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EVALUATION REPORT ON PRIMARY HEALTH CENTRES IN NAGALAND

EVALUATION ORGANISATION
(PLANNING AND CO-ORDINATION DEPARTMENT)
GOVERNMENT OF NAGALAND

PREFACE

Primary Health Centers constitute the spearhead of the Rural Health Programme in the stats to ensure better medical facilities to the majority of the rural based population in Nagaland. In this state, the scheme started towards the adhoc-years after the 3id Five Year Plan with a modest beginning and expanded considerably thereafter.

It would be of interns! to know the progress of P. H. Cs. in the state not only to the Government for determining the future course of action with a view to extending the facilities to areas/ population not covered so far but also to genera! Public who are actually supposed to be benefiting from this scheme.

At the instance of the Planning & Coordination Department of the state Government, the Evaluation organization, initiated the Evaluation Study of P.H.C's towards the end of 1978. The field worth was started in 1977 and a part of it was completed in 4977 itself. However, a fresh perusal of the information collected necessitated further collection of information in 1978.

The information was collected in. a specially designed schedule from the 6 (six) selected P. H. C.s /Sub-Centers as it would have' been rather difficult to collect information from all the 11 (eleven) P.H.C s and SO Sub-Centers in the state. However, it can safely be presumed that what is true for the selected P.H.C.s'Sub-Centres would largely hold good for the other P. H. C s/Sub-Centers as well. Apart from gathering information from P.H.C s/Sub-Centre, it was also considered necessary to collect information on views/reactions of actual beneficiaries of the scheme. Thus 6 to 10 beneficiaries were selected at each centre/sub-centre to elicit their views. The village head-men were also consulted to record their impressions on the working of the scheme.

In most of the cases it was observed that proper records were not maintained and the information presented in various tables was based on general impression of the Medical Officers in charge of the P.H.C.s, and hence, might not be very much reliable. Never-theless, an attempt has been made to analyze the information, so obtained and the conclusions drawn may not be far from the actual position obtaining at various centers.

But for the unstinted cooperation of the Directorate of Health Services and the Medical Officers inchoate of various P H.C.s it would not have been possible -to complete this study. I am, duty bound to record my gratitude to them. The beneficiaries also came forward and extended their cooperation, and 1 shall be failing in my duty if I do not acknowledge their help in the conduct of the study, especially the help rendered by the various village headmen.

I shall also thank the investigating staff of the Evaluation Unit who had borne the burden of collecting information from ibe field and tabulation of data. A special mention of Shrj N. Zeliang's Assistant Director, Evaluation name becomes necessary. Viewing the assistance rendered by him not only in collection, scrutiny and tabulation of information, but also in drafting .this report, f gratefully acknowledges the help rendered by him. 1 shall also thank Mrs. Press&nnakumari. B. Stenographer, who helped in typing out the report. My thanks are also due to Shii L. G. .Go swami Joint Secretary Planning who, from time to time, extended his help and gave guidance in the conduct of the study and drafting of the report. .

The Report was placed before the Steering Committee on Evaluation in its meeting held on 4-6-1979 under the Chairmanship of the Hon'ble Deputy Chief Minister. The fmdings/recommandaii-ons contained in the seaport were appreciated by the Committee members. The Director of Health Services was aUo present in this meeting. Her comments/views on some of the, suggestions contained in the report and clarifications on some of the issues raised therein are given ai appendix. ...

In the end, I can only hope that the suggestions contained in the report will lend a helping hand to the Government in better implementation of the scheme for P.H.Cs so that the benefits intended to be extended to the public through this scheme actually accrue to them and the rural population feels assured in matters of health and sanitation.

H.G. GUPTA
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Nagaland : Kohima,

May 1980.

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LIST OF TABLES CONTAINED IN THE REPORT

ABBREVIATIONS USED IN. THE REPORT

1. P.H.C.	- Primary Health Center.
2. S.C	- Sub-Center
3. MO.	- Medical Officer.
4. S.D.M.O	- Sub-Divisional Medical Officer
5. P.M.W.	- Para Medical Worker.
6. H.V.	- Health Visitor.
7. S.I.	- Sanitary Inspector
8. Vacc	- Vaccinator.
9. L.H.V.	- Lady Health Visitor
10. L.D.A. cum S.K.	- Lower Division Assistant Cum store Keeper.
11. A, N, M,	- Auxiliary. Nurse-Cum-Midwife.
12. S/Worker	- Surveillance Worker
13. N.A.	- Not Available
14. N.R.	- Not Reported.
15. M.I.	- Malaria Inspector.

CONTENTS

3. On Duties and Responsibilities.
4. On Medicines.
8. On Opening of *P* H C s/S C.s.
6. On Touring of Staff.
7. On Visit and Supervision.
8. On Immunisation of Children.
9. On Health Education.
10. On Laboratory.
11. On PH.Cs and the Village council.
12. On P.H.C.s and Educational Institution.
13. Conclusions,

VI. Comments/Views of the Health Department on Some of App-I the points raised in the Report.

Chapter I
INTRODUCTION AND BACKGROUND

1.1. Out of the many health programmes undertaken by the Medical Organization, the Primary Health Centre is an important scheme to provide basic minimum medical and heath care facilities to the rural and back-ward people and at the same time to educate them in matters of preventive and promotive health needs.

Position of Primary Health Centres at the all India level.

1.2. In India, it was the Bhore Commitee on Health Survey and Development appointed by the Government of India in 1945 which defines the concept of Primary Health Centres. The Central Council of Health in its meeting held in January 1953 accepted the setting up of Primary Health Centres in each block. Since then the Primary Health Centre emerged as the focal point for the health package. The country has now a net work of 5,301 Primary Health Centres and more than 37,000* Sub-Centres. About 4 230+ Primary Health Centres are functioning with two or more doctors and the rest with one doctor. These centres spread over 5,247* Community Development Blocks with a population of about 60000 to 80000 each.

Objective of the Primary Health Centres,

1.3. The Primary Health Centres (P.H.C.) are entrusted to render multi-purpose services to the back-ward and rural community. Some of these are enumerated below :—

I. Medical Relief through better Hospital Services,
II. Maternity and Child Welfare,
III. Family Planning,
IV. Environmental Sanitation,
V Control of Communicable Diseases,
VII. Spread of Health Education,
VII. School Health, ;
VIII. Collection of vita! Statistics etc.

Growth of P.H.C.s in Nagaland**.**

1.4. In Nagaland the P.H.Cs were started only in the Adhoc-plan years after the 3rd Five Year Plan by opening 6 PHCs with 15 Sub-Centres. During the Fourth Five Year Plan 4 P.H.C.s with 26 Sub-Centres were further opened. Thus at the end of the Fourth Five Year Plan there were 10 P.H.C s and 41 Sub-Centres in the state. The total strength of the P.H.C s in the state at the time of enquiry was eleven. These were as follows ;- 1. Tseminyu 2. Chazuba 3. Ghaspani 4. Peren 5. Chaagtongya fi Mangkolemba 7. Champang 8. Satakha 9 Bhandari SO. Noklak and 11. Samatsor. There were 50 Sub-Centres attached to different P H.C.s in 21 Blocks in the state.

Objective of the study.

1.5 The improvement of health of the rural masses depends largely on the effective and efficient functioning of the P.H.C.s It is also the only means of medical aid being available to the rural people. Hence, in recent years, the Government have been giving much emphasis on the expansion, extension and development of the P.H.C.s in the state. But, so far, the only means of assessment of progress and its impact on the people had been the periodical reviews and return. These by their view nature had inherent limitations in meeting the requirement of a scientific assessment

The Evaluation organisation was, therefore, entrusted with, the job of undertaking a study on the scheme with the following main objectives :—

I. To assess its working and progress,

II, To assess the impact of the scheme on the rural population, and

III. To ascertain its shortcomings and difficulties and to suggest possible measures for removing them,

Scope of the Study

1.6. This study was intended to be a snap study but later on it was considered necessary to cover a wider area of its operation. The main focus of enquiry was on the physical performances of the P.H.C.s and its impact on the beneficiaries/rural population. Due to the non-availability of financial data the analysis of the financial performance of the P- H C. s was not attempted in the report. The study also does not bring out administrative problems faced by the P.H.Cs

Methodology :-

1.7. A random sample of 4 (four) P.H.C.s namely I. Peren *2*. Ghaspani *'A*. Changlongya and 4. Satakha was taken for the study, This was considered to be enough to give a reasonable idea of the functioning of P. H.C.s in the entire state which was having 1! (eleven) P.H.C.s A Sub-Centre under P.H.C Peren and Changioneya were also covered. While there is no Sub-Centre attached to Ghaspani J',H C the one attached to the Sataka P *H.C.* could not be covered A structured schedule' 'I' was used in course of field enquiry for collection of information from the P H C and Sub-Centres and a structured schedule[1] 'II' was used for collection' of information from *the* general public to get their views and comments on the working of the P.H.C/S.C About 10 (ten) respondents were interviewed from each P.H C. areas and 10 (ten) from each Sub-Centre areas. The secondary information was collected from the Government reports as well as from the officials of the concerned department. Eight years data from 1969-70 to 1976-77 have been collected for the purpose of this study.

Imitations.

1 8. The major limitations of the study were non-availability of the required data from the implementing-agency *In* the absence of readily available official records, the Medical Officer Sub-Divisional Medical Officers furnished the information mostly from their knowledge and memory and is, therefore, expected to suffer a great recall lapse,

Chapter II
ORGANISATION AND PERSONNEL

Prescribed norms at all India level.

2.1. The norms prescribed by the Government of India for a Primary Health Centre to be opened was that one Primary Health Centre should be had for rural population of 1,00,000 (One lakh) as per 197l census or for each Community Development Block. The basis of planning a Sub-Centre was to have one Sub-Centre for a rural population of 10,000 (Ten thousand) as per 1971 census.

Prescribed norms in Nagaland.

2.2- In Nagaland, the density of population is relatively low, the villages arc scattered in a very extensive area and are not having adequate transport and communication facilities. Therefore, the ail India norms of coverage as mentioned above was found to be impracticable to follow in Nagaland. Considering the peculiar locational aspect of villages, the Government of Nagaland decided that one Primary Health Centre should cover on an average 20-30 thousand rural population. Accordingly, the norm prescribed by the slate Government with regard to the coverage was 20-30 thousands rural population for a Primary Health Centre. Similarly the norm prescribed for a sub-centre was 5 (five) thousand rural population. It was prescribed that for an efficient and effective working of a P.H.C. there should be four/five Sub-Centres under each Primary Health centre.

Present position of P.H.C /S.C. in Nagaland.

2 3. The present position of the Primary Health Centres and its Sub-Centres in Nagaland is presented in Table-1 below: -

TABLE—I

BASIC PARTICULARS OF EXISTING PRIMARY HEALTH CENTRES/SUB-CENTRES IN NAG ALAND AS ON-31-3-77.

