Finance Management training for all District & Block F&A staff in December 2012.
    - State F&A staff undertook a refresher training of BAMs in September 2013.

Planning

- District Health Action Plan (DHAP) is being prepared by all districts, but it does not contain the financial outlays / budgets against the activities. Without the financial outlays, the DHAP is not being considered while making release to the districts.

Fund flow and banking arrangements

- E-transfer of funds has been implemented upto block level. Wherever banking facility is available, e-transfer is also being done upto sub-centre / VHC level.

- CPSMS is still being rolled out. One training of CPSMS was done in June'2012. Registration of CPSMS enabled accounts has been done upto District level.
- The Group Bank Accounts system has not been fully implemented in the State. Only the SHS has opened Group Bank Accounts but same is not been implemented in the Districts.

- Financial integration has not been implemented with all the programs. Funds under RNTCP and NVBDCP are released separately by the concerned division to the respective program accounts at the district level. The State has not opened a separate bank a/c for NCD. The funds released by GoI are lying under the NRHM a/c.

State Share contribution:

- There is no pendency under the State share contribution against the releases made to the State up to 2013-14.

Rs. in crore

Year	Amounts required on basis of releases	Amount Credited in SHS Bank A/C	Short/ (Excess)
2007-08	6.30	6.00	0.30
2008-09	8.27	9.00	-0.73
2009-10	11.09	9.22	1.88
2010-11	9.11	12.62	-3.51
2011-12	13.19	14.70	-1.51
2012-13	10.56	10.07	0.49
2013-14	7.09	6.58	0.51
Total	**65.61**	**68.19**	**-2.58**

Financial utilisation

- The following table shows pool-wise utilisation for FY 2012-13, which is especially low for NVBDCP, and NPCB:

Rs. in crore

Sl. No.	Programme	Approved Budget	Release	Audited Expenditure	% utilisation against budget	%ge utilisation against release
1	RCH-II	44.86	24.79	33.22	74.1%	134.0%
2	Additionalities under NRHM	46.71	30.37	35.59	76.2%	117.2%
3	Routine Immunization	1.75	0.76	1.54	88.0%	202.6%
4	P.P.I.	0.95	0.90	1.30	136.8%	144.4%
5	Infrastructure Maintenance	18.87	21.87	21.87	115.9%	100.0%
6	I.D.S.P.	1.36	0.60	1.13	83.1%	188.3%
7	N.I.D.D.C.P.	0.48	0.31	0.53	110.4%	171.0%
8	N.L.E.P.	0.57	0.57	0.57	100.0%	100.0%
9	N.P.C.B.	2.90	2.80	0.42	14.5%	15.0%
10	N.V.B.D.C.P.	14.80	9.06	4.86	32.8%	53.6%
11	R.N.T.C.P.	3.34	3.01	3.17	94.9%	105.3%
Grand Total		**136.59**	**95.04**	**104.20**	**81.0%**	**110.5%**

- Within RCH and Mission flexipools, key budget heads with poor utilisation for FY 2012-13 include:
  - Maternal Health (Other than JSY & JSSK) – 43.0%
  - Child Health (Other than JSSK) – 33.3%
  - Family Planning Services (Other than Sterilization) – 16.6%
  - Training – 43.2%
  - JSSK – 37.5%
  - Regional Drug Warehouse – 0%
  - Hospital Strengthening – 10.1%

- Panchayati Raj initiative – 46.2%
- Referral Transport – 48.9%
- Innovations – 15.9%
- Planning Implementation & Monitoring – 39.1%

- The following table shows financial utilisation under major pools in FY 2013-14:

Rs. in crore

Programme	Budget 2013-14	Funds released	Utilization upto 31.10.2013	% Utilization against budget	% Utilization against release
RCH Flexi Pool	35.74	19.91	19.12	53.5%	96.0%
Mission Flexi Pool	32.74	22.56	6.64	20.3%	29.4%

