IPP758

Social Assessment and Social Safeguards Management Framework for Nagaland Multisectoral Health Project (NMHP) (P149340)

(Includes Tribal Development Plan, Resettlement Policy Framework, and Gender and Social Inclusion Guidelines)

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AWO	Angami Women Organization
BMWM	Bio-Medical Waste Management
BPL	Below Poverty Line
CFMC	Ceasefire Monitoring Cell
CHC	Community Health Centre
CMO	Chief Medical Officer
CWWS	Chakhesang Women Welfare Society
DH	District Hospital
DMC	Dimapur Municipal Corporation
DoHFW	Department of Health and Family Welfare
DUDA	Development of Under-Developed Areas
ECS	Eleutherous Christian Society
EG	Expert group
ENPO	Eastern Naga People Organization
FNR	Forum for Naga Reconciliation
GB	*Gaonburas* (including hereditary village chiefs and *Anghs*)
GDI	Gender-related Development Index
GRC	Grievance Redress Committee
GSDP	Gross State Domestic Product
HADO	Hill Area Development Society
HCMC	Health Centre Management Committee
HDI	Human Development Index
HNP	Health, Nutrition and Population
HPI	Human Poverty Index
ICT	Information and communication technology
ICDS	Integrated Child Development Services
IEC	Information Education & Communication
KMC	Kohima Municipal Corporation
MMU	Mobile Medical Unit
MO	Medical Officer
MoU	Memorandum of Understanding
NBCC	Nagaland Baptist Council of Churches
NCF	Nagaland Christian Forum
NEFA	North East Frontier Agency
NEN	North East Network
NEIDA	North East Initiative Development Agency
NFHS	National family and Health Survey
NGO	Non Governmental Organization
NMA	Naga Mothers Association
NNC	Naga National Council
NPCB	Nagaland Pollution Control Board
NRHM	National Rural Health Mission

NSCN	National Socialist Council of Nagaland
NWH	Naga Women Hoho
NWU	Naga Women's Union
PAP	Project Affected Person
P&AR	Personnel and Administrative Reform
PBCA	Phom Baptist Christian Association
PDO	Project Development Objective
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PIP	Project Implementation Plan
PMU	Project Management Unit
RBA	Rongmai Baptist Association
R&R	Relief and Rehabilitation
RAP	Resettlement Action Plan
RPF	Resettlement Policy Framework
SC	Sub Centre
SHG	Self Help Group
SIA	Social Impact Assessment
SMF	Social Management Framework
SIA	Social Impact Assessment
SRS	Sample Registration Survey
ST	Schedule Tribe
STH	Sumi Totimi Hoho
TOT	Training of Trainers
UHC	Urban Health Committee
ULB	Urban Local Body
UT	Union Territory
VC	Village Council
VDB	Village Development Board
VHC	Village Health Committee
WM	Watsü Mungdang

PREFACE

This Document has been prepared by the Department of Health and Family Welfare, Government of Nagaland for the World Bank assisted Nagaland Multisectoral Health Project (NMHP) and it has two parts: Social Assessment and Social Management Framework. The Social Assessment presents a larger social and institutional context to planning and implementing NMHP and has been prepared with compiling useful data, information, and analyses of various issues from primary and secondary sources. This SA makes no claim to original scholarly analysis of issues discussed herein, and has relied on the works of various scholars and information providers that have been cited in the footnotes. Any failure to cite any contributor's name and information source in the footnotes is regretted.

In the Second Part of the Document, the Social Management Framework (SMF) provides: (a) Indigenous People's Framework, (b) Resettlement Policy Framework (RPF), (c) Gender and Social Inclusion Guidelines, and (d) Implementation Arrangements. The SMF has been prepared based on stakeholder consultations held at different levels.

Table of Contents

SOCIAL ASSESSMENT

1.0 INTRODUCTION

1.1 Background of the Project

Nagaland has a population of approximately 2 million (0.16% of India's population), spread over 11 districts, 74[1] blocks and 1405[2] villages. The State has the density of 119 persons per sq. Km as compared to national average of 382 per sq.km., and North East average of 176 per sq.km., and belongs to five least densely populated states in India (the other states/ UTs includes Sikkim, Mizoram, Arunachal Pradesh and Andaman and Nicobar Islands).

The state has an estimated infant mortality rate of 18 per 1,000 (2013), an estimated maternal mortality ratio of 240 per 100,000 births (2007), and an estimated 39% of under-five children are malnourished (stunted) (2005-06). There are significant problems with access to basic health services, as over 80% of the population lives in rural areas while health facilities are available in only 42% of villages in the state. Only 42.5% of one year old children are fully immunized, including only 9.5% of the poorest children (2009). Similarly, only 30% of births are delivered in a health facility (2009). Geographic accessibility, as well as availability and quality of services, are important factors. The state and central governments have made significant efforts to improve availability of health and nutrition services through investments in infrastructure, mobile medical units, and human resources, as well as addressing barriers to access (i.e. through conditional cash transfers for institutional delivery and referral transport).

Despite of continuous efforts from the state, majority of the health facilities are partially functional. Availability of basic services like water supply and sanitation to maintain the health facility is one of critical challenge. On the other hand, intermittent power supply impedes optimum utilization of equipment dependent on power supply

1.1.1 Social Assessment

Objective: A Social assessment was undertaken to understand the larger social context, identify key social issues and risks, adverse impacts, if any, and accordingly prepare a Social Management Framework (SMF) which defines actions to be undertaken to ensure inclusion of vulnerable and marginalized groups in equitable and accessible service delivery and to mitigate any adverse impacts emerging out of the Project. The specific objectives of the study is to understand the applicability of the World Bank social safeguards policies of the World Bank, and requirements of the special status enjoyed by Nagaland under the article 371 (A) of the Indian Constitution. The SA discusses the population, health care services, system of governance and explores the gaps and barriers associated with health care service delivery in the state so as to suggest necessary inclusive and mitigation measures to avoid, minimize, and mitigate where unavoidable any adverse impacts emerging out of activities undertaken under the Project.

Method Adopted: The methodology involved: review of secondary literature, analysis of social and demographic context, cultural practices, economic circumstances, governance

[1] Annual Administrative Report 2013-14, Department of Rural Development, Govt of Nagaland
[2] Census PCA 2011

systems and available health care facilities that influences the health care service delivery in the state, and stakeholder consultations to identify risks and impacts, and discuss the implementation arrangements. In addition to review of primary and secondary data and information, field visits were made to various health care facilities right from sub-centre to district hospitals across 9 out of 11 districts in the state. Discussions were also held with staffs of various health care facilities, communitization groups, Village Councils and members of the community. In addition, consultations were also held at state level in Kohima along with other line departments, members of civil society organizations and community representatives.

1.2 NAGALAND: Historical Setting and Physical Terrain.

The State of Nagaland was formally inaugurated on December 1st, 1963, as the 16th State of the Indian Union. The state lies between 25°6' and 27°4' latitude, North of Equator and between the longitudinal lines 93°20'E and 95°15'E. It is bounded by Assam in the West, Myanmar (Burma) on the east, Arunachal Pradesh and part of Assam on the North and Manipur in the South. The State consists of seven Administrative Districts, inhabited by 16 major tribes along with other sub-tribes. Each tribe is distinct in character from the other in terms of customs, language and dress.

It is a land of folklore passed down the generations through word of mouth. Here, music is an integral part of life; folk songs eulogising ancestors, the brave deeds of warriors and traditional heroes; poetic love songs immortalising ancient tragic love stories; Gospel songs that touch your soul (should you have a religious bend of mind) or the modern tunes rendered exquisitely to set your feet a-tapping.

