# Health Policy of the Mizoram State-2022

## 1.Introduction

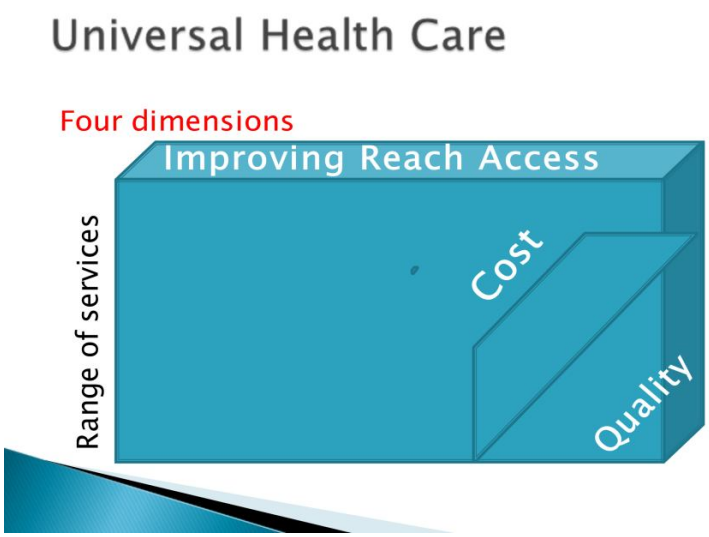
Health as a human right is central to the "right to life" guaranteed in the constitution of India. In this spirit, the government of Mizoram, Department of Health and Family Welfare has drafted a Health Policy for the state of Mizoram.

The Health Policy will be catalysing the working relationship between the government of Mizoram and the Union of India based on the principles of cooperative federalism for diverse health challenges faced by the state. Both the State governments and Central government have played complementary role in spreading and improving the infrastructure, capacity building of the health system and enabling the individual's availability, accessibility, affordability of quality health services leading to client satisfaction and partnership in its planning, implementation, monitoring and governance.

Mizoram has adopted the State Vision 2030 in the year 2018, which provides a framework for achieving the SDGs by strategically aligning and allocating sectoral budgets. Also, it has been implementing all the specific projects and program activities under the National Health Mission.

## 2.Vision

The vision of the Mizoram state health department is to increase the quality of life for its people by attaining the highest level of physical, mental, social and spiritual health; that will contribute towards the development of the state. Towards this vision it has fully accepted the principles and vision of the globally acclaimed **Universal Health Coverage and Care.** UHC is a solemn affirmation of social solidarity, which is the most enabling attribute of an advancing and progressive civilization. UHC requires that all essential health services be available to every person, based on need, or equity principle rather than equality, with assured quality, without anyone suffering financial hardship.




World Health Organization recommends a path of progressive universalization, in the form of a cube with four expanding dimensions: 1. Population coverage 2. Service coverage 3. Cost at affordable level and 4.an overarching Quality Assurance leading to Client satisfaction.

As a policy Mizoram State shall undertake the following ten key measures to achieve the objectives of UHC in the state,

1. Increase public expenditure on health and reduce out of pocket expenditure on health
2. Improve the situation of human resources for health (HRH)
3. Strengthen Service Delivery at Primary Care Level
4. Develop an efficient procurement and disbursal mechanism for drugs
5. Ensure quality at every level of service delivery
6. Increase public participation and feedback
7. Communicate benefits available under UHC to people
8. Engage and regulate private health care sector
9. Strengthen overall healthcare governance and management
10. Transparency and accountability in resource utilization

As Universal Health Care also includes various social determinants of health like safe water, sanitation, nutrition, food security, primary education, livelihood and poverty alleviation, community empowerment, gender and social equity etc, the health department shall be serious for convergence with allied sectors and shall build up its capacity for inter-sectoral

coordination. It will also recognize the right to receive food, water, affordable housing, sanitation, and finally the right to a healthy environment as they are the determinants of health.

In order to achieve Universal Health Care, the Mizoram state is in line with the National Health Mission which has a vision of decentralization for district management of health, participatory bottom-up planning, quality assurance in services& client satisfaction, inter-sectoral convergence and improving access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

The state government continue to cherish the paradigm shifts in the key principles of National Health Mission such as: First, distrust to trust, second, inflexibility to flexibility, third, centralized to decentralized action, fourth, funds functions, functionaries for service and fifth, building capacities at all levels.

The policy shifts towards a significant step of the operationalization of the right to health as a state duty. The state will also introduce mechanisms for people involved, participatory monitoring and governance at the village, district as well as the state level.

## 3.State Responsibility to provide Health Care

The Health Policy envisions and takes inspiration from the core values of The Right to Health and Healthcare bill 2021.As a Policy the State will uphold its responsibility to maintain optimum health of its citizen and will deliver Comprehensive Universal Health Care through Public health system. It will not expect or fully rely on Private sector for Primary or Secondary Care. Only feasible and mutually beneficial PPP will be embarked upon for Tertiary Care where there is absolutely no chance of Public Health System delivering it in the near future. Strengthening PH System will be a priority for the next 5 years.

The State shall embark upon a framework of AAAQ to assess healthcare policies and programmes enacted under the right to health. A.A.A.Q refers to availability, accessibility, acceptability and quality assured.

The policy shall be recognizing the *right to receive essential pharmaceutical medicines, devices and implants to those who need it.*

## 4. Denial of Rights and Equity in Health Service

The policy undertakes the responsibility to watch against denial of healthcare services on any basis whatsoever, irrespective of current condition, identity, nationality, or lack of documentary proof of the individual thus safeguarding a large section of those deprived.

In the same wave length it will be watchful on an often-violated fundamental right, that is the right to die with dignity wherein individuals have the right to receive a dignified funeral in accordance with their chosen rights and practices. This has become more relevant during the outbreak of a serious communicable disease like Covid Pandemic.

By including the right to continuity of care, the Policy shall ensure that healthcare users have access to uninterrupted healthcare goods, services and facilities irrespective of a temporary or permanent change in geographical location thus acting as a safety net for those without a permanent resident address.

The policy envisages a positive move towards the right to access caregivers which can act as a possible amenity for those with no caregivers, the establishment provides caregiving services, thus protecting those abandoned or stranded.

By including the *right of protection against discrimination on the basis of sexual orientation, rights of infants and children, rights of elderly and incarcerated persons*, the policy seeks to protect those discriminated on the basis of sexual orientation, the LBTQI2+ community by providing access to healthcare and by providing legal protection against pseudo-scientific coercive practices, including but not limited to, conversion therapy.

The policy protects the elderly from physical, mental or emotional abuse at their place of residence, and in case of the latter, they shall receive an adequate supply of goods, services and facilities, while simultaneously ensuring redressal mechanisms in case of a proven violation of the said right.

The policy shall ensure the right of all categories of Health workers to receive agreed remuneration and wages in time, to receive free, appropriate, safe, sufficient, ergonomic, and quality personal protective equipment while serving patients with communicable diseases. The policy shall also ensure the right to be involved in decision-making, the right to be

included and consulted during the formulation of health plans, programmes and policies, thus giving its healthcare policy a bottom-up approach in planning and governance.

## 5.LONG TERM VISION & SHORT- TERM GOALS

***Long Term Vision.***

*a)*The long-term vision of the policy is strengthening the health care system of the state

b) Bring the health parameters such as MMR, CMR, Life Expectancy to that of Nordic Countries.

c) To truly achieve the principles of UHC and right to health for all individuals in the state.

d) To reduce the prevalence of cancer in the state.

***Short Term Goals.***

a) To improve the SDG score of the state while progressing towards the goal of Mizoram Vision 2030.

b) To strengthen the health infrastructure in the purview of different unpredictable waves of COVID-19 and similar Epidemics and Disasters.

c) To increase transparency, accountability and service efficacy in every level of health service delivery in the state.

# 6. Thrust Areas

Although Mizoram is one of the best performing small states in health index of NITI Aayog, it has its share of both achievements and challenges in the health sphere. Ranging from Cancer, Tobacco, Malaria, Malnutrition, the state faces some of the toughest health challenges.

The government aims to bring down the 14% of below poverty level (BPL) families in 2019-2020 to 3% by 2030. The schemes like NRLM, PMKSY, NERLP etc aim to provide 100% coverage of poor and vulnerable households under health care scheme.

Malnutrition is a major state health issue, and the State as a policy would like to bring down from the year 2016 level of Children under the age five with Malnutrition, 28 % children stunted, 2.30 % wasted and 6.10 % underweight prevalence, to less than 10, 1 and 2.5% respectively. By the year 2029 the government aims to provide nutrition for all who are in the age group of 0-6 years old and nutrition for all pregnant and lactating mothers.

For tackling Malnutrition, the state's Anganwadi workers will be trained with the launching of a new training programme for them with the focus on curbing malnutrition. The emphasis will be on the promotion of exclusive breast feeding till six months of age, the timely introduction of complementary feeding and early detection of growth faltering by monthly weighing and monitoring their growth chart till 2 years as a priority. This will help these workers to spread awareness to the remotest part of the state about malnutrition. The Anganwadi centres in the state, will be provided with more funds to procure protein rich food materials for cooking. Hot cooked meals will be given priority over precooked packaged food. These will be for both the child and their mother.

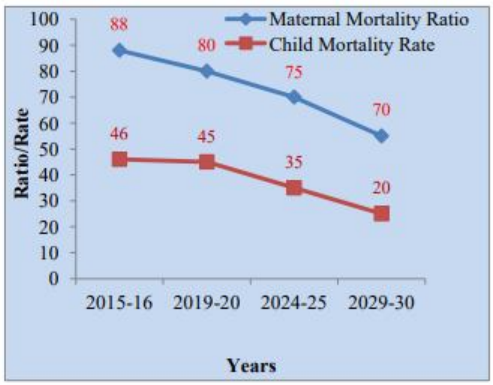
**Target**

**Maternal Mortality Ratio**
**(Per lakh pregnant Women)**

| | | |
|---|---|---|
| 2019-20 | : | 80 |
| 2024-25 | : | 75 |
| 2029-30 | : | 70 |

**Child Mortality Rate**
**(Under age 5 Years)**
**(Per thousand lives birth)**

| | | |
|---|---|---|
| 2019-20 | : | 45 |
| 2024-25 | : | 35 |
| 2029-30 | : | 20 |




**2030 Goal to reduce the level of Maternal Mortality Rate and Child Mortality Rate**

The Malaria epidemiology in the state is also of grave concern. To reduce the malaria incidence rate and its effect on people every local council will be provided with machinery for the dissemination of indoor residual spraying (IRS) and funds will be released well before the seasonal peak. Established mechanism for distribution of insecticide-treated nets (ITN) for households sponsored by the state government will be activated.

Mizoram faces an acute issue of cancer, with Aizawl even called as the cancer capital of India by many popular media houses. There is an urgent need to setup a platform for international collaboration with Australian health professionals preferably. (Australia has the highest index score in policy and planning against cancer among all countries) The aim will be to incorporate strategies of early awareness towards cancer identification. Also, the state's health staff is to be sensitized so that they are prepared against cancer and the need for its treatment.

A State-of-the-art Cancer hospital will be set up with either central assistance or donor funds to provide early detection and full treatment of all cancers arising in Mizoram.

The major cause of cancer in the state of Mizoram is Tobacco and its daily consumption is high. The Guthka is banned too. To counter that it's important to impose a full ban on cigarettes and all tobacco products. For raising awareness against tobacco, the state had formed an anti-tobacco squad in the year 2010. But in recent years the anti-tobacco squads have become redundant. There is an urgent need to reform these squads with better capacity building similar on the lines of Delhi's Civil Defence staff personnel.

## 7. Health Financing and Fund absorption capacity

Mizoram State will be committing to a proportion of total (Central and State) budget for Health on par with current Union government of 2.26% with an annual increase to reach 5% of total budget in the next 5 years. This is to achieve the level of 2.5% of GDP of State at the earliest and consistent with the National Health Policy 2017. Further efforts will be made to reach ultimately the goal of 5% of GDP.

All centrally sponsored programmes and innovations under National Health Mission in both Rural and Urban sectors will be implemented fully absorbing the allocated funds. For this Techno-Managerial support through the State/District management units and its staff will be provided.Contractual appointment of those positions will be in a phased manner absorbed into the State health system and budget for regularisation of those posts will explored.

## 8. Governance and Monitoring

Mizoram State Health Society (MSHS) will be in charge of implementing the National Health Mission (NHM), which is led by Mission Director (MD), NHM. NHM will continue to be

implementing 31 health programmes in the areas of reproductive and child health, communicable illnesses, non-communicable diseases, and health system improvements.

The policy will encourage situational analysis of basic structural bottlenecks and periodical program review and planning sessions.

Under the new state Policy there shall be a strong Monitoring and Participatory Governance Mechanism. The local communities will be active co-facilitators articulating their needs, identifying key indicators and creating tools for monitoring and evaluation, providing feedback and validating the functioning of the Public Health system.

For this there shall be the establishment of Health Councils at each of the village, block and district levels. Meanwhile, States shall formulate State Health Councils and promote the functioning of community-based health monitoring, evaluation, governance and planning bodies. Additionally, these bodies are responsible for organizing periodic public hearings to ensure accountability of the health system to the community. Finally, the councils are to ensure that their respective healthcare establishments act in accordance with provisions of this policy and perform all or any functions necessary to fulfil rights and obligations enunciated under this policy.

The State Health Council shall promote access to primary, secondary and tertiary healthcare and simultaneously oversee the functioning of Village, Block and District Health Councils. Additionally, it also oversees community outreach and establishes performance standards for health care infrastructure, service providers, quality or performance improvement that are necessary for the objectives under this policy. Lastly, the State Health Councils, are also responsible for developing mechanisms for empowering the decentralized monitoring committees at all levels, rural as well as urban, thus paving the way towards institutionalization of the right to health at the grassroots level.

## 9. Health Infrastructure

In the state is on highly inadequate, with only one good medical college in the state i.eZoram Medical College. There is an urgent need to build more Medical Colleges in the state meeting the universal standards. As the students appearing for the medical entrances in the state is

high, due to lack of colleges they have to miss their ambition and face unemployment. With building of more colleges in districts like Lawngtlai, will be a boon for the students, the residents as well as it will ensure a robust production system for better availability of doctors of high calibre and professional skill within the state.

A proposal to create Special Medical Zones (SMZ) taking inspiration from special economic zones. The Special Medical Zones in the state will be demarcated in non-agricultural area, where private medical companies like, Apollo, Fortis, Vedanta, etc may be invited to setup hospitals within the state. The Special medical zones will have special provisions for these private investors to suit their requirement and to improve their ease of doing business.

## 10. Human Resource Policy

To achieve the above goals, the State of Mizoram requires a structure and Human Resources with clear cut roles and responsibilities. Currently there are only two Directorates i.e. Directorate of Health Services and Directorate of Hospital and Medical Education. There is an evolving demand for a cadre of Public Health Administration and Management separate from the clinical care and hospital services and the academic stream of Medical and Nursing Colleges. This is spearheaded by NITI-Ayog and many States have embarked upon this restructuring.

The new Health Policy will initiate the following changes in the current organogram:

1) Evolution of a separate public health management cadre

2) Improved promotional avenues for those opting for clinical management in CHCs and DH or Medical college/nursing college teaching positions.

3) Focus should be placed on excellence in performance, deriving a job satisfaction and catalysing motivation among the HRH for which we have to include also performance-based incentives.

4) Special emphasis will be on the filling up of requirements of the health care workers.

Many Consultants in medical and surgical specialities, Dentists, Psychologists/Counsellors, MBAs, M.Com/ CAs, Physiotherapists, Lab Technicians

appointed through NHM are needed for the State PHS. Assurance of continuity of service and privileges of pension and gratuity will be a motivating factor to continue with government service. The pull factor from private sector will be a constant threat to the staff strength of PH System.

State will proactively attract young MBBS graduates to join PHS and post them in areas of their choice if that can be accommodated after fully achieving the needs of institutions in remote and difficult areas. Depending on the ethnography and geography of the applicants posting in their home districts and among their own tribes and clans will be beneficial both for the system and the doctors, nurses, and other health staff.

State will identify and sponsor meritorious undergraduates posted in PH System for Postgraduate studies outside the State with a service bond of 5 or 7 years. Once they finish specialization their posting as Consultant Specialists should be automatic and without uncertainty. This will solve the high vacancies in CHCs and District hospitals.

## 11. Strengthening referral services-secondary and Tertiary care services

State will make immediate plans to upgrade all eight District hospitals to deliver the full complement of Tertiary services. The existing district hospitals can be renovated, restructured to deliver the full complement of Tertiary care. Some of those essential components over and above OPD/IPD and Operation theatres, Labour room, Accident and Emergency, are Coronary Care Unit, Intensive Care Units for General and Paediatric cases, Neonatal ICU, Burns Unit, Blood bank, Liquid Medical Oxygen generation plant, Dialysis Unit, Radiation, and Chemotherapy wards, etc. That was a need intensely felt in many District Hospitals in the country during the Pandemic crisis during the delta wave.

Incorporating the recommendations NEDfi Study five new FRU at CHC level and five new model DH will be established to ensure better access to health. A model DH, will house specialists and functional departments and serve as a hub for three- four adjoining districts and new units as per requirement will be set up. Regular service doctors are not routinely absorbed as per vacancy. For the up gradation of DH, the state will develop four Model District Hospitals/ Tertiary care hospitals- at Lunglei, Champai, Mamit and Lumbli by 2030 out of which by 2023,

one at Mamita and the other in Lunglei, providing all facilities and HR as per IPHS norms will be created.

The policy will be giving importance to sanitation in healthcare establishments as a habitable, clean and safe environment. It is a basic necessary requirement in healthcare establishments.Since Medical Colleges are inadequate, the State will make immediate plans to upgrade all 8 District hospitals to deliver the full complement of Tertiary services. The existing district hospitals can be renovated, restructured to deliver the full complement of Tertiary care. Some of those essential components, over and above OPD/IPD,Operation theatres, Labour room, Accident and Emergency, are Coronary Care Unit, Intensive Care Units for General and Paediatric cases, Neonatal ICU, Burns Unit, Blood bank, Liquid Medical Oxygen generation plant, Dialysis Unit, Radiation, and Chemotherapy wards, etc. That was a need intensely felt in many District Hospitals in the country during the Pandemic crisis during the delta wave.

The policy sees the requirement of free transportation for the poor to and from healthcare establishments, elsewhere in the country for tertiary specialised care.

## 12. Free Drugs and Diagnostics

**Free Drugs Service Initiative** implemented since 2014 and**Free Diagnostic Service Initiative** implemented since 2016 will continue as a state policy. Through these initiativesall public health institutions have access to free critical pharmaceuticals in order to keep the health system running smoothly and to decrease out-of-pocket health care costs of its citizens during illness. Also it provides free, a set of key diagnostics at SCs, PHCs, CHCs, and DHs much to the solace of citizens.

## 13. Application of information technology and -e governance

To eliminate possible corruption in Health department and prevent diversion of NHM funds, to make the whole governance fair and transparent to public, to strike at the root of corruption, the state will have a Web based- advertisement of vacant and new posts, recruitment including test and selection interview, appointment and transfer of health staff, for award of contracts for civil works and intake of human resource, Electronic payment of bills and invoices - helps tracking of undue delay in payment of cheques with provision for satisfactory reasons for rejection or modification of claim bills.

An IT enabled system for human resource recruitment, placement, promotion and transfers will ensure transparency and elimination of corruption and favouritism. Similarly, IT enabled system of procurement and supply of medicines, diagnostics and equipment will ensure transparent, timely, merit-based procurement and supply, assure quality and boost efficiency of Public Health System.

## 14. Community Participation

Apart from the vital role of Community as a stake holder, in governance and monitoring, the state of Mizoram has tried to harness the power of communities for creating a strong sense of ownership for the AB-HWCs and this will be continued.