SI No	Type of Centre P.H.C/S.C	Location	Year of Establish-ment.	No of beds	No .of Blocks covered	No of Villages covered.	Approximate Population covered.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	**PHC PEREN**		1954	30	1	61	15,000
	1. Sub-Centre	Heningkunlwa	-	-	-	-	3,500
	2. Sub-Centre	Benreu	-	-	-	-	1,500
	3. Sub-Centre	Chalkot (Althibung)	-	-	-	-	1,800
	4. Sub-Centre	Jaluke	1967	-	-	18	3,000
	5. Sub-Centre	Mowlwa	-	-	-	-	3,500
	6. Sub-Centre	Bongkoleng	-	-	-	-	2,000
	7. Sub-Centre	Khelma	2976	-	-	-	2,500
2.	**P.H.C. TSEMENYI**		1967	12	1	-	3,570
	1. Sub-Centre	Gatashi	1973	-	-	-	1,890
	2. Sub-Centre	Sendenyu	1968	-	-	-	3,890
	3. Sub-Centre	Tesophenyu	1967	-	-	-	3,018
	4. Sub-Centre	Asukika	1972	-	-	-	1,374
	5. Sub-Centre	Lazami	1976	-	-	-	884

3	**P.H.C. CHAZOUBA**		1965	12	1	13	6,895
	1. Sub-Centre	Kikrüma	-	-	-	1	2,330
	2. Sub-Centre	Kilome	1967	-	-	-	1,248
	3. Sub-Centre	Dzülhami	1965	-	-	2	1,135
	4. Sub-Centre	Chetheba	1965	-	-	6	3,271
	5. Sub-Centre	Khezakenoma	1971	-	-	-	1,170
	6. Sub-Centre	Thipuzumi	1977	-	-	1	2,145
	7. Sub-Centre	Lophori	1977	-	-	-	1,090
4	**P.H.C CHANGTONYA**		1967	12	1	4	4,600
	1. Sub-Centre	Yaonyimti	-	-	-	-	800
	2. Sub-Centre	Tuli	1968	-	-	5	6,000
	3. Sub-Centre	Kangtsutuluba	-	-	-	-	3,700
	4. Sub-Centre	Asangma	1973	-	-	-	1,400
	5. Sub-Centre	Yisemyong	1976	-	-	-	500
5	**P.H.C. MANGKOLEMBA**		1967	6	-	7	2,100
	1. Sub-Centre	Salulemony	1977	-	-	-	350
6	**P.H.C. SATAKHA**		1957	12	1	34	12,676
	1. Sub-Centre	Akhulaito	-	-	-	-	3050
	2. Sub-Centre	Tizu-Island	-	-	-	-	2,900
	3. Sub-Centre	Hoshepu	-	-	-	-	2,875
	4. Sub-Centre	Satoi	-	-	-	-	2,645
	5. Sub-Centre	Tokiye	1976	-	-	-	1,060
7	**P.H.C BHANDARI**						
	1. Sub-Centre	Changpang					
	2. Sub-Centre	Sanis					
	3. Sub-Centre	Aitepong					
	4. Sub-Centre	Moilang					
	5. Sub-Centre	Ralam					
	6. Sub-Centre	Baghty					
	7. Sub-Centre	Longtsung					
8	**P.H.C. NOKLAK**		1970	12	1	2	8,824
	1. Sub-Centre	Chingmai	-	-	-	-	1,899
	2. Sub-Centre	Pangsha	-	-	-	-	2,305
	3. Sub-Centre	Chahglanshu	-	-	-	-	4,946
	4. Sub-Centre	Baru Naisang	1976	-	-	-	1,943
	5. Sub-Centre	Mapang	1976	-	-	-	4,303
9	**P.H.C. SHAMATOR**		1970	12	1	5	5,096
	1. Sub-Centre	Sangpur	1971	-	-	2	2,352
	2. Sub-Centre	Panso	1971	-	-	2	3,448
	3. Sub-Centre	Anachinre	-	-	-	-	726
	4. Sub-Centre	Tsorrongto	-	-	-	-	900
	5. Sub-Centre	Samkhumty	-	-	-	-	2,577
	6. Sub-Centre	Mimi	1974	-	-	-	2,657
10	**P.H.C CHAMPANG**		1955	12	1	14	10,100
	1. Sub-Centre	Chenwetnyu	1965	-	-	7	3698
	2. Sub-Centre	Totok	1970	-	-	5	1578
	3. Sub-Centre	Sangyu	-	-	-	-	1163
	4. Sub-Centre	Chungnyu	1977	-	-	-	1618
11	**P.H.C. GHASPANI**		1958	20	1	95	15,000

2.4 It has been considered by the Government of Nagaland, that in order to function effectively there should be four/five Sub-Centres attached to each PH.C But it has been observed that in actual practice, there was no proper system. The fact that Peren, Chazuba, and Bhandari P. H. C s have 7 (seven) Sub-Centres attached to each P. H. C , Tseminyu, Satakha, Noklak and Sha*mator 5 (five) Sub-Centres each, Changtongya and Champang 4 (four) Sub-Centres each and, Mangkoleraba one Sub-Centre under it, while there being no Sub-Centre under Ghaspani P.H C. This uneven distribution of sub-Centres under various P H.C s indicates that proper criterion was not fixed and careful consideration was not made before opening a P. H. C. or Sub-Centres. It appears that the *P*. H. C and Sub-Centres were opened according to exigency of the situation and no proper system of opening P. H. C s Sub-Centres was evolved to ensure an optimum benefit to the rural population from them.

2.5. During the course of the present study, the Evaluation team had an opportunity to see the records of the various sampled P H.C. as also the records maintained at the Headquarteis namely the Directorate of Health Services. lt is really surprising that the records maintained at the centre level depict a different picture than those maintained at the Headquarters. It shows that there is no relationship between the two sources of information. The information collected from the two sources present at times, a contradictory picture which leaves one in doubt about the veracity of one information over the other. It has been observed that as per records of the Medical Directorate there were 7 Sub-Centres under Peren, 4 Sub-Centres under Changtongya and 5 Sub-Centres under Satakha. But, the Primary Health Centres authorities contacted by the Evaluation team had maintained that under Peren P. H. C, there were 3 Sub-Centres only, one Sub-Centre under Satakha and no Sub-Centre under Changtongya and Ghaspani. In fact in actual practice, it is the record of the P. H C. themselves and not of the Directorate of Health Services which matters for, Sub-Centre under various P. H. C are being operated upon by the P. H. C. authorities themselves This is likely to be the case with other P. H.C.s which have not come in the sample for the current study as well. In these conditions how other S. C.s are running is any-body's guess.

2.6 Due to non-maintenance of proper records by the Department, it was not possible to analyse the coverage of blocks, villages and Hie rural population. The analysis of the available data will not give any idea of how many blocks-, villages and rural population have been covered and how many are yet to be covered although a very rough idea about its coverage has been provided in table-I. However, even the year of establishment is not available in most of the cases. In view of these limitations further discussion on these aspects was not possible. Organizational Set-up.

2.7 The over-all administrative and financial control rests with Hi;: Director of Health Services, Nagaland. Under the control of the Director there are Civil Surgeons and Sub-Divisional Medical Officers. Usually, the Primary Health Centres are under the administrative and technical Control of the Civil Surgeons or Sub-Divisional Medical Officer of the respective District or Sub-Division. In Nagaland, the Medical Services are operated

on the basis of the old set-up of 3 (-three) Districts viz. Kohima, Mokokchung, and Tuensang although there are now 7 (seven) Districts. In those Sub-divisions which-have now become Districts, the Primary Health Centres are under the control of Sub-Divisional Medical Officers whereas in the old Districts the Primary Health Centres are under the control of the Civil Surgeons. The responsibilities of executing different schemes under the P H. Cs/Sub-Centres devolves on the Medical Officers incharge of the Primary Health Centres, and as such he is in over-all charge of the staff attached to the Primary Health Centres and the Sub-Centres under them Each Sub-Centre is headed by a Pharmacist with other subordinate staff. Staffing Pattern.

2 8. An idea about the organisational structure can be bad from the above description. The Goyt. of India have laid down some specific norms for a 6 bedded P. H C. The Govt. of Nagaland have also adopted a specific pattern of staffing a 12 bedded and a 30 bedded wards attached to various P. H. C.s For a 6 bedded P H. C. no specific norm is prescribed. Nevertheless, the staff is provided according to exigencies of the situation subject to a limit placed for a. 12 bedded P. H C Similarly for a 20 bedded P H. C , the staff is provided according to requirements keeping in view that it should not exceed the one prescribed for a 12 bedded P. H C The norms prescribed., by the Government of India for a 6 bedded P. H. C. vis-a-vis the norms prescribe by the Govt. of Nagaland for a 12 bedded and 30 bedded P H C.s are given in Table-II (A). In Table-II (B) is presented the staffing pattern m the P. H. C.s covered under the study.

TABLE-II (A)
STATEMENT OF STAFFING NORMS IN P.H.C.'S

Category		All India	Nagaland	
		6 Bedded.	12 Bedded.	30 Bedded.
(l)		**(2)**	**(3)**	**(4)**
1.	Medical Officer	1	13	2
2.	Staff Nurse	-	1	5
3.	Health visitor / P. M. W.	1	1	-
4.	Pharmacist.	1	1	2
5.	Sanitary Inspector	1	1	-
6	A. N. M.	4	1	-
7	Dai	-	1	1
8	Vaccinatator	-	1	1
9.	L D. A. Cum. Store Keeper	-	1	2
10	Driver	1	1	2
11	Ayah	-	1	2
12	Medical Attendant.	-	-	3
13	Cook	-	2	-
14	Sweeper	-	2	1
15	Personal Peon for M.O	-	1	-
16	Chowkidar	2	1	1
17	Health Inspector	1	-	-

18	Lab Technician	-	-	1
19	Nursing Sister	8	-	1
20	Basic Health Worker	2	-	-
21	Auxiliary	-	-	-
22	L.D.A	-	-	1
23	Lab Attendant	-	-	1
24	Dresser	-	-	1
25	X-Ray Technician	-	-	1
26	Office Peon	-	-	1

(Source: - Directorate of Health-Services.)