Each of the 16 odd tribes and sub-tribes that dwell in this exotic hill State can easily be distinguished by the colourful and intricately designed costumes, jewellery and beads that they adorn. The present generation of Nagas have ventured into fashion designing in a big way, reproducing fabrics that represent the ancestral motifs blended with modern appeal. Indeed, it is a beautiful mix of the past with the present…… a paradise for those who are into fashion designing. This is an affluent fashion station of the East.

The traditional ceremonial attire of each tribe is in itself, an awe inspiring sight to behold; the multi-coloured spears and daos decorated with dyed goat’s hair, the headgear made of finely woven bamboo interlaced with orchid stems, adorned with boar's teeth and hornbill's feathers, elephant tusk armlets….. You name it! In days of yore every warrior had to earn each of these items through acts of valour, to wear them.

Nagaland, sometimes referred to as the Switzerland of the East, is known for picturesque landscapes, the vibrantly colourful sunrise and sunset, lush and verdant flora. Its people belong to the Indo-Mongoloid stock, whose ancestors lived off nature's abundant gifts, blessed with sturdy formidable dispositions. The people are warm-hearted and hospitable.

The people of Nagaland are almost entirely tribal consisting of 16 major tribes, each having its own distinctive language and cultural features. The 16 major tribes include Angami, Ao, Chakhesang, Chang, Khiamniungan, Kuki, Konyak, Kachari, Lotha, Phom, Pochury, Rengma, Sumi, Sangtam, Yimchungr, and Zeliang along with other sub-tribes. Each tribe is distinct and unique in character from the others in terms of customs, language and attire. The colourful and intricately designed costumes and ornaments, that were traditionally worn, can

easily distinguish each of the tribes and sub-tribes. The multiplicity of tribes, within such a limited space, could be due to the fact that the Naga ancestors migrated to the present location in different groups and they remained confined to their ridges and mountainous terrain. This, subsequently, resulted in their unique characteristic of appearing to be both one people and many tribes, displaying both unity and diversity in their customs, traditions, attire and political systems[3].

More than 95% of the population is Christian in faith. Immigrants consisting of a small percentage of the population are mostly Hindus, Muslims and Buddhist.

Family is the fundamental unit in the society and is based along patrilineal and patriarchal lines. The structure of the society is complex. A clan comprises of a group of consanguineous families descending from a common ancestor, a number of such clans constitute a village while villages constitute a tribe. The clan functions as a unit of collective responsibility and provides a criterion of identification. Clan membership determines the choice of marriage partners.

Linguistically the Naga tribes belong to two different families based on the classification of the Linguistic Survey of India, namely the Mizo-Kuki-Chin and Bodo-Konyak-Jinghpaw subgroups of the Sino-Tibetan family. There is dialectic variation between tribes and even within the tribe. Therefore, in absence of indigenous lingua franca, with the advent of the British Rule, English became the official language, while Nagamese is a pidgin.

The District-wise distribution of the different tribes is shown in the table below:

Table (1): District wise Major Tribes in Nagaland

Sl.No.	District	Main Tribe
1	Kohima	Angami, Rengma, and small groups of Kuki and Sema
2	Phek	Chakhesang, Pochury and Sangtam
3	Mokokchung	Ao and small groups of Sema
4	Wokha	Lotha
5	Zunheboto	Sema
6	Tuensang	Khiamniungan, Chang, Sangtam, and Yimchungrü
7	Mon	Konyak
8	Dimapur	The district has cosmopolitan nature consisting of all the tribes of Nagaland and other people from the rest of the country. However among the Naga tribes Kachari and Kuki form the major proportion.
9	Peren	Zeliangrong, Kuki
10	Kiphire	Sangtam, Yimchungrü, Sema
11	Longleng	Phom
Source: NRHM PIP 2008-09		

[3] Nagaland State HDR, 2004

1.3 Socio-Economic Profile of Nagaland

The State of Nagaland was formally inaugurated on December 1, 1963, as the 16th State of the Indian Union. Nagaland is predominantly mountainous with an area of 16,579 sq. km. It is subdivided into 11 districts sharing its boundary with Assam in east and north, Arunachal in north, Myanmar in west and Manipur in south.

1.3.1 Demographic Profile

Scheduled Tribes form an overwhelming majority of the state's population. About 86.5%[4] (93% in rural areas) of Nagaland's population is tribal belonging to 16 tribes with many sub-tribes and clans. Each tribe has its distinct socio-cultural practices and exhibit strong bondage. The economy is largely (~72%) agrarian, following traditional practices.

Table (2): Demographic Profile of Nagaland

Sl. No.	Particulars	1961	1971	1981	1991	2001	2011
1	Total Population ('000)	369	516	775	1210	1989	1980
2	Decennial Growth of Population (%)	--	39.88	50.05	56.08	64.41	-0.45
3	Density of Population (per sq. km)	22	31	47	73	120	119
4	Percentage of Rural Population	94.8	90	84.48	82.79	82.26	71.03
5	Level of Urbanization (%)	5.2	10	15.52	17.21	17.74	28.97
6	Growth of Urbanization (%)	16.6	10.4	8.9	5.6	5.4	63.30
7	Literacy Rate (%)	20.4	27.4	42.57	61.65	67.11	80.11
8	Literacy Rate: Male (%)	27.2	35.02	50.1	67.52	71.8	83.29
9	Literacy Rate: Female (%)	13	18.65	33.9	61.65	61.9	76.69
10	Sex Ratio (females per 1000 males)	933	871	863	886	909	931
11	Percentage of Workers	NA	NA	48.23	42.68	42.74	57.73

Source: Census of India 1961-2011, State Statistical handbook, 2011

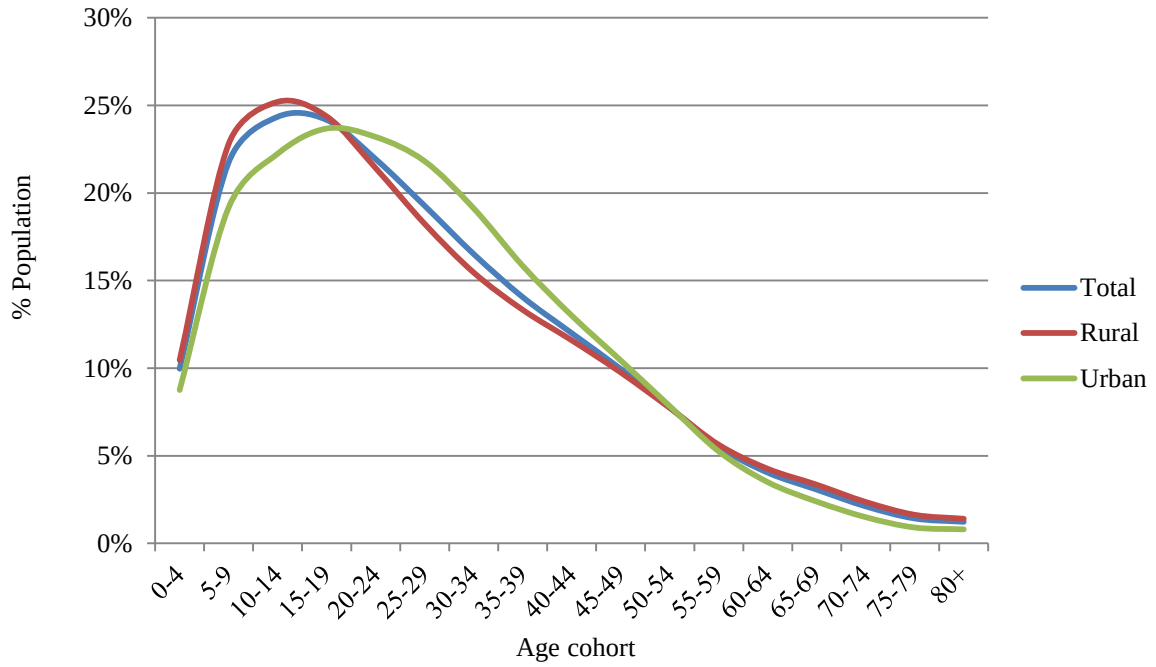
The decadal growth of population during 2001-2011period shows negative growth (in absence of any major famines, natural calamities, political disturbances, or dramatic changes in the correlates of fertility over the last decade), which has been contested by state that the 2001 census was not correct and had errors in estimating the state population[5]. Another view is that there has also been a substantial out-migration from the state to other parts of the country.