Community participation and ownership will be encouraged for rejuvenation of a weakened and not so efficient public health system, it must rely on strong ownership by the public, user

involvement. RogiKalyanSamithis and hospital management committees will be expanded with more broadly represented user groups and Community watchdogs rather than just one MLA or MP. These user groups and community watchdogs can facilitate social audit of major activities undertaken by health institutions.

Collaborating with different media houses, civil societies and church organisations, awareness on different government health schemes and family planning will be raised in a sustained manner.

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# Mizoram State Health Policy

**A Guidance Document**

# PREFACE& ACKNOWLEDGEMENT

The lifeline of this document is in placing importance to health as a human right central to right to life. In this spirit, the government of Mizoram, Department of Health and Family Welfare has sought the assistance of the Public Health Foundation of India, to draft the Health Policy for the state of Mizoram. The Public Health Foundation of India initiated the activities with the Hon Minister of Health, Dr R.Lalthangliana and the Principal Secretary of Health, Pu R.Lalramnghaka, along with other relevant stakeholders.

The Public Health Foundation of India was established 16 years ago with the goal of increasing India's broadband public health capacity through interdisciplinary and health-system-connected education, specific skill-oriented training, policy and program-relevant research, evidence-based and equity-promoting policy development, people-empowering health communication, and persuasive advocacy for priority public health causes.

We at PHFI are delighted to present the final report to the Government of Mizoram, which is the product of these extensive deliberations. We gratefully acknowledge the Hon Minister of Health, Dr R.Lalthangliana and the Principal Secretary of Health, Pu R.Lalramnghaka, IAS, as well as the technical experts that assisted us. We are grateful to everyone on the PHFI team who made the committee's work so much easier.

The draft report, based on the analysis of existing literature, data and deliberation with the stakeholders from department of health and family welfare was submitted to the government of Mizoram on 31$^{st}$ March 2022. We at PHFIare delighted to present the final report to government of Mizoram which is a result of rich, engaging and wide-ranging consultations with the stakeholders.

We express our sincere gratitude to the Hon Minister of Health, Dr R.Lalthangliana and the Principal Secretary of Health, Pu R.Lalramnghaka, IAS as well as the internal and external technical experts for their inputs. We are very thankful to all those in the draft committee who greatly facilitated the working of the committee.

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# PREAMBLE

In 1946 the World Health Organization constitution envisioned, the highest attainable standard of health as a fundamental right of every human being. Thus, Right to health is a non-negotiable right bestowed over every individual. The spirit of this policy draft incorporates the visions of WHO and the Indian Constitution, with envisioning the state's obligation to achieve the right to health through the allocation of "maximum available resources" to progressively realise the vision of right to health.

The achievement of this policy draft would be realised in catalysing a working relationship between the government of Mizoram and the central government based on the principles of cooperative federalism for diverse health challenges faced by the state. Both the State governments and Central government have played an active role in the capacity building of the health infrastructure and enabling the individual's accessibility towards clean and safe surroundings, sanitation facilities, optimum nutrition, safe drinking water, and a lifestyle that prioritises physical exercise and healthy living habits while discouraging unhealthy lifestyle.

The average NITI Aayog Health Index score among the smaller states in the reference year (2017-18) was 53.11, compared to 53.13 in the Base Year (2015-16). In Nagaland, the Index score was 38.51, whereas in Mizoram, it was 74.97. Mizoram scored the best among all the smaller states. However, Mizoram as a state poses different set of health challenges as compared to the rest of India. Mizoram, with its high development potential, community ties and relatively under developed health-care delivery systems, faces a number of difficulties that are numerically and qualitatively distinct from other states. Although, there are central health policies in place and action, these national policies may not be adequate to address the state's health challenges and diverse stakeholder's development holistically. Thus, there is a need for a state health policy exclusive to Mizoram, which will also strive towards an action plan to achieve universal standards of health care as enshrined into the policy. This policy draft proposes a tailored set of recommendation which takes into account development of diverse stakeholders holistically. This action plan will serve as a blueprint for other states especially small states in India for coming decades.

# GLOSSARY

1. AB-PMJAY- Ayushman Bharat Yojana- Pradhan Mantri Jan Arogya Yojana
2. AIDS- Acquired immune deficiency syndrome
3. AMB-Active Magnetic Bearing
4. ANCDR- Annual new case detection rate
5. ANM-Auxiliary nurse midwife
6. APL-Auxiliary nurse midwife
7. ART- Antiretroviral Therapy
8. ASHA -Accredited Social Health Activist
9. AYUSH- Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
10. BCG- BacilleCalmette-Guerin
11. BMW-Biomedical Waste
12. BPL- Below Poverty Line
13. BRIDGE- Boosting Routine Immunization Demand Generation
14. BSCs- Blood storage facilities
15. CAH-Congenital Adrenal Hyperplasia
16. CBNAAT- Cartridge-based nucleic acid amplification test
17. CHA- Canine Hydrotherapy Association
18. CHC- Community Health Centers
19. CHO-Community Health Officer
20. CRM- Common Review Mission
21. DEIC-District Early Intervention Center
22. DH- District Hospitals
23. DIO/MO- Master of Obstetrics/ diet-induced obesity
24. DPMU-Defects per Million Units.
25. DST -Drug Susceptibility Testing

26. DTC- direct-to-consumer
27. DVDMS- Drugs and Vaccines Distribution System
28. EDL- Essential Drugs List
29. EPI- Exocrine pancreatic insufficiency
30. GDP- General Dental Practitioner
31. HCF- Host Controlled Factor.
32. HCFS- Health Care Financial Services
33. HITES - HLL Infra Tech Services Ltd
34. HIV- Human immunodeficiency virus infection
35. HMIS- Health Management Information System.
36. HPD- Highest Posterior Density.
37. HPDs- High Priority Districts
38. HPDS- High Potential Development Scheme.,
39. HRIS-Human Resource Information System
40. HWC- Health and Wellness Centres (HWCs)
41. ICDS- Integrated Child Development Services Scheme
42. ICU- Intensive care unit
43. IDSP- Integrated Disease Surveillance Programme
44. IEC-Information, Education and Communication
45. IMR-Infant mortality rate
46. IPD-Inpatient Department Care.
47. JSY- Janani Suraksha Yojana
48. LWE-Left-Wing Extremism
49. MD- Doctor of Medicine, Mission Director
50. MDR TB - Multidrug-resistant TB
51. MLA -Medical Library Association, Medical Laboratory Assistant
52. MMR- Maternal Mortality Ratio

53. MMU- Mobile Medical Units

54. MO-Medical Officer

55. MoU- Memorandum of Understanding

56. MP- Member of Parliament

57. MR - Chlorzoxazone

58. MSCI-Mizoram State Cancer Institute

59. MSHCS- Mizoram State Health Care Society

60. MSHS- Mizoram State Health Society

61. MTC- Medullary thyroid cancer

62. NCC- Neurocysticercosis

63. NCD- Non-Communicable Disease

64. NCDR -new case detection rate;

65. NER SDG- North Eastern Region District Sustainable development goals index

66. NERLP- North east rural Livelihood Project

67. NFHS-National Family Health Survey

68. NGO- non-governmental organization

69. NHM- National Health Mission

70. NID 2019- National Immunisation Day

71. NITI-National Institution for Transforming India

72. NOHP- National Oral Health Programme

73. NPCDCS- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke

74. NPHCE- National Programme for Health Care of the Elderly

75. NPPC- National Programme for the Palliative Care

76. NPPCD- National Programme for prevention and control of deafness

77. NRLM-National Research Laboratory of Metrology

78. NSS- National Service Scheme

79. NSSO -National Sample Survey Office
80. NUHM-National Urban Health Mission
81. NVHCP - National Viral Hepatitis Control Programme
82. NYK-Nehru Yuva Kendra
83. OPD - Outpatient Department
84. OPV- Oral Polio Vaccine
85. Penta-Pentavalent Vaccine (Pantoprazole Sodium Tablets)
86. PHC – Primary Health Centre
87. PHFI- Public Health Foundation of India
88. PIP- Program Implementation Plans
89. PMKSY- Pradhan MantriKrishiSichayeeYojana
90. PR -per rectum, personal relations
91. RBSK-Rashtriya Bal SwasthyaKaryakram
92. RCH- Reproductive & Child Health
93. RKS –Rogi Kalyan Samiti
94. RMI- Registered Medical Institute License
95. RMNCH+A- Reproductive, Maternal, Newborn, Child Health & Adolescents
96. RNTCP- Revised National TB Control Programme
97. ROP - Retinopathy of Prematurity
98. SCs- Sub Centres
99. SDGs- Sustainable Development Goals
100. SDRF- State Disaster Response Fund
101. SRHF – State Referral Hospital, Falkawn
102. SRS- Sample Registration System
103. TB – Tuberculosis
104. TI -Targetted Intervention
105. UHC-Universal Health Coverage

106. UHND- Urban Health and Nutrition Day
107. UPHC-Urban Primary Health Center
108. UIP'S-Universal immunization Programme
109. VHSNCs -Village Health, Sanitation and Nutrition committee
110. WHO- World Health Organization
111. YAC-Youth Advisory Council

# EXECUTIVE SUMMARY

Mizoram is one of the small states in the country in north-eastern area. It has adopted the State Vision 2030 in the year 2018, which provides a framework for achieving the SDGs by strategically aligning and allocating sectoral budgets. Also, it has been implementing all the specific projects and program activities under the National Health Mission. To provide better healthcare across the states, including to the poor and vulnerable, the state's economy must be strengthened. According to a poll conducted in 2016, 19.63 percent of households were expected to be living below the poverty line, which has fallen to 14 percent in 2019-2020. By 2030, the government hopes to reduce it by 3%. Currently, schemes such as NRLM, PMKSY, NERLP, and others are being implemented with the goal of providing 100% coverage of poor and vulnerable households under health care systems. Malnutrition in Mizoram is one of the factors that contribute to the development of various diseases, which is why proper nutrition for pregnant women and children is critical. In comparison to States' 2016 data, child malnutrition has decreased in 2019-2020. (28 percent stunted, 2.30 percent wasted and 6.10 percent underweight).

The draft policy emphasizes on ensuring healthy lifestyles and promoting well-being for people of all ages. Mizoram State Health Society (MSHS), under the leadership of Mission Director (MD), NHM, is in charge of implementing the National Health Mission (NHM). It encompasses 31 health-related programs. Another milestone is the Reproductive & Child Health (RCH) Program, which is part of the larger Reproductive, Maternal, Newborn, Child Health & Adolescents (RMNCH+A) initiative that focuses on lowering maternal, child, and newborn morbidity and death. Infants, pregnant and breastfeeding women have received supplemental nutrition as the coverage of interventions have been the four ANC visits (58%), health and nutrition education for women (50%); postnatal care for babies (37%), zinc during diarrhea (30%), growth monitoring (62%).

Implementing tobacco control is the state's most pressing health issue and challenge. The World Health Organization (WHO) and country’s Health Ministry have collaborated to develop the Tobacco Cessation Counseling Clinic to help people quit smoking. In Mizoram, ten Tobacco Cessation Clinics are now active. The policy draft is an attempt to improve the state's health status by coordinated policy action across all sectors, as well as extend preventative, promotive, curative, palliative, and rehabilitative services offered by the public health sector, with a focus on quality and as a right of every citizen in Mizoram.

# CHAPTER- ONE

# MIZORAM: AN OVERVIEW

***The first chapter of the policy draft provides an insight towards the state of Mizoram, its geographical, administrative and demographic profile. The State of Mizoram has adopted the State Vision 2030 in the year 2018 which provides, an implementation framework for the SDGs through strategizing sectoral budget alignment and allocation. This chapter will set a tone for the policy draft with outlining its objectives towards the end.***

# 1

# MIZORAM: AN OVERVIEW

## 1.1 Introduction

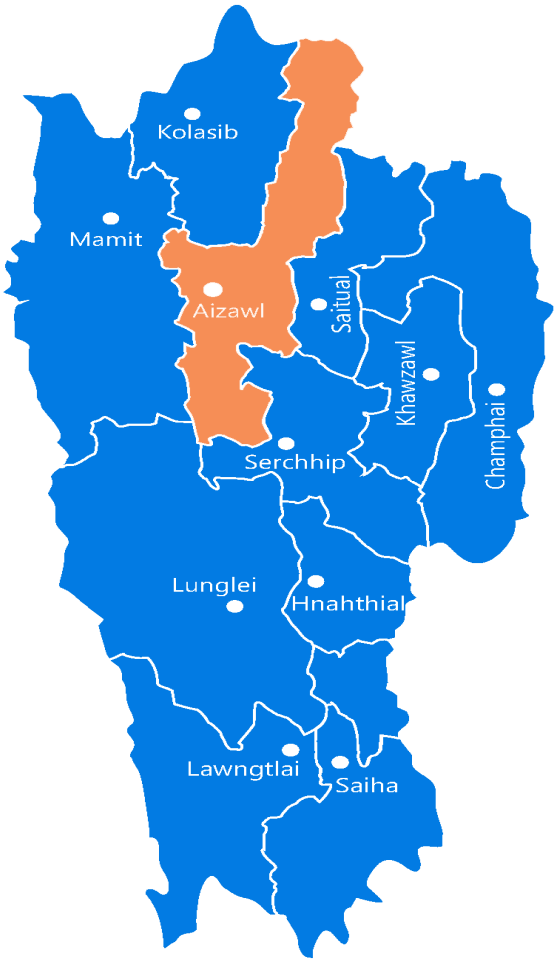



**Figure 1.1: Map of the State of Mizoram**

Land of the Mizos, Mizoram in 1954 was known as the Lushai Hills District of Assam before it was renamed the Mizo Hills District. It shares border with other states of Assam, Tripura, Manipur and international border with Myanmar and Bangladesh. It occupies area of 21,081 square km which is of great strategic importance. Mizoram achieved statehood

in the year 1987 and became the 23rd state of the country. Prior to this, it was one of the districts of Assam till the year 1972.

Mizoram is one of the seven states in the north-east region of India.It shares its borders with three of the other seven sister states viz. Manipur, Tripura and Assam. The land locked state also shares approximately 720kms of border with neighbouring countries of Bangladesh and Myanmar. It derives its name from Mi (People), Zo (Lofty place such as hill) and Ram(land), thus implying land of the hill people.Like its sister states,it is blessed with a rich culture and nature abundant in dense forests,lush green hills,bamboogroves,pristine waterfalls and transparent lakes.

### 1.2 Administration

The state of Mizoram comprises of eleven districts, namely Mamit, Kolasib, Aizawl, Champhai, Serchhip, Lunglei, Lawngtlai, Saihaand newly added Hnahthial, Saitual and Khawzawl. It has three autonomous districts, twenty-three sub-divisions and twenty-sixblocks. The deputy commissioner – executive head of the districts – is entrusted with the district administration

### 1.3 Geography

The Tropic of Cancer passes near the capital Aizawl. Occupying the northeast corner of India, Mizoram is bounded on the north by the states of Assam and Manipur, on the east and south by Chin Hills and Arakan (Myanmar) and on the west by the Chittagong hill tracts of Bangladesh and State of Tripura. The state of Mizoram majorly has hilly terrains which are steep and separated by rivers creating deep gorges between the hill ranges. Approximately 91% of the state is forested. The highest peak in Mizoram is the Phawngpui (Blue Mountain) with a height of 2210 metres. Mizoram has great natural beauty and endless variety of landscape and is very rich in flora and fauna. The dominant activity in Mizoram is agriculture as more than two-thirds of the workforce is engaged in this. Rice, corn (maize), cotton, and vegetables are the main crops.

### 1.4 Demographic Indicators

According to the 2011 census, Mizoram's population was 1,091,014 making it second least populous state of the country. The state comprises of several social groups but the majority

is of tribal communities with 95% of the populations which is the highest concentration of tribal people in India. Mizoram is spread across an area of 21,081 square kilometers. With a population of 10.97 Lakhs, it has the second-lowest population density among Indian states. Thedistribution of the population is equal in rural and urban areas.

**Table 1.1: Demographic profile of the state[1]**

| | |
|---|---|
| Density (per sq km) | 52 |
| Total Population | 10,97,206 |
| Total Population (Female) | 5,41,867 |
| Total Population (Male) | 5,55,339 |
| Total Population (Rural) | 5,25,435 |
| Total Population (Urban) | 5,71,771 |
| Scheduled Tribe Population | 1,036,115 |
| Percentage of Scheduled Tribe | 94.4% |
| Number of districts | 11 |
| Decadal Growth | 23.48% |
| Birth Rate | 18.05 |
| Death Rate | 5.01 |
| Sex Ratio | 975 |
| Sex Ratio at Birth | 974 |
| Child Sex Ratio | 970 |
| Total Literacy Rate | 91.33 |

Accordingtocensus2011,Mizoramhashighestproportionofpopulation(37.62%)inthe15-34(youngadult)years 'agegroup.32.45%ofthestatepopulationisinthe0-14yearsofagegroup,while20.78%ofthepopulationisinthe35-54yearsofagegroup(middleaged).Only 9%ofthepopulationaccountsformorethan55years.

[1]Census 2011, www.census2011.co.in

Each of the district has varying demographics as presented in table 1.2 (data on new districts is unavailable). Mamit is the least populated (28 person per sq.km) with lowest literacy rate and lowest sex ratio. Lawngtlai is the next district on the following parameters.As per assessment of NITI Aayog, among the 28 states in India, Mizoram is 7$^{th}$ rank in having lowest percentage of Multi-dimensional poor with 9.8%, Kerala being lowest with 0.71% and Bihar having highest with 51.9%.

**Table 1.2: District wise demographics**[2]

| Districts | Population | | | Density (per sq km) | Sex Ratio | Literacy Rate |
|---|---|---|---|---|---|---|
| | Male | Female | Total | | | |
| Mamit | 44567 | 41190 | 85757 | 28 | 924 | 60 |
| Kolasib | 42456 | 40598 | 83054 | 60 | 956 | 94.54 |
| Aizawl | 201072 | 202982 | 404054 | 113 | 1009 | 98.5 |
| Champhai | 63299 | 62071 | 125370 | 39 | 981 | 93.5 |
| Serchhip | 32824 | 32051 | 64875 | 46 | 976 | 98.76 |
| Lunglei | 79252 | 74842 | 154094 | 34 | 944 | 89.40 |
| Lawngtlai | 60379 | 57065 | 117444 | 46 | 945 | 66.41 |
| Saiha | 28490 | 27876 | 56366 | 40 | 978 | 88.41 |

The state of Mizoram has adopted the State Vision 2030 which provided for an implementation framework for the SDGs through strategizing sectoral budget alignment and allocation. Based on the NITI Aayog's NER SDG index (2021), seven districts are front runners implying that majority of the districts are performing well on all indicators. The score for the state ranges from 63.40 to 74.87 with Serchhip with a score of 74.87 at 5th overall rank (highest) and Lawngtlai with a score of 63.40 at 79th overall rank (lowest).

[2] https://mizoram.nic.in/about/glance.htm

**Table 1.3: District Wise Performance on SGDs**

| District | Overall Rank | Rank within State | Score |
|---|---|---|---|
| Serchhip | 5 | 1 | 74.87 |
| Lunglei | 8 | 2 | 72.87 |
| Kolasib | 12 | 3 | 72.27 |
| Champhai | 15 | 4 | 71.93 |
| Mamit | 19 | 5 | 71.47 |
| Aizawl | 20 | 6 | 71.27 |
| Saiha | 39 | 7 | 68.27 |
| Lawngtlai | 79 | 8 | 63.40 |

*(2021)*[3]

*Source: NITI Aayog NER SDG Index (2021)*[3]

Economic survey of the state of Mizoram (2019-2020)[4] acknowledged that the state faces challenges in terms of SDGs Good Health and Well Being, Quality Education, Sustainable Cities, Sustainable Communities and Life on Land which has impacted their overall score. Particularly speaking of the SDG related to health i.e. Good Health and Well Being, the state has improved from the previous edition of the report.