2.9. There is no uniformity in the strength of staff in all the P.H.C.s as is seen from table-H on the previous page. This is due to the fact that the number of beds maintained by these centres differ (there are 6 bedded, 12 bedded, 20 bedded, and 30 bedded P.H.C.s.) However, the nature of job is such that each P.H.C. may require a minimum number of staff in a particular job irrespective of the size of the P. H. C. To illustrate, each P. H C. should have a nursing Sister, lady health visitor, etc. It will be seen from table-II (B) that no such posts were sanctioned for some of the P. H. C s under study. Further, in some P. H C.s although sanction existed, the staff were not in position. A special mention in this context may be made of Peren P H C. where the sanctioned strength of staff nurses were 6 whereas only one was in position In absence of the required staff, it will be hard to imagine (hat the P.H.C.s discharge (heir assigned duties properly and are able to accomplish their objectives. It is, therefore, felt absolutely necessary that required staff is made available to all the P. H. Cs/Sub-Centres, immediate steps have to be initiated by the Government in this direction

TABLE—II(B)
STAFF POSITION OF P.H C, AS ON DATE VISIT (EXCLUDING SUB CENTRES)

Category of Staff	P.H.C Peren		P.H.C. Chantongya		P.H.C Ghaspani		P.H.C. Satakha	
	Sanctioned	In Positions	Sanctioned	In Positions	Sanctioned	In Positions	Sanctioned	In Positions
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1. Medical Officer	2	2	1	1	1	1	1	1
2. Pharmacist	1	1	1	1	1	1	1	1
3. Lady Health Visitor	1	1	Nil	Nil	1	1	Nil	Nil
4. L.D.A. Cum S.K.	1	Nil	1	1	1	1	1	1
5. ANM	3	2	2	2	2	1	2	2
6. Dresser	2	2	1	1	1	1	1	1
7. Vaccination	1	1	2	2	1	1	1	1
8. Sanitary Inspector	1	Nil	1	1	1	1	Nil	Nil
9. Dai	1	1	1	1	1	1	1	1
10. Medical Attendant	9	9	5	5	5	5	3	3
11. Ayah	2	2	2	2	Nil	Nil	3	3
12. Chowkidar	1	1	Nil	Nil	Nil	Nil	1	1
13. Store-Chowkidar	1	1	Nil	Nil	Nil	Nil	Nil	Nil
14. Cooks	2	2	2	2	Nil	Nil	3	3
15. Sweeper	4	4	2	2	Nil	Nil	1	1
16. Driver	1	1	1	1	1	1	Nil	Nil
17. Non-Medical Inspector	1	1	Nil	Nil	Nil	Nil	Nil	Nil
18. Surveillance	1	1	Nil	Nil	Nil	Nil	Nil	Nil
19. S/Worker	2	Nil	Nil	Nil	Nil	Nil	Nil	Nil
20. P.M.V.	1	1	‘’	‘’	‘’	‘’	‘’	‘’
21. Lab Technician	1	-	‘’	‘’	‘’	‘’	‘’	‘’
22. Lab Attendant	1	-	‘’	‘’	‘’	‘’	‘’	‘’
23. M/I	1	-	‘’	‘’	‘’	‘’	1	1
24. B.C.G. Technician	1	1	‘’	‘’	‘’	‘’	Nil	Nil
25. Small Pox Supervision	Nil	Nil	1	1	1	‘’	‘’	‘’

[Source : Field Investigation]

Chapter –III

WORKING OF THE PRIMARY HEALTH CENTERS.

Medical Relief.

3. 1. Normally, Preventive and Promotive functions of a Primary Health Centre received more attention than the curative ones which were regarded as the work of Hospital. However, due to the prevailing condition of mal-nutrition, unhygienic living conditions and ignorance of rural population, there is high incidence of different kinds of diseases especially in rural areas. The P.H.C.s are the only source through which medical aid is made available to the rural people. Hence, rendering effective medical treatment to the people is also incorporated as a function of P. H. C.

3.2. In Nagaland, the Primary Health Centres are mostly engaged on curative aspect of its functions and thus are performing the duties of a Hospital rather than of a P. H. C. In the course of visits to the centres, the Evaluation team was informed by the Medical Officers and their staff that they felt, their existence was only for remedial measures. .During the course of the study, information on various aspects including the one on number of indoor-outdoor patients treated was collected. The year-wise break-up of patients treated by each Centre selected for the study is presented in the Table-Ill on the next page.

3. 3. It may be seen from the table-Ill at the next page that the number of patients (indoor as well as out-door) does not exhibit any increasing or decreasing trend over years. The figures are more or less uniform with slight variation in one year over the other. For Peren P. H. C. the figures for indoor patients could not be collected for the years S969-7G to 3974-75 as the records were not available. However, the figures for the years 1975-76 and 1976 77 show that a larger number of patients were treated at Peren P. H. C. as compared to those at other centres surveyed for the study. At Ghaspani and Changtongya P. H. C.s the average daily number of patients varied from 2*1* to 34 per day. At Satakha P. H. C, however, the average daily number of patient:, treated was rather low and varied from 5 to 7 per day during 1969-70 to 1976-77. No special reasons could be adduced to these low figure of the Satakha P. H. *C.* On the whole, there was no notable difference in the number of cases treated between the years 1969-70 to 1976-77. This may be taken as an indication to show that the scheme could not gain the confidence of the general public even after a lapse of a decade of its functioning and especially in view of the fact that the Centres were doing only curative work.

3. 4. If the number of patients being treated, along with other duties of the P. H. C. sis any guide for the efficient working of the P. H. C. s one would wonder on the deplorable functioning of the P. H. *C.s* in Nagaland. The Statistics of one of the P. H. C. s in tamilnadu state namely Salem district shows that there were as many as 126 patients being treated per day on an average. This is, along with other jobs assigned to the

TABLE-III
CENTRE-WISE BREAK-UP OF OUTDOOR AND INDOOR PATIENTS TREATED AT VARIOUS SELECTED- P H. C.' s.

Years	P.H.C. PEREN			P.H.C. Changtongya			P.H.C. Ghaspani			P.H.C. Satakha		
	Outdoor patients treated (No.)	Indoor patients treated (No.)	Average No. of patients treated per day (No.)	Outdoor patients treated (No.)	Indoor patients treated (No.)	Average No. of patients treated	Outdoor patients treated (No.)	Indoor patients treated (No.)	Average No. of patients treated	Outdoor patients treated (No.)	Indoor patients treated (No.)	Average No. of patients treated per day (No.)
1	2	3	4	5	6	7	8	9	10	11	12	13
1969-70	N. A.	154	-	1374	398	4,85	9451	665	2772	1760	120	5.15
1970.71	N. A.	335	-	8727	355	24.88	9702	677	28.44	1859	131	545
1971-72	N. A.	523	-	12,033	450	34.02	9901	617	29.04	1731	120	5.07
1972-73	N. A.	555	-	7468	627	22.18	9177	633	26.8S	1760	124	5.16
1973-74	N. A.	355	-	7515	637	21.79	10,716	740	31.52	2600	111	7.43
1974-75	N. A.	-	-	9796	584	28.44	0,176	622	29.5S	1959	141	5.75
1975-76	19,876	615	56.13	9912	568	28.71	0,816	530	31.08	1687	146	5,02
1976-77	17.885	806	51.21	9676	559	28.04	N. A.	N A.	-	N. A.	N.A.	-

[Source : Field Investigation]

P. H. C. s. Similar will be the position of other P. H. C. s in other stales, in comparison to that, in Nagaland the average daily number of patients varies from 22 to 34 (Satakha P. H. C. is not taken in to account because of its rather very low figure)

3.5. It is true that the number of cases treated depend upon many factors for example general health of the local population, their faith in P. H. C.s treatment etc. But it is not understandable as to why the P. H C.s should not carry out the other functions such as Health Education, School Healthy Environmental Sanitation etc. When the number of cases is so less to be treated in the centres, there is all the more reason had the centre authorities could have time and resources at their disposal to attend to such other allied duties.

3. 6. . In table- IV are presented Statistics relating to the - number of indoor patients in various P. H. C. s who died. It may be seen from this table that the death rate of indoor

patients at Satakha P. H. C. is the highest in all the years and' is rather alarming. It is 5 to 9 percent of admitted patients. As the age wise and cause wise breakup of indoor patients who died during the years is not available it is not possible to arrive at some valid conclusions with regard to reasons of death; But the number of deaths indicate that the medical facilities available in this P. H. C. are far from satisfactory and much is left to be desired. The death rate of indoor patients at Peren and Gbaspani is not so high. The figures for Changtongya P. H. C. could not be collected.

TABLE-IV

NUMBER OF INDOOR PATIENTS WHO DIED

Year	P.H.C. Peren			P.H.C. Ghaspani			P.H.C. Chantongya			P.H.C. Satakha		
	Indoor Patients treated (No.)	Indoor patients died (No.)	Percentage Col. 3 to Col.2	Indoor Patients treated (No.)	Indoor patients died (No.)	Percentage Col. 6 to Col.5	Indoor Patients treated (No.)	Indoor patients died (No.)	Percentage Col. 9 to Col.8	Indoor Patients treated (No.)	Indoor patients died (No.)	Percentage Col. 12 to Col.11
1	2	3	4	5	6	7	8	9	10	11	12	13
1969-70	154	2	1.30	665	3	0.44	398	N.A.		120	6	5,00
1970-71	335	2	0.60	677	4	0.60	35S	N.A.		131	10	7.63
1971-72	523	7	1.34	697	1	0.14	450	N.A.	_	120	11	9.17
1972-73	555	9	1.72	633	2	0.32	627	N.A.	-	124	3	2.42
1973-74	355	4	1.13	740	4	0.54	637	N.A.	-	111	9	8.1!
1974-75	N.A.	N.A.	N.A.	622	2	0.32	584	1	0.17	141	12	8 51
1975-76	613	5	0.82	530	3	0.57	563	2	0.35	146	13	8.90
1976-77	113	N.A.	N.A.	-	-	-	559	7	1.25	—		

(Source > Field Investigations)

[Source : Field Investigation]

3. 7. It may be seen from table- V that the refereral services seem to be very exceptional cases in all the Centres except Satakha where some not- able cases were referred to District Hospital. These figures *also go lo indicate that the facilities available at Satakha P. H. C. are inadequate.

Maternity And Child Welfare

3- 8. , Maternity and Child Welfare Service is another important function of a P. H. C. The Maternity Services are, Pre-natal, Natal, Post-natal as well as mother-craft, whereas the Child Welfare Services are the health supervision, treatment of ill health, correction of defects.