Accounting and internal controls

- The Customized Version of Tally has been implemented at the State & District level but not at the Block level. Two rounds of training have been provided – first in November 2009 (on Tally ERP) and second in July 2011 (on Tally ERP 9 – customised version). The State has a Tally partner located in Dimapur, for resolving issues related to tally implementation.
- At State level, books of accounts are maintained both manually and in customized version of Tally. During the time of visit all the cash books were found updated. Other requisite ledgers & registers have been printed out of Tally on periodical basis. In Dimapur District, although the books of accounts are prepared in Tally, the periodical printouts of ledgers and other registers are not being taken. This may result in loss of data on malfunctioning of either the computer or the Tally software.

- Bank Reconciliation Statements have been made for all the bank accounts on monthly basis at the SHS and DHS but not at the block level.

- The double entry book keeping system is followed in the State Health Society but at District & the Block level the same has not been fully implemented. The Statutory and the Concurrent auditors have pointed out absence of requisite books of accounts, ledgers, proper voucher system and file routing mechanism at the district and block levels.

Audit

- The Statutory Audit for FY 2012-13 has been completed and the report has been submitted to GoI.
  - In the Statutory Audit report of Dimapur district for FY 2012-13 the auditor has observed that a laptop worth Rs. 24,500/- has been purchased for the BPM of Kuhuboto block out of the RKS funds in violation of the RKS guidelines, and it needs to be corrected.
  - Further, the District Health Society has spent an amount of Rs. 3,95,120/- from the interest earned on the bank account, but no approval was taken from SHS.

- The Concurrent Audit for FY 2012-13 has been completed but the Executive Summary of the fourth quarter has not been shared with GoI.
    - The Concurrent Audit for the 1st & 2nd quarters of FY 2013-14 has been completed but the reports are yet to be submitted by the Auditor. Also during the verification of the cash book of the IDSP programme at the SHS, it was found that the auditor has certified the cash books even though it has not been signed by the authorized person and also some of the entries were made in pencil.

- A CAG audit was done in November 2012, however the reports have not been shared with the State.

Rogi Kalyan Samiti (RKS) / Health Centre Management Committee (HCMC):

- The HCMCs are governed by the community process guidelines implemented in the State since 2005. All the activities to be undertaken by the HCMCs are approved in the District Coordination Committee Meeting held under the Chairmanship of the Deputy Commissioner of the district. The HCMCs operate two nos. of accounts i.e. one current account for salary disbursement and one savings account for deposit & utilization of development funds.

- The GoI guidelines are not being followed up for making expenditure against grant released under RKS to HCMCs. For example, a laptop worth Rs. 24,500/- has been purchased for the BPM of Kuhuboto block out of the RKS funds.

Untied Funds/Annual Maintenance Grants

- There are issues with reporting on untied funds. In District Peren, all releases of untied funds to sub-centres and VHCs are treated as expenditure. In District Dimapur, while the expenditure reporting is done upon receipt of SOE, the full amount released is reported as expenditure irrespective of actual amount spent.

- These funds usually reach the units very late in the financial year, as they are not prioritised for disbursement.

Financial reporting and monitoring

- The District reports the expenditure under the various activities under which the funds have been released by the State in the Financial Monitoring Reports extracted from Tally on monthly basis. The CHCs/PHCs report their expenditure in the monthly SOE format along with the original vouchers to the Districts and the same is compiled in the District FMRs for onward reporting to the State.

- The State and district F&A staff rarely undertakes monitoring visits to the lower levels. Due to lack of proper guidance to the newly recruited BAMs, they are not able to maintain all the requisite books of accounts at the block level and the same has been highlighted by the Statutory and the Concurrent Auditors in their respective reports.