**Table 1.4: District wise performance on SDG 3**

| District | Score |
|---|---|
| Champhai | 76 |
| Saiha | 71 |
| Lunglei | 70 |
| Aizawl | 66 |
| Kolasib | 65 |

[3] https://www.niti.gov.in/sites/default/files/2021-08/NER_SDG_Index_NITI_26082021.pdf

[4] https://planning.mizoram.gov.in/uploads/attachments/4d6a424cb421f1fafef5c29cb0068b83/economic-survey-2019-20.pdf

| | |
|---|---|
| Serchhip | 65 |
| Mamit | 60 |
| Lawngtlai | 51 |

*Source: NITI Aayog NER SDG Index (2021)*[5]

Based on table 1.4, we can understand that the performance of districts- Lawngtlai, Mamit, Kolasib and Serchhip need more attention and efforts in terms of health indicators. Lawngtlai in particular has higher proportion of anaemic population and proportion of stunted children is relatively higher, which is a grave concern.

Having discussed the overview of the state, it is important to glance at the goals and objectives of this policy document.

## 1.5Goals and Objectives:

The goal of the policy draft is to provide a guidance document to assist the state government of Mizoram in strengthening the health systems of the state, by identifying and addressing the challenges. The key objectives of the report are as follows:

**a)** Identify the key health related challenges being faced by the state.

**b)** Interact with the stakeholders and present their opinions derived from expertise which will be included in the recommendations.

**c)**Present the findings of the stakeholder interactions and data analysis from the existing national/state level reports.

**d)**Assist the state of Mizoram in strengthening the health systems of the state by proposing a set of recommendations which can be implemented.

[5]https://www.niti.gov.in/sites/default/files/2021-08/NER_SDG_Index_NITI_26082021.pdf

# CHAPTER- TWO

# VISION OF HEALTH AND FAMILY WELFAREDEPARTMENT

***The second chapter of the policy draft provides an insight on the Health Vision of the State's Health and Family Welfare Department. It Incorporates the State Vision 2030 adopted in the year 2018.In Mizoram it was estimated that 19.63 % of the households were living under the BPL which has decreased to 14% in 2019-2020. The government aims to bring it down to 3% by 2030. Also, by 2029 the government aims to provide nutrition for all who are in the age group of 0-6 and nutrition for all pregnant and lactating mothers. Further, it lists the long term vision and short term vision of the policy. The chapter furthers examines whetherthe policy principles envisaged for the Government of Mizoram is in tune with the National Health Policy 2017 or not. The chapter concludes with the organogram of the State health department.***

# 2

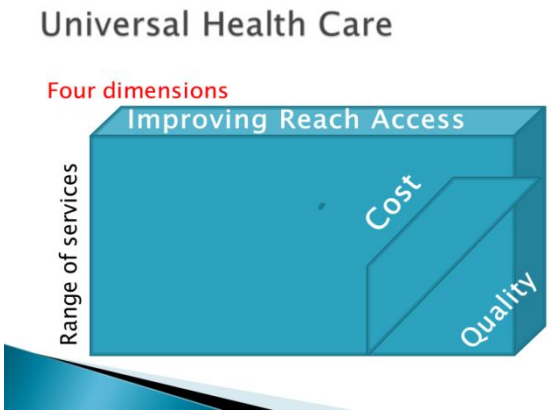
# VISION OF THE HEALTH & FAMILY WELFARE DEPARTMENT

The vision of the Mizoram state health department is to increase the quality of life for its people by attaining the highest level of physical, mental and spiritual health; that will contribute towards the development of the state. Towards this vision it has fully accepted the principles and vision of globally acclaimed **Universal Health Coverage and Care.**

UHC is a solemn affirmation of social solidarity, which is the most enabling attribute of an advancing and progressive civilization. UHC requires that all essential health services be available to every person, based on need and with assured quality, without anyone suffering financial hardship.

World Health Organization recommends a path of progressive universalization, in the form of a cube with three dimensions:

1. Population coverage
2. Service coverage
3. Cost coverage
4. Overarching Quality Assurance leading to Client satisfaction

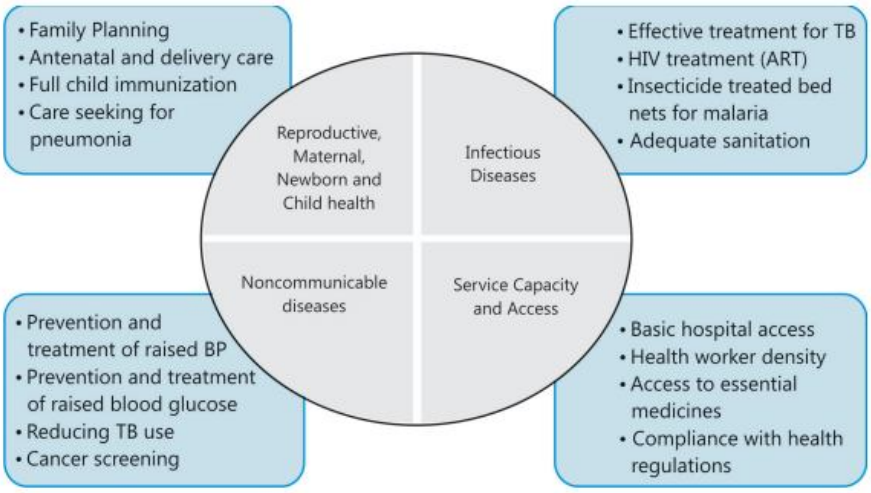


Apart from health financing, all other elements of the health system too must be assured. They include:

- adequate infrastructure at all levels of care
- a multi-layered, multi-skilled health workforce
- uninterrupted supply of essential drugs, vaccines, and technologies
- accurate and time-sensitive health information systems
- community engagement
- good governance and administrative efficiency

### 2.1 Key Areas of provision under UHC.

While all the components of health systems need to be strengthened to achieve UHC, WHO stresses on the following four key areas to be addressed on priority basis, to ensure equity of coverage. These areas are presented in Figure



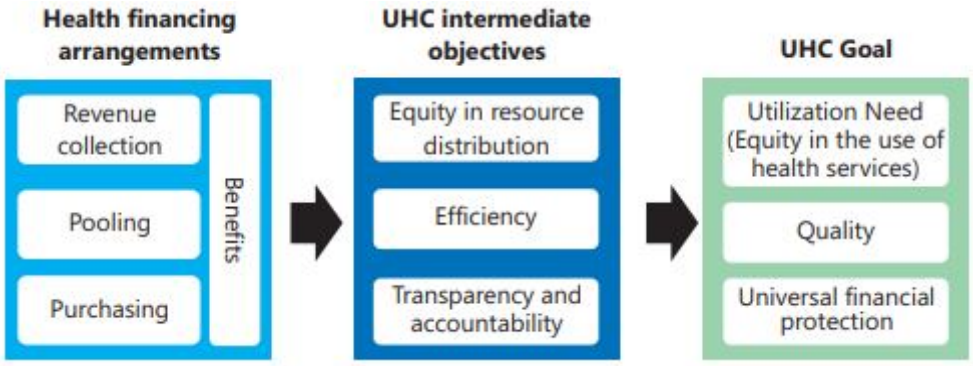

### 2.2 Universal Health Coverage

Following are the ten key measures that are needed to achieve the objectives of UHC in the state,

14. Increase public expenditure on health and reduce out of pocket expenditure on health
15. Improve the situation of human resources for health (HRH)
16. Strengthen Service Delivery at Primary Care Level
17. Develop an efficient procurement and disbursal mechanism for drugs

18. Ensure quality at every level of service delivery
19. Increase public participation and feedback
20. Communicate benefits available under UHC to people
21. Engage and regulate private health care sector
22. Strengthen overall healthcare governance and management

### 2.2.1 Goal and objectives of UHC: Health financing system




UH Care includes various social determinants of health like safe water, sanitation, nutrition, food security, primary education, livelihood and poverty aversion, community empowerment, gender and social equity etc

So, the health department shall be serious for convergence with allied sectors and shall build up its capacity for inter-sectoral coordination.

Fortunately the above vision of Universal Health Coverage and Universal Health Care which includes Health determinants also is amply reflected in National health Mission of India since 2005.The Mizoram state is in line with the National Health Mission which has a vision of decentralization for district management of health, participatory bottom-up planning, quality assurance in services& client satisfaction, inter-sectoral convergence and improving access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

The National Health Mission incorporates the following key principles in its operationalization stage. The paradigm shifts in the key principles are:

First, distrust to trust, second, inflexibility to flexibility, third, centralized to decentralized action, fourth, funds functions, functionaries for service and fifth, building capacities at all levels.

They key missions of the state department are the following:

a) Promotion of healthy behaviours and life styles, undertake preventive steps against death and diseases, Provide quality curative health services.

b) Improving maternal and child health services & child sex ratio along with population stabilization.

c) Developing human resources for health and revamping of local health traditions under the purview of AYUSH and usage of common medicinal plants.

The Health Policy also envisions and takes inspiration from the core values of The Right to Health and Healthcare bill 2021. It focuses on the incremental steps to conceptualize the "Right to Health" for the whole state. The policy shifts towards a significant step of the operationalization of the right to health as a state duty. The state will also introduce mechanisms for monitoring governance at the village, district as well as the state level. The right will also encompass the right to continuity of care, the right to a habitable, clean and safe environment and the right to access caregivers/care giving services within its domain. On the similar lines as The Right to Health and Healthcare bill 2021, this policy draft proposes the formulation of a Committee for the realization of health in prisons and an established redressal mechanism through District Mediation and Conciliation Committee.

They key objectives of the state department are the following: First, control of Communicable and Non-Communicable Diseases including HIV/AIDS and promotion of Community Action for Health (CAH). Second, reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Third, improving Maternal and Child Health and its service delivery. Fourth, ensuring Population Stabilization and enforcement of health related regulatory matters in the state. Fifth, promotion of adolescent health and

development of AYUSH hospitals & dispensaries including IEC under AYUSH Programme.

### 2.3 State Vision 2030:

Mizoram adopted the State Vision 2030 in the year 2018. Mizoram is among the top four high growth states in India with its economy continuously growing at the rate of more than 8% during 2013 to 2016. Strengthening the economy of the state is crucial to provide better healthcare across the states including poor and vulnerable population. According to a survey done in 2016, it was estimated that 19.63 % of the households living under BPL, has decreased to 14% in 2019-2020. The government aims to bring it down to 3% by 2030. In contemporary year schemes like NRLM, PMKSY,NERLP etc have been implemented. These schemes aim to provide 100% coverage of poor and vulnerable households under health care scheme.

Malnutrition is a major state health issue and one of the reasons that lead to different diseases. Thus, it is important to ensure nutritional well-being of pregnant women and children. Child malnutrition has decreased in 2019-2020 as compared to the year 2016. In the year 2016, Children under the age five, 28 % children were stunted, 2.30 % wasted and 6.10 % underweight prevalence. Supplementary Nutrition has been given to a large number of children, pregnant and lactating mothers. (Fig 2.1)

**Percentage of Stunted, wasted, underweight children under age 5 Years**

| Years | | Stunted | Wasted | Underweight |
|---|---|---|---|---|
| 2019-20 | : | 13 | 2 | 4.50 |
| 2024-25 | : | 10 | 1 | 3.66 |
| 2029-30 | : | <10 | <1 | <2.5 |

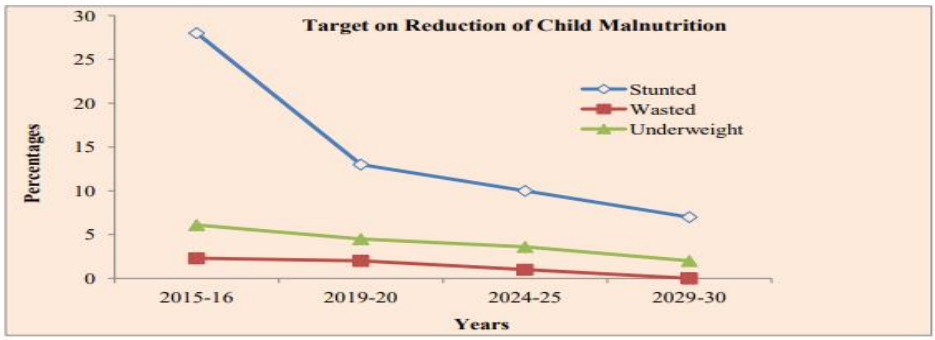



**Figure 2.3.1: Percentage of Stunted, wasted, underweight children under age 5 years**

By the year 2029 the government aims to provide nutrition for all who are in the age group of 0-6 years old and nutrition for all pregnant and lactating mothers. It can be achieved by strengthening the implementation of central sponsored schemes like ICDS, National Nutrition Mission, National Health Mission and others health programme.

Our main emphasis is to ensure healthy lives and promote well- being for all. According to a 2015-2016 survey the maternal mortality ratio of the state was 88, Under Five Mortality Rate was 46, and Neo Natal Mortality Rate was 9.13. The given chart (Fig 2.2) shows the estimated ratio to be followed in order to achieve decreased maternal mortality ratio, child mortality ratio by the year 2030. Figure 2.3 shows the ratio to be followed in order to achieve decreased neo-natal mortality ratio and annual malaria death by 2030.

**Target**

**Maternal Mortality Ratio**
(Per lakh pregnant Women)

| | | |
|---|---|---|
| 2019-20 | : | 80 |
| 2024-25 | : | 75 |
| 2029-30 | : | 70 |

**Child Mortality Rate**
**(Under age 5 Years)**
(Per thousand lives birth)

| | | |
|---|---|---|
| 2019-20 | : | 45 |
| 2024-25 | : | 35 |
| 2029-30 | : | 20 |

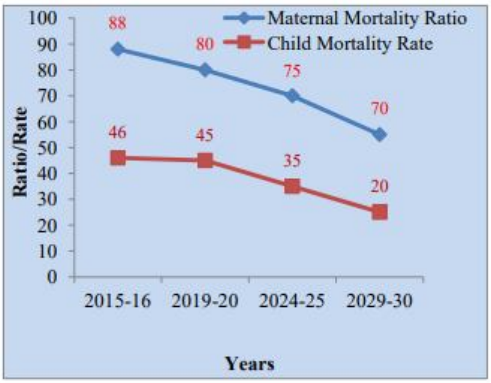



**Figure 2.3.2: Maternal Mortality Rate and Child Mortality Rate**

**Neo Natal Mortality Rate**
(Per Thousand)

| | | |
|---|---|---|
| 2019-20 | : | 8 |
| 2024-25 | : | 7 |
| 2029-30 | : | 6 |

**Annual Malaria Death**
(Per Lakh)

| | | |
|---|---|---|
| 2019-20 | : | 10 |
| 2024-25 | : | 5 |
| 2029-30 | : | 1 |

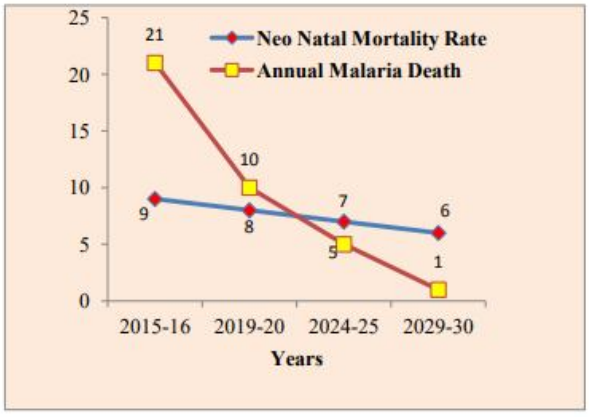



**Figure 2.3.3: Neo Natal Mortality Rate and Annual Malaria Death**

The government also aims to reduce HIV/AIDS cases and strengthen the healthcare facilities. Strategies required to attain the estimated goal are:

1. Re-structuring of primary health care by remodelling PHCs, CHCs, UHCs, DHs,and strengthening of service delivery and capacity building of health workers under the National Health Mission and NEDP.

2. Strengthening implementation of Health care schemes such as Ayushman Bharat Jan Arogya Yojana, ICDS, National AIDS Control Programme, National Vector Borne Disease Control Programme, Routine Immunization Programme, etc.

3. Ending all preventable maternal death, infant and under five deaths as one of the commitments of Government of Mizoram and

4.Improving the reach of services of health facilities to everyone in the State.

### 2.4.1 Long Term Vision & Short-Term Goals

***Long Term Vision.***

*a)* The long term vision of the policy is strengthen the health care system of the state

b) Bring the health parameters such as MMR, CMR, Life Expectancy to that of Nordic Countries.

c) To truly achieve the principles of UHC and right to health for all individuals in the state.

d) To reduce the prevalence of cancer in the state.

***Short Term Goals.***

a) To improve the SDG score of the state while progressing towards the goal of Mizoram Vision 2030.

b) To strengthen the health infrastructure in the purview of different unpredictable waves of COVID-19 and similar Epidemics and Disasters.

c) To increase transparency, accountability and service efficacy in every level of health service delivery in the state.

### 2.4.2Policy Principles

The policy principles envisaged for the Government of Mizoram is in tune with the National Health Policy 2017. The policy principles listed below were strictly followed in every step of drafting and ideation of the health policy.

- **Professionalism, Integrity and Ethics**: The health policy commits itself to the highest professional standards, while upholding the values of integrity and ethics, which will be reflected in the entire system of health care delivery in the state, supported by a credible, transparent and responsible regulatory environment.
- **Equity:** The policy will commit to reduce health inequity and affirm transformative action to reach all sections of the society. It will focus on minimizing disparity on the account of gender, poverty, caste, disability, geographical barriers and other forms of social exclusion. It would imply greater investments and financial protection for the poor who suffer the largest burden of disease.
- **Affordability:** As the costs of care increases, affordability as a parameter distinct from equity requires emphasis. Catastrophic household health care expenditures are defined as health expenditure, exceeding 10% of an individual total monthly consumption expenditure or 40% of its monthly non-food consumption expenditure. The catastrophic household health care expenditure is unacceptable. The Policy would attempt to ensure an affordable and equitable healthcare system in place.
- **Universality:** Prevention of exclusions on social, economic grounds or on grounds of current health status. In this backdrop, systems and services are envisaged to be designed to cater to the entire population including special groups, specially-abled etc.
- **Patient Centric& Quality of Care:** Gender sensitive, effective, safe, and convenient healthcare services to be provided with dignity and confidentiality. The need to evolve and disseminate universal standards and guidelines for all levels of health facilitieswill be addressed. A robust system to ensure that the quality of healthcare is not compromised.
- **Accountability:** Financial and performance accountability, transparency in decision making, and elimination of corruption in health care systems, both in public and private.
- **Inclusive Partnerships:** A multi-stakeholder approach with partnership building& participation of all non-health ministries and communities. This approach would include

partnerships with academic institutions, not for profit agencies, and health care industry as well.

- **Pluralism:** Patients who want to avail the scheme and when appropriate, would have access to AYUSH care providers based on documented and validated local, home and community- based practices. These systems, inter alia, would also have government support in research and supervision to develop and enrich their contribution to achieving the national health goals and objectives through integrative practices.
- **Decentralization:** Decentralisation of decision making to a level consistent with the practical considerations and institutional capacity. Community participation in health planning processes, to be promoted side by side.
- **Dynamism and Adaptiveness**: Constantly improving dynamic organization of health care based on contemporary knowledge and progressive evidence. The learning for the same will be incorporated from the communities and from the national and international knowledge partners, is designed.

### 2.5 Current organogram of the state health department

Consistent with the vision of the Mizoram state health department expressed at the beginning of this chapter to fulfil the key strategies, requires a structure and Human Resource with clear cut roles and responsibilities. Currently there are two Directorates i.e. Directorate of Health Services and Directorate of Hospital and Medical Education.