TABLE-V

NUMBER OF CASES REFERRED TO DISTRICT HOSPITALS

Year	P.H.C. Peren			P.H.C. Ghaspani			P.H.C. Chantongya			P.H.C. Satakha		
	Indoor Patients treated (No.)	Cases referred to District Hospital (No.)	Percentage Col. 3 to Col.2	Indoor Patients treated (No.)	Cases referred to District Hospital	Percentage Col. 6 to Col.5	Indoor Patients treated (No.)	Cases referred to District Hospital (No.)	Percentage Col. 9 to Col.8	Indoor Patients treated (No.)	Cases referred to District Hospital (No.)	Percentage Col. 12 to Col.11
1	2	3	4	5	6	7	8	9	10	11	12	13
1969-71	154	N. A.	_	665	5	0.75	398	N.A.	-	120	30	25.00
1970-71	335	5	1,49	577	6	0.89	355	N.A.	-	151	49	3.74
1971-72	533	10	1,91	697	6	0.88	450	N.A.	-	120	29	54.17
1972-73	565	9	1,62	633	5	0.79	627	N.A.	-	124	11	8.97
1973-74	355	6	169	740	3	0.95	657	N.A.	-	111	6	5.41
1974-75	N.A	N.A.	N.A.	62!	6	0.96	584	N.A.	-	141	3	2.13
1975-76	613	2	0,33	530	3	0.57	566	5	0.88	146	9	6.16
1976-77	113	2	1.50	-	-	-	559	1	0.18	-	-	-

(Source > Field Investigations)

[Source: Field Investigation]

TABLE—VI
PROGRESS OF ACTIVITIES ON MATERNITY AND CHILD WELFARE SERVICES IN P.H.C.s

Year		Maternity Care				Child Care		
						Cases of advice tendered	Discussion group or classes conducted	Mother benefited
	Pre-natal cases treated	No. of cases treated	No. of deaths	No. of cases treated	No. of deaths			
1	2	3	4	5	6	7	8	9
P.H C, Peren								
1971-72	5	4	—	—	—	—	—	—
1972-73	5	3	—	—	—	—	—	—
1973-74	5	2	—	—	—	----	—	—
1974-75	—	—	—	—	—	—	—	—
1975-76	8	2	—	—	—	—	—	—
P.H.C. Changtongya								
1971-72	-	29	-	24	-	24	—	—
1972-73	-	61	-	60	1	59	—	—
1973-74	60	51	-	38	1	38	—	—
1974-75	36	37	-	15	-	15	—	—
1975-76	61	27	-	-	-	-	—	—
P.H.C. Satakha								
1971-72	**Nil**							
1972-73								
1973-74								
1974-75								
1975-76								
P.H.C Ghaspani								
1971-72	61	46	-	35	-	-	-	-
1972-73	68	51	-	31	-	12	-	-
1973-74	78	49	1	26	-	18	20	10
1974-75	81	62	-	20	-	14	12	12
1975-76	89	58	-	25	-	20	10	10

3. 9. The performance with regard to Maternity and Child Welfare Services in Nagaland are found to be much discouraging in view of the fact that only a very small number of cases have been performed by all the centres. The Table-VI presented below shows the progress of activities on Maternity and Child Welfare Services in the P. H. *C.* s

3.10 The data presented in Table-VI is a clear indication that no centre could perform the task of Maternity and Child Care cases adequately. Infect, a nil performance was recorded in Satakha Centre and the performance in Peren Centre was almost nil, Ghaspani and Changtongya bad shown at least some progress on maternity cases even though number of cases is small. Not a single centre could conduct group discussion on child care. An interesting record was maintained in Ghaspani centre where each group discussion consisted of only one mother. This is very unlikely to happen and it clearly shows that the records are not maintained properly. In actual practice, the performance on maternity and child health cares in all the P.H.C.s appears to be nil.

Family Planning

3.11 The progress with regard to Family Planning in Nagaland is quite negligible. Nagaland is a state where .majority of the people-regard that Family Planning is against their conscience and belief. Hence, neither the people came forward for Family Planning nor the medical Department took the initiative to propagate and convince (he rural populace about its desirability. The Evaluation Unit after careful consideration of the progress of the P.H.C. s on Family Planning as well as by interviewing the people through a structured schedule has come to the conclusion that the scheme on Family Planning in Nagaland has been a total failure so far and it will take some more time to educate the people about the importance of Family Planning Welfare. But there is no gainsaying the fact that unless a Family is limited the standard of living of the local population is not likely to improve very much.

Environmental Sanitation

3. 12. In spite of the fact that without a proper Environmental Sanitation many a. health programme undertaken by the department is likely to give only a temporary relief. Despite a lot of time, energy and money, having been spent, the Primary Health Centres do not appear 10 have done anything worth-while on this important function of the P. H. C The performance with Regard to Environmental Sanitation in ail the P H. C. s is virtually nil. The staff appeared to be fully satisfied with their duties according to their job chart within the P. H. C. itself. Even the Medical Officers incharge of the P H. C did not appear to' be aware of this important aspect of P H C s function nor did they care to pay any attention to it.

Control of Communicable Diseases.

3.13 Diseases such as Malaria, Tuberculosis, Leprosy, Dysentery, Skin diseases etc., are easily communicable to one another. A large proportion of our rural population is badly affected by these communicable diseases, As such, a Primary Health Centre is expected to and entrusted with the job to pay special attention to eradicate and control these dreadful communicable diseases

3. 14. Except specialised disease control programmes of the Government (Viz. National Malaria Eradication Programme, Smallpox Eradication Programme, Tuberculosis Control Programme etc) no proper attention seems to have been paid by the Primary Health Centres in Nagaland for Control of Communicable diseases. Due to the no availability of

records from the implementing departments on the performance of the P. H. Cs. with regard to control of Communicable diseases no assessment of progress over the years could be made However, it is gathered through discussions that the performance in this regard is still quite negligible. The P. H C, have, therefore, to pay a special attention towards this problem as well. Spread of Health Education.

3. 15. Health Education plays an important role in preventing diseases which are a source of great health hazard in urboan /rural areas. How a man can lead a healthy life by adopting certain ways of living is the objective of health education. The aim of health education is, therefore to make the public know the causes of different diseases and how best these could be prevented by taking precautionary measures

3. 16. Unfortunately, the P, H. C s in Nagaland are not paying due attention to Health Education, InTable-VlI is presented the information on i) number of inspection carried out -by the P.H.C staff for ensuring Health and Sanitary condition, ii) number of occasions where P H.C. staff discussed health problems with villagers and Hi) number of group discussions, organised by P. H. C.s The data present a very dismal picture on these aspects and it can be presumed that the performance of (he P. H- C s in this regard is rather disappointing.

3. 17. The data presented in the table are based on the verbal information given by the M.O. at the time of the Evolution Teams visit to the Centres. It has been reported by the Medical Officers that the Centres are actually doing nothing on health education, In absence of any record we have to rely on the verbal information obtained from the various P. H.C. s But considering the limitation of such information further-analysis is not attempted. Nevertheless, one cannot escape concluding that much needs to be desired and done by the P. H. C, s in respect of health education as well. School Health.

3.18. The School Health Services consist of detection and treatment of diseases amongst school children. School Health Sanitation, Improvement of Nutrition, Physical Education and School Health Education-through teachers etc.

3. 19. The performance of the P.H.C. in the field of School Health *h* also really discouraging. The Medical Officers of the selected P. H. C. s did not appear to be even aware of this requirement that the

TABLE NO – VII
INFORMATION ON HEALTH EDUCATION

	P.H.C. Peren			P.H.C. Ghaspani			P.H.C. Changtongya			P.H.C. Satakha at group		
Year	No. of inspection for ensuring health and sanitary condition.	No. of occasion when P.H.C. staff discussed health problems with village.	No. of group discussion organized by P.H.C. staff.	No. of inspection for ensuring health and sanitary condition.	No. of occasions when P.H.C. staff discussed health problems with villagers.	No. of group discussion organized by P.H.C. staff.	No. of inspection for ensuring health and sanitary condition.	No. of occasions when P.H.C. staff discussed health problems with villagers.	No. of group discussion organized by P.H.C. staff.	No. of inspection for ensuring health and sanitary condition.	No. of occasions when P.H.C. staff discussed health problems with villagers.	No. of group discussion organized by P.H.C. staff.
1	2	3	4	5	6	7	8	9	10	11	12	13
1971-72	-	-	-	-	10	-	3	2	-	-	-	-
1972-73	-	-	-	5	10	-	3	2	-	-	-	-
1973-74	-	-	-	6	10	-	3	2	-	-	-	-
1974-75	10	4	-	6	10	R	3	2	-	-	-	-
1975-76	15	4	-	7	10	10	3	3	-	-	-	-

(source:- filed investigations)

School Health Services is also one of the important functions of a P.H.C. The Evaluation study team was furnished with some data with regard to the performance on the School health Services But these details are not beyond doubts as the figures furnished, are only, on the basis of verbal information given out by Medical Officers from their memory as no records in this connection were maintained by the Nevertheless, the figures so obtained are presented in Table-VIII below:-

TABLE NO – VIII
INFORMATION ON SCHOOL HEALTH SERVICES

Year	P.H.C. Peren P.H.C. Ghaspani				P.H.C Satakha		P.H.C. Chang-tongya.	
	No. of school visited by P.H.C. staff.	No. of children examined	No. of school visited by P.H.C. staff	No of children examined	No. of school visited by P.H.C. staff	No of children examined	No. of school visited by P.H.C. staff	No of children examined
1	2	3	4	5	6	7	8	9
1971-72	-	-	-	-	-	-	1	150
1972-73	-	-	6	250	-	-	1	150
1973-74	-	-	7	300	-	-	1	200
1974-75	2	80	5	240	-	-	1	200
1975-76	3	150	6	250	-	-	1	500

(Source : Field Investigation)

3.20. It had been reported that the visits . to school were only at the time when there was out break of diseases such as Cholera etc. But the veracity of information furnished is not beyond a reasonable doubt and as such much reliance either on the information presented or on the statements of MO of the selected P. H. Cs., cannot be placed. Further, the school health services such as detection and treatment of diseases amongst school children, sanitation, Physical Education, School Health through teachers etc were not taken up by the P. H. Cs so far at all.

Collection of Vital Statistics.

3.21. No health programmer can be formulated effectively without a reliable and accurate; vital Statistics relating to the population, brittle and death rates, incidence of diseases etc. Without having basic information on those aspects the efforts initiated may lead to wastage of money, and material resources. Hence collection of vital statistic has been included as an important function of the P. H. C. 3.22 While the statistics on births and. deaths are being collected under the aegis of the. department of Economics and Statistics, the collection of Statistics on immunizations, maternity and child health.

prevalence of diseases etc. are the functions of the P *H.C.s* Unfortunately, this important function-also remains unattended to by. the P. H. C in Nagaland.

Medicines and Equipments.

3.23. At present, purchase of medicines and equipments were made by the Civil Surgeon for the P. H. C./Sub-Centres under their respective jurisdiction. The medicines/equipments are supplied monthly by the civil Surgeons to the P. H. C /Sub-Centres through their respective Sub- Divisional Medical Officers on the basis of indent placed by the Medical Officers of the P. H. C.s. At the time of making purchases- of medicines and equipments by the civil Surgeons, the Medical Officers of the P. H.C.s were not consulted with regard to their likely requirements for their P. H. C.s/Sub Centres.

3. *24.* It had been reported by the Medical Officers of the P. H. C.s surveyed that the medicines supplied to the centres were not at all adequate. It had also been reported that medicines for the treatment of even common diseases (eg. for treatment of Scabies, Round-worm, etc.) were not received by the P. H. C.s because such medicines were said to have not been available in the Central Medical Store. Complaint by all the P. H. C.s under-study on shortage of even common medicines show that all was not well with the procurement of medicines by the Civil Surgeons which needs immediate correction by the Government.