Key Issues

a) Weak capacities for finance and accounting, especially at sub-district levels – however no training calendar / systematic plan for their training.

b) Lack of systematic dissemination of GoI guidelines / accounting handbooks.

c) Lack of preparation of budget while preparing DHAP, and budgets prepared only at State level.

d) Activity-wise release of funds to districts, rather than pool-wise, results in parking of funds under slow-moving activities.

e) Delays in disbursement of untied grants – not prioritised.

f) CPSMS implementation is slow – accounts below district level yet to be registered.

g) Weak internal controls, e.g. cash books and others registers not being signed by the person in charge of maintaining the same.

h) There is no mechanism for monitoring of advances at the sub-district level.

i) Most of the beneficiary payments such as JSY, Family Planning are done in cash. Even the JSSK in-kind benefits for food & transports are disbursed in cash to the beneficiaries.

j) Timeliness and quality of Concurrent Audit, is a concern.

k) Incorrect reporting of expenditure under untied funds – reported on release basis in some cases

l) Lack of systematic monitoring and supervision mechanisms.

Recommendations

i. State needs to prepare a plan for systematic training for F&A staff at district and lower levels. A training needs assessment may be undertaken to identify key areas requiring training. E-training modules developed by GoI and available on the MoHFW website, may be used.

ii. Model Accounting Handbooks for sub-district units should be fully disseminated at appropriate levels and DAMs can provide orientation on the handbooks during regular meetings.

iii. State needs to ensure that expenditure under Untied Funds is reported on actual basis.

iv. State and District finance personnel should plan for making monitoring visits to the implementing units and provide hand holding support to the finance staff at the units so that the quality of the maintenance of accounts can be improved. This is especially true for the newly recruited BAMs.

v. CPSMS implementation should be fast-tracked, and enabled accounts registered. This will enable in real-time monitoring of advance and balance position with various units.

vi. State needs to address the weaknesses in Concurrent Audit.

TOR 8: MEDICINES AND TECHNOLOGY

- A State Drug Policy is in place with rational procurement, supply chain and inventory management and warehousing strategies specified. This is uploaded on the State website. Essential drug list (EDL) and standard treatment guidelines (STGs) have been adapted from TNMSC.
    - A copy of the STG was available at the facilities, though the doctors had no knowledge of such a document or the concept of STG. The document, which is an adopted version of the TNMSC guidelines, has no specific information related to Nagaland added; nor the state specific contents of TN removed.
    - Doctors in the facilities visited, and programme officers, were not fully aware of the State EDL.

- Procurement of the drugs was done centrally at the State level. Quality testing of drugs is yet to be adopted properly in the State.
    - The store in-charge could not explain or produce supporting documents of the drug quality testing processes adhered to at the State level.

- Pharmacists at the CHCs and PHCs were not well-equipped to manage the drug store and pharmacy; e.g. in one of the CHCs visited, the pharmacist could not even trace some of the basic drugs.

- Inventory management was not computerised, including at the State level.
    - No indent/ requisition mechanisms were seen to be adopted for drug supply, at any level.
    - Drugs have been supplied from the upper level of store to the next level, in lump sum quantities, without assessing the actual stock level.
    - Further, the drugs supplied do not follow the EDL.

- Most of the drugs were procured supplied in brand name, not in generic name. In most of the facilities, stock registers were also maintained in brand names of the drugs, NOT in generic names, leading to multiple stock entries for the same drug in different brand names.

- "First Expiry First Out (FEFO)" was prominently displayed at all facilities visited. However, it was not adequately followed.
    - No tracking of batch numbers and expiry dates were practiced in State, district or block level stores. For example, in a DH store, 400 units of amoxicillin 500 mg tabs were expiring in Oct 2013, however there was no entry of distribution/ use of this drug. The store keeper could not trace this drug as well. In case of vaccines, issue note even from the State level store was not showing diluents, batch numbers or expiry dates.
    - Further, arrangement of drugs in the facility stores was not in alphabetical order.

- Availability, record-keeping and supply of drugs was found satisfactory in case of both Ayurvedic and Homeopathic drugs at CHCs and DHs.

- All primary level medicines were available for Ayurveda and all constitutional remedies in the case of Homeopathy.