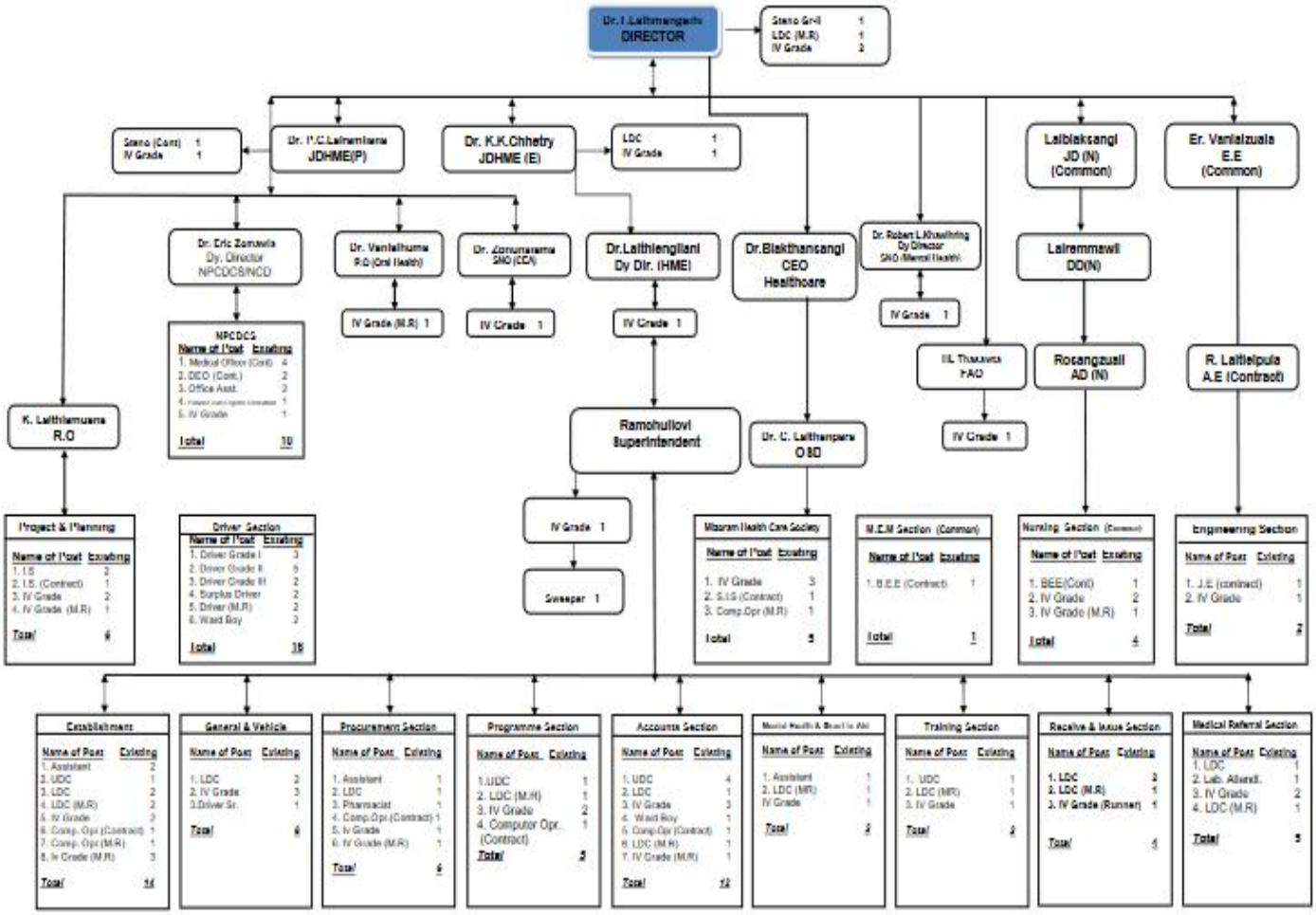



**Fig 2.4: Organizational chart of Directorate of Hospital & Medical Education**

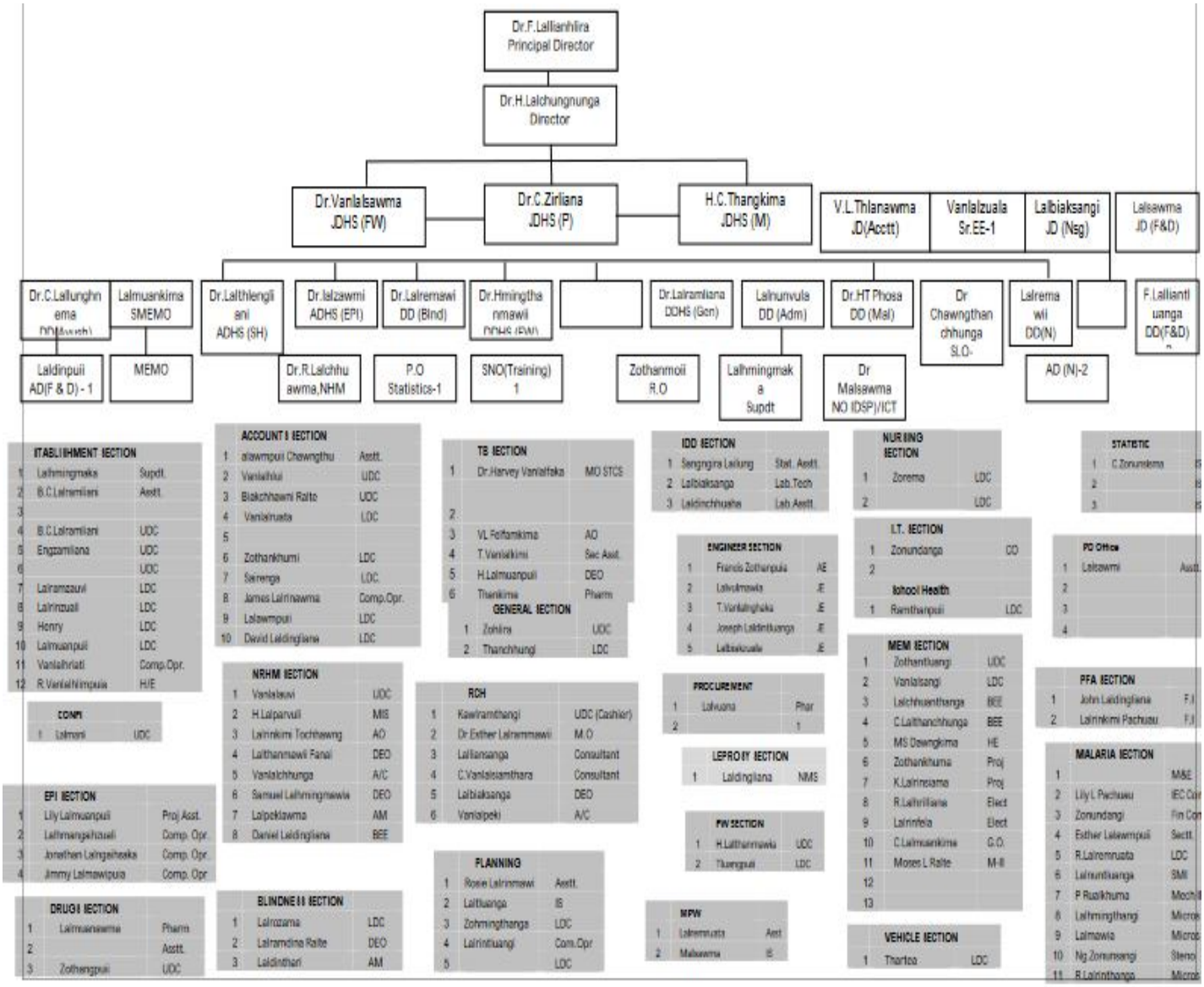



**Fig 2.5: Organizational chart of Directorate of Health Services**

There is an evolving demand for a cadre of Public Health Administration and Management separate from the clinical care and hospital services and the academic stream of Medical and Nursing Colleges. This is spearheaded by NITI Ayog and many States have embarked upon this restructuring.

The new Health Policy will initiate the following changes in the current organogram:

1) Evolution of a separate public health management cadre

2) Improved promotional avenues for those opting for clinical management in CHCs and DH or Medical college/nursing college teaching positions.

3) Focus should be placed on excellence in performance, deriving a job satisfaction and catalysing motivation among the HRH for which we have to include also performance based incentives.

4) Special emphasis will be on the filling up of requirements of the health care workers.

Of all facets of an effective health service, the presence of health worker is the most fundamental requirement. The successful implementation of health care plan requires close attention, not just to the needs of end users of care but also to frontline providers of health care, their antecedents, the circumstances that they live and discharge their duties. The web of interactions which define their role in health systems and societies, their interest, aspiration and needs.

# CHAPTER-THREE

# HEALTH MODEL OF MIZORAM

***The third chapter of the policy draft delves into, the health profile of the state. It also briefly discusses the different parameters of healthcare utilization. The chapter explores the various good health practices in the state. a) Strengthening Wellness activities through Tobacco Cessation Counseling Clinics (TCCC) b) Involvement of village councils and schools in AB-HWCs. It concludes with comprehensive investigation on the aspects of Universal Health Coverage (UHC), Disaster Preparedness and Medical Preparedness.***

# 3

# HEALTH MODEL OF MIZORAM

The data presented below offers a brief summary of the status of health outcomes, healthcare challenges, resources, and service delivery in the State. The information has been obtained from the National Family Health Survey (NFHS) 2019-20, Sample Registration System (SRS) 2020, National Sample Survey Office (NSSO) 2017-18, State Data and various reports of the World Health Organization (WHO).

## 3.1 Healthcare utilisation level

As on March 31st 2020, there are 311 sub-centres, 57 PHCs and 9 CHCs functioning. The required numbers of health workers/ ANM are 368 at sub-centres and PHCs, but there are only 346 female worker/ANM and 302 male worker/ANM are working in the sub-centres and PHCs. No health assistants are available in any of the PHCs. All PHCs have doctors available for treatment. In CHCs there are no specialist (surgeons, OB&GY, Physician, and Paediatrician) available which is a matter of concern. The number of pharmacists is less in PHCs and CHCs as compared to the requirement. Among 66 pharmacists posts sanctioned, only 42 are available. The number of laboratory technicians (74) and nurse staffs (245) are sufficient in PHCs and CHCs.

### 3.1.1 Assessment of Healthcare services

As on March 31st 2020, there are nine district hospital, two sub divisional hospital, one medical college and one hundred and four health and wellness centre (42 HWC-SCs, 54 HWC-PHCs and 8 HWC-UPHCs) functional in Mizoram.The total number of hospital beds in Mizoram is 1,997 in the public sector and 499 in the private sector. In comparison to the national average, this is quite low.

### 3.1.2 Health Infrastructure Capacity

As on March 31st 2020, all building required for sub-centres, PHCs and CHCs (368) are government building. 213 sub-centres have ANM quarters in 311 sub-centres. 56 sub-centres are without regular water supply and 121 HSC are without regular electricity supply. None of the sub-centres function as per the IPHS norms. All 57 PHCs are functioning and all have labour room and at least 4 beds. Only 41 of the PHCs are working on full time basis. Two of the PHCs have no electricity supply and 4 don't have regular water supply. In 47 PHCs there are computer and telephones in 22 PHCs. All PHCs have registered RKS.

There are 9 CHCs which are fully functional and well equipped.

### 3.2 Current status of health indicators

**Table 3.1: Status in Mizoram**

| Category | Indicator | Data source (Assessment year) | Status in Mizoram |
|---|---|---|---|
| Family planning | Married women 15–49 years women who are using modern methods of contraception | NFHS-5 (2019-20) | 30.8 % |
| Antenatal care coverage | At least 4 visits to any care provider during pregnancy | NFHS-5 (2019-20) | 58.0 |
| Skilled birth attendance | Births assisted by a doctor/nurse/LHV/ANM/other health personnel) | NFHS-5 (2019-20) | 87.7 |
| Immunization coverage (DPT) | 12-23 months-old children who have received 3 doses of vaccine containing diphtheria, tetanus and pertussis (DPT) | NFHS-5 (2019-20) | 80.7 |
| Immunization coverage (fully immunized) | 12-23 months-old children fully immunized (BCG, measles, and 3 doses each of polio and DPT) | NFHS-5 (2019-20) | 72.5 |
| Treatment of childhood diseases (pneumonia) | Children < 5 years with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility | NFHS-5 (2019-20) | 53.0 |
| Percentage of population using improved sanitation facilities- | Population living in a household with:<br>flush or pour-flush to piped sewer system, septic tank or pit latrine; ventilated improved pit latrine; pit latrine with slab; or composting toilet | NFHS-5 (2019-20) | 95.3 |

| | | | |
|---|---|---|---|
| Tuberculosis treatment success rate *Number of persons per 100,000 suffering from: | All the patients that were cured and those that completed treatment | India TB report 2020, MoHFW (data for 2018)[6] | Female- 607 Male- 641 |
| Hypertension coverage* | Adults 30-69 years and currently taking antihypertensive medication | National NCD Survey (2017-18)[7] | |
| Diabetes coverage* | Adults 30-69 years and currently taking medication for diabetes (insulin or glycaemic control pills) | National NCD Survey (2017-18) | |
| Prevalence of tobacco use* | Adults 15-49 years and older who have not smoked tobacco in the past 30 days | NFHS-5 (2019-20) | |
| Hospital beds per capita | Total number of hospital beds (public+private) | HMIS | 2,496 |
| Health workforce | Health professionals (physicians, psychiatrists, surgeons) per capita | Health Labour Market Analysis:[8] | |

The state of Mizoram is also plagued by the endemic Malaria. Malaria remained persistent throughout the year and throughout all districts in the state, according to data collected between 2010 and 2018. The surveillance coverage accounted for ≥95% in all sites of study. P. falciparum infection caused the majority of malaria infections and deaths, accounting for 89.3 percent of all malaria cases.

## 3.3 Good Health Practices in the State

### 3.3.1. Strengthening Wellness activities through Tobacco Cessation Counseling Clinics (TCCC)

[6] India TB Report 2020. https://tbcindia.gov.in/showfile.php?lid=3538
[7] National NCD monitoring survey. Can be accessed at https://www.ncdirindia.org/nnms/

According to the Global Adult Tobacco Survey (GATS) 2009-10, Mizoram has the highest tobacco prevalence in India at 67.2 percent, with 72.5 percent males and 61.6 percent females using tobacco in some form. It also has the country's lowest "planning to quit tobacco" rate. At home, second-hand smoking exposure is exceedingly high, at 97.7%. To avoid many more illnesses, disabilities, and deaths in the state, more concerted tobacco control activities must be implemented on a long-term basis.

The World Health Organization (WHO) and India's Ministry of Health have teamed together to launch the Tobacco Cessation Counselling Clinic. Individual assistance in the form of behavioural counselling, medicine, and nicotine replacement treatment is available at the clinic. The Directorate of Hospital and Medical Education, Aizawl, housed Mizoram's first TCCC. There are presently ten operational Tobacco Cessation Clinics in Mizoram, with nine in Health and Family Welfare District Hospitals and one in the Cancer Hospital, following the inauguration of a Tobacco Cessation Clinic at State Referral Hospital, Falkawn on September 26, 2017.

**Financial Progress in 2019-20:**

Total Budget Approved (RoP) was Rs. 138.43 Lakhs. But the total funds received from the government of India were only Rs.84 Lakhs. The total expenditure was 121.55 lakhs in total expenditure. The aforementioned costs are covered by a loan from the State Health Society/National Health Mission.

**Physical Achievements:**

**Table 3.3.1.1: *Physical Achievements***

| Sl.No. | Name of Activity | No of Activity | Details/No of participants |
|---|---|---|---|
| 1. | Training and Sensitization Workshop | 67 | 2163 |
| 2. | Anti-Tobacco Awareness Campaigns and programmes at Churches/Community | 48 | 1857 |
| 3. | Anti-Tobacco Awareness programmes at Educational Institutions | 48 | 4010 |

| | | | |
|---|---|---|---|
| 4. | Others (Important Meetings, Talk show etc.) | 63 | 416 |
| **Total** | | **1020** | **57025** |
| 5. | Total No. of Clients at Tobacco Cessation Clinics (TCC) | 2333 | |
| 6. | Quit Rate | 20.89 % | |
| 7. | Total No. Of Anti-Tobacco Squad drives conducted | 256 | |
| 8. | Total No. of Offenders for violation of COTPA | 196 | |

According to the Ministry of Health and Family Welfare's criteria, 49 educational institutions were designated as tobacco-free educational institutions during the reporting period.

The current quit rate is 20.89% for the total 2333 clients who visited Tobacco Cessation Clinics. Since July 2011, the society has implemented another two years project on "Advancing tobacco control in Mizoram through capacity Building, strengthening National Tobacco Control Programme and Effective enforcement of tobacco control laws", which was funded by Bloomberg initiative to reduce tobacco use.The project's objective was to reduce tobacco prevalence in Mizoram, strengthen and expand the NTCPs institutional framework for tobacco control in all eight districts and capacity building in organizations and workforce to conduct effective implementation of tobacco control strategies. The Implementation and enforcement focus was based on the Control of Tobacco Products Act (COTPA) which addresses prohibition on smoking in public places, advertisement of tobacco products, sales to minors and restrictions on trade, commerce, production, supply and distribution of tobacco products. The society has so for successfully undertaken activities like training and sensitization workshops, anti-tobacco awareness campaigns and programmes, anti-tobacco club and spot-the-smoker activities, meetings, talk shows etc. and other activities have all been effective for the society.

The key hurdles and issues in implementing tobacco control are noted as pro-tobacco attitude and social acceptance of tobacco, low awareness, tobacco users are also among health professionals and enforcement officers, and low priority assigned to tobacco control

by most departments. The Mizoram State Tobacco Control Society has recently boosted its efforts to enhance Mizoram's national tobacco control programme. From April 2017 to March 2018, the society engaged in a variety of activities, as indicated in Table 3.3.1.2. Mizoram's government has recently made a number of initiatives to speed up the state's National Tobacco Control Program.

**Table 3.3.1.2: Achievement of Tobacco Control Programme**

| Sl.No. | Activity | No of Activity | No of participants |
|---|---|---|---|
| 1. | Training and Sensitization Workshop | 56 | 3296 |
| 2. | AntiTobacco Awareness Campaigns and programmes | 128 | 11619 |
| 3. | AntiTobacco Programmes at Educational Institutions | 153 | 12227 |
| 4. | Others (Important Meetings, Talk show etc.) | 128 | 673 |
| **TOTAL** | | **465** | **27815** |

### **3.3.2.** Non Communicable Diseases and Cancer Control

In terms of geographical boundaries and population size, Mizoram has the largest number of cancer patients. The State also conducts awareness, early diagnosis, and management of non-communicable illnesses, including cancer, as part of the National Program for the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke. The police department has carried out operations such as Grand Slam, Favang, anti-drugs awareness campaigns, canine squads, and the establishment of a special narcotics police station, among others.

Everyone over the age of 30 gets checked for five NCDs: hypertension, diabetes, mouth cancer, cervical cancer, and breast cancer. This screening is done at all levels of the health

care delivery system, from sub-centers to hospitals. NCD screening clinics have been established in all district hospitals, sub-district hospitals, and community health centers.

Tobacco cessation clinics (TCC) have been established at district hospitals, with an additional TCC at the Mizoram State Cancer Institute in Zemabawak. Under the chairmanship of the Deputy Commissioners, an anti-tobacco team is formed in each district. The TCC scheme project intended to modernise the Mizoram State Cancer Institute for 44.27 crores, but the programme could not be finished due to a lack of funds. The remaining Rs. 28.00 crore was managed to get sanctioned in some way. In 2020, construction of a new 50-bed cancer hospital will begin, with 60% of the structural component completed as of now.

Free treatment is provided to all Mizoram Health Care/PMJAY patients and government employees. Furthermore, a CO monitoring equipment was used to check for CO levels, and nicotine gums (2baconil - 2mg and 4mg) were supplied according on CO levels. The consumers were also contacted by phone and referred to tobacco cessation clinics at Aizawl District Hospital, Falkawn State Referral Hospital, and Emabawk State Cancer Institute. This led to a greater public awareness of the harmful effects of tobacco and the availability of medications to help people quit smoking.