3. 25. At the time of placing their indents, the Medical Officers . should also follow some proper procedure based on their expected requirement during the year. At present, the normal practice of placing indent by the M. O. is "Check the stock position and place indent of the medicines to replenish the old stock". This practice does not seem to be advisable because a medicine which is widely in use in a particular time, place and season may not be so much necessary at another time, place and season. Therefore, there should be a specific basis on which indent of medicine* is prepared.

3.26. Stock verification of Medicines and equipment was never done by the Department. It had been reported by some Medical Officers of the P. H. C.s that the stock verification was usually done by the Accountant Genera', Nagaland every year. This is a misstatement of fact which clearly shows that the Medical Officers were oblivious of the procedure of stock verification. It is surprising that the Medical department could not realise the necessity and usefulness of stock verification of medicine and equipment till now.

3. 27 In order to avoid loses due to improper storage of medicine and not so careful handling, "proper medical storage facilities should be provided where there is no storage facilities and the importance of proper handling emphasized on those concerned with the job.

3.28. The views expressed by the Medical Officers storage facilities are presented in table-IX below:-

TABLE NO.—IX
VIEWS OF THE MEDICAL OFFICERS ON MEDICINE AND STORAGE

M.O.'s Reporting supply of Medicines to be		M.O's Reporting Procurement of Medicines.		Facilities of Storage	
Sufficient	Not sufficient.	received in time	Not in time	Adequate	Not adequate
1	2	3	4	5	6
90 %	100 %	75 %	25%	75 %	25 %

3 29 It had been reported by J00% of the respondent that the supply of medicines was not sufficient for the .use in the centre. On further enquiry it had been reported that not only the supply was inadequate but more often than not the medicines which tile indented were substituted by other medicines not so much required. Some Medical Officers even went to the extent of saying that forced by the circumstances they were prescribing medicines rather unwillingly after seeing the stock and supply position of the medicines. However, the supply of medicines to the centre in times does not scam to be a great problem except that type of medicines indented were not received by them. It is encouraging to see that 75 %. of the centre were provided with storage facilities. However, wherever such facilities were not available these should be made available to them.

During and Inspection.

3.30. Operational efficiency of the scheme depends not Only on proper functioning of the centres but on frequent visits to the villages under their charge by the staff of the P. *H. C*. If the staff arc engaged on performing their duties only at the Primary Health-Centres the main objective of providing minimum needs to rural poor will never be a success. Purposeful, meaningful and effective touring by the staff of their areas is, therefore, a prerequisite through which the rural masses could get the real minimum benefit out of the schemes. Frequency of tours undertaken by the staff of the P. H C. are presented in table X (A) on the next page.

3.31 It is strange to see that not a single time the field staff of all categories had undertaken tour in Peren and Changlongya" P. H. C. In. such a situation efficient and effective implementation of the scheme is afar cry. Unless the field staff perform their duties by undertaking extensive tour, the P H C. cannot gain the confidence of the general' public and the purpose of spreading health knowledge in the rural areas through the centres can never be achieved. In the absence of records being maintained, the figures were furnished by the Medical Officers; from their memory and general impression- Hence, it is difficult to say whether the data furnished by the Ghaspani and Satakha Centres are actually reliable. Similarly it is difficult to vouchsafe the veracity of' statement of M O. Percn and Salakha Centres in so far as the touring days of M.O. at

TABLE NO.—X (A)
INFORMATION ON TOURS OF STAFF

Items	1973-74				1974-75				1975-76			
	M.O.	H.V.	S. L.	Vacc	M.O.	H.V	S. L.	Vacc	M.O.	H.V.	S.L.	Vacc
1	2	3	4	5	6	7 .	8	9	10	11	12	13
P.H.C. Peren												
No. of days on tour.	-	-	-	-	64	-	-	-	150	-	-	-
No. of villages visited	-	-	-	-	8	-	-	-	9	-	-	-
No. of cases treated	-	-	-	-	200	-	-	-	150	-	-	-
P.H.C. Changtongya												
No. of days on tour	81	-	-	-	70	-	-	-	97	-	-	-
No. of villages visited	6	-	-	-	5	-	-	-	5	-	-	-
No. of cases treated.	51	-	-	-	30	-	-	-	60	-	-	-
P.H.C. Ghaspani												
No. of days on tour	50	40	-	120	48	35	39	135	52	42	45	150
No. of villages visited	1	20	-	25	9	25	12	25	10	25	25	25
No of cases treated	251	39	-	2212	269	45	-	7298	301	63	-	3510
P.H.C. Satakha												
No of days on tour	60	120	-	165	60	120	-	150	60	120	-	162
No of villages visited	34	34	-	32	34	54	-	32	34	34	-	32
No. of cases treated.	600	300	-	1000	500	290	-	1070	632	295	-	1079

(Source :-Field Investigations)

these centres are concerned. The M. O. Peren, for example, was stated to have been on tour for 150 days in ; 1975-76 and visited 9 villages during this period. This is highly exaggerated figure and could not be taken as dependable. Similarly the Satakha M O's, claim of reaming on tour for 120 days in 1975-76 ! did not appear to be correct. Despite the limitations of the above data, one thing is clear that in Ghaspani and Satakha, the services of field staff were being utilized for sending them to rural sjide I on P.H.C. work whereas in Peren and Changtongya the services) of j field staff were not being utilised at all in this direction No proper reasons could be adduced by the M. O.s. of the P. H. C. in these cads.

Transport

3.32. All the sample P. H. C s were provided with a Jeep each The Jeep is meant for the use of Doctors and their staff for the performance of their normal duties on health extension and medical relief as well as for visit to Sub-Centres and lifting of emergency patients and for Transporting patients from the P. H. C.s to the General Hospitals in exigencies. It was reported by the Medical Officers in most of the P. H. C.s that the vehicle attached to the Centres was frequently out of order But this does not appear to be a reasonable excuse The vehicles must be maintained properly and used for the purpose required.

Staff of the P. H C s/S. C. s

3, 33. Efficient and effective functioning of the Centres depend mostly on staff. The first requisite is that the staff sanctioned are posted in various P.H.C.s At present in most of the centres the actual sanctioned strength is not in position. If the staff employed were- not properly trained or if the willingness lo serve was lacking the scheme cannot be a success. The views expressed by the Medical Officers at Peren and Tuli carters are that the staff employed in the centres were not properly trained in the job with the result that inspire of their long services their performance was very poor. It was reported that due to the appointment of unqualified personnel, the staff were not knowing what was expected of them. To cite an example, an illiterate vaccinator could not submit his report on how many persons had been vaccinated and in which villages etc. Delay in appointment of staff was reported to be another handicap for the smooth functioning of the centres. the genuine grievances of the M. O. in this respect need to be carefully looked into by the Govt. and remedial measures taken so that the P.H. C. s start functioning properly.

On Building.

3-34. All the sampled P. H. C. s and their sub-centres were provided with Government accommodation. The land at Peren and Tuli Centres was provided by individuals, at Changtongya and Gaspani it was provided by village community while at Satakha and Jalukie it was provided by the Government. It had been reported by Medical Officers at Peren, Ghasrani and Satakha that the Centres buildings were too small to accommodate all patients coming to the centres. As regards the location of the centres it was reported to be o. ideal sites.

Financial.

3.53 In spite of the best efforts made by the Evaluation Unit, it was not possible to get the financial data. No separate financial accounts were maintained by the Department for P.H.C.s. and hospitals. The figures available were a combination of all the Hospitals, P.H.C.s. sub- center and Dispensaries, Hence it became impossible to segregate these figures to assess the financial commitment on account of PHCs Even a rough idea as to how much was the expenditure on P.H.C.s. and sub-centers was not possible. As such, it was not possible to attempt and present any financial analysis in this report. Nevertheless, the Directorate could supply the figures of expenditure patterns for various type of P.H.C.s. which form the basis of formulating budget estimates. These figures are presented below in Table-X-(B). the norms prescribed by the Govt. of India for a 6 bedded P.H.C. are that the expenditure on drugs is Rs. 12,000/- per annum and the recurring expenditure for a period of 2 years for a P.H.C. is Rs. 60,000/- per annum. In the context of the all India norms the estimated expenditure of a P.H.C. in the state will still be higher than the one indicated in table X (B) But this may be so because of peculiar circumstances in which P.H.C.s have to function in the state.

TABLE NO.—X (B)
EXPENDITURE PATTERN ON VIRIOUS TYPES OF P.H.Cs. IN NAGALAND

Items of expenditure	6 Bedded	12 Bedded	30 Bedded
1	2	3	4
1. Salaries and wages	1,22,500.00	1,35,000.00	1,95,000.00
2. T.A.	5,000.00	10,000.00	15,000.00
3. Medicines	12,000.00	50,000.00	50,000.00
4. Office Expenses	2,000.00	3,000.00	3,000.00
5. Vehicle etc.	7,000.00	7,000.00	7,000.00

(Source:- Directorate of Health Services)..

CHAPTER-IV

Impact of the scheme on the people.

4.1 The success, partial success or failure of a Welfare. Scheme such as the one under study could be judged only by gathering the opinion of the general public who are the actual beneficiaries of the scheme, their reaction and the extent of impact it had on them. Hence, a structured schedule was prepared and canvassed to elicit information from the beneficiaries i. e. the general public.

Selection of Respondents.

4. 2. About 10 (ten) respondents were interviewed from each P. H. C. and S. C. Respondents were picked up from the P. H. C./S. C. area who happened (o visit the Centres on the day the Evaluation Team visited the Centres. In cases, where sufficient respondents were not available, the village leaders, knowledgeable and responsible persons of_ the locality were interviewed.

Land And Building.

4. 3. The views expressed by the respondents on land and building of the P. H. C. and Sub-Centers are presented in the table-XI
below: -

TABLE NO.—XI
RESPONDENTS'
VIEWS/REACTIONS TOWARDS LAND AND BUILDING.

Name of the P.H.C./S.C	No. of respondents interviewed.	Respondents views on location.		Respondents views on space accommodation.		Respondents views on maintenance of PHC/SC Building	
		Ideal	Not ideal	Sufficient	Not sufficient.	Maintained properly.	Not maintained properly.
1	2	3	4	5	6	7	8
Peren	10	8	2	2	8	3	7
Ghaspani	10	9	1	-	10	5	5
Satakha	6	2	4	-	6	2	4
Chantongya	13	4	6	1	9	7	3
Tuli *	9	5	4	1	8	9	-
Jalukie *	9	9	-	1	8	9	-

* Sub-Centres (Source :- Field Investigations)

4.4. From the above table it is clear that except Changtongya and Satakha P. H. C. s where 60% or more of the respondents reported that the site was not ideal, for mojority of the rural masses, all other P. H. C.,'S. C. are leporied to be ideally located.