The age wise population trend in Nagaland (Refer Figure-1) is very similar to national average and 34% of the population is less than 15 years of age. 31% of the population

[4] As per Census 2011
[5] http://www.iegindia.org/workpap/wp311.pdf

belongs to 15-30 years of age. There is marginal shift between rural and urban areas. There is relatively more number of people between the age group of 20-50 years compared to in rural areas. This is linked to rural-urban migration due to people engaged in government or private service.

Figure (1): Population Distribution with Age in Nagaland (2011)



Source: Census 2011

The state is predominantly rural with about 71% population living in rural areas. The population density is 119 persons per sq. km. with a sex ratio of 931 compared national averages of 940. The population density varies from low of 76 in Tuensang, Longleng and Khiphire to the high of 410 in Dimapur. Nagaland predominantly inhibited by schedule Tribe population with about 86.5% of the state population belonging to Schedule Tribe (ST). Eight out of eleven districts have more than 90% ST population, with another two over 80% and only one district (Dimapur) have 59% of ST population.

Table (3): Population Distribution

Sl. No.	Name	Total Population	Sex Ratio	% ST Population	% Urbanization	Population Density (per sq.km.)
1	Mon	2,50,260	899	95.2%	13.8%	140
2	Mokokchung	1,94,622	925	91.7%	28.6%	120
3	Zunheboto	1,40,757	976	97.0%	19.6%	112
4	Wokha	1,66,343	968	94.2%	21.0%	102
5	Dimapur	3,78,811	919	59.1%	52.2%	410

Table (3): Population Distribution						
Sl. No.	**Name**	**Total Population**	**Sex Ratio**	**% ST Population**	**% Urbanization**	**Population Density (per sq.km.)**
6	Phek	1,63,418	951	96.2%	15.0%	81
7	Tuensang	1,96,596	929	97.1%	18.7%	76
8	Longleng	50,484	905	96.3%	15.1%	76
9	Kiphire	74,004	956	96.5%	22.3%	76
10	Kohima	2,67,988	928	83.9%	45.2%	117
11	Peren	95,219	915	88.5%	14.5%	117
Nagaland		**19,78,502**	**931**	**86.5%**	**28.9%**	**119**
Source: Census, 2011; Statistical Handbook of Nagaland 2012						

The literacy level in Nagaland is much higher than the national average. The overall literacy in Nagaland is 80% with male literacy being 83% and female literacy being 76% compare to national average of 74%, 82% and 65% respectively. It is also evident from the table below that eastern districts bordering Myanmar which are hard to reach areas have relatively lower literacy rate.

Table (4): Literacy Level				
Sl. No.	**Name**	**Total Literacy Rate**	**Male Literacy Rate**	**Female Literacy Rate**
1	Mon	57.0%	60.9%	52.6%
2	Mokokchung	91.6%	92.2%	91.0%
3	Zunheboto	85.3%	87.9%	82.6%
4	Wokha	87.7%	90.8%	84.5%
5	Dimapur	84.8%	87.5%	81.8%
6	Phek	78.1%	83.7%	72.2%
7	Tuensang	73.1%	76.3%	69.6%
8	Longleng	72.2%	74.5%	69.6%
9	Kiphire	69.5%	74.9%	64.0%
10	Kohima	85.2%	88.7%	81.5%
11	Peren	77.9%	82.8%	72.6%
Nagaland		**79.6%**	**82.8%**	**76.1%**
Source: Census 2011				

Seventy–two percent of children ages 6-17 years attend school; school attendance is 8 percentage points higher in urban areas than in rural areas. Seventy-four percent of primary school age children (6-10 years) attend school. School attendance increases to 80 percent for

children age 11-14 years but then drops to 54 percent for children age 15-17 years. In the age groups 6-10 years and 15-17 years, school attendance in urban areas is 12-13 percentage points higher than school attendance in rural areas; however, the urban-rural differential in school attendance, at only 3 percentage points, is much lower in the age group 11-14 years[6]. In contrast to several other states in India, there is a consistent, if slight, gender disparity in school attendance in Nagaland in favour of girls. In all the three age groups and in both urban and rural areas, school attendance is higher for girls than for boys7.

1.3.2 Workforce and Occupational Pattern

The economy in Nagaland is largely agrarian, following traditional practices. The workforce participation ratio is about 58% (72% including marginal workers). The workforce participation is much higher in rural areas (64%) compared to urban areas (43%). The women participation in workforce is also quite high about 52.5% women (62% in rural areas and 30% in urban areas) 4 are working. Of the total workforce about 44% are women.

Table (5): Women Participation in Workforce

Sl.No.	Name	% Worker	% Male Worker	% Female Worker	Women participation in Total Work Force
1	Mon	70.3%	71.8%	68.7%	46.2%
2	Mokokchung	57.5%	63.0%	51.5%	43.0%
3	Zunheboto	65.9%	67.6%	64.1%	48.2%
4	Wokha	53.6%	56.7%	50.4%	46.3%
5	Dimapur	46.2%	58.1%	33.1%	34.2%
6	Phek	59.2%	60.0%	58.3%	48.2%
7	Tuensang	61.0%	63.5%	58.4%	46.1%
8	Longleng	73.9%	75.1%	72.5%	46.8%
9	Kiphire	53.9%	55.4%	52.3%	47.5%
10	Kohima	49.6%	56.5%	42.1%	40.7%
11	Peren	76.9%	77.2%	76.6%	47.5%
Nagaland		**57.7%**	**62.6%**	**52.5%**	**43.8%**

Source: Census 2011

The main workers[7] account for 76% of the total workforce and 60% of the main workers are engaged in agricultural activities (75.5% in rural areas). About 1.3% of the workers engaged in household industry and 39% in other livelihood activities including in Government and private services (24% in rural and 90% in urban areas). The proportion of agricultural

[6] NFHS-3 (2005-06)

[7] Main Workers are defined as persons who 'worked' for 6 months or more in the last one year preceding to the date of enumeration

labourers is low because almost everyone gets a piece of land allotted for cultivation from the village council or the headman[8].

Table (6): Occupational Pattern Across Districts						
Sl. No.	**Name**	**% Main Worker**	**% Cultivator**	**% Agricultural Labourers**	**% Household Industry**	**% Other Workers**
1	Mon	71.1%	80.4%	3.8%	0.6%	15.3%
2	Mokokchung	81.0%	52.1%	6.0%	2.4%	39.5%
3	Zunheboto	62.1%	62.2%	3.6%	1.2%	32.9%
4	Wokha	81.0%	65.9%	3.7%	1.4%	29.0%
5	Dimapur	80.8%	16.8%	3.7%	1.9%	77.6%
6	Phek	79.3%	69.2%	2.1%	1.0%	27.7%
7	Tuensang	74.9%	78.2%	1.3%	0.7%	19.8%
8	Longleng	68.5%	80.4%	1.3%	1.0%	17.3%
9	Kiphire	80.8%	71.4%	1.7%	1.3%	25.6%
10	Kohima	86.6%	38.2%	0.9%	1.1%	59.7%
11	Peren	59.5%	70.3%	3.4%	1.0%	25.4%
Nagaland		**76.1%**	**56.7%**	**3.0%**	**1.3%**	**39.0%**
Source: Census 2011						

1.4 Health Status in Nagaland

In Nagaland the crude Birth Rate is 15.6 compared to Crude Death rate of 3.2 per thousand population. The infant mortality rate is currently estimated at 18 deaths before the age of one year per 1,000 live births. At current fertility levels, a woman in Nagaland will have an average of 3.7 children in her lifetime. The fertility level in Nagaland is the fourth highest among all Indian states and the second highest among the North-eastern states[9].