### 3.3.3. Involvement of village councils and schools in AB-HWCs

The state of Mizoram has tried to harness the power of communities for creating a strong sense of ownership for the AB-HWCs. In view of this the traditional Hnatlang' – community work model was utilized where the Village Community President (VCP) calls out to the community to support the activities as per need. These VCPs were involved to mobilize the public for wellness activities such as walkathons, clean-up for Fit India, etc. In addition, Ayushman Ambassadors activities have been planned to mobilize schools for conducting wellness activities at Lunglei and Aizawl districts. World Heart Day 2019 was conducted at Chawlhhmun UPHC HWC in collaboration with local primary and middle schools. Involvement of schools played a critical role in raising awareness among school children, their parents and the wider community.

### 3.3.4School Health Programme

The National School Health Program began as a Centrally Sponsored Scheme in 1977. It began in 1978 in Selected PHC and lasted until 1991 in Mizoram. After the Centrally Sponsored Scheme ended in 1991, the State took over the programme in 1993, and it was expanded to include all PHCs and CHCs where Medical Officers (MOs) were stationed, as well as the urban areas in all of the State's districts headquarters. It is now suggested that the beneficiaries be school students in grades I through XII who would be sponsored by the NRHM in order to improve their performance in the SHP, as is done in most other states across the country.

**Table 3.3.4: School Health Programme under Ayushman Bharat was implemented in the Districts of Champhai, Mamit&Siaha during FY 2020-21**

| Districts | No. of Schools (H/S – HSS) | No. of HWAs Trained | No. of Principals Trained |
|---|---|---|---|
| Champhai | 91 | 216 | 91 |
| Mamit | 37 | 65 | 16 |
| Siaha | 27 | 29 | 25 |

### 3.3.5 Achievements Under Weekly Iron Folic Acid Supplementation (WIFS) In School Health

The total number of schools that were covered was 1653.The total number of Anganwadis that have been covered is 2244.The total number of students in school is 99,709 males and girls.Out of school females (MS - HSS) are 1,067. The target adolescent population are 1,00,776 individuals. IFA coverage in FY 2020-21 was 1.86 percent as per reports received from Schools & Anganwadi Centres for the months of November 2020 to March 2021 due to closure of schools and anganwadiduring Covid-19 pandemic.

## 3.4. Application of information technology and -e governance

To eliminate possible corruption in Health department and prevent diversion of NHM funds,

To make the whole governance fair and transparent to public

To strike at the root of corruption,

The state will have a Web based-

- advertisement of vacant and new posts,
- recruitment including test and selection interview,
- appointment and transfer of health staff
- for award of contracts for civil works and intake of human resource.
- Electronic payment of bills and invoices - helps tracking of undue delay in payment of cheques with provision for satisfactory reasons for rejection or modification of claim bills

### 3.5. Ensuring free drugs and diagnostics will be part of the state Policy

Tamil Nadu model of Procurement and Supply of medicines, equipment and consumables shall be enforced in Mizoram State.Insurance-based purchase of secondary and tertiary health care from Private sector can continue with very stringent oversight and guard against misuse and exploitation. Out sourcing or rate-contract based purchase of diagnostics from private sector should give way for an in-house provision.

Community participation and ownership will be encouraged

- For rejuvenation of a weakened and not so efficient public health system, it must rely on strong ownership by the public, user involvement.
- RogiKalyanSamithis and hospital management committees need expansion with more broadly represented user groups and Community watchdogs rather than just one MLA or MP.
- These user groups and community watchdogs can facilitate social audit of major activities undertaken by health institutions.

### 3.6. Future perspective

As a Policy the State will uphold its responsibility to maintain optimum health of its citizen and will deliver Comprehensive Universal Health Care through Public health system. It will not expect or fully rely on Private sector for Primary or Secondary Care. Only feasible and mutually beneficial PPP will be embarked upon for Tertiary Care where there is

absolutely no chance of Public Health System delivering it in the near future. Strengthening PH System will be a priority for the next 5 years.

All centrally sponsored programmes and innovations under National Health Mission in both Rural and Urban sectors will be implemented fully absorbing the allocated funds. For this Techno-Managerial support through the State/District management units and its staff will be provided. Contractual appointment of those positions will be in a phased manner absorbed into the State health system and budget for regularisation of those posts will explored. Many Consultants in medical and surgical specialities, Dentists, Psychologists/Counsellors, MBAs, M.Com/ CAs, Physiotherapists, Lab Technicians appointed through NHM are needed for the State PHS . Assurance of continuity of service and privileges of pension and gratuity will be a motivating factor to continue with government service. The pull factor from private sector will be a constant threat to the staff strength of PH System.

State will proactively attract young MBBS graduates to join PHS and post them in areas of their choice if that can be accommodated after fully achieving the needs of institutions in remote and difficult areas. Depending on the ethnography and geography of the applicants posting in their home districts and among their own tribes and clans will be beneficial both for the system and the doctors, nurses, and other health staff.

State will identify and sponsor meritorious undergraduates posted in PH System for Postgraduate studies outside the State with a service bond of 5 or 7 years. Once they finish specialization their posting as Consultant Specialists should be automatic and without uncertainty. This will solve the high vacancies in CHCs and District hospitals.

State will make immediate plans to upgrade all eight District hospitals to deliver the full complement of Tertiary services. The existing district hospitals can be renovated, restructured to deliver the full complement of Tertiary care. Some of those essential components over and above OPD/IPD and Operation theatres, Labour room, Accident and Emergency, are Coronary Care Unit, Intensive Care Units for General and Paediatric cases, Neonatal ICU, Burns Unit, Blood bank, Liquid Medical Oxygen generation plant, Dialysis Unit, Radiation, and Chemotherapy wards, etc. That was a need intensely felt in many District Hospitals in the country during the Pandemic crisis during the delta wave.

### 3.7Disaster Preparedness

As part of its Health Policy the State shall have a robust Disaster Preparedness Plan and shall execute, its initiation, the moment a disaster occurs in any part of the state.

Owing to its geographic, geological and physical features, Mizoram is vulnerable to all major natural hazards (Drought, Flood, Cyclone, Earthquake, Landslide etc.). The State is also under constant threat of cloud burst and landslide disasters which is well supported by the fact that more than 71% of the total area are in Very High to Moderate Hazard Zone. In addition, occurrence of biological disasters and other technological/human caused hazards such as road accidents, forest and urban fires, flash floods, animal disasters etc. are most likely in the State.

**Table 3.7: History of Damages caused by Natural calamities in Mizoram (2013-2019)**

| Nature of Calamities | Human Casualties | | House Damaged | | |
|---|---|---|---|---|---|
| | **Deaths** | **Injuries** | **Fully** | **Severely** | **Partially** |
| Landslide | 68 | 37 | 600 | 313 | 659 |
| Fire | 20 | 21 | 775 | 161 | 386 |
| Flood | 14 | - | 1016 | 84 | 1327 |
| Hail Storm | - | - | 50 | 115 | 1432 |
| Storm | - | - | 142 | 102 | 1496 |
| Cyclone | 5 | 2 | 687 | 586 | 2813 |
| Cloud burst | - | 1 | 3 | 1 | 11 |
| Lightening | 4 | - | - | 2 | 2 |
| Earthquake | - | - | 1 | - | - |
| **Total** | **111** | **61** | **3237** | **1364** | **8126** |

*(Source: DM & Department Records)*

Mizoram Remote Sensing and Application Centre (MIRSAC) has developed Atlases on Landslide, Earthquake, Wind and Cyclone, Flood, Forest and Urban Fire Hazard Risk & Vulnerability.

### 3.7.1 Prevention and Mitigation

Provide better early warning methods for flood, storms, and cyclone

- Reduce the destruction and loss of life within buildings
- Provide for safer environments for transportation systems
- Eliminate flooding in populated areas
- Ensure redundant water supply systems
- Reduce effects of the natural environment on the infrastructure
- Ensure redundant power systems on critical facilities
- Ensure adequate materials available for road maintenance

### 3.7.2 Preparedness Measures

Preparedness involves activities undertaken in advance of an emergency to develop and enhance Operational capacity to respond and recover from an emergency. As part of a comprehensive preparedness program, there should be established - plans and procedures, prevention programs, resource management system, MoU/agreements with service providers (PPP), training awareness programs.

### 3.7.3 Preparedness Planning:

Planning is the one of the key elements in the Preparedness cycle. Preparedness cycle illustrates the way the plans are continuously evaluated and improved through a cycle of planning, organizing, training, equipping, exercising, evaluating and taking corrective action. The state government and its departments/ ministries assigned emergency responsibilities in this plan will prepare appropriate supporting plans and related standard operating procedures that describe how emergency operations will be carried out.

District Disaster Management Plan:

- City Disaster Management Plan
- Hazard specific planning
- Public Private Partnership
- Recovery Plan

Training program should include all stakeholders including – community, Mizoram Home Guard, NSS, NCC, NYK, YAC, Schools and Colleges, Civil society, NGO's, corporate entities, SDRF, Fire brigade, Media, Police etc.

### 3.7.4 Preparedness Exercise:

Exercises provide personnel with an opportunity to become thoroughly familiar with the procedures, facilities and systems which will actually be used in emergency situations. State agencies and its departments shall plan for and/or participate in an all-hazards exercise program that involves emergency management/response personnel from multiple disciplines and/or multiple jurisdictions.

Exercises should

- Stress the application of standardized emergency management.
- Be based on risk assessments (credible threats, vulnerabilities and consequences).
- Include non-governmental organizations and the private sector, when appropriate.
- Incorporate the concepts and principles of IRS.
- Demonstrate continuity of operations issues.
- Incorporate issues related to special needs populations. Exercises range from seminars/workshops to full scale demonstrations

Seminars/Workshops are low-stress, informal discussions in a group setting with little or no simulation. It is used to provide information and introduce people to policies, plans and procedures.

- Drills/Tests are conducted on a regular basis to maintain the readiness of operational procedures, personnel and equipment. Examples include tests of outdoor warning systems and the Emergency Alert System.
- Tabletop Exercises provide a convenient and low-cost method designed to evaluate policy, plans and procedures and resolve coordination and responsibilities. Such exercises are a good way to see if policies and procedures exist to handle certain issues.

Functional Exercises are designed to test and evaluate the capability of an individual function such as communications, public evacuation, or medical.

- Full-Scale Exercises simulate an actual emergency. They typically involve complete emergency management staff and are designed to evaluate the operational capability of the emergency management system

### 3.8 Medical Preparedness

**Table 3.8 Medical Preparedness**

| Task | Activity | Responsibility |
|---|---|---|
| Medical Preparedness | 1. Preparation of Authentic medical database for public and private facilities available in the state<br>o Collection of data<br>o Mapping and gap analysis<br>o Strengthening | **H & FW** |
| Medical Preparedness | 2. Resource management<br>o Manpower, logistics, medical equipment, antidotes, personal protective equipment, disinfectant, vaccine<br>3. Identification of medical incident command system<br>- Incident Commander<br>o State Level<br>o Dist. Level<br>o Disaster site<br>- Identification of each section head at each level<br>o Operation<br>o Planning<br>o Logistic<br>o Administration & Finance<br>o Media and Public information<br>- Identification of key members of different task force<br>- Control room arrangement<br>o Departmental control room<br>o State and district control room<br>- Appointment of liaison officer in shifts<br>- Planning<br>o Preparation of medical management plan<br>➢ State Level<br>➢ Dist. Level<br>➢ Hospital preparedness plan<br>- Training and capacity building<br>o Hospital preparedness<br>o Pre-Hospital care<br>o Mass casualty management, etc. | • **H & FW** |

### 3.8.1 Medical Response:

Medical response has to be quick and effective. The execution of medical response plans and deployment of medical resources warrant special attention at the State and District level in most of the situations.

The following measures shall be taken by the States/Districts:

- A mechanism for quick identification of factors affecting the health of the affected people shall be established for surveillance and reporting.
- An assessment of the health and nutritional status of the affected population shall be done by experts with experience of emergencies and, if possible, local knowledge.
- The deployment of the nearest medical resources to the disaster site, irrespective of the administrative boundaries, will be warranted.
- Mobile medical hospitals and other resources available with the Central Government shall be provided to the States/UTs.
- Adequate supply of medicines, disinfectants etc. shall be made.
- Where necessary inoculation shall be done.
- Vaccination of the children & pregnant women shall be undertaken.
- Vector-borne diseases are a major cause of sickness and death in many disaster situations. Vector control measures shall be undertaken.
- Water borne diseases may cause sickness and deaths and therefore adequate measures shall be taken to prevent such outbreaks.

### 3.8.2 Disposal of dead bodies:

The State Government/District authorities shall earmark authorities responsible for disposal of bodies in event of mass casualties. The process of identification and handing over to next of kin shall be followed. Mass burial/disposal of bodies shall be done as a last resort. Local religious & cultural practices shall be honoured while disposing dead bodies

### 3.8.3 Disposal of carcasses:

The State Government/District authorities shall earmark authorities responsible for disposal of carcasses in event of mass destruction. The process to be followed for mass disposal of carcasses shall be decided by Police, NGOs and, Department of Animal Husbandry& Veterinary in case of animal

### 3.8.4 Provision for Disabled and Persons with Special Needs:

Special provisions shall be made for persons with special needs on threatening disaster situation, during and after disaster. These persons with special needs include Persons with Disability (Physical and Mental), Children and Old-aged, Pregnant & Lactating Women, etc. These provisions may include special medical facilities, separate shelter/accommodation, bathroom and sanitary facilities, guide & companion, counselling, etc.

### 3.8.5 Mental health services during disasters:

Special teams will have to be deputed to screen and provide counselling and medications for Post- trauma stress syndrome.

# CHAPTER FOUR

# NATIONAL HEALTH MISSION ACHIEVEMENTS AND CHALLENGES IN MIZORAM

***The fourth chapter of the policy draft incorporates the achievements of National Health Mission and other various health schemes under it. Against assured central assistance, to what extent the State health machinery showed its functional efficiency and fund absorption capacity is a pointer to areas where health policy should focus. It concludes with a section on Mizoram's major health challenges.***

# 4

# NATIONAL HEALTH MISSION ACHIEVEMENTS AND CHALLENGES IN MIZORAM

Although Mizoram is one of the best performing small states in health index of NITI Aayog, it has its share of both achievements and challenges in the health sphere. Ranging from Cancer, Tobacco, Malaria, Malnutrition, the state faces some of the toughest health challenges.

## 4.1 Success of National Health Mission (2018-2019) (updated data not available)

Mizoram State Health Society (MSHS) is in charge of implementing the National Health Mission (NHM), which is led by Mission Director (MD), NHM. NHM is now implementing 31 health programmes in the areas of reproductive and child health, communicable illnesses, non-communicable diseases, and health system improvements. The following are the achievements of health-related programmes:

### Reproductive & Child Health (RCH)

Programme under the wider umbrella of Reproductive, Maternal, Newborn, Child Health & Adolescents (RMNCH+A) is focused on reducing maternal, child and newborn morbidity and mortality. A lifecycle approach called the RMNCHA+N approach has been adopted under NHM from 2013 to improve maternal and child health.

The Health & Family Welfare Department of Mizoram has implemented the following activities and strategies to promote Maternal and Child Health, reduce IMR & MMR, and ultimately lead to the attainment of SDG 3. Strategies are; First, to reduce MMR to less than 70 per 100,000 live births by 2030 and second, to reduce preventable deaths of newborns to at least as low as 12/1000 live births and deaths of children less than 5 years to at least as low as 25 deaths per 1000 live births.

### Achievements Under RBSK between 2018- 2019

Number of infants tested for birth abnormalities at delivery centres were 11080. The total number of children screened (6 weeks to 18 years old) was 231579. Out of the total 231579, 21997 found positive for a variety of health conditions. 8720 (CHC=1543, DH=2993, DEIC=4184) children were sent for follow up and interventions to a referral health facility. 12112 children received treatments.

**Achievement of UIP 2018- 2019 (HMIS)**

a) Out of the target Infants of 19225 in Mizoram, Fully Immunized were 15704. (82%).

b) Under NID 2019, there was intensified pulse polio immunisation on March 12$^{th}$. Also, routine Immunization Microplan training for Medical Officers was held in conjunction with WHO in Champhai, Siaha, Tlabung, Kanghmun, Aizawl East and West, Kolasib, Mamit, and Lunglei in March 2019.

c) Measles Case-based Monitoring training for Medical Officers, Staff Nurses at the District Hospital, Private Practitioners, and Media Personnel for the entire district, in conjunction with WHO was conducted.

d) A District Task Force for Immunization was held for all districts, led by the corresponding district's Deputy Commissioner. A meeting of the State Task Force on Immunization was conducted. DIO/MO, Health Staff, ASHAs, and Anganwadi workers receive BRIDGE training.

e) In August 2019, the rotavirus vaccine was introduced in Mizoram and was included in the monthly routine vaccination session.

**Achievements of the National Tuberculosis Elimination Programme NTEP (RNTCP)**

1. Total number of cases reported was 2880. A 92.68% success rate was recorded. The Universal DST was 54%.

2. Total TB patients tested for HIV were 84.28% (13.67% of tested are HIV positive). Active Case Finding data are that 8508 people were screened, 334 were tested for tuberculosis, and 8 people were diagnosed with the disease.55.67% TB patients tested for Diabetes Mellitus.

3. The percentage of TB patients who were examined for tobacco use was 64.22 percent (12.67 percent of which are referred to Tobacco Cessation Clinic). The number of patients who were tested for MDR TB was 4782. The number of people with MDR TB who have been diagnosed is 81. Total of 95 cases of MDR TB have been treated and the success rate for MDR TB is 63 percent.

## NATIONAL LEPROSY ERADICATION PROGRAMME

Since the program's beginning in 1983, a total of 1429 instances have been identified. 1524 cases have been discharged from treatment. Total number of cases being treated (currently) is eight. The Annual New Case Detection Rate (ANCDR) is 0.41%. The Prevalence Rate (PR) is 0.06%.

## MIZORAM STATE AIDS CONTROL SOCIETY

**Care and Support Treatment**

| Indicator | Number |
|---|---|
| No of patients registered in ART Care | 14,751 |
| No. of patients in Active Care | 8,864 |
| No of Deaths among ART registered patients | 2,212 |
| Viral Load Tested | 1,403 |
| Viral load suppresed | 1,138 |

**Integrated Counselling and Testing Centre**

| Indicator | Number |
|---|---|
| No of Blood samples tested (General Clients) | 75,077 |
| No of samples tested HIV+ve (General Clients) | 2,557 |
| No of Blood samples tested (Pregnant Woman) | 24,900 |
| No of HIV+ve (Pregnant Woman) | 208 |

## NATIONAL VIRAL HEPATITIS CONTROL PROGRAMME (NVHCP), NHM, MIZORAM

Training in the financial year 2018-2019, commenced with Physician training at MTC, CHA, and DTC, SRHF in March 2019. In March 2019, the State Laboratory, CHA, held a training session for lab technicians.

The Vision, of the programme is that Hepatitis C will be eradicated by 2030 and to achieve significant reduction in the infected population, morbidity and mortality associated with Hepatitis B and C viz. Cirrhosis and Hepato-cellular carcinoma (liver cancer). Lower the

risk of Hepatitis A and E related to morbidity and death. Challenges include a lack of manpower and a lack of internet access, particularly in Siaha and Lawngtlai district.

**National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS)**

1. Indicators:-

| (Clinic + Camps) | FY 18 – 19 |
|---|---|
| No. of Patients screened | 1,17,359 |
| No. of patients -Physiotherapy | 3,181 |
| No. of persons counselled | 22,010 |
| ***Patients diagnosed with*** | |
| Diabetes | 8,703 |
| Hypertension | 8,978 |
| CVDs | 156 |
| Stroke | 41 |
| Cancer | 116 |
| No of Screening camps | 55 |

Free clinics (outreach camps) were 52. During FY 18-19, there were screening camps cum awareness campaigns were held. Health Melas were also organised, on April 24, and June 29, 2018, in partnership with the Public Health Foundation of India (PHFI) in Kolasib and Serchhip districts, respectively.

**NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS(NPPCD)**

Dissemination of equipment and furnishings to districts was one of the accomplishments. On the 10th of May, 2019, a stakeholder meeting was held. The World Day of the Deaf was observed on September 27, 2019.

Case detection status:

| Particular | FY 2018-2019 |
|---|---|
| No. of patients examined | 29,128 |
| Morbidities Detected | 15,388 |
| Hearing Loss | 3,716 |
| Referral for Hearing Aid / Rehabilitation | 1,305 |
| Ear Surgeries | 221 |
| Ear Diseases / Problems | 11,686 |
| Investigation Performed | 5,339 |

**ACHIEVEMENT UNDER NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)**

The primary objective is to provide, patients with life-limiting illnesses, with excellent pain treatment and supportive care for their families.

a) At present, nine district hospitals have been granted a Registered Medical Institute License (RMI) for the procurement, storage, and distribution of morphine, including Civil Hospital Aizawl, Mizoram State Cancer Institute (MSCI), State Referral Hospital Falkawn, and District Hospitals of Champhai, Kolasib, Mamit, Lawngtlai, Lunglei, and Siaha.

b) A proper mechanism for morphine procurement and distribution to districts is in place. A morphine dispense card printing and equipment and furniture distribution to districts undertaken.

- **Case detection Status :**

| Indicators | 2018 - 19 |
|---|---|
| No. of OPD case | 1715 |
| No. of IPD case | 6 |
| No. of new case | 436 |
| No. of home visit | 6 |

**Achievement of NATIONAL PROGRAMME FOR HEALTH CARE OF THE ELDERLY (NPHCE) FY 2018-19**

Community/Primary Health Centres in the chosen districts built up Geriatric Clinics/Rehabilitation Units for domiciliary visits.

a) Geriatric Clinics/Rehabilitation units set up for domiciliary visits in Community/Primary Health Centres in the selected districts; The sub-centres were enabled with equipment for community outreach services.

b) Training of Human Resources in the Public Health Care System in Geriatric Achievement were; New facilities in four districts, Serchhip, Mamit, Lawngtlai and Siaha. They were operationalised under NPHCE during FY 2018-2019.

2. *Achievements during FY 18-19 :-*

| Sl.No | ACHIEVEMENTS DURING FY 2018 – 2019 | |
|---|---|---|
| 1 | No. of Elderly Person attended OPD | 8,476 |
| 2 | No. of Elderly admitted in wards | 1,035 |
| 3 | No. of Elderly provided rehabilitation services | 1,237 |
| 4 | No. of Lab test undertaken on Elderly patients | 8,048 |
| 5 | No. of Elderly Died in Hospitals | 62 |

## BLOOD SERVICES & DISORDERS (STATE BLOOD CELL), MIZORAM

Mizoram's State Blood Cell Program began in October 2016 and is now being implemented in nine (9) districts: Aizawl East, Aizawl West, Champhai, Lunglei, Kolasib, Mamit, Siaha, Lawngtlai, and Serchhip. Mizoram now has 11 licenced blood banks, nine of which are government-run and two of which are privately owned. There are a total of 12 (twelve) blood storage facilities (BSCs).

## ACHIEVEMENT UNDER NATIONAL ORAL HEALTH PROGRAMME

Out of the state's 9 (nine) districts, the National Oral Health Programme (NOHP) under NHM has been implemented in Mizoram from January 2015 at the state level, spanning Darlawn PHC in Aizawl East District, Lungdai PHC in Kolasib District, and Chawngte CHC in Lawngtlai District.

**NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)from April 2018 to March 2019**

| S.No | Name of Activity | No of Activities | Details/No of participants |
|---|---|---|---|
| 1. | Training and Sensitization Workshop | 141 | 6,648 |
| 2. | Anti-Tobacco Awareness Campaigns and programmes at Churches/Community | 200 | 17,025 |
| 3. | Anti-Tobacco Programmes at Educational Institutions | 529 | 40,880 |
| 4. | Others (Important Meetings, Talk show etc.) | 243 | 1,612 |
| **TOTAL** | | **1,113** | **66,165** |

- Anti-Tobacco Squad drives were conducted 588 times
- There are 5646 new clients at Tobacco Cessation Clinics during the reporting period.
- Average Quit rate is 21.85%

## NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

Due to funding constraints, only seven out of nine approved DMHPs have been established in the states. TI (Targeted Intervention) under the DMHP was also opened.

2. ACHIEVEMENTS - PHYSICAL

| 2018 – 2019 | |
|---|---|
| DMHP | 8 nos. (Aizawl E&W covered by 1 team) |
| TI under DMHP | The state of Mizoram covered by 1 T.I. team |
| Early detection and treatment of mentally ill patients (OPD/IPD | 13,913 |
| No. of Free Clinic cum awareness campaign | 118 |
| No. of Awareness organized | 244 |
| Suicide Helpline | 282 |
| Training Organized | 4 |

**MOBILE MEDICAL UNITS (MMU)**

The primary goal of the mobile medical unit is to provide a range of health care services to people living in distant, difficult, un-served, and underserved regions, primarily with the goal of bringing health care to their doorsteps.

The Nature of the services provided are, clinical services given by a medical officer and his/her team, which include basic laboratory investigations, screening activities, and referral to a higher level of care.

***Performance of MMU 2017-2018***

| District | Number of Clinics | No. of Patient Examined |
|---|---|---|
| Aizawl East | 29 | 2766 |
| Aizawl West | 34 | 3338 |
| Champhai | 54 | 3651 |
| Mamit | 33 | 2962 |
| Lawngtlai | 9 | 731 |
| Kolasib | 31 | 2069 |
| Serchhip | 34 | 1674 |
| Saiha | 36 | 2522 |
| Lunglei | 34 | 2114 |
| Total | 294 | 21827 |

**Free Drugs Service Initiative(FDSI) Programme 2018 –2019**

The programme was implemented in Mizoram in the year 2014. The primary objective is to guarantee that all public health institutions have access to free critical pharmaceuticals in order to keep the health system running smoothly and to decrease out-of-pocket health care costs. Against an ROP allocation of 66.46 lakhs, essential medications were purchased and distributed to all SCs, PHCs, CHCs, and DHs across the state.

**Free Diagnostic Service Initiative Programme 2018–2019**

The programme was implemented in the year 2016. The primary objective is to provide a free set of key diagnostics at SCs, PHCs, CHCs, and DHs to decrease out-of-pocket healthcare costs. During FY 2018-2019, the programme was executed at Mamit District Hospital, which is an aspirational district. A total of 23 lakhs has been granted for essential diagnostics, both pathological and radiological diagnostics. During FY 2019-20, a process was underway to include all SCs, PHCs, CHCs, and DHs in the Mamit District to provide free diagnostic services to the public.

**Biomedical equipment management and maintenance Programme 2018 – 2019**

The programme was introduced in the year 2016 in Mizoram. The primary objective is that all public health institutions should have well-functioning biomedical equipment to ensure seamless operations and delivery of high-quality health care. Since April 2016, maintenance work has been outsourced to HLL Infra Tech Services Ltd (HITES). As of March 2019, the total number of biomedical equipment under the service provider is 4740. 94 percent of the total equipment is in good working order. After negotiations with service providers, a proposal is being developed to eliminate the annual price escalation of 10% on maintenance costs.

**Pradhan Mantri National Dialysis Programme2018 – 2019**

The primary objective is to ensure that district hospitals provide comprehensive dialysis services and that patient' out-of-pocket expenses for dialysis are minimised. Aizawl Civil Hospital and Lunglei District Hospital both have functioning dialysis centres. 503 people enrolled for dialysis, with 3524 sessions since the program's launch in the state in 2018-2019. A process is underway to give free consumables to all dialysis patients.

**4.2NATIONAL URBAN HEALTH MISSION (NUHM)**

The Zemabawk UPHC and Hlimen UPHC were completed in 2018. Both Hrangchalkawn UPHC and Lawipu UPHC are now under construction and will be completed shortly. ITI UPHC and Sihphir UPHC are now undergoing renovations. On February 2nd, 2018, a NUHM workshop for city-level employees was held and on February 7th, 2018, the first

responder training was held. Collaboration of H&FW, UD&PA, AMC, RIPANS, and Apollo School of Nursing initiated.

Sixty camps were held as part of the approval process (Rs. 10,000 sanctioned per camp). 332 times, Urban Health and Nutrition Day (UHND) was observed (Rs. 200 sanctioned per camp). At the UPHC, a specialist visit is scheduled once a month. Medicines and equipments are obtained through an Open Tender published in the local newspaper in accordance with each UPHC's requirements, which are tallied to fall within the budget approved by the ROP. In August 2018, ITI and Chawlhhmun UPHC were upgraded to a Health & Wellness Centre.

### 4.3MIZORAM STATE HEALTH CARE SOCIETY (MSHCS)

The Mizoram State Health Care Society has taken bold steps to ensure the success of the schemes it manages.

a) AB-PMJAY; Till date, the Society has awarded 3,87,529 Golden Cards, and a Golden Card drive is now underway.

b) Mizoram State Health Care Scheme; During the 2018-2019 fiscal year, Rs.2,40,73,460 was distributed to 1,12,760 BPL and APL recipients.

c) Government Medical Reimbursement; The Society examines and screens the Govt. MR Bill in accordance with the Medical Attendance Rules.

d) Mizoram State Health Care Scheme coverage for enrolment of beneficiaries up to Rs. 3 lakhs per family.

### 4.4 HealthChallenges and Evidences

***Malnutrition and Neonatal-Infant-Child mortality and Maternal Mortality has been described in chapter 2 above.***

***Cancer.*** In terms of geographical boundaries and population size, Mizoram has the largest number of cancer patients. On the basis of information shared by the PBCR (Civil hospital, Aizawl) there were 1731 new cancer cases in 2017 across Mizoram. The cancer incidence cases

and cancer incident rate per lakh across districts of Mizoram are shown in figure 15. Cancer Incidence is higher in Aizawl (48 % of total new cancer cases; 839 new cancer cases in 2017) followed by Lunglei 14% of the overall new cases (242 new cancer cases in 2019), and lowest in Siaha and Lawngtlai (73 and 52 new cancer cases in 2017, respectively).

Although Mizoram has a high cancer incident rate it contributes far less to the total case in the country due to its small population size. Aizawl and Kolasib districts have the highest cancer incidence rates of 183 and 164 per lakh population respectively. The lowest rate was in Lawngtlai (52 per lakh). The variation within districts is mostly because of differences in the exposure of the population to risk factors.

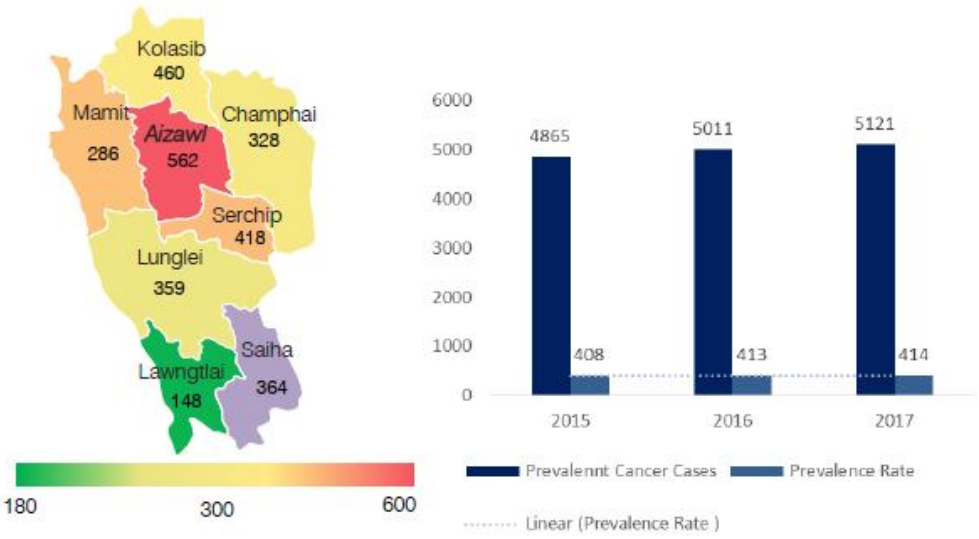



**Figure 4.4: Prevalence rates (per one lakh) and number of prevalent cancer cases across Mizoram states in 2017 and year wise trend in prevalence cases (Source PBCR Data, Civil Hospital Aizawl)**

In 2017, there were 5121 cancer patients in Mizoram (three-year complete prevalence) with a prevalence rate of 414 cancer cases per lakh. Like incidence rate, Aizawl district contributes half of the cancer prevalence cases of the state (50.3 % of the overall cases, 2577 cancer cases in 2017), followed by Lunglei which has 13% of overall cancer cases (643 cancer cases in 2017). Similar to Incidence cases, the lowest prevalence is in Lawngtlai and Saiha (148 and 364 cancer cases in 2017). Prevalence is highly sensitive to Incidence rate, early diagnosis, high survival rate and availability of treatment resources is the main reason for the variation across districts.

***Malaria.*** Mizoramshares international borders with Myanmar and Bangladesh and is considered to be one of the key routes through which drug-resistant parasites of Southeast Asia enter mainland India. The state of Mizoram is challenged by the peculiarity of the epidemiologyof Malaria. It remained persistent throughout the year and throughout all districts in the state, according to data collected between 2010 and 2018. The surveillance coverage accounted for ≥95% in all sites of study. P. falciparum infection caused the majority of malaria infections and deaths, accounting for 89.3 percent of all malaria cases.

***Poor Infrastructure and lack of health-related human resources.***

From the last two CRM learnings that is the 13th and 14th CRM, there have been key learning about the accountability, transparency and health sector in the health sector of the state.The total number of hospital beds in Mizoram is 1,997 in the public sector and 499 in the private sector. In comparison to the national average, this is quite low. The government has established a medical college at the Falkwan Referral Hospital (267 beds). The Vanaspati Van Project enhances the availability of herbal medicines to rural populations. Under the Ministry of AYUSH, the state government provides free medicines to the poor. The only medical college of Mizoram Zoram Medical College (ZMC) (previously known as The Mizoram Institute of Medical Education and Research (MIMER)) has received the approval from the Medical Council of India in May 2018 and the first batch has commenced from August 2018.

The state government has allotted INR 455.05 crore for medical and public health under budget 2018-19. In terms of health-related human resource, Mizoram has a significant deficit of doctors.

**Table 4.4: Details of health-related human resource at Sub-centre, PHC and CHC level for Mizoram State**

| No. | Particulars | Required | Sanctioned | In Position | Vacant | Shortfall |
|---|---|---|---|---|---|---|
| 1. | **Health worker (Female)/ ANM at Sub-Centres & PHCs)** | **427** | **405** | **629** | **0** | **0** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2. | **Health worker (Male) at sub-Centres** | **370** | **382** | **337** | **45** | **33** |
| 3. | **Health Assistants (Female)/LHV at PHCs** | **57** | **85** | **19** | **66** | **38** |
| 4. | **Health Assistants (Male)at PHCs** | **57** | **86** | **22** | **64** | **35** |
| 5. | **Doctors at primary health centres** | **57** | **152** | **59** | **93** | |
| 6. | **AYUSH Doctors at PHCs** | | **NA** | **20** | **NA** | |
| 7. | **AYUSH Doctors at CHCs** | **9** | **NA** | **6** | **NA** | **3** |
| 8. | **Surgeons at CHCs** | **9** | **7** | **0** | **7** | **9** |
| 9. | **Obstetricians & Gynaecologists at CHCs** | **9** | **11** | **0** | **11** | **9** |
| 10. | **Physician at CHCs** | **9** | **5** | **0** | **5** | **9** |
| 11. | **Paediatricians at CHCs** | **9** | **10** | **0** | **10** | **9** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12. | **Total Specialists at CHCs** | **36** | **33** | **0** | **33** | **36** |
| 13. | **General Duty Medical Officers - Allopathic at CHCs** | | **NA** | **16** | **NA** | |
| 14. | **Radiographers at CHCs** | **9** | **5** | **3** | **2** | **6** |
| 15. | **Pharmacists at PHCs & CHCs** | **66** | **99** | **53** | **46** | **13** |
| 16. | **Laboratory Technicians at PHCs & CHCs** | **66** | **92** | **83** | **9** | |
| 17. | **Nursing Staff at PHCs & CHCs** | **120** | **570** | **198** | **372** | |
| 18. | **Para Medical Staff at DH** | | **NA** | **847** | | |
| 19. | **Para Medical Staff at SDH** | | **NA** | **44** | | |

*Source- Rural Health Statistics 2018 MoHFW, Government of India*

***Tobacco.*** According to the Global Adult Tobacco Survey (GATS) 2009-10, Mizoram has the highest tobacco prevalence in India at 67.2 percent, with 72.5 percent males and 61.6 percent females using tobacco in some form. It also has the country's lowest "planning to quit tobacco" rate. At home, secondhand smoking exposure is exceedingly high, at 97.7%. To avoid many more illnesses, disabilities, and deaths in the state, more concerted tobacco control activities must be implemented on a long-term basis. The key hurdles and issues in implementing tobacco control are noted as pro-tobacco attitude and social acceptance of tobacco, low awareness, tobacco users among health professionals and enforcement officers, and low priority assigned to tobacco control by most departments.

***Lack of accountability, transparency and governance:***

Several reports like CRMs and research studies have found the following challenges in this theme:

- There are no sanctioned posts at some health facilities, and vacancies are filled as per the availability of staff.
- Irrational deployment of HR and irrational filling of the vacant posts seen.TOR/JD not given to any staff at the time of joining.
- Most of them are not even aware of their key responsibilities.
- There is no HR policy for recruitment, performance appraisals, carrier progression, posting and transfer and retention of the staff. The districts face shortages of human resources in regular cadre as well as NHM and the issue of irrational deployment of the staff prevails in the districts.
- Human Resources Information System (HRIS) is accessible to the state staff but not to district staff.
- Staff in the districts is also not aware of any standard operating procedures and guidelines for HR.
- Attendance registers are not properly maintained and has no bearing on salary processing.
- No systematic Grievance redressal system including for ASHAs.
- State PIP is not being prepared in consultation with Districts and Blocks Units and thereby denigrating the ethos of bottom-up participatory planning under National Health Mission.
- Due to the low community awareness and absence of referral mechanism, the referral linkages with higher centre is inefficient.
- The IT based reporting system includes HMIS, IDSP, NCD Portal and NCD App is functional. Monitoring and Supervision mechanism is not in place and completely invisible in DPMU Unit.
- Most of the funds collected through user fees are used for procurement of Drugs and Reagents.
- Accounting Practices followed at facilities is violative of the financial guidelines and General Procurement Rules.

# CHAPTER- FIVE

# ASSESSMENT OF GAPS IN STATE'S HEALTH PROFILE

***Chapter five of the policy draft addresses the gap assessment in state's health policy. It summarises the important findings of the 14th CRM (2021) and 13th CRM (2019). Further, it identifies the key challenges of Mizoram's health profile. Corrective measures are to be taken to resolve the health staff shortage in the state. The Current policies/strategies should be implemented to improve the quantity and quality of health staff. The challenges related to the implementation of polices related to the health staff, is strategic planning for the production of health staff to meet the need of the state.***

# 5

# ASSESSMENT OF GAPS IN STATE HEALTH'S PROFILE

## 5.1 Learning of the 14th Common Review Mission (2021)

The focus of the CRM is to undertake a rapid assessment of the implementation status of NHM and its key strategies and priority areas, analyze strengths and challenges with respect to strengthening health systems, identify trends in progress of key indicators, particularly relating to coverage, equity and affordability, document innovations and best practices, evaluate the readiness of the state to undertake implementation of new initiatives, and review the progress and coordination mechanisms with various partners in the context of High Priority Districts (HPDs) and Left Wing Extremism (LWE) Affected Districts. Of particular focus during the assessment is to assess Ayushman Bharat – Health and Wellness Centres.