4. 5. As regards, space accommodation of the P. H. C. majority of the respondent from various Centres/Sub-Centres selected for the study have expressed the view that the accommodation was not sufficient

.

4- 6. On maintenance of P. H. C./S. C. buildings, 70% of the respondents from Peten, 50% from Ghaspani, 67% from Satakha and 30% from Changtongya expressed the view that the buildings were poorly maintained. However, 100% of the respondents in both the Sub-Centres at Tuli and Jalukie were of the opinion that the buildings were maintained properly.

On Staff of the P. H. C./S C.

4.7. The comments offered by the respondents towards the staff of P. H. C. and sub-centres are presented in table-XII on the next page.

TABLE NO. XII
RESPONDENTS VIEWS/REACTIONS TOWARDS STAFF OF P.H.C./S.C

P.H.C. S.C.	Resppondents' views and satisfactory performance of duty		Respondents' views on examination of patients		Respondents' views on shortage of staff		Respondents' views on qualifications of staff		Respondents' views on politeness and sympathy shown to patients by staff	
	Yes (Number)	No (Number)	Carefully examination	Not examined carefully	Short	Not Short	Qualified	Not Qualified	Yes	No
Peren	4	6	3	7	7	3	2	8	2	8
Ghaspani	7	3	6	4	9	1	6	4	8	2
Satakha	3	3	5	1	5	1	4	2	5	1
Changtongya	8	2	8	2	9	1	10	-	9	1
Tuli*	9	-	9	-	7	2	9	-	9	-
Jalukie *	8	1	8	1	5	4	7	2	6	3

* Sub-Centre (Source : Field Investigation)

4.8 It is an undisputed fact that the satisfactory performance of duty by the staff engaged in the work is the only condition for the success of the scheme. However, adjudged from the opinions expressed by the beneficiaries, it is clear that the performance of duties by the P.H.C. staff is not so much encouraging. It will be seen form the above table that 60% of the respondents from peren, 30% from Ghaspar.i, 50% from satakha, 20% from Changtongya have expressed their opinion that the staff engaged in the P.H.C. were not properly performing their duties

4.9 On the question of proper examination of patients by the doctors, the general impression given by the respondents was that Doctors

were not carefully examining the patients. Some respondents even went to the extent of saying that before the patient could explain to the doctor the type of his ailment that he was suffering from, Doctor would be ready with his prescription. This illustrates the type of examination the Doctor was undertaking. In this way a patient would be lucky to get a right type of medicine in absence of any proper diagnosis worth the name. As many as

70°/, respondents from Peren, 40",;from Ghaspani, *JQ%* from Satakha, 20',; from Changtongya and KKfrom Jalukie Sub-Centers expressed the view that the doctors did not examine the patients properly and they prescribed the medicines by a guess work only. It was distressing to learn that in Peren P. H. C, the Courrpoundcr used to examine patients and prescribe medicines instead of the Doctor who was said to be busy all the time in administrative work in the absence of any Clerical Staff. This peculiar arrangement had actually been found to be in operation when the Evaluation team visited the centre. Adjudged from the information presented in table-XIII it appears that the Tuli Sub-Centre, however, had gained the confidence of the genial public.

4. 10 With regard to shortage of staff most of the respondents repotted at various selected Centres Sub-Cenntres that in their view the staff shortage existed in eachPHC. Sub-Centie. As many as 70°', respondents from Peren' 90% from Ghaspani, 83% from Satakha.80[1];,, from Changn-togya, 100% from Tuli and 90% from Jalukie reported that there was shortage of staff.

4.11. It had been reported by the respondents that (80% from Peren, 40% from Ghaspani, 33;$_0$ from Satakha and 20% from Jalukie) the staff employed in the P. H. C. were not properly qualified in the job entrusted to them. However, all the respondents from Changtongya P. H. C. and Tuli Sub-Centre reported that the staff were properly trained.

4. 12. Politeness and sympathy shown to the patients by the medical staff has been regarded as the most essential qualities necessary to be possessed by any medical staff because such treatment metted out to the patients make them feel that they had been paid due attention by the staff which normally bring psychological satisfaction and relief to them (patients) These important qualities of the medical staff are actually lacking in Peren P.H.C. where 80% of the respondents reported that the staff were so rude that the patients used to go back home with a heavy heart instead of relief. Except Tuli Sub-Centre other P.H.Cs. and Sub-Centres were also not free from these defects even though the percentage of respondents reporting that the staff was not polite was not as high as in Peren.

Timely Action Diet and Family Planning

4.13 A picture of how the public felt on timely action taken by the medical workers in the centers about supply of diet to indoor patients and on Family Planning programme can be seen from the table-XIII below :-

TABLE NO.-XIII ,
RESPONDENTS' VIEWS ON ATTENTION TO PATIENTS DIET AND FAMILY PLANNING

Name of P.H.C./S.C.	Total number of persons irQerviewd.	Whether prompt attention paid to patients.		Whether staff visited patients house on request.		Whether diet supplied to indoor patients satisfactory.		Whether favoured Family Planning Programme.	
		Yes (Nos)	No. (Nos)	Yes (Nos)	No. (Nos)	Satisfactory !	Not Satisfactory	Yes (Nos)	No. (Nos)
1	2	3	4	5	6	7	8	9	10
Peren	10	2	8	7	3	2	8	3	7
Ghaspani	10	7	3	8	2	3	7	1	9
Satakha	6	6	-	2	4	2	4	5	1
Changtongya	10	9	1	10	-	3	8	2	8
Tuli*	9	9	-	9	-	NR	NR	4	5
Jalukie *	9	7	2	6	3	NR	NR	-	9

NR=Not Relevant * Sub-Centre.
(Source:- Field Investigations)

4. 14. The above table indicates that 80% of the respondents from Peren, 30% from Satakha and 20% from Jalukie felt that the staff did not pay prompt attention to patients. The data on P. H. C. Satakha and Sub-Centre Tuli, however, revealed a very encouraging Performance in this respect.

4. 15. Out of the sampled respondents, 60% from Satakha, 33% from Jalukie 30% from Peren and 20% from Ghaspani reported that the staff never visited their house even in serious cases. The respondents from Changtongya and Tuli, however, expressed satisfactory response from the staff. On the whole the response of the respondents interviewed for the purpose was very favorable. However, no data was collected on the extent of actual visits by the M.O. to the patients houses.

4. 16. The data presented in table-XIFI above indicate that not a single P. H. C. could supply diet to the expectations of the patients In some P. H. C. the Evaluation team gathered from sources (not to be specified) that articles such as Horlicks, Eggs etc. shewn on records to have been distributed to patients never reached the hands of the actual beneficiaries. This might be one of the reasons that out of the sampled

respondents, 8»>% from Peren, 70% from Ghaspani, 6f% from Satakha and 80% from Changtongya expressed the view that they did not get the diet expected from the P. H. C. This aspect needs a thorough probe and loop-holes, if found, need be plugged so that the benefit accrues to the actual beneficiaries.

4. 17. The general public in Satakha area showed their awareness-s to the need of Family Planning. In fact, 83% of the respondents in Satakha expressed their willingness to adopt Family Planning. From Tuli also approximately 45% of the respondents expressed their willingness for Family Planning. In other centers, however, the percentage of those who could willingly accept Family Planning methods was negligible. None of the respondents from Jalukie area favoured Family Planning.

Visit of Villages by the Staff of P. H. C./S. C.

4. 18 The success of a scheme depends upon the performance of duty by the field staff. In the case of P. H. C.s one of the important duties of the stasis to pay visits to different villages covered by a P. H. C.,/ Sub-Centre and carry the medical facilities to the rural population. The number of visits to villages by the field staff can be seen from the table-XIV.

TABLE NO.—XIV
INFORMATION ON VISITS OF VILLAGES BY THE P. H. C./S. C. STAFF.

Name of the Centre	Number of times visited.						Total No. of respondents.
	Nil	Once	Twice	Thrice	Four times	More than four times.	
1	2	3	4	5	6	7	8
Peren	8	1	-	-	-	1	10
Ghaspani	10	-	-	-	-	-	10
Satakha	4	-	-	2	-	-	6
Changtongya	7	1	2	-	-	-	10
Tuli*	6	2	1	-	-	-	9
Jalukie *	8	1	-	-	-	-	9

* Sub-Centres
(Source .- Field Investigations)

4.19. The Statistics presented in the above table is a clear evidence that the field staff had been neglecting the core duties for which they have been appointed. Barring a few cases the respondents had reported that, visits to the villages by the field staff were almost negligible. It is therefore, imperative that Directorate of Health Services takes a note of it and takes effective steps to ensure that the field staff performs their duties well so that it infuses a confidence among the rural population that they are being looked after by the Government in matters of health and sanitation.

Visit to village Schools by the Staff of P. H. C./S. C.

4.20. On school health functions, the staff of the P. H. C. are expected to visit village schools as frequently as possible. The reaction and views of the public on the efficiency of school health services by the P. H. C. scheme are presented in table-XV .

TABLE NO.—XV
INFORMATION ON VISITS BY THE P.H.C./S.C. STAFF TO SCHOOL OF THE VILLAGES.

Name of Centre.	Number of times visited						Total No. of respondents
	Nil	Once	Twice	Thrice	Four times	Above Four times	
I	2	3	4	5	.6	7	8
Peren	10	-	-	-	-	-	10
Ghaspani	10	-	-	-	-	-	10
Satakha	3	2	1	-	-	-	6
Changtongya	8	1	1	-	-	-	10
Tuli*	4	1	2	1	1	-	9
Jalukie *	8	1	-	-	-	-	9

* Sub-Centres

(Source :- Field Investigations

4.21 The Statistics presented in the above table clearly indicate that except at Tuli Sub-Centre, the performance in other centres is quite unsatisfacory. A nil performance on school health services in Peren and Ghaspani P. H. C.s clearly shows that the authorities are not taking any interest in the direction of school health activity of the P. H. C.s

Health Publicity Through Group Discussion with Villagers.

4.22 It has been reported by the Medical Department that most of the diseases in Nagaland are preventable provided the people are having the knowledge of its prevention, but due to the ignorance of the people many diseases would occur. This shows that the Medical Department is fully aware of the necessity of publicity and spread of health knowledge to overcome these preventable diseases. But not much headway has been made by the P. H. C.s in this direction also. The progress of P. H. Cs, S.C. s in this respect is presented in table-XVI.

TABLE NO.-XVI
INFORMATION ON THE NUMBER OF TIMES THE P.H.C./ S.C. STAFF DISCUSSED HEALTH PROBLEMS WITH VILLAGERS.