Table (7): Health Status in Nagaland

[8] Land ownership and management is unique in Nagaland and different from the rest of the country, where local customary laws govern the land. Depending upon the tribe, the land either belongs to the headmen, the community or individual. Except for some tribes where the chief owns the land, the village councils and headmen are generally mere custodians of the land. In most community land, all members have a right to use it freely but with prior consent of the custodians. *Jhum* lands are usually owned by the community but regulated by the respective village councils. The respective village councils decide the areas to be cleared for *jhumming* each year. Individual's plots are allotted by village council. A very democratic system is adopted for the allotment of annual *jhum* plots. And hence, everyone has a piece of *jhum* land to cultivate and is allotted based on ability and need to cultivate by the family. Long-term holding of land for permanent cultivation, gardens and homesteads are usually undertaken after prior consultation with village authorities, clan elders or with respective owners.

[9] NFHS-3 (2005-06)

Health Indicators	Total	Rural	Urban
Crude Birth Rate (Per 1,000 population) (SRS 2013)	15.6	15.7	15.1
Crude Death Rate (Per 1,000 population) (SRS 2013)	3.2	3.4	2.8
Infant Mortality Rate (Per 1,000 live birth) (SRS 2013)	18	18	18
Total Fertility Rate (2004-05)	3.7	4.2	2.7
Maternal Mortality Rate (per 100,000 live births)[10] (2007)	240		

In Nagaland only 27.8% children of the age of 12-23 months are fully immunized. Followed by 40.6% partially immunized and about 31.6% did not receive any vaccination[11]. Only 31 percent of births take place in a health facility; the remaining 69 percent take place at home11.

At household level allopathic system of medicine is generally used by about 92 percent of the population. Other system of medicine such as Ayurvedic and/or tradition medicines is used by about 8 percent of the population**Error! Bookmark not defined.**.

The median age at first marriage is 20 years among women age 25-49 and is about 26 years among men age 30-49. About one-fifth (21%) of women age 20-24 years got married before the legal minimum age of 18 years and 18 percent of men age 25-29 years got married before the legal minimum age of 21 years. At current fertility levels, a woman in Nagaland will have an average of 3.7 children in her lifetime. The fertility level in Nagaland is the fourth highest among all Indian states and the second highest among the North eastern states. Fertility in the rural areas, at 4.2 children per woman, is 1.5 children higher than in the urban areas where fertility is 2.7 children per woman. Among births in the three years preceding the survey, 40 percent were of birth order four or higher9.

1.4.1 Health Care Infrastructure in Nagaland

As of 2012-13, Nagaland has 398 Sub-Centres (SCs), with each SC servicing a population of about 5,000[12] or two villages. The mean distance between the SC and the farthest point of a village is approximately 6 kms. Over 62% of the SCs in the state are not accessible by motorized transport.[13]

The state has 130 Primary Health Centres (PHCs), with a PHC servicing a population of approximately 15,700. The farthest distance to a PHC is 15 kms. Data from the Directorate of Health and Family Welfare indicates that 25% of the PHCs (33 in number) have three staff nurses each and function 24X7.

[10] http://nrhm.gov.in/images/pdf/monitoring/crm/4th-crm/report/nagaland.pdf
[11] Coverage Evaluation Survey Report 2009
[12] Nagaland NRHM PIP 2012-13
[13] NRHM CRM Report, 2009

Twenty one Community Health Centres (CHCs) provide round the clock services in the state, with each CHC servicing a population of approximately 94,000. The farthest distance to a CHC is 31 kms; the district of Longleng alone does not have a single CHC.

Table (8): Population Per Health Facility				
District	**Population Per**			
	District Hospital	**CHC**	**PHC**	**SC**
Longleng	50,593		16,864	6,324
Kephrie	74,033	74,033	18,508	3,896
Pheren	94,954	94,954	11,869	5,935
Zunheboto	1,41,014	70,507	10,847	3,000
Phek	1,63,294	54,431	7,100	3,798
Wokha	1,66,239	83,120	13,853	4,493
Mokokchung	1,93,171	64,390	13,798	3,788
Tuensang	1,96,801	98,401	16,400	5,179
Mon	2,50,671	1,25,336	16,711	5,013
Kohima	2,70,063	90,021	19,290	6,752
Dimapur	3,79,769	1,89,885	47,471	8,080
Nagaland	**1,80,055**	**94,314**	**15,719**	**5,002**
Source: Nagaland NRHM PIP 2012-13				

Each district in Nagaland is supported by a district hospital, which is often designated as a first referral unit. Also, a functional Mobile Medical Unit (MMU) is available in all eleven districts.

Distribution of health facilities across the districts is not even, with the districts of Peren, Longleng and Kiphire particularly lacking in basic and primary health facilities.

Table (9): District wise Health Care Infrastructure in Nagaland (2012-13)							
Sl. No.	**District**	**Health units**					**Total**
		District Hospital	**Community Health Centre**	**Primary Health Centre**	**Dispensary**	**Sub- centre**	
1	Kohima	1	3	14	-	40	58
2	Dimapur	1	2	9	1	51	64
3	Mokokchung	1	3	16	2	39	61
4	Tuensang	1	2	13	-	50	66

Table (9): District wise Health Care Infrastructure in Nagaland (2012-13)							
Sl. No.	District	Health units					Total
		District Hospital	Community Health Centre	Primary Health Centre	Dispensary	Sub- centre	
5	Zunheboto	1	2	13	-	44	60
6	Wokha	1	2	12	-	37	52
7	Phek	1	3	23	-	47	74
8	Mon	1	2	15	-	47	65
9	Peren	1	1	8	-	16	26
10	Longleng	1	-	3	-	8	12
11	Kiphire	1	1	4	-	19	25
Total		**11**	**21**	**130**	**3**	**398**	**563**
Source: Department of Health and Family Welfare, 2014							

Adequacy of man power is always a problem in delivery of services in Nagaland especially the doctors that limit the delivery of services as required. In case of PHCs, as of March 2012, only 78% have Doctors (67% with at least one doctor and 11% with two doctors); 47% PHCs have no Lab technicians and 23% without Pharmacists. Also, only 14% PHCs have lady doctor. Also, majority of CHCs (95%) do not have Surgeons and/or Gynaecologists as required. Similar is the case with specialists at CHCs. Services are further limited with availability of infrastructure e.g. only about 17.2% Sub-Centre has ANM quarter, only 81% PHCs have labour rooms, 31% PHCs have minor Operation Theatres and 25% PHCs have referral transport.

Geographic accessibility, as well as availability and quality of services, are key challenges faced by the state. Over 80% of the population lives in rural areas while health facilities are available in only 42% of villages in the state. The state and central governments have made significant investments in infrastructure, mobile medical units, human resources, and demand side interventions to improve access to and availability of public health care.

Despite these continuous efforts, majority of the health facilities are challenged by the availability of basic facilities like water supply, power and sanitation, preventing optimal provision of services. On availability of infrastructure in the health facilities, the data indicates that majority of the Sub Centre (97%); PHCs (95%) and CHC (100%) are function in government buildings and rest on rent free premises given by Village councils[14]. In Nagaland, about 51% SC and 16% PHCs do not have regular water supply. Similarly, about 44% SC and 14% PHC do not have electricity supply. Also, a third of the SCs and a fifth of the PHCs are not approachable with all-weather motorable road. These facilities are quite low compared to national average. Even though, facilities those which have access to water supply and electricity including CHCs and District Hospitals) often complain about its adequacy for proper delivery of services. Primary visit to some of the health facilities

[14] Rural Health Statistics of India, 2012, Ministry of Health and Family Welfare, Govt. of India

suggests that in absence of adequate water supply and/ or adequate electricity supply, delivery of some services are either reduced or temporarily shut down.