**5.1.1.** ***Free Drugs and Diagnostic.*** DVDMS is implemented up to PHC, but is widely used only for updating stock and not for indenting purpose. Some MO made request for drugs/ medicine supply via WhatsApp, phone call to CMO or CMS. At DH Mamit, only 10 drugs were found to be in Pharmacy and majority was procured from private Pharmacy operationalized under PPP (with availability of ~300 types of drugs) Free drugs were not available. Near expiry drugs supplies were seen across SC and PHC. Discarding of expired drugs is not as per the SOPs. Out of Pocket Expenditure (OOPE) above 60% observed at DH, CHC and PHC due to following reasons:

a) User charges on diagnostics
b) Beneficiary has to procure medicine from outside – non availability of medicine;
c) Expenditure for Drugs and diagnostics amounting to INR 25 Lakhs were made from RKS funds of DH Champai for which there is no record for utilization

Beneficiaries charged for X-Ray and USG service. Reagents are being supplied through CMS, or procured from RKS funds, or procured using user charges collected.

Recommendation

- State should ensure timely procurement and supply of drugs, reagents and consumables
- Drugs and Diagnostics to be provided free of cost as per NFDSI
- DVDMS to be implemented across all facilities and used for indenting and supply
- Requirement for drugs to be calculated by the facilities based on their OPD caseload
- Optimal utilization of lab and X-Ray services at the facilities must be ensured.
- Better coordination b/w DHS and Dept. of Medical Education will lead to adequate supply of drugs, reagents and equipment in the facilities.

***5.1.2 Referral Transport.*** All the Public Health Facilities in the district have established Poor Fund in the facilities through which they support the poor patients for bearing all the OOPE expenditures. Community mobilization is employed, with the community-based organizations like the Young Mizo Association often financially supports the poor families in the villages who need support for bearing costs of referral services.

No centralized toll-free number available for ambulances. There are no ambulance services available for the transport of pregnant women. The Referral Transport System in the Districts is poorly performing. MMUs are not functional in both the districts.

Recommendation

- National Ambulance System to be made functional in all the districts by pooling of funds available under various schemes
- Referral Chains need to be altered and defined for each facility, considering the terrain, proximity and availability of services

***5.1.3 IT Initiatives.*** HMIS data found to be *accurate, reliable and credible* (at all level). NIKSHAY portal data found to be accurate in terms of reporting identified cases and for e-aushadi only. Health workforce is skilled inCOWIN application. Biomedical medical equipment management system is well established by state government and HITES. PMJAY is widely implemented. Branding and IEC was seen during visitse-Sanjeevani: Low utilization of telemedicine largely due to network issues. WhatsApp and phone calls used as alternate mode of

tele-consultation. NCDData is not being updated in portal in any of the facilities visited. Reason cited was around lack of training, but offline registers are maintained and send to DPMU.

***5.1.4 Community Processes and Mobilization.*** Department of Urban Development and Poverty Alleviation department has initiated a week-long observation programme titled "CLEANLINESS COMPETITION 2021". The initiative has brought people from all walks of the community, women, adolescent girls and males for bringing change. Though the initiative covers the work that a VHSNC is aimed to cover, but on war footing, this initiative have played very critical role. Working collectively to keep the village and vicinity clean and hygienic. Pastors and churches are working on the same line.

**ASHAs**

a) All ASHAs are in place and trained on Module 6 & 7, HBYC and NCD
b) Irrational Distribution -
c)
d) No structured supportive supervision and the support is being provided through personal contact with ASHA Mobilizer
e) No grievance redressal mechanism is in place for ASHAs at any level, except at DH Mamit - ASHA complain box was placed.
f) HBNC kit and its content including drug kit was majorly missing
g) ASHAs were given smartphone (LAVA) in 2016 but was found to be dysfunctional
h) ASHA Mobilizer was engaged in OPD registration at CHC; not performing the designated role

<u>Recommendation</u>

- A refresher training need to be planned for ASHAs on priority to keep motivated, up and going
- Regularization of disbursement of incentives
- HBNC Kit need urgent replenishment – Untied funds of PHC-HWC may be utilized
- Decision making processes need to be inclusive with VHSNC members
- Directive should be sent to hold VHSNC meeting regularly

- The VHSNCs untied funds register (Bank passbook and cash book) should be handed over to ASHAs (Presently lying with ANM)
- State should work further to bring in the process of seeking community feedback
- Funds to VHSNCs must be sent directly from state to VHSNC instead of through DPMU and BPMU and then to VHSNC
- JAS/RKS members should be oriented in their roles and the meetings should be organized regularly
- SOPs need to be adopted and implemented for monitoring the work at facilities*

***5.1.5 Human Resources for Health.*** Direct access to Medical Officers and Specialists at the DH through phone and WhatsApp was available**.** DNB courses have been initiated at the Civil Hospital Aizawl under fields of General Medicine, General Surgery, Pediatrics, Anesthesiology, Obstetrics and Gynecology**.**

<u>Availability</u>

- Lack of comprehensive HRH plan leading to irrational deployment and poor service provision.
- Posting of HRH is not as per the IPHS: No Specialists in the CHCs, only EmOC trained MO posted in CHC without Anesthetist/ LSAS trained MO, no Pharmacists in facilities visited in Champhai district except UPHC

<u>Management of HR</u>

- No HRH Policy. HRH Management is completely centralized
- Lack of clear recruitment process and job descriptions leading to mismatch in the qualification/ skills and actual responsibilities of the HRH
- HRMIS: Only at the state level; linked to salary disbursement of only SPMU staff

<u>Recommendation</u>

- Comprehensive HRH Policies to be developed
- Decentralization in recruitment processes is required
- CHCs to have specialists and provide care as per IPHS. (A team of MOs trained in EmOC and LSAS should be posted together to make the FRU functional).

- State must initiate steps to undertake preparedness assessment for the District Hospitals that have the potential to initiate the Diploma NBE (Post MBBS – 2 year) courses
- Trainings to be streamlined and as per training need assessment. Induction training for newly recruited staff
- Multiskilling for the areas/ specialties where there is shortage of specialists. Medical officers (MOs) may be trained through special short-term training programmes. E.g. 6-month training in Psychiatry is offered by NIMHANS.

***5.1.6 Quality Improvement.*** Mamit DH Labour room had overall scoring of 93% in NQAS LaQshya certification. Some facilities have strong linkages with local community & youth groups like Young Mizo Association (YMA) for conducting sanitation drive on volunteer basis. Open burning of bio medical waste was seen at sub centre and PHCs.

Recommendations

- Ensure BMW management as per BMW guidelines, 2016
- Capacity Building of Healthcare personnel on quality assurance initiatives
- Implementation of Mera-aspataal
- Display of citizen charter with complete information of mission statement, access to services, rights of the patient, services available, grievance redressal mechanism

***5.1.7 Family Planning. .*** Insertion of IUCD is done by HW (F) at very few sub-centers and the record is maintained**.** Injectable contraceptive is done at the level of PHC and above. IUCD and PP sterilization are performed at CHC and above level.

Maternal Health and CAC

a) District Hospital (DH) Labour Room in Mamit is State and National level Laqshya certified. DH at Champai is State certified.
b) DHs are maintaining patient satisfaction scores for pregnant women
c) Most Labour rooms have an attached clean Washroom for pregnant women.
d) The partograph is being maintained in some facilities.

e) ANM/ASHAs in some villages created WhatsApp group with Pregnant Women for effective communication about service provisions
f) DH, Mamit is conducting C-section audits
g) Safe Birth Checklist is being maintained
h) IEC material of key maternal health programmes like PMSMA, SUMAN, JSSK, JSY are not displayed at most facilities
i) Provision of full PMSMA service package is limited to District Hospital only
j) No mechanism for High-risk Pregnancy identification and tracking was found
k) Availability of IFA and Calcium was not seen at some sub-centres
l) CAC is missing in peripheral health centres, available only in DH

Recommendations

- To strengthen the reporting mechanism under HMIS
- Ensure the implementation of the free JSSK services (exemption of user charges for pregnant women)
- Strengthening Maternal Death Review & Sensitization about MDSR is required
- IEC/BCC activities need to be strengthened
- Display of IEC for creating awareness on entitlements under JSSK, SUMAN
- State to develop a mechanism for High-risk pregnancy identification and tracking
- Capacity Building of health care staff (ANM/HWO/SN) esp. SBA/Daksh/Dakshata Trainings need to be strengthened
- Develop a strong referral mechanism to minimize the out-of-pocket expenditure for mothers during delivery.
- Ensure Branding of SUMAN notified facility including display of Service Guarantee charter
- Ensure Availability of drugs like IFA/Ca at Sub Centres

***5.1.8 Immunization.***Micro plans do not include session site wise specific day of immunization.Some of the session sites cover more than 1000 population, yet outreach sessions are not planned for such areas.Only birth doses given at facility level (PHC and above)**.**Not all delivery points offer birth dose immunization, owing to the apprehension of vaccine wastage.

- Variations in the practice of open vial policy across Cold Chain points.
- Storage of different medicines and testing kits was done in the ILR along with the vaccines.
- E.g. used Covid Vaccine vial, Anti rabies vaccines, Rickettsia Testing Kits, Unused Oxytocin Vials, Old Samples of Covid Patients.
- Inadequate power backup supply at health facilities
- Huge gap in Supply Chain: Indenting mechanism is largely unutilized. Indenting done in eVIN only after receiving vaccines at CCH
- However, ANMs submit their monthly vaccine requirements as per the due lists
- Poor recording and reporting of AEFI
- AEFI kit were unavailable in most of the facilities
- Lack of awareness among health workers on utility of AEFI kits

***5.1.9 Health Financing.*** Records of Proceedings were timely disseminated till block level and being used as a guiding document.Consolidated ASHA Payment through PFMS portal was done.Good accounting practices were observed (Cash book, Bank reconciliation, fixed assets and staff register).Strong community participation –Pastor /local priest/Village council member actively participate in health-related activities.

| Observations: | Recommendations: |
|---|---|
| **Single Nodal Account: Process started, yet to be completed** | **State needs to ensure mapping of PFMS codes and implement SNA across the districts.** |
| **DBT payment is a norm for NHM & State schemes. However, payments are made monthly leading to delays.**<br>**DSC based payments exists only for TB schemes.** | **DBT payments to be made real-time and not monthly.**<br>**Follow-up actions of failed payments required strengthening.**<br>**Use of DSC to be ensured for all programmes at all levels** |
| **Auditing and internal control mechanisms: In place.**<br>**Statutory Audit and Concurrent Auditors appointed.** | **Timely completion of audit for FY 2020-21 to be ensured.** |

| | |
|---|---|
| **RKS meetings need to be regularized and their records to be duly maintained, particularly at the block level.** | **Minutes of meeting, Signature of competent authorities and ATR of decisions arrived must be maintained properly.** |
| **15th Finance Commission-SLC,DLC constituted, facilities identified, plan approved by GoI** | **State to ensure no duplication of activity from various grants viz. NHM, 15th Finance Commission, FC& PMABHIM grants, DMFF and ECRP-1 & 2 grants.** |

The main area of concern was the delay in funds transfer from State Treasury to SHS as illustrated in table 6.1.1.

**Table 5.1: No. of Days delay**

| Sr. No. | F.Y . | No. of days |
|---|---|---|
| 1 | 2021-22 | 150 days |
| 2 | 2020-21 | 80 days |
| 3 | 2019-20 | 40 days |
| 4 | 2018-19 | 40 days |

**Table 5.2: Utilisation of Funds**

| Sr. No. | Programmes | Outlay (2021-22) | Utilization till sept.2021 | % Utilization |
|---|---|---|---|---|
| 1 | RCH Flexible Pool | 77.62 | 13.98 | 18.01% |
| 2 | Health System Strengthening under NRHM | 50.58 | 11.12 | 21.98% |
| 3 | NUHM Flexible | 4.47 | 0.74 | 16.55% |

| | | | | |
|---|---|---|---|---|
| | Pool | | | |
| 4 | Flexible Pool for Communicable diseases | 21.57 | 1.40 | 6.49% |
| 5 | Flexible pool for NCDs | 2.60 | 0.74 | 28.46% |
| 6 | Details of Expenditure under ECRP-I | 886.00 | 789.16 | 89.00% |
| 7 | Details of Expenditure under ECRP-II | 166.64 | 0.00 | 0.00% |

***5.1.10 PM-JAY.*** Number of golden cards issues are 11,118.AB- PMJAY scheme awareness is good among population. No. of unique beneficiaries provided services in AB PM-JAY are 37, 607. Theyearly target/ estimated population eligible under scheme are not provided by SNO for AB PM-JAY.

***5.1.11 Management of COVID-19.*** Refusal among some of the communities for Covid Vaccinations emerged as one of the major challenges behind low level of vaccination percentages. PPE Kits, three layered mask, gloves were available in PHC, CHC and DH visited in Champai district (Stock not maintained). Local procurements done to meet the requirement of drugs and consumables for COVID management**.** Isolation ward was seen at PHC Khawung and DCHC was functional at DH Champhai. Home Isolation record is maintained in all facilities**.** Rapid Antigen Test kits were available across the facilities.

**5.1.12 COVID Vaccination: Mamit District Scenario**

The uptake of Covid vaccination, especially second dose among the Health Care Workers and Front-Line Health Workers is low.

| Category of Health Worker | 1st Dose Uptake | 2nd Dose Uptake |
|---|---|---|
| **HCWs** | 90% | 76% |
| **FLWs** | 75% | 61% |

The uptake of Covid Vaccination especially second dose among the Health Care Workers and Front-Line Health Workers is low.

| Age Group | 1st Dose Uptake | 2nd Dose Uptake |
|---|---|---|
| **> 60 years** | 89% | 71% |
| **45-60 years** | 73% | 58% |
| **18-45 years** | 72% | 43% |

The uptake of Covid Vaccination in the age group of >60 years is comparatively higher than the people in the age groups of 18-45 and 45-60 years.

### 5.2 Identified Key Challenges

- Limited IEC materials at HWCs. EDL list, list of medicines and diagnostics test, citizen charter, HR not displayed.
- Yoga and wellness activities, health calendar and other services not displayed at HWCs in both districts, and not initiated.
- User fee being charged in DH East Aizawl, & there are limited diagnostic tests.
- Referral transport services for delivery is not available & high Out of Pocket Expenditure
- Family planning services poor. ASHAs had no supply of FP commodities. New Contraceptives are limited to the District Hospital only with poor retention rate.
- Adolescent Health programme weak. Role of peer educators and ASHA in community mobilization negligible. AnemiaMukt Bharat (AMB) program not implemented.
- MCP Cards are being filled up partially, documentation in facilities below district level is poor, standard registers are not being used.

- Line listing of HIV cases with chest symptoms being referred for CBNAAT testing is maintained in ART centre but back referral records not being maintained. Monthly meeting between the TB and HIV department is not happening regularly.
- There is no TB treatment centre in Civil Hospital Aizawl.
- Data is being recorded and compiled under IDSP but not being analysed for giving feedback
- Transportation & network coverage problem, Weak IEC, and Less special outreach camps conducted, are seen under Urban Health
- ASHA programme support and payment system has major gaps at Block / PHC level.
- ASHA incentives are being paid separately for different programmes & not as consolidated payment, Payments irregular, substantial delays. No Grievance redressal system for ASHAs.
- Three social security schemes for ASHAs, announced by Hon. Prime Minister not implemented.
- No/poor record keeping systems and minutes of the meetings of VHSNCs and RKS
- Disposal of BMW, not as per Rules. Some facilities have no authorization from State Pollution Control Board.
- Various Committees and Policies for quality assurance, BMW Management, Sexual Harassment at workplace etc. are not constituted. No Prescription Audits.
- Districts not aware on state HR policy, for recruitment, performance appraisals, carrier progression and posting and transfer. Salaries of NHM staff are delayed by 2-3 months.
- Districts do not have access to Human Resources Information System (HRIS). Attendance registers are not properly maintained and have no bearing on salary processing.
- There is no Nodal Officer for trainings in the NHM. Inadequate Infrastructure for trainings.
- Delays in disbursement of funds from State to various Operational level facilities. Financing Systems are poorly managed for incentive schemes like, JSY, RNTCP, ASHA Incentives.
- Direct Facility Purchase being done without Rate Contract.
- Improper Mapping of Ambulances under National Ambulance Services.

## 5.3Learning from the 13th CRM: [As per documented in 13th CRM (16thOctober, 2019 to 23rdOctober, 2019)]

One of the objectives of this CRM is to assess the implementation of states and districts to operationalize HWC.

Comprehensive Primary Health Care through Health & Wellness Centres

- Population enumeration and NCD screening at facility and community level is initiated but follow-up of NCD cases is limited. Cancer screening is only performed at DH level
- CHOs and MOs are not very well-versed with the concept of Comprehensive Primary Health Care. It is assumed by the field staff that CHO has come for NCD, ANM's role is for RCH, MO is for OPD, and MPREGNANT WOMEN-M is for malaria and TB.
- Desktops are available at all visited HWCs. Internet connectivity is not available in few functional HWCs
- IT based Daily reporting is not yet initiated in any of the visited HWCs. Data entry is being done at CHC level.
- Tele-consultation not yet initiated in District/ State under CPHC-HWC.
- Community awareness about HWCs is poor.
- Drugs are not available as per EDL.
- Wellness related activities have not been yet initiated.

### 5.3.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH (RMNCH+A)

- Labor room of Civil Hospital Aizawl is well organized. SBA/Dakshta trained staff are posted in most of the labor room. Also, Essential drugs and commodities are available at all LRs
- HIV screening of pregnant women during ANC is being done at PHC level & above.
- State has initiated Midwifery initiative and elected 3 Midwifery trainers.
- Referral transport services for delivery are not available in the District and found to be managed by the beneficiaries or family members, which lead to high out of pocket

expenses. Also, there is no ambulance at DH, Mamit (recently received one ambulance donated by TATA Trust).

- Availability of blood banks and blood storage units below district level remains a serious limitation in establishing CEmONC services and making FRUs functional.
- Documentation of delivery, High Risk Pregnancies and other services is poor throughout the facilities except Civil Hospital Aizawl.
- Provision of PMSMA services are limited to District Hospital and POC services not given. Poor Quality of ANC services is a concern in the state. Also 1st trimester ANC registration is low.
- Post-Partum Family planning services (Sterilization & PPIUCD) are limited to the District Hospital with poor footfall for the same. Also, CAC services are available at DH only.
- Capacity building of doctors and nurses in ENBC and resuscitation at PHC & CHC is required.

### 5.3.2 NON-COMMUNICABLE DISEASE CONTROL PROGRAMME

- At community level, the universal screening of NCD's has started and ASHAs are filling CBAC. However, follow up activities are not being 13th Common Review Mission | Report - 2019 83 undertaken for individuals identified or referred or those under treatment for NCDs.
- Community awareness activities are reported poor.
- At CHC/PHC, in absence of a dentist, Medical officers are undertaking the activities like oral health screening and tooth extraction.
- In district Mamit, primary level health facilities did not report of conducting any awareness activities or providing services related to NTCP.
- At the Sub district level and below, mental health services are not being provided at present.
- Palliative Care services not yet implemented in the state.

### 5.3.3 COMMUNICABLE DISEASES

- TB-HIV coordination between facilities, ICTC and ART Centres under NTEP (erstwhile; RNTCP) programme is found to be good in majority of the States; however, it is found that Isoniazid Preventive therapy is not being given to HIV patients in Mizoram.
- A separate 6 bedded DR-TB ward has been created at Mamit District hospital for management of DR-TB cases. But there is no TB treatment centre or DOTS centre in Civil Hospital Aizawl and TB Patients are referred to DTC Falkwan for treatment initiation, which is approximately 15 km away from the civil hospital

National Urban Health Mission

- The state has RKS constituted and functional in all of its 77 facilities – 9 DHs, 9 CHCs, 57 PHCs. 37 UHNDs are being conducted every month and a monthly calendar is prepared for these camps.
- Insufficient funds for transportation for conducting outreach camps due to hilly area.