Thames of Centres.	Number of times health problems discussed with villagers.						Total No. of res-pondents.
	Nil	Once	Twice	Thrice	Four times	Above Four times	
1	2	3	4	5	6	7	8
Peren	10	-	-	-	-	-	10
Ghaspani	10	-	-	-	-	-	10
Satakha	4	2	-	-	-	-	6
Changtongya	8	2	-	-	-	-	10
Tuli*	7	2	-	-	-	-	9
Jalukie *	9	-	-	-	-	-	9

* Sub-Centre
(Source :-Field Investigations)

4. 23. A perusal of the above table will show beyond any reasonable doubt that though the Medical Department, feels the importance and necessity of group discussions for the spread of health knowledge, yet they are hardly doing anything in this respect. Even the respondents of Satakha, Changtongya and Tuli Centers the figures of which are presented in Col 3 of the above table reported these discussions of a very casual nature and not of an organized one with villagers. Hence, the performance of the P. H. C s/S. C.s on health publicity through group discussions with villagers is virtually nil.

On Medicines and Equipments of the P. H. C.

4. 24 An over-all picture of the reaction and opinion of the general public on the question of availability of medicines and equipments at the P. H. Cs is presented in table. XVII.

TABLE NO. XVII
RESPONDENTS' VIEWS AND MEDICINES AND EQUIPMENTS OF THE P.H.C.

Name of Centre	Respondents' reaction availability of medicines prescribed by M.O.		Respondents' reaction on common medicine		Respondents' views on equipments			
					Cleanliness		Adequacy	
	No. of respondents getting all the medicines from P.H.C./S.C.	No. not getting all the medicines from P.H.C./S.C	Available (Nos.)	Not available (Nos.)	Cleaned properly (Nos.)	Not Cleaned properly (Nos.)	Sufficient (Nos.)	Not Sufficient (Nos.)
1	2	3	4	5	6	7	8	9
Peren	-	10	4	6	8	2	1	9
Ghaspani	-	6	-	6	3	3	4	2
Satakha	-	10	1	9	9	1	7	3
Changtongya	-	10	7	3	2	8	2	8
Tuli*	-	9	4	5	8	1	6	3
Jalukie *	1	8	5	4	9	-	2	6

*Sub-Centre (Source : Field Investigation)

4.25 The above table clearly demonstrates that the P. H. C. and S. C. seems to be working on the thesis of prescribing medicines to patients and not making these medicines available to them. One is really surprised to see that even the minimum need programmed

of the rural population for which special funds are allotted could not ensure supplyof medicines according to the minimum requirement. It might be recalled in this context that the estimated requirement of medicines for indoor and outdoor patients are put by the Directorate of Health Services at Rs. 8.50 and Rs. 2.00 respectively per head per day. With this estimated expenditure which should be adequate enough to meet the requirements of the patients and the types of views expressed by the respondents showing a complete lack of faith in supply of medicines, one cannot escape concluding that there is something wrong somewhere with the operation of the scheme. This needs immediate remedial measures to be adopted by the Government for correcting deficiencies so that the laurel masses start getting benefits under the scheme to their satisfaction.

4. 26. The study revealed a much discouraging picture that except at Ghaspani and Jalukie no other centres supply even the most common medicines. The respondents from Satakha and Changtongya had a very poor opinion about the availability of even the most common medicines at these centers.

4. 27. On equipments used by the centers, 80% and 60% of the respondents from Ghaspani and Stakha respectively were of the view that the centers do not clean properly the equipments before their use. The percentage having negative reaction in other centers is, however, negligible.

V 28. Majority of the respondents from Satakha, - Changtongya and Tuli Centre reported that the Centers were well equipped whereas at Peren, Ghaspani and Jalukie Centers the majority of respondents reported that the centers were not so well equipped. However, these observations are based on their general impression on working of the P. H. Cs. Sub-Centers.

On Transport Facilities.

4.29. A vehicle was provided to all the P. H. Cs to facilitate the working of the centers as will as for lifting of serious .patients from their residences to the P. H. Cs How far the provision of a vehicle to the centre had served the interest of the Public could be seen from the table-XVIII on the next page.

TABLE-XVIII
RESPONDENTS' REACTION ON TRANSPORT FACILITIES

PHC/SC	Total No. of Respondents	Views on arrangement for prompt Transport of serious cases to District Hospital		Respondents views on providing Transport/vehicle for lifting serious cases		Arrangement of bringing serious patients to Hospitals		
		Satisfied	Not satisfied	Vehicle provided	Vehicle not provided	By Govt. vehicle	By hiring private vehicle	Carrying on shoulders
1	2	3	4	5	6	7	8	9
Peren	10	-	10	-	10	-	2	8
Ghaspani	10	-	10	-	10	-	6	4
Satakha	6	4	2	1	5	1	2	3
Changtongya	10	-	10	-	10	-	10	-
Tuli*	9	-	9	-	9	-	7	2
Jalukie *	9	5	4	5	4	-	5	4

*Sub-Centre (Source : Field Investigation)

4. 30. From the above statistics, it is found that according to the respondents interviewed for the purpose, provision of a vehicle to the centre has served the interest of the public in Satakha and Jalukie Centres. But at no other centre, the patients were being helped for bringing them to the Hospital by the vehicle attached to the centre. In this context it should be remembered that the vehicle attached to the centers is not meant for the use of officers and other officials on duty alone but also for lifting of serious patients etc. This aspect needs further: investigation with a view to ensuring that the vehicle attached to the centers is also made available to public for lifting serious patients from their residences and bringing them to hospital for making medical facilities available to them as quickly as they need.

CHAPTER-V

MAIN FINDINGS AND SUGGESTIONS

On Maintenance of Records

5. 1. It is needless to mention that in the absence of proper records, the task of Evaluation Unit became extremely difficult. Neither the officials of the Directorate nor those of various P. H. Cs appeared to be awake of the need for proper maintenance of even the most essential records. At the P. H. Cs, necessary records-such as number of days on tour by staff, number of villages under its jurisdiction, total population covered by a Centre, number of cases treated by the staff while on tour etc. were not maintained. What is more interesting and surprising is that the Directorate does not maintain any record on financial targets and achievements of each P. H. C. and Sub-Centre, total amount of medicines used by each centre & year of establishment of each centre etc. There is, therefore, immediate need to bring the records in respect of the various items, a few of which have been enumerated above, up to date. The Directorate should take effective measures to ensure proper maintenance of records at the Headquarters and at the P.H.C.s Sub-Centers. This needs immediate attention of the Government, otherwise, meaningful and Purposeful assessment cf the progress of functioning P.H.C.s will never be possible.

On Orientation Course for Medical Officers.

5. 2. It is found that in most of the P. H. Cs the Medical Officers do not seem to have a clear idea of what is the function of a P. H. C All the Medical Officers in charge of the Centers were under the impression that the function of a P. H. C. is the same as that of a Hospital. If the Medical Officer, who is the leader of the team does not have a clear idea of the type of work a P. H. C. is expected to perform, how can we expect efficient and effective management of the scheme for P.H.Cs. Hence orientation courses need to be conducted prior to the posting of medical officers to the P. H. C. so that they can acquaint themselves with the type of work that they would be expected to do. Further, the Medical Officers, being both professional and administrative head experienced personnel should be posted to the P. H. Cs. for proper and efficient discharge of duties. There is also need for periodical refresher courses for the in-service incumbents, so that they are kept abreast of the latest requirements and cor accepts of the scheme which may go a long way in proper implementation of the scheme.

On Duties And Responsibilities.

5.3. The Evaluation team had come across a peculiar practice of improper distribution of work and responsibilities among the staff in the Centre. At some places, the Medical Officers were found to be in charge of administrative work including the clerical jobs of

correspondence etc. while the Pharmacist was found to be in charge of examining patients and prescribing of medicines to them, the illiterate medical attendant was in charge of distribution of medicines at the Dispensary Other para-medical staff viz. Xi'H V., S. I. etc. did not have a clear idea about their responsibilities. The Evaluation unit, strongly feels that such irrational arrangement should immediately be stopped, and the duties and responsibilities of each category of staff should clearly be demarcated, specified and brought home to all concerned by the Government based on the discipline and line of experience. This needs immediate attention of the Government.

On medicines. : -

5 4 Short supply of medicines to the centers has become an undisputed fact. All the centers reported that the supply of medicines was quite insufficient to meet the requirement. Even the most essential and common medicines were reported to have not been supplied in adequate quantity. Non - availability of medicines from the Centers was a common complaint of the beneficiaries. This was revealed by interviews conducted among the beneficiaries It was reported that the medicines were not only in short supply, but sometimes the supplied medicines too were old enough to havo crossed the expiry date by the time these reached the centers. It came to the notice of the Evaluation team that the P.H.C. Pcren had actually vaccinated the general public with expired vaccine just to satisfy the innocent public. Luckily, these medicines were reported to have produced no adverse effect. But this shows the total callousness on the part of the authorities The Department of Health services should ensure that no such gambling on precious human lives is done in future. The Government should also probe into the reasons for not supplying the minimum needs of medicines to the centers during the past years. Further opening of P H.C.s/S, C s without providing the basic minimum needs of medicines to the existing P. H. Cs has little meaning, and hence, the existing P. H. C s should be toned up to meet the growing health needs of the local population.

5. 5. At present, purchase of medicines are said to have been done by the Medical Directorate without consulting the Medical Officers of the P H. Cs with regard to their likely requirements of different types of medicines. This was said to be one of the reasons that the types of medicines required by the Centers were normally out of stock in the Central Medical store. Hence, a purchase Board of Medicines | should be constituted where all the M O.s of the P. H Cs should be included as members. These M. O.s who are actually operating in the field may have a better idea about the local requirements and may contribute greatly to proper requisition of the medicines.

5.6. So far, there appears to be no arrangement for stock checking of medicines/equipments How much of the medicines/equipments had been supplied to a centre, how much had actually been utilized and how much is the balance left is never checked by the higher authorities and is never known. Without these basic facts it is wondered as to how would it be possible to assess the tentative requirement of medicines equipments for a particular period of time. The Evaluation team strongly feel that stock verification arrangements should be made an inescapable concomitant of future supplies.

In case of P. H. C./S. C, the S. D. M. O of the respective areas may be given the charge of checking the stock every quarter of the year and this should be scrupulously followed.

5. 7. The present practice of indenting medicines by M Os is on the basis of replenishment of the old stock.The procedure is not free from serious defects inasmuch as latest medicines which might be the need of the day get excluded. Indenting of medicines by M. Os. should be done on the basis of requirements and not on the basis of the existing stock position, because a particular type of medicine may be much in use for a particular time, place and season; but it may not be so much in use another time, place and season. It is strongly felt that the Medical Officers while placing indents should take care of the actual, requirements Their demand should properly be examined and met.

On Opening of P. H C./S. C.