Table (10): Status of Basic Facilities at SC and PHC in Nagaland		
	Sub-Centre	**PHC**
In Nagaland		
Without regular Water Supply	51.3%	15.9%
Without Electricity Supply	43.9%	14.3%
Without all-weather motorable approach road	32.8%	24.6%
All India Average		
Without regular Water Supply	25.5%	10.7%
Without Electricity Supply	25.5%	8.0%
Without all-weather motorable approach road	6.6%	5.8%
Source: Rural Health Statistics of India, 2012, Ministry of Health and Family Welfare, Govt. of India		

1.5 The Economy

Agriculture & allied sectors, Animal Husbandry and Veterinary, Forestry and handloom & handicrafts are the chief economic occupation of the Naga people with 73% of the population engaged in these primary economic sectors of the State. The secondary sector is negligible with small-scale industries. The State has reported oil reserves and the untapped mineral deposits.

The Gross State Domestic Product (GSDP) of Nagaland is Rs. 11,120 crores in 2013-14 (at constant 2004-05 prices) which has almost doubled in last 10 years with about 61.4% being contributed by tertiary sector followed by 25.9% being contributed by primary sector and only about 12.65% being contributed by secondary[15]. Over the last 10 years (2004-05 to 2013-14) the Primary Sector comprising of Agriculture, Forestry & Logging, Fishing and Mining & Quarrying Sectors registered an average growth rate of 3.94% during the period under consideration. Within the primary sectors, the mining and quarrying sector grew at a reasonable rate of 8.21% as a result of the change in the state's policy of legalizing the mining of coal. Over this period the Secondary Sector comprising if Manufacturing, Construction, Electricity, Gas and Water Supply Sectors registered an average growth of 7.32% and the Tertiary Sector registered an average growth of 9.34% within which the trade, hotels and restaurants grew at 9.55%[15].

[15] Draft Action Plan 2014-15, Govt. of Nagaland

The sectoral composition of the economy has not changed much over the last 10 years and shows a marginal decline in the share of primary sector (34.87% in 2004-05 to 25.93% in 2013-14) and increase in the tertiary sector (52.36% in 2004-05 to 61.41% in 2013-14). The share of secondary sector can be considered as low.

The per capita income of Nagaland at constant prices has shown increasing trend over the preceding years. It has increased from Rs. 32,784 in 2004-05 to Rs. 51,914 in 2013-14 (at constant 2004-05 prices) registering an increase of 58.35 percent. Although the per capita income may be relatively higher than most states in India, however, the distribution of income in the State is highly skewed[15]. The population below poverty line is about 32.67% compared to national average of 37.2%.

Budget

The largest expenditure was committed to the Social Sector (mainly education and health) followed by Agriculture and Allied Sector, Energy Sector, and Special Area Programs. Most of the expenditures allocated to Forest Department fall into the agriculture and allied sectors and Science, Technology & environment sector.

Table (11): Sectoral Outlay of 10th, 11th and 12th Five Year Plan (2012-17) (in Rs. Crore)

	Broad Sectors.	Projected Outlay for 12th Plan	Actual Expenditure 2012-13	Anticipated Expenditure 2013-14
1	Agriculture & Allied sectors (including Irrigation)	296.50	646.18	2,937.21
2	Rural Development	163.80	311.81	507.07
3	Special Area Development	194.55	578.93	834.14
4	Energy	248.45	646.94	701.88
5	Industries & Mineral	192.05	375.70	341.70
6	Transport & Communication	170.35	821.90	1,144.85
7	Science & Technology/ IT	4.50	55.39	83.39
8	General Economics Services	78.03	341.06	1,930.12
9	Social Services	753.95	1,854.19	3,386.61
10	General Services	43.50	281.40	558.83
11	Extremely Aided Projects			574.20
12	Non Plan gap	81.97	64.50	
Total		**2,227.65**	**5,978.00**	**13,000.00**

Source: Draft Annual Pan, 2014-15. Govt of Nagaland and various plan documents

Nagaland is one of the 11 special category states that receive budgetary assistance from the central government in the form of 90% grants and 10% loans. These states are given special

permission to use up to 20% of central assistance for meeting the 'non plan gap,' which is unexpected expenditure at the time of budget approval (North Eastern Council, 2009). The state is highly dependent on Central assistance to meet the budget requirement. An analysis of annual plan of 2013-14 and 2014-15 suggests that for many of the development schemes, state has been unable to contribute 10% of their share (in part or full) and hence unable to fully leverage the 90% funds provided by Centre.

Analysis of revenue and expenditure of the Government of Nagaland suggests that there is large gap between revenue and expenditure.

Table (12): Receipt and Expenditure of the Government of Nagaland (in Rs. Crores)

Sl. No.	Item	Budget 2010-11	Actual 2010-11	Budget 2011-12	Revised 2011-12	Budget 2012-13
I.	**Consolidated Fund**					
	Revenue Receipts	5,354.37	4,999.99	5611.61	5,846.32	6,521.71
	Expenditure met from Revenue	4,365.22	4,187.84	4,600.55	5,119.45	5,230.60
	Surplus/ Deficit on Revenue a/c	989.16	812.15	1,011.06	726.87	1,291.11
	Capital receipts	1,062.02	465.66	1,257.15	1,213.32	1,337.70
	Expenditure met from capital including loans & Advances (Net)	2,069.62	1,388.22	2,255.77	2,209.80	2,627.65
	Surplus/ Deficit on Capital a/c	-1,007.60	-922.56	-998.62	-996.47	- 1,289.96
	Total Consolidated Fund (Net)	-18.44	-110.41	12.44	-269.60	1.15
II.	**Contingency Fund (Net)**					
III.	**Public Account (Net)**	**12.50**	**107.05**	**-13.30**	**-47.35**	**-11.22**
	Total Net transaction	-5.94	-3.36	-0.86	-316.95	-10.07
	Opening Balance	-597.70	-599.34	-601.44	-368.56	-685.52
	Closing Balance	**-603.64**	**-602.70**	**-602.30**	**-685.52**	**-695.59**

Source: State Statistical Handbook, 2013

1.6 Poverty in Nagaland

Nagaland presents a unique situation in terms of poverty. The traditional practices and norms have helped create a largely egalitarian society. Due to strong community structures and social capital, the poor are looked after-and cared for-by the community. The community shares the responsibility of taking care of the basic needs of the disadvantaged, for instance the landless are provided opportunity to cultivate the community-owned land. This ensures that there are no destitute, shelterless and famished in the society. There is no case of starvation deaths and no one is shelter-less. This has also meant that the usual measures of poverty are not readily applicable to the State.

The population below poverty line in rural Nagaland is about 19.93% compared to national rural average of 25.70%[16].

The developmental experience of Nagaland has been full of challenges. Apart from its late start, geographical remoteness and inaccessibility, hilly terrain, lack of infrastructure, population composition, and scarce resource base, the State also had to face continuous insurgency, spending much of its resources on administration and related costs at the expense of development.

1.6.1 The Human Development Indices

The Human Development Index (HDI[17]) of Nagaland is 0.61 which is among the higher bracket of the States of the Country. The Gender-related Development Index (GDI[18]) also varies from 0.295 in Mon to 0.72 in Dimpaur. The Human Poverty Index (HPI[19]) varies from highest of 0.54 in Mon to lowest of 16.4 in Dimapur. It is quite evident from the Table-13 below that large disparities exist in Mon, Tuensang, Zunheboto, Longleng and Kiphire Districts across the indices and they remain comparatively underdeveloped requiring attention. These districts have had lower income levels, literacy rates and enrolment than the rest of the State.