- State has an AYUSH pharmacy and drug testing facility under the AYUSH Ministry's scheme, with state-of-the-art infrastructure and equipment, at a very good location.
  - However, there is no staff posted here since 2009.
  - The AYUSH doctor in DH Dimapur has been given additional charge of the controlling officer, without any necessary technical and support staff or powers- though such provisions are available under AYUSH component.
  - One chowkidar at the facility mentioned that he has not received salary for the past two years.

Key Issues

- Although Drug Policy has been adopted by the state, it is yet to be implemented.
- Centralised procurement and supply are taking place without having indents from districts/ below and needs assessments.
- FEFO policy not adequately adhered to.
- Concept of EDL and STG not yet penetrated to district and lower levels.
- No information about the processes for drug quality testing was available
- Warehouse management is poorly done; Pharmacist and storekeepers need training.
- No staff posted at the state-of-the-art AYUSH drug testing facility.

Recommendations

- ✓ State needs to urgently disseminate and orient staff on EDL and STGs, and monitor their adherence.
- ✓ Staff at various levels should be trained on storage and indenting procedures.
- ✓ Staff should be urgently posted at the AYUSH drug testing facility.

TOR 9 – NATIONAL URBAN HEALTH MISSION

- State has recently initiated the mapping of urban slums. Slums areas under Dimapur Town include:
  Ward no 1 – covers 4 colonies
  Ward no 4 – covers 7 colonies
  Ward no 7 – covers 5 colonies
  Ward no 16 – covers 3 colonies
  Ward no 18
  Ward no 22 – covers 3 colonies

- Under the Mission, State has identified establishment of new Urban PHC at Burma Camp of Dimapur district, as there is no other public health facility in this area which has a huge slum/ migrant population.

- The area has a potential to be an epidemic hotspot and at present, the whole area is covered only by 2 Vaccinators (for immunization only)[2].

- The team interacted with slum dwelling communities such as Rickshaw pullers, Dhalai workers, vegetable dwellers and Rag pickers. FGDs were held with commercial sex workers as well.
    - All revealed very poor coverage of health and related services to these vulnerable populations.

- Chiefs of the slum areas and elected chairman of the area showed interest in extending health services in the slum areas.
    - In Burma camp, the communities have already donated land for the urban PHC.
    - Some of the slum dwelling communities indicated a positive approach through organizing themselves and initiating support measures by forming a union. They have done sanitation initiatives such as cleaning the drainage, supporting the deprived families providing healthcare, purifiying water etc. These unions could be seen as future foundations for the urban health committees.
    - In addition, some slum areas are already represented by Gawang Para – a person nominated by District Administration per block who in turn elects the Chairman of the colony. The Chairmen of such colonies are also member of DHS.

- An overcrowded private health clinic is available in the slum which is managed by Christian Institute of Health and Research under PPP mode. Patients are unable to meet small expenses for tests, consultation, etc.

- Targeted intervention initiatives are being undertaken in the urban areas, particularly with commercial sex workers.
    - Akimbo Society, an NGO working in new market on target intervention seems to have achieved excellent coordination between clients and health systems.
    - ALFA Care, another NGO, working in Burma Camp, was also providing exceptional services to the children of deprived communities.

- Urban ICDS outreach seems to be poor.
    - An Anganwadi centre visited in Burma camp, was found to be non-functional and used for non ICDS activities.
    - There were plenty of children of the target age for ICDS in the area who were deprived of the services.

- Team also visited an Urban sub-center which has coverage of 15,417 urban population, conducting weekly OPD.
    - The center is staffed with two ANMs, two pharmacists, two male attendants, four female attendants and one dai.

[2] Although in focus group discussion it came out clearly that no immunization session has been held in the camp for years.

- There is active community involvement, and the building of sub-centre has been provided by the community members.
- For most of the services patients are referred to District Hospital which can be reached in 30 minutes.