### 5.3.4 COMMUNITY PROCESSES AND GENDER

- NCD training for ASHAs has been conducted and 258 ASHAs and 109 Facilitators have been trained.
- Limited trainings have been undertaken for urban ASHAs where only the induction module training has been done for urban ASHAs
- ASHA incentives payments are irregular with substantial delays. State is yet to enroll ASHAs and ASHA facilitators in the three schemes
- Grievance redressal system and ASHA restrooms are not found operational.

### 5.3.5 QUALITY ASSURANCE

- Documentation throughout the facilities below district level is poor, standard registers are not being used.
- Unavailability of signage for guidance of patients to access the services seen.
- Out-of-pocket expenditure is reported due to irregular supply of medicine and travel cost from village to HCFs
- Facility wise Essential Drug List is not present, and the documentation related to dispensation is not maintained.

### 5.3.6 ACCESS AND EQUITY

- It is observed that fire safety norms are not followed. Only the availability of Fire Extinguisher is reported in the facilities.
- Online Drugs and Vaccine management system (DVDMS) is yet to be implemented
- Buffer Stock is not maintained at health facilities and drug warehouses. High local purchasing as well as High Out of pocket expenditure is observed.
- There is no equipment tagging and online equipment inventory management system functional in the facility
- Secondary level public health facilities are empanelled under PM-JAY. DNB/CPS courses have not been initiated in the state yet
- Improper mapping of ambulances under National Ambulance Services is seen. There is no ambulance at District Hospital Mamit (this DH recently received one ambulance donated by TATA Trust).

**5.4 Learnings from the NEDfi Study** (on 'Regional plan and strategy for upgradation of secondary and tertiary health- care facilities in NER by 2030')

- On the recommendation of the North Eastern Council (NEC), NEDfi under its TEDF undertook a study titled, 'Regional plan and strategy for upgradation of secondary and tertiary health- care facilities in NER by 2030' in 2020. As per the study, given below are the findings specific to the state of Mizoram which highlight critical existing gaps to be filled, in order to truly realise the right to health in the state.
- Mizoram does not have any super-Specialty private hospitals as of now.
- The state has existing nine District Hospitals (DH) out of which
- 8 DHs are to some extent fully functional.
- Lack of HRH is a chronic challenge to the region of NER.
- Absence of a common bank account for various programs has been observed across all states.
- Super Specialty unit in Manipur (JNIMS) is functional.

**Recommendations**

It recommends five new FRU at CHC level and five new model DH to ensure access to health. A model DH, as per the document will house specialists and functional departments and serve as a hub for three- four adjoining districts and setting up new units as required. For the population bed ratio per thousand population, it recommends 3.5 for the state of Mizoram. Though it notes that Mizoram does not have a shortfall in bed population ratio. For HRH specifically, it mentions that Mizoram does not have a specific HR Policy for engagement, promotion and incentives, however it recommends a ratio of 2.3 to be maintained. Regular service doctors are not routinely absorbed as per vacancy. For the up gradation of DH, it recommends that among these nine DHs, the state can develop four Model District Hospitals/ Secondary care hospitals- at Lunglei, Champai, MamitandLumbli by 2030. By 2023, the two models can be created one at Mamita and the other in Lunglei providing all facilities and HR as per IPHS norms.

# CHAPTER- SIX

# SUMMARY OF THE FINDINGS

***This concluding chapter lists out the summary of the findings of the report. The emphasis of the policy is on ensuring healthy lifestyles and promoting well-being for people of all ages. Mizoram State Health Society (MSHS), directed by Mission Director (MD), NHM, is in charge of implementing the National Health Mission (NHM). The Policy Solutions and Suggestions aim to improve the state's health status by coordinated policy action across all sectors, as well as extend preventative, promotive, curative, palliative, and rehabilitative services offered by the public health sector, with a focus on quality.***

# 6

# SUMMARY OF THE FINDINGS

The important findings of the report were as following:

a) Lawngtlai, Mamit, Kolasib and Serchhip need more attention in terms of health indicators. Lawngtlai in particular has higher proportion of anemic population and proportion of stunted children is relatively higher.

b) Malnutrition is one of the reasons that leads to different diseases and that is why it is very important to ensure nutrition of pregnant women and children. Child malnutrition has decreased in 2019-2020 as compared to 2016 data of 28 % stunted, 2.30 % wasted and 6.10 % underweight prevalence.

c) Policy intervention for re-structuring of primary health care by remodeling PHCs, CHCs, UHCs, DHs, strengthening of service delivery and capacity building of health workers under the National Health Mission and NEDP.

d) Strengthening implementation of Health care schemes such as Ayushman Bharat Jan Arogya Yojana, ICDS, National AIDS Control Programme, National Vector Borne Disease Control Programme, Routine Immunization Programme, etc.

e) To end all preventable maternal death and infant death as one of the commitments of Government of Mizoram and improving the reach of services of health facilities to everyone in the State.

f) Under Mizoram State Health Care Society, the health sector has strengthened with AB-PMJAY; Till date, the Society has awarded 3,87,529 (Three Lakh Eighty-Seven Thousand Five Hundred and Twenty-Nine) Golden Cards, and a Golden Card drive is now underway.

g) Also, the Mizoram State Health Care Scheme was pivotal as, during the 2018-2019 fiscal year, Rs.2,40,73,460 (Rupees Two Crore Forty Lakhs Seventy-Three Thousand Four Hundred

and Thirty) was distributed to 1,12,760 (One Lakh Twelve Thousand Seven Hundred and Sixty) BPL and APL recipients.

h) For the technological advancement in the health sector application of information technology and e governance will be incorporated for the elimination of possible corruption in Health department and prevent diversion of NHM funds.

i) To make the whole governance fair and transparent to public the state will have web based; advertisement of vacant and new posts, recruitment including test and selection interview, appointment and transfer of health staff, for award of contracts for civil works and intake of human resource and electronic payment of bills and invoices.

j) For rejuvenation of a weakened and not so efficient public health system, it must rely on strong ownership by the public, user involvement.

k) RogiKalyanSamithis and hospital management committees needs expansion with more broadly represented user groups and Community watchdogs rather than just one MLA or MP.These user groups and community watchdogs can facilitate social audit of major activities undertaken by health institutions.

# CHAPTER- SEVEN

# POLICY RECOMMENDATIONS

# 7

# POLICY RECOMMENDATIONS

The policy recommendation for the state of Mizoram is based on the principles of broad-spectrum vision of Health for all and the inclusive, holistic development of all stakeholders.

The policy encompasses important solutions and suggestions with an aim to improve the state's health status by a coordinated policy action across all sectors, as well as extension of the preventive, promotive, curative, palliative, and rehabilitative services offered by the public health sector, with a focus on quality.

As a Policy the State will uphold its responsibility to maintain optimum health of its citizen and will deliver Comprehensive Universal Health Care through Public health system. It will not expect or fully rely on Private sector for Primary or Secondary Care. Only feasible and mutually beneficial PPP will be embarked upon for Tertiary Care where there is absolutely no chance of Public Health System delivering it entirely in the near future. All Centrally sponsored programs and innovations under National Health Mission in both Rural and Urban sectors will be implemented fully absorbing the allocated funds. For this Techno-Managerial support through the State/District management units and its staff will be provided.

It recognizes the “right to health” as a constitutional right. Right to Health is understood as the fulfilment of complete physical, mental, and social wellbeing and more than merely the absence of disease or sickness. The Article 21 of the Indian constitution mandates the provision of bare necessities required for living a life with human dignity. The Directive Principles of the Mizoram State Policy emphasize state responsibility in minimizing inequalities and establishing a just social order. The policy proposes the operationalization of the right to health, as a responsibility of the state, for all individuals within the territory of Mizoram.

The State shall embark upon a framework of AAAQ to assess healthcare policies and programmes enacted under the right to health. AAAQ refers to availability, accessibility, acceptability and quality assured.Availability, here, refers to the sufficient supply of medicinal goods and services. Accessibility is understood as goods, services and facilities that are accessible at convenient time and free, if not free, but affordable to each individual within the territory of the state without discrimination.Acceptabilitymeans goods, services and facilities that are respectful of medical ethics and of individual preferences and leads to Client satisfaction. Finally, quality is to be understood as goods, services and facilities that are safe, effective, patient-centric and ensure rationality of care.

As part of the Policy, the *right to life-saving, emergency medical care and healthcare services* provides legal validity to the provision of these services without a compromise on quality of care or the safety of the citizen concerned. The policy shall be recognizing the *right to receive essential pharmaceutical medicines, devices and implants to those who need it.*It will also recognize the right to receive food, water, affordable housing, sanitation, and finally the right to a healthy environment as they are the determinants of health.

The participants who shall remain the focus of the Policy will be i.e.the Healthcare User, Healthcare Worker, and the Caregiver. The broad definition of *healthcare workers* as individuals providing healthcare services/treatment irrespective of their terms of employment (contractual, temporary, volunteers etc) including the staff not employed by the healthcare establishments such as practitioners of alternative medicine, sanitation and social workers, Secondly, the healthcare users are defined as individuals and their caregivers that seek, access, or use the services of a healthcare worker, including individuals requiring Medicare or treatment from health care establishments. Lastly, the caregivers are individuals including family members or individuals of the healthcare user's choice who provide care support, assistance to the user with or without payment.

The policy undertakes the responsibility to watch against denial of healthcare services on any basis whatsoever, irrespective of current condition, identity, nationality, or lack of documentary proof of the individual thus safeguarding a large section of those deprived. In the same wave length it will be watchful on an often-violated fundamental right, that is the right to die with dignity wherein individuals have the right to receive a dignified funeral in

accordance with their chosen rights and practices. This has become more relevant during the outbreak of a serious communicable disease like Covid Pandemic.

By including the right to continuity of care, the Policy shall ensure that healthcare users have access to uninterrupted healthcare goods, services and facilities irrespective of a temporary or permanent change in geographical location thus acting as a safety net for those without a permanent resident address. The policy will be giving importance to sanitation in healthcare establishments as a habitable, clean and safe environment. It is a basic necessary requirement in healthcare establishments. The policy envisages a positive move towards the right to access caregivers which can act as a possible amenity for those with no caregivers, the establishment provides caregiving services, thus protecting those abandoned or stranded.

By including the *right of protection against discrimination on the basis of sexual orientation, rights of infants and children, rights of elderly and incarcerated persons,* the policy seeks to protect those discriminated on the basis of sexual orientation, the LBTQI2+ community by providing access to healthcare and by providing legal protection against pseudo-scientific coercive practices, including but not limited to, conversion therapy.

The policy protects the elderly from physical, mental or emotional abuse at their place of residence, and in case of the latter, they shall receive an adequate supply of goods, services and facilities, while simultaneously ensuring redressal mechanisms in case of a proven violation of the said right.

The policy shall ensure the right of all categories of Health workers to receive agreed remuneration and wages in time, to receive free, appropriate, safe, sufficient, ergonomic, and quality personal protective equipment while serving patients with communicable diseases. The policy shall also ensure the right to be involved in decision-making, the right to be included and consulted during the formulation of health plans, programmes and policies, thus giving its healthcare policy a bottom-up approach in planning and governance.

The Policy shall protect the Rights of people during a Public Health Emergency, their right to access accurate information on real-rate of infection, recovery and mortality at the local

and state levels, so that misinformation is curtailed especially in an epidemic. No coercive measures are adopted in the light of the emergency that goes against basic individual rights, thus protecting those marginalized in the society.

Under the new state Policy there shall be a strong Monitoring and Participatory Governance Mechanism. The local communities will be active co-facilitators articulating their needs, identifying key indicators and creating tools for monitoring and evaluation, providing feedback and validating the functioning of the Public Health system.

For this there shall be the establishment of Health Councils at each of the village, block and district levels. Meanwhile, States shall formulate State Health Councils and promote the functioning of community-based health monitoring, evaluation, governance and planning bodies. Additionally, these bodies are responsible for organizing periodic public hearings to ensure accountability of the health system to the community. Finally, the councils are to ensure that their respective healthcare establishments act in accordance with provisions of this policy and perform all or any functions necessary to fulfil rights and obligations enunciated under this policy.

The State Health Council shall promote access to primary, secondary and tertiary healthcare and simultaneously oversee the functioning of Village, Block and District Health Councils. Additionally, it also oversees community outreach and establishes performance standards for health care infrastructure, service providers, quality or performance improvement that are necessary for the objectives under this policy. Lastly, the State Health Councils, are also responsible for developing mechanisms for empowering the decentralized monitoring committees at all levels, rural as well as urban, thus paving the way towards institutionalization of the right to health at the grassroots level.

The policy lays down the financial obligations of the state, which include undertaking appropriate financial measures and ensuring transparency in all budgetary decisions and measures and in allocation of funds and distribution of resources and prioritizing and increasing resource allocation to health and healthcare. The policy mandates the state and local authorities to expand resources and facilities at the primary, secondary, tertiary and district levels according to AAAQ criteria so as to ensure better healthcare.

The policy sees the requirement of free transportation for the poor to and from healthcare establishments, elsewhere in the country for tertiary specialised care.

The policy will encourage situational analysis of basic structural bottlenecks and periodical program review and planning sessions.

The state of Mizoram has different health hurdles ranging from high cancer rates, malaria, malnutrition, intervention for health infrastructure and robust medical staff employment system. The state needs to make efforts both in terms of generation of financial resources and capacity building.

As per the analysis by PRS Legislative[9], in 2021-22, Mizoram has allocated 5.9% if their budget to healthcare which includes expenditure on schemes such as the National Health Mission, Ayushman Bharat, and construction and maintenance of hospitals. The National Health Policy, 2017 had recommended that by 2020, states should allocate at least 8% of their budget towards health which has been iterated by the 15th Finance Commission and recommended states to meet this target by 2022.

All Centrally sponsored programmes and innovations under National Health Mission in both Rural and Urban sectors will be implemented fully absorbing the allocated funds. For this Techno-Managerial support through the State/District management units and its staff will be provided. Contractual appointment of those positions will be in a phased manner absorbed into the State health system and budget for regularisation of those posts will be explored. Many Consultants in medical and surgical specialities, Dentists, Psychologists/Counsellors, MBAs, M. Com/CAs, Physiotherapists, Lab Technicians appointed through NHM are needed for the State PHSystem. Assurance of continuity of service and privileges of pension and gratuity will be a motivating factor for Contractual staff to continue with government service. The pull factor from private sector will be a constant threat to the staff strength of PH System.

State will proactively attract young MBBS graduates to join PHS and post them in areas of their choice if that can be accommodated after fully achieving the needs of institutions

[9]State of State Finances 2021-22, PRS Legislative; can be accessed at https://prsindia.org/files/policy/policy_analytical_reports/State%20Finances%202021-22.pdf

in remote and difficult areas. Depending on the ethnography and geography of the applicants,posting in their home districts and among their own tribes and clans will be beneficial both for the system and the doctors, nurses, and other health staff.

State will identify and sponsor meritorious undergraduates posted in PH System for Postgraduate studies outside the State with a service bond of 5 or 7 years. Once they finish specialization their posting as Consultant Specialists should be automatic and without uncertainty. This will gradually solve the high vacancies in CHCs and District hospitals.

Since Medical Colleges are inadequate, the State will make immediate plans to upgrade all 8 District hospitals to deliver the full complement of Tertiary services. The existing district hospitals can be renovated, restructured to deliver the full complement of Tertiary care. Some of those essential components, over and above OPD/IPD,Operation theatres, Labour room, Accident and Emergency, are Coronary Care Unit, Intensive Care Units for General and Paediatric cases, Neonatal ICU, Burns Unit, Blood bank, Liquid Medical Oxygen generation plant, Dialysis Unit, Radiation, and Chemotherapy wards, etc. That was a need intensely felt in many District Hospitals in the country during the Pandemic crisis during the delta wave.

Some of the other policy recommendations for the state are as following:

1) The state of Mizoram has faced a series of lockdown due to the Covid-19 crisis this has led to economic hardship for the people, and the healthcare workers have faced the wrath of the people apart from overwork and depletion of savings. The state government can establish a mechanism for direct benefit transfer to the healthcare workers of Rs. 2000 per month (excluding doctors) for the next two years. The budget for the DBT can be borne by the state and central government.

2) Mizoram faces an acute issue of cancer, with Aizawl even called as the cancer capital of India by many popular media houses. There is an urgent need to setup a platform for international collaboration with Australian health professionals preferably. (Australia has the highest index score in policy and planning against cancer among all countries) The aim will be to incorporate strategies of early awareness towards cancer identification. Also, the

state's health staff is to be sensitized so that they are prepared against cancer and the need for its treatment.

3) The major cause of cancer in the state of Mizoram is Tobacco and its daily consumption is high. The Gutkha is banned too. To counter that it's important to impose a full ban on cigarettes and all tobacco products. For raising awareness against tobacco, the state had formed an anti-tobacco squad in the year 2010. But in the contemporary times the anti-tobacco squads have become redundant. There is an urgent need to reform these squads with better capacity building similar on the lines of Delhi's Civil Defence staff personnel.

4) Health Infrastructure in the state is on highly inadequate, with only one good medical college in the state i.eZoram Medical College. There is an urgent need to build more Medical Colleges in the state meeting the universal standards. As the students appearing for the medical entrances in the state is high, due to lack of colleges they have to miss their ambition and face unemployment. With building of more colleges in districts like Lawngtlai, will be a boon for the students, the residents as well as it will ensure a robust production system for better availability of doctors of high calibre and professional skill within the state.

5) A proposal to create Special Medical Zones (SMZ) taking inspiration from special economic zones. The Special Medical Zones in the state will be demarcated in non-agricultural area, where private medical companies like, Apollo, Fortis, Vedanta, etc may be invited to setup hospitals within the state. The Special medical zones will have special provisions for these private investors to suit their requirement and to improve their ease of doing business.

6) For tackling Malnutrition, the state's Anganwadi workers will be trained with the launching of a new training programme for them with the focus on curbing malnutrition. The emphasis will be on the promotion of exclusive breast feeding till six months of age, the timely introduction of complementary feeding and early detection of growth faltering by monthly weighing and monitoring their growth chart till 2 years as a priority. This will help these workers to spread awareness to the remotest part of the state about malnutrition. The Anganwadi centres in the state, will be provided with more funds to procure protein

rich food materials for cooking. Hot cooked meals will be given priority over precooked packaged food. These will be for both the child and their mother.

7) The Malaria epidemiology in the state is also of grave concern. To reduce the malaria incidence rate and its effect on people every local council will be provided with machinery for the dissemination of indoor residual spraying (IRS) and funds will be released well before the seasonal peak. Established mechanism for distribution of insecticide-treated nets (ITN) for households sponsored by the state government will be activated.

8) Collaborating with different media houses, civil societies and church organisations awareness on different government health schemes and family planning will be raised.

9) Adoption of new technology and e- application system for medical records at all levels of health centres will ensure better documentation of schemes availed, higher transparency and accountability and better efficacy in health services delivery. (Vaccination drive, Polio drive etc.) This will be in tune with the Centrally sponsored National Digital Health Mission.

10) An IT enabled system for human resource recruitment, placement, promotion and transfers will ensure transparency and elimination of corruption and favouritism. Similarly, IT enabled system of procurement and supply of medicines, diagnostics and equipment will ensure transparent, timely, merit based procurement and supply, assure quality and boost efficiency of Public Health System.

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# ANNEXURES

**Policy Drafting Team:**

Honorary Advisor: Prof.K. Srinath Reddy, President, PHFI

Lead: Dr. Priscilla C Ngaihte, Advisor, PHFI

Co- Lead and Technical Advisor: Dr. Antony K R, Independent Monitor, National Health Mission, Govt. of India

Members: Ms. Ravneet Kaur, Senior Research Assistant

Ms. Shivangi Kumari, Medical Researcher

Mr. Aditya Shrey, Policy Research Intern

Peer Reviewer: TBC