Table (13): Human Development Indices of Nagaland, 2013

District	HDI	Rank	GDI	Rank	HPI	Rank
Dimapur	0.81	1	0.72	1	16.4	1
Peren	0.60	5	0.54	6	27.1	3
Kohima	0.82	1	0.76	1	27.2	1
Phek	0.67	2	0.55	3	40.67	6
Mokokchung	0.61	4	0.57	3	22.56	2
Zunheboto	0.51	9	0.49	9	28.3	9
Wokha	0.66	3	0.61	2	32.56	2
Mon	0.42	8	0.295	8	54.65	7
Longleng	0.54	7	0.5	8	27.95	5
Tuensang	0.53	8	0.49	9	36.6	9
Kiphire	0.50	10	0.54	10	36.6	8

[16] Source: http://www.rbi.org.in/scripts/PublicationsView.aspx?id=15283

[17] The Human development index (HDI) has three vital dimensions - longevity, measured by life expectancy at birth; educational attainment, measured by adult literacy rate and gross enrolment ratio; and standard of living or command over resources, measured by per capita GDP.

[18] The gender-related development index (GDI) measures achievements in the same dimensions and using the same indicators as the HDI, but captures inequalities in achievement between men and women. GDI is simply the HDI adjusted downward to measure gender inequality.

[19] The HPI measures the levels of deprivation in the three essential dimensions of human life reflected in the human development index. It reflects the distribution of progress and measures the backlog of deprivations that still continue to exist.

Table (13): Human Development Indices of Nagaland, 2013						
District	**HDI**	**Rank**	**GDI**	**Rank**	**HPI**	**Rank**
Nagaland	0.61		0.55		31.87	
Source: Draft Annual Plan 2014-15, Planning and Coordination Department, Govt of Nagaland						

1.6.2 Backward Region and Tribes in Nagaland

Amongst the Naga tribes as many as 9 tribes have been declared as educationally and economically backward tribes by the state Government. This is largely caused by disparities and other related development activities which contributes to the backwardness of some tribes in Nagaland. This is also evident from the HDI.

When Nagaland was carved out of Assam to be a separate State, certain areas from other regions were also included in the newly formed State. Tuensang district was part of North East Frontier Agency (NEFA), which later was included in Nagaland and form a part of Eastern Nagaland region. The areas in Eastern Nagaland, the Mon and Tuensang districts (now Tuensang district further divided into Longleng, Tuensang and Kiphire) were classified as 'Un-administered Areas' during the colonial period. This structural demarcation during the colonial period also led to the continuation of this region being categorized as the 'Backward Areas'[20]. The State has identified Mon and Tuensang districts as well as Meluri subdivision in Phek, Bhandari in Wokha, Peren in Kohima and Pughoboto in Zunheboto as its backward areas. These areas were 'traditionally' remote and inaccessible. Present Mon and Tuensang districts were also part of the 'un-administered areas' during the British period[21].

In terms of education and Christianization process, Naga tribes in Eastern Nagaland were late receivers of Western religion and education, as compared to other tribes in Nagaland. On the whole, the level of socio-economic development in the western regions of Nagaland is higher than in the eastern side. This is because proximity to Assam provides better connectivity while on the Myanmar side accessibility still presents formidable problem. Eastern Nagaland lags behind in every aspect in comparison to other districts in the state[20, 21].

Nagaland is not a classless society in contemporary times; it is far more stratified and socially different from one tribe to another. The state has significant role in employment generation and up-liftment of the disadvantaged sections but benefits are not distributed evenly leading to economic inequality among the people[20].

Presently there are 16 major tribes each having a specific geographical area and out of which six-inhabiting Eastern Nagaland-are considered backward tribes in Nagaland. The six tribes are Khiamniungan, Chang, Phom, Sangtam, Konyak, and Yimchunger. Another three tribes

[20] Khiamniungan, T. Longkoi 2014. Inequality in Nagaland: A Case Study Of 'Advanced' and 'Backward' Tribes. OIDA International Journal of Sustainable Development 07:02 (2014). Ontario International Development Agency. ISSN 1923-6654 (print) ISSN 1923-6662 (online) Available at http://www.ssrn.com/link/OIDA-Intl-Journal-Sustainable-Dev.html

[21] Govt of Nagaland (2004). State Human Development Report 2004. Department of Planning and Coordination, Govt. of Nagaland

Chakhesang/Pochury, Zeliang living in Phek district and Sumis of Kiphire District are considered as backward tribes[20,21].

These are further reflected in access to basic infrastructure and other developmental indicators reflected from various districts. The four districts namely Mon, Tuensang Longleng and Kiphire are ranked much lower than the rest of the districts. In order to address the concern, the Government had set up Development of Under-Developed Areas (DUDA) for up-liftment of the six most backward tribes. In addition, the Nagaland service rules notified by Personnel and Administrative Reforms Department, Government of Nagaland have made 25% reservations in Govt jobs for the 6 backward living in four eastern districts and relatively lower rate of reservation 2%-6% for the remaining three tribes[22].

[22] Govt of Nagaland (2011). Notification No. RCBT-5/87 (PI-II), 2011. Personnel and Administrative Reforms Department, Govt of Nagaland

2.0 GENDER ANALYSIS

Tradition and customary law play a pivotal role in determining gender equations in Naga society. The traditional governing system of the Nagas is either chieftainship, under the Village Council or a selected council of elders. Only males have the right to chieftainship while memberships in village councils are on the basis of clan, which only males can represent. Women are not allowed to participate in such traditional gatherings. A common traditional feature of most Naga tribes, i.e. the annual citizens' conference, comprises only the men folk of the village[23].

Traditionally, Naga society was constituted in such a way that men and women were assigned different roles. While the men were responsible for protection and provide shelter, women were responsible for looking after the house and taking care of the children. The roles were clearly demarcated. Each village functioned as an independent unit with very little interaction with other villages. A system of direct democracy was practiced in almost all the tribes but in the patriarchal set up women had few decision-making powers. Little has changed as regards the position of women. Marriages are preferred within the village, and on very rare occasions do women marry outside their village. They are not entitled to a share in the ancestral property and they have no representation in village councils or village bodies[24].

The early evolution of Naga society characterized by frequent raids and wars, but the system has long outlived its relevance in the contemporary era with its focus on human rights and social justice for all. Traditionally, women performed one function outside the home: as arbitrators in times of conflict. They played the role of peace-makers for instance, in the pitched battles between their village of birth and the village they married into. They would enter the battlefield holding up a long Y-shaped stick, and try to stop the war. Since they were related to both parties by blood and through marriage, neither side could harm them[25]. Today, the women's organizations in Nagaland are continuing this tradition through new forms.

Almost every Naga tribe has a women's organization. Some of the prominent women's organizations are Naga Mothers Association (NMA), Watsü Mungdang (WM), Naga Women's Union (NWU), Angami Women Organization (AWO), Sumi Totimi Hoho (STH), and Naga Women Hoho (NWH). While some of these organizations like the Watsü Mungdang arose primarily as a socio-cultural organization with the backing of the Church, others were organized as a response to certain specific events**Error! Bookmark not efined.**.