Recommendations

- ✓ Potential for community health workers were visible in all the slums visited. State should ensure proper selection and training of link workers.
- ✓ State needs to identify key health issues in these areas, for focused intervention.

TOR 10: GOVERNANCE AND MANAGEMENT ARRANGEMENTS

Program Management

- At the state level it was found that a robust coordination mechanism between Directorate and the NRHM SPMU has been built up.
  - One of the senior most directors have been appointed as the MD, NRHM on secondment, who is in line reporting to the Principal Director, Health Services and to the Commissioner. The integration of Directorate Health Services and Mission Directorate was found good in State.
  - One Joint Director level officer of the Directorate has been seconded to the NRHM SPMU as the State Programme Officer under whom two of the Deputy Directors are also seconded, looking after (a) HR, Quality Management, Transport, and (b) Policy, Planning and Administration
  - Various consultants appointed under NRHM are working under these officers directly. These include the Finance and Accounts consultants (as already detailed in Section 7); consultants for Human Resources, HMIS, MCTS, Training, RCH, Child Health, ARSH, Procurement, Publicity, IEC, and Community Monitoring; and State ASHA Coordinator. State Facilitator from NE-RRC also provides technical support.

- The state has functional PMU both at district and Block level. The details are as under:

District	Dimapur		Peren		Nagaland		
	Sanctioned	In position	Sanctioned	In position	Sanctioned	In position	Gap
District Level							
D.P.M	1	1	1	1	11	11	0
Dist. A/c Manager	1	1	1	1	11	11	0
Media Officer	1	1	1	1	11	11	0
DCM	1	0	1	1	11	10	1
Accountant	1	1	1	1	11	11	0
DEO DPMU	1	1	1	1	11	10	1
Block Level							
B.P.M	5	5	4	4	56	55	1
B.A.M	5	5	4	4	56	52	4
ASHA Co-	5	8	4	4	56	66	-10

District	Dimapur		Peren		Nagaland		
	Sanctioned	In position	Sanctioned	In position	Sanctioned	In position	Gap
coordinator							

- Observations on the HR Management at State level have revealed several key issues.
    - There is no point person such as a State Programme Manager for the overall team within the group of consultants. Hence their function is mostly as individual consultants than as a Programme Management Unit. This could be leading to fragmented work and reporting.
    - The SPMU and directorate lack sufficient skills to manage and support the AYUSH contractual staff- indicates the need of a team of officials with technical understanding of the systems to be placed rather than the current arrangement, of a contractual doctor with no background of Ayurveda or Homeopathy supporting the SPO AYUSH, who is also an allopathic specialist. However the SPO AYUSH was having sufficient understanding on mainstreaming issues and was consulting subject experts informally.
    - Role definition and objective ToRs for each category of technical consultants- yet to be achieved. The contractual staff have not been issued proper terms of reference, as part of their appointment orders.
    - No policies and guidelines on management of contractual staff and their entitlements could be verified by the team. During the FGDs with the state consultants, it was told that a draft on this was prepared but not approved yet.
    - Salaries of the different consultants were found to be very low, if compared to the same provided by other states- need a rationalisation.
    - There is only one increment of salaries given by the state to the PMU staff, since the inception of NRHM.
    - Staff Induction was not undertaken for any level of PMUs, leading to orientation even on basic functions such as filing and documentation seemed weak. Training on technical areas was indicated as missing too- need to be adequately focused.
    - Team meetings, reviews and mentoring support to consultants at different levels- still an evolving area. Team Meetings of the SPMU is not held; nor do they have responsibilities divided on supervision of districts.
    - Staff appraisals were done of the contractual staff by the CMO, however, there was no feed-back or follow-up of such a process

- The DPMU has a DPM, DAM, DDM, IEC consultant, School Health Consultant and a Data Entry operator in place. Office spaces and arrangements for this team is relatively congested, though all of them are allocated spaces. The DPM or the DAM has no leadership roles assigned in the DPMU but they were seen as assistants. ToRs with specific responsibilities were not given to them while appointing. Salaries are comparatively lower, to the same level of staff in other states, which needs consideration for hike and for annual increments.