5. 8. There are some P. H. Cs. having as many as 7 Sub-Centers attached to them, whereas with some P.H.Cs. no Sub-Centre is attached. It was found that the Sub-Centers located at a far-off distance could not be properly attended to by the M. O. of the P. H. C. If he is to look after the work of all the Sub-Centers under his charge, his normal duties at the P. H C. would be hampered. Moreover, there did not appear to be a clear policy of opening P. H. C. & S. C. under them. As such the indiscriminate opening of P. H. C./S. C. without studying properly the other conditions to formulate a judicious choice should te avoided in future. There should be some uniform policy keeping n view the local needs, so that some P. H. Cs. are not over-burdened and some are left without much work of Sub Centers with them.

On Touring of Staff

5. 9. Excepting the Medical Officer, no other field worker in P H. Cs. had undertaken tQur in Peren and Changtongya P H. C. during ihe last three years. It is not the intention of the Government that ihe filed s'aff should be confined to their duties within the premises of the Primary Health Centres only The Medical Officers should ensure that the touring staff actually go to the field so that the efficiency of the scheme is not hampered by their abstaining from field duties Thus, the Medical Officers should send field staff on tour regularly as may be required for effective working of the scheme.

On Visit and Supervision.

5. 10. The Medical Officers of the P.H.Cs. should visit and supervise the work at each Sub-Centre on a regular basis every month.

This is essential because complicated cases at the Sub-Centers cannot be treated by Pharmacist/Compounded. The dates of visits should be decided and notified in advance for the benefit of the public and should be adhered to scrupulously. With this arrangement the general public will know on which particular day the doctors will be

coming to their areas. Similarly, arrangements should be made that a specialized doctor from Civil Hospital is deputed to P. H. C. twice a month or as often as possible.

On Immunization of Children.

5. 11. Even though a little care cau prevent common diseases for children, immunization of children had not been given due attention to by P. H. Cs. The Evaluation Unit strongly feel; that childhood immunization should receive special attention of the P. H. C Triple vaccine immunization, tetanus immunization for pregnant women, Polio vaccine etc. should be made freely available in all the P H. Cs. S. Cs.

On Health Education.

5 12. Educational aspect of health should not be left unattended to by the P. H. Cs. as is at present Neglecting educational technique on delivering lectures, group discussions, decision making with villagers, individual consulting etc means neglecting the very basic function of a P. H C, because the formation of a P H. C mainly for educational promotional and preventive measures. Curative work is only an additional function of a P H. C. Hence the P. H C. authority should make special efforts and pay particular attention on the educational aspect of P. H. C. on a regular basis

On Laboratory

5. 13. Each P. H. C. Should be provided with a laboratory for carrying out examination and testing of blood/stool etc of simple cases wherever such facilities had not been provided yet.

On P. H. C. and the Village Council

5. 14. Effective implementation" of a scheme such as the one under-study require involvement of all concerned The P. H. C, authorities can convince the members of the village councils under their jurisdiction and enforce cleanliness drive in villages The present practice of disposing waste materials on the street, disposing human excreta in the open, polluting water tank/ponds by cleaning dirty clothing and utensil in and around the ponds etc. can be stopped by involving the members of the village council. The P. H. C. should organize cleanliness competition among villagers in collaboration with the village council and award prizes in cash or kind to the most clean areas and clean houses of the village as an incentive. This practice should be continued till cleanliness becomes a permanent part of our rural culture.

On P. H. C and Educational Institution.

5. 15. Cleanliness and environmental sanitation method can be enforced effectively by the P. H. C. is collaboration with the Education Department. In most of the village schools, even teachers used to come to schools without washing their faces property. The medical department, therefore, in collaboration with the education department can

enforce personal hygiene and environmental sanitation methods through schools. In recent times student organizations are also taking active part in cleanliness drive in various villages. The P. H. C. authority
also should properly influence the leaders of the students so that they feel involved in the implementation of cleanliness in the villages.

Conclusions

5. 16. Any impartial observer, who examines the 8 (eight) years performance of the P. H. Cs. will come to the conclusion that the present P. H. Cs in Nagaland are existing merely in name. For all practical purposes they are nothing but hospital and dispensaries. Their Activities have virtually been confined only to curative work The other ' quall important functions of the P. H. Cs. are not attended to properly as it ought to be The Medical Department and the Government should see that the present state of affairs of the P. H Cs. no longer continues. It should start carrying out all the important functions of the P. H. C. so that rural-u'ban imbalances in matters of health and sanitation is removed and medical facilities reach the people of the state on an equitable basis So far, the few P. H. Cs. opened could not solve even a fringe of the problem faced by the rural population. Concerted efforts (o carry the benefits to rural population is the demand of the day and we should endeavor *fe* achieve that objective.

APPENDIX
Comments/Views of the Director of Health Services Nagaland

Para of the reported Comments/Views

2 (1) The revised norm for setting up of Primary Health Centers and Sub-Centers is as under :—

1) Primary Health Centre—per 50,0''0 population.
2) Sub-Centers —per 5,' 00

2 (4) As per norms, Sub-Centers should be established for a population of 10,000 and one Primary Health Centre should have at least 3 Sub Centers (minimum). Accordingly Sub-Centers were opened/attached to Primary Health Centers. However, in some cases more Sub-Centers were opened due to exigency of the situation. Moreover in some cases Sub-Centers were opened due to Public/Political pressure which is beyond the control of this Department which has caused imbalance in the number of Sub-Centers under each Primary Health Centre. Moreover in one of the Primary Health Centers namely Ghaspani no Sub-Centers were opened as there are 2-3 Dispensaries near-by. The matter is under review of Department to correct them.

2(5) It may be due to ignorance *of* the; Medical Officer I/C of the Primary Health Centre that they do not know as to how many Sub-Centers are functioning under the control of the Primary Health Centre. This may also be due to the fact that, in Nagaland 50% of the Doctors are on contractual basis and as a result, there is change every now and then and most of the Doctors of Primary Health Centers go on changing and the new Doctors may not be aware of the actual position. However, action has already been taken to avoid such contradiction in future.

Staffing Pattern :-

In all the 12 bedded Primary Health Centers same staff is being provided as per staffing pattern. It is not clear as to how the Medical Officer of the P. H. C. could give statement that some staff are not sanctioned against a particular P. H. C. In each of the P. H. C. the post of Lady Health Visitor has been sanctioned whereas the post of Nursing Sister is meant for the medical units where bed-strength is 25 and above. In many of the P. H. Cs. staff are not available as per sanctioned strength due to the fact that in the State of Nagaland there is an acute shortage of medical and para-medical personnel. However, efforts are being made to fill up the vacancy by training the local candidates by granting stipends.

Medical Relief—It is true that in Nagaland the P. H. Cs. are doing only curative aspect. This is due to the fact that in Nagaland the service of Multipurpose Workers is yet to be provided which is the main source for doing preventive and primitive work among the

rural masses. Moreover, we are so short of key staff like Lady Health Victor and Sanitary Inspector that only 2-3 P. H. Cs. out of 11 P. H. Cs. have the above categories of staff, who are to function as a guide among the rural masses for propagation of various topics like sanitary Inspection, Health education and immunization of children etc.

The main reason for such low daily attendance of patients in the P. H. Cs. as mentioned in report may be due to the fact that the rural population in Nagaland does not like to attend hospital unless they suffer from serious illness. For example, recently in Tosophenyu village quite a big number of children died of measles and various other ailments. On inspection of the village by a Medical Officer of this Directorate it was revealed that, although a medical unit exists in the village only a few persons have reported to the dispensary for medical care. Most of the villagers want that the doctor/Pharmacist as the case may be should visit each and every house to give them treatment at their home. However, non maintenance of records by the PHC. as indicated in the report is deplorable and action is being taken to streamline the administrative machinery to avoid such situation.

Maternity & Child Welfare.

It is true that in Nagaland, due emphasis was not given on maternity & Child Welfare in the past due to various reasons However, this has been geared up in al! the medical units

Family Welfare

Family welfare Programmer was only launched in the state at the end of 1976-77 by creating a Cell in the Directorate of Health Services and it is yet to be introduced at the lower level like District and PHC 's. The family welfare Programmer is running in the state Programmer on Voluntary basis, and the result is encouraging and hence it is not correct to say that this programmer is a total failure in Nagaland when we have only made a small beginning.

Control of Communicable diseases

In Nagaland most of the staff under various centrally sponsored schemes are attached to the respective civil surgeons/ Sub-Divisional Medical Officer and these staff are covering their respective jurisdiction and submitting report to their Directorate through their CSs/ SDMOs. And hence no record could be made available in the PHCs. This can only be introduce in the state.

Spread of Health Education.

3.(15) In Nagaland there was no agency by name Health Education in the medical department nor any staff were trained in this aspect. Very recently a cell called " Health Education Bureau " has been established in the Directorate of Health services and during the current financial year it has been proposed to decentralize the same in the district/ PHC level by creating necessary post and filling up of same by trained personnel. The post or extension educator is yet to be created in the PHCs in the state. Hence it is

quite natural that the PHC could not do anything on health education in absence or trained staff.

School Health.

3.(18) In Nagaland there are 3 school Health service Team who are regularly visiting school all over the state for check up or health and immunize the school going children. Apart from them, the Govt. of India has introduced school health programmer which should be performed under selected PHCs and this scheme is likely to be introduced from 1979-80 onwards in collaboration with Education Department.

Collection or Vital Statistics.

3 (21) Collection of vital static's is lacking for want of trained personal. However, every efforts are being made to make them available in the medical units and improve the situation.

Medicine & Equipment.

As a matter of fact, every year, demand for medicines, equipment and other scorers are being collected by this Directorate at the beginning of the year for assessment of fund and procurement and hence it is not being consulted by the Civil surgeons. Moreover, as per procedure in vogue all the medical units are required to submit yearly stock position of medicines and other stores to this Directorate for perusal and taking necessary action.

In this connection it is stated that the Govt. of India has selected standard drugs to be issued to the PHCs. In 1973 and understood how the Medical Officers could give such statement to the Evaluation team that medicines are not available in PHC. Whereas common medicines are being procured for all the medical units as a matter of routine procedure. However, it is true that medicines now purchased for the medical units is inadequate and can hardly be sufficient for 6-7 months due to limited funds placed at the disposal of the department for purchase of drugs. In Nagaland the people impression from the medical unit which is not possible to supply due to limited resources available with this department.

As regards stock verification of medicines and other stores, it may be stated that necessary orders/ instructions have been issued to all medical units for physical verification of stores, long back. Follow up action is being taken on this.

On Building.

3 (34) As regards buildings of PHCs and sub-centers it is stated that most of 10 PHCs. Which were established prior to fifth plan period were just converted from the existing 12 bedded Hospital/ Dispensaries and hence these building require reconstruction/ renovation. But due to paucity of funds these could not be taken up.

Timely action Diet & Family Planning.

4 (16) As regards issue of diets especially Horlics Eggs, this Directorate is taking necessary action to check such malpractices in issuing those items.

On Orientation Courses for Medical Officers.

5 (2) Action is being taken to arrange orientation course for PHC Medical Officer so that they are kept abreast of their duties and functions.

-: THE END :-