One of the first instances where the women bodies of Nagaland effectively influenced public policy was in the movement against liquor consumption. Under the initiative of the Nagaland Baptist Council of Churches (NBCC), the different women's organizations in the state

---

[23] Jamir, Toshimenla (2009). Engendering Public Space in Naga Society: Tradition and Modernity. Indian Folklife, Serial No,33, July 2009. Available at http://www.indianfolklore.org/journals/index.php/IFL/article/download/108/119

[24] Impact of Armed conflict on Women in the North East – A case of Nagaland and Tripura. National Commission for Women. Available at: http://ncw.nic.in/pdfreports/The%20Impact%20of%20Armed%20Conflict%20on%20Women%20Case%20Studies%20from%20Nagaland%20&%20Tripura.pdf

[25] Shimreichon, Luithui (2000). Women for Peace in Nagalim. New Delhi: NPMHR Publication, Winter 2000-200. Available at http://www.iwgia.org/iwgia_files_publications_files/IA_3-00.pdf

headed by the NMA, pressurized the state Government to pass the Nagaland Liquor Total Prohibition Bill in 1994. Also, In October 1994, NMA formed a peace team to help stabilize the deteriorating political situation as a result of the conflict between the Armed forces of India and the 'National Workers' of the Naga national movement, fighting for Naga independence[25].

Naga women's organizations have over the years evolved from being mere socio-cultural organizations into political entities, capable of negotiating for space in the institutionalized political process through calls for peace and efforts to stop violence in the society. The activities of the NMA and the WM highlight the ways in which Naga women have appropriated a public role which hitherto was denied to them[23].

Almost every village has the traditional women's organization with women members of different clan/ *khel* as member of the same. The tribal women's organizations are actively involved in raising their voice against violence in society, particularly gender-based violence. Their main objectives now are safeguarding the rights of women, besides mediating between warring factions or groups in any conflict situation[23].

Some studies have identified that the discrimination faced by women in Naga society is particularly emerging from heredity and in education. The parent's property belongs mainly to their male children. Female children are given some property upon marriage, but after the death of females their property, particularly the land, goes back to their brothers[26].

The ownership and inheritance laws reflect patriarchy. The main form of cultivation among most tribes of the region is *jhum*. Women share with men domestic tasks as well as work such as clearing jungles, food and firewood collection from the forest, washing clothes, cleaning utensils etc. Women cook, fetch water, take care of children, weave, knit, stitch clothes and brew rice beer for the family but are not allowed in the village court or partake in the community worship[27]. Even within a family itself, gender disparity is quite common. Women have limited rights in all walks of life, be it in decision making, in voicing opinion or inheriting property. The peoples' attitudes and mindsets have been deeply rooted by customs[28].

Violence against women through incidents of dowry deaths, female infanticides, and neglect of the girl child are absent in Naga culture, there are other forms of violence like wife beating, rape and molestation which are on increase. This is a clear violation of the rights of women and can impact their participation in the project and therefore needs specific attention[29].

Women in Nagaland play a significant role in the economy of the state. A large number of them are economically active in agriculture and cultivation. A substantial proportion of them are also engaged in small income generating informal trading activities. They comprise the

[26] Amer, Moamenla (2013). Rethinking Women Economic Empowerment Challenges & Opportunities. Journal of Business Management & Social Sciences Research (JBM&SSR) ISSN No: 2319-5614.Volume 2, No.4, April 2013.
[27] http://ncw.nic.in/pdfreports/Customary%20Law.pdf
[28] http://www.morungexpress.com/public_discourse_public_space/110435.html
[29] http://www.outlookindia.com/news/article/Domestic-violence-against-women-on-rise-in-Nagaland/611954 ; http://www.nagalandpost.com/channelnews/State/StateNews.aspx?news=TkVXUzEwMDA2NzE2OA%3D%3D

majority of market stallholders and vendors selling vegetables and other foodstuffs, second hand clothes, readymade garments, flowers, cosmetics, toys, handicrafts, etc. There are many women whose entrepreneurial activity is the major source of support for their families. Yet, the role played by women as economic drivers largely remain on the margin of debate and action[26].

The state human development indicators also suggest a huge gender disparity among districts that varies from lowest of 0.295 in Mon to highest of 0.72 in Dimapur. The eastern Nagaland districts Mon, Longleng, Tuensang and Kiphire along with Zunheboto and Peren are lower than the state average of 0.55 GDI.

3.0 LEGAL INSTITUTIONAL SETTING

This section discusses the local governance framework prevalent in Nagaland which provides the backdrop for the implementation of the Multi-Sectoral Health Project.

Nagaland is unique as it is the only state in the Indian Union created out of a political agreement. The signing of the Sixteen Point Agreement in July 1960 between the Prime Minister of India and representatives of Naga People's Convention paved the way for the creation of Nagaland as the 16th state of the Indian Union on the 1st December 1963. The state was formed by merging the Tuensang Frontier Division of the North East Frontier Agency (NEFA) and the Naga Hills district of Assam[30]. The Naga people have had a very distinct and complex relationship with modern democracy. So far, they have participated in ten general elections, and seen 17 chief ministers.

The structural framework of the administrative system in Nagaland is largely similar to that of other states in the country. However, the distinction with the rest of the country arises owing to the distinct sanction given by Article 371 (A) of the constitution, giving the Naga customary law[31] and procedure, including with regard to ownership of land and its resources, an overriding supremacy over the national statutes.

The Article 371-A

Nagaland, created in 1st December 1963, is a special category State of Indian Union. The people of Nagaland enjoy certain privileges through the special provisions in the Indian Constitution. The regulation of 1945 gives powers to the Tribal Council to try criminal as well as civil cases and to impose fines according to their Customary Law. Article 371-A of the Constitution of India regarding special status of Nagaland includes "*Notwithstanding anything in this Constitutions, (a) no Act of Parliament in respect of (i) religious or social practices of the Nagas, (ii) Naga customary law and procedure, (iii) Administration of civil and criminal justice involving decisions according to Naga customary law, (iv) Ownership and transfer of land and its resources shall apply to the State of Nagaland unless the Legislative Assembly of Nagaland by resolution so decides…..*".

3.1 Traditional System of Governance

Nagaland is known for its tribes with their rich culture and traditions. There are 16 major tribes and numerous other sub-tribes that differ from one another in terms of language, customs and traditions or even the systems of governance. Commenting on the unusual nature

[30] Jamir, Amba (2011). Understanding Local Self Governance in Nagaland, India: An essence of local institutions and activities. Decentralization Community Solution Exchange United Nations India. Available at ftp://solutionexchange-un.net.in/public/decn/comm_update/res-55-030311-20.pdf

[31] Customary Laws: There is no universally accepted definition of a customary law. It can be described as a set of rules through which a tribe practises its culture and expresses its worldview. It is "an established system of immemorial rules which had evolved from the way of life and natural wants of the people, the general context of which was a matter of common knowledge, coupled with precedents applying to special cases, which were retained in the memories of the chief and his counsellors, their sons and their sons' sons, until forgotten, or until they became part of the immemorial rules…". It governs a person's marriage, divorce, inheritance, child custody, etc as well as community relations such as tenurial rights over forests, lands, water bodies and other natural resources.

of the tribes, Verrier Elwin[32] said, 'Naga society presented a varied pattern of near-dictatorship and extreme democracy.' For example, there is the autocratic system of the Konyak tribe where there are 'commoners' and the powerful Chiefs (Anghs) or the hereditary chieftainship system of the Sema tribe where the chief's words are considered law. Then there is the kind of 'republican' system of governance of the Ao tribe where the citizens of the village have an active role in the affairs of governance, and the government is not headed by a hereditary ruler such as a king or chief but by a council of elders representing the clans and family groups in the village. There also is the 'extreme democratic' system of governance of the Angami tribe where the search for consensus was the norm. In almost all the forms of governance the concept of decision making or appointment through adult franchise was unknown (Jamir, Amba. 2011).

Each Naga Village was like an 'independent sovereign republic' where each village own and govern their resources, plan development activities, maintain law and order, deliver justice and secure defence. At the same time the villages forge and maintain diplomatic relationships, as well as, make treaties to share or jointly manage resources in contiguous areas30.