- Block programme management unit has yet to evolve as a team. The account managers were brought into the scene recently who is yet struggling to fully understand and involve

in the system. The members have their appointment orders in hand, but no specific terms of reference or deliverables in place. Comparative salaries to this cadre to salaries provided for this level by other states are much lower BPMs draws 15 k pm, BAM 10 K pm and Block ASHA coordinator 8K pm- reconsideration on this would be important to ensure retention of competent people. Most of the BPM's time goes into data entry on different issues, which has made negative impact on the leadership of this cadre.

- It was noted that the BPMU and DPMU officials are involved in putting together the programmatic requirements annually- though without budgeting. Process of PIP preparation at block and district was agreed to be weaker, by the state officials. Supporting mechanism and capacity building for improving this to be initiated soon.

Institutional Mechanisms

- Although the State health Society meetings are held regularly, the MD, NRHM and the SPO informed that they are in the process of streamlining and strengthening these meetings.

- As told by the state level health officials, the state has yet to achieve the full involvement and leadership of District collectors in NRHM, largely due to the varying priorities and busiest schedules of the DCs. This is leading to irregular meetings of the District Health Societies, in some districts.
    - Agenda notes are not self-explanatory; minutes of the meetings not kept properly, nor have regular reviews been done of the action taken on decisions of last meetings.

- Monthly review meetings at the district need to be sharpened- though it appears from the records that these are done regularly, clear articulations of decisions, responsibilities and timelines and follow ups are missing in minutes.

- Block level team meetings, division of responsibilities are areas to attend. No information on planning and review meetings at the block level, except of Health Centre Management Committees and ASHAs were available.

- Health Centre management committees at these facilities give a mixed impression. For example, the committee's involvement was visibly there in the Medziphema CHC (Dimapur) which was able to mobilize a huge amount of community support and participation with excellent institutional processes such as availability of guidelines, adherence, timely meetings, adequate documentation, accounting and reporting mechanisms. However, other CHCs were not able to inform about such level of management.

Supervision & Monitoring:

- Robust policies, guidelines and tools put in place in the areas of communitisation; Rational drug use/ EDL/treatment protocols; vigilance and monitoring committee;

grievance redress committees; supportive supervision and so on. However, dissemination, penetration and ownership on most of these policies and guidelines are very poor though.

  - Knowledge on different guidelines and familiarity to them were minimal both at DPMU team and amongst DPOs. System for proper keeping and access of guidelines were missing too. There were no integrated indexing mechanisms for different communication and guidelines send by district officials to block level and below- they were not aware about whether the blocks are using the proper versions of the guidelines or the outdated ones. The DPMU members and the DPOs were not sure about whether the particular guideline was the final version or it has been revised later.

- Supportive supervision by the block team to the periphery level team members is not happening. Key reason being the lack of such plans/guidelines and provision of mobility support. In the case of ASHA coordinator, one can't expect a proper supportive supervision with the limited monthly support that she gets. While there are more number of ASHA facilitators in other states, the single block coordinator has to cover the entire block in Nagaland, wherein additional mobility support sufficient to cover the requisite distance is a must for ensuring their function. So far their direct interactions with ASHAs are limited to the monthly meetings and to the occasions ASHAs visit there.

RECOMMENDATIONS

- ✓ There is a need of having a lead consultant such as SPM either recruited or assigned to perform this role, who could be held responsible for managing different actions of the technical consultants.
- ✓
- ✓ Induction training to be done. More involvement and leadership of RRC required on these issues.
- ✓ State level supervisory visits to districts need immediate attention and priority improvement. Measures such as State Review Mission adopted by Jharkhand, or supportive supervision model of Haryana could be referred to as examples.
- ✓ A communication and orientation plan to be put in place to improve actualisation of different policies and guidelines.