Decision-making among those tribes with republican system, members of the Village Council, elected/ nominated by the various clans/ *khels,*[33] decide together. While among those where 'extreme democracy' prevailed, it was a complicated and long-drawn affair and search for broad consensus was the norm. Here, no 'leader' spoke on behalf of the village community without thorough deliberation and decision by the entire community. Frequently, the specific issues would be passed down to the *khels,* clans and families before the village could come to a decision. The notion of electing leaders was alien; leaders were recognised and accepted for their qualities and abilities through an informal but stringent process[34].

3.1.1 Traditional Institutions of Naga Society

Some traditional institutions and instruments that continue to influence the normative framework of societal governance:

i) ***Age-group system***: Practised by many tribes, serves to weave the social fabric of the community and promoted healthy competition, especially in the area of social development. The dynamism of community life and activities are manifested through the age-groups. Although membership of the age-group is for life, this is most visible as a youth group. This was the traditional base of societal bonding and leadership training.

ii) ***Morung*****:** 'Morung', or communal dormitory, separate for young men and women, was the most important and primary traditional institution of the Naga tribes within the village community. There was a Morung for every *khel* (cluster of clans). In some tribes like

[32] Verrier Elwin (29 August 1902 – 22 February 1964) was an English self-trained anthropologist, ethnologist and tribal activist, who began his career in India as a Christian missionary. He wrote many books on tribes in India including on Naga tribes "*The Nagas in the Nineteenth Century"*, Oxford University Press, 1969.

[33] *Khel* is a distinct Naga institution that brings together several clans within the village community. Membership of a *khel* is either decided by birth or heredity. This is the most important and effective institution in village governance. The *khel* also had power to overrule individual clan decisions although this was avoided because of the harmful consequences for *khel* unity.

[34] Government of Nagaland (2004). State Human Development Report 2004.

Angami, every clan would have its own Morung. It was the primary educational institution that nurtured and prepared the young of every clan for life and living.

iii) ***Village Council***: At the village level, each village is administered by the village councils which handle both the administration and judicial matters. These tribal administrative institutions that have evolved from the traditional village chieftain set up of the Nagas are government recognized bodies.

Similar to Village Council, "*Putu Menden*" was there in Ao Areas - to function according to their custom and usage - as a village council. The *Putu Menden* - roughly translates as 'seat/government' (*menden*) of a generation (*putu*) - is the federal assembly of elders representing different founding clans of the village. Elders are also selected according to the *mepus* (sectors) of a village and hence the size of *Putu Mendens* vary from village to village30.

The Apex Body of each tribe is the Tribal *Hoho* (Tribal Councils), in which the Chairman of every Village Council (VC) is a member.

iv) ***Tribal Courts*****:** Traditionally, Nagas did not have regular courts. Later, with the advent of the British, tribal courts were set up and judges were appointed from among reputed persons within the tribal community to decide cases. Thus, the first regular courts were started. The British also created the posts of '*Gaonburas*' (village elders) and '*Dobashis*' (interpreters) to assist them in the administration (Nagaland State HDR, 2004).

3.2 The Current System of Governance

The present administrative framework in Nagaland is essentially similar to that in other states of the country and consists of the Secretariat - Directorate structure of governance at the State level, with the districts being the main unit for implementation of development programmes and maintenance of law and order. Though the judicial and executive powers in the district are still exercised by the Deputy Commissioner, the process of separation of the executive and judiciary is already in an advanced stage. A separate bench of the Guwahati High Court at Kohima provides an easier and closer access to the higher justice systems. The State has its own legislature, which is a witness to some keen debates among the representatives of the people of the State.

3.2.1 State Government

The Legislative Assembly of Nagaland is constituted to act as a law making body. There are 60 Assembly Members, who are chosen by direct election. The Governor, who is appointed by the President of India, acts as the Constitutional Head of Nagaland. He exercises power over the Legislative Assembly, the High Court, and the Council of Ministers. The Governor serves a five-year term, which may be extended by another five years. The Chief Minister is the Political Head of the State. He acts as the Chairperson of the Council of Ministers, which consists of 12 members. The Council is the state executive body, and its members are selected from among the elected Legislative Assembly Members.

Each Minister is assisted by Parliamentary Secretary and further assisted by an Administrative Head of Department, who is responsible for mandates, schemes, programs and projects that are specific to his/her department. For example, the Administrative Head of

Department is given the power to give financial approval on salaries and other administrative costs. The Administrative Heads of Departments are normally called Secretary, Commissioner-cum-Secretary, or Principal Secretary in Nagaland.

There are eleven districts in Nagaland. Each district is administered by one Deputy Commissioner, who belongs to the Indian Administrative Service/ Nagaland Civil Service. The Deputy Commissioner oversees regulatory affairs, including law and order, land administration and tax collection as well as development administration. Each Deputy Commissioner is assisted by Additional Deputy Commissioners and Sub divisional Officers who are stationed at the sub-division level.

3.2.2 Decentralized Governance in Nagaland

A major strength that contemporary Naga society has inherited is the 'social capital' that has stemmed out of traditional institutions and practices. There is strong social bonding and community spirit, and absence of caste and social discrimination.

Naga traditional life revolved around the village. Village Councils are an important component of modern governance system in Nagaland. While the District Planning and Development Boards provide the needed flexibility to ensure a responsive and holistic approach towards development for the district, linkages to the grassroots through the Village Development Boards have been established for delivering the rural developmental objectives.

The Village Council

Traditionally, a Naga village was an independent entity having its own governance systems and laws, with varying traditions across villages and tribes. Given that such functional traditional systems existed in each Naga village, the government built upon it and enacted the Nagaland Village and Area Councils Act 1978 to give it legitimacy and recognition as a local self-governance institution. Every recognized village in Nagaland is required to have a Village Council (VC). The Village Councils are empowered for carrying out administration, and administration of justice as per local customs and traditions. VC Members are chosen by villagers in accordance with the prevailing customary practices and usages and as approved by the State Government. Hereditary village chiefs, *Anghs* and *Gaonburas* (GB) as per usage and customary practices of the community are to be ex-officio members with voting rights of the VCs. The VC is required to meet at least once every three months or as and when the situation requires. It is also required to form the Village Development Board (VDB) to carry out the overall development of the village30.

In order to restore the esteem of the traditional village authority systems, weakened due to the gradual introduction modern democracy, the Government codified the powers and functions of the Village Councils, recognising the traditional village bodies like the *Putu Menden* of the Aos, through the Nagaland Village and Area Councils Act, 1978. This law, applicable to the entire State, included the following important elements:

1. Every recognised village shall have a Village Council. The tenure of Village Council shall be five years.
2. Village Council members to be chosen by villagers in accordance with the prevailing customary practices and usages. Hereditary Village Chiefs, Gaonburas and Angs shall

be ex-officio members with voting right. A member of the Village Council has to be an Indian and not less than 25 years of age.

3. Village Council chairman and secretary to be chosen from among the members. In the case of secretary, the person can be a non-member, provided that in such case he/she will have no voting right.
4. The Village Council will meet once every three months or more frequently if requisitioned by one-third of the members.

Special Powers: The Village Council has special powers to maintain law and order and administer justice within the village limits in accordance with the customary laws and usages as accepted by the canons of justice established in Nagaland. Section 15(1) of the Village Council Act provides that 'the village shall … have full powers to deal with internal administration of the village'. The Councils act as the village courts in accordance with the powers entrusted under the Rules for Administration of Justice and Police in Nagaland, 1937. In disputes between villages, two or more Village Councils can settle the dispute in a joint session. These provisions have helped in decentralising governance and placing the power of change in the hands of the people (Nagaland State HDR, 2004).

The VC is the overall authority in the administration and justice within the village. Its powers and duties are enshrined in the said Act, as under:

- To formulate village development schemes/ plans to supervise proper maintenance of water supply, roads, trusts, education and other welfare activities;
- To help government agencies in carrying out development works in the village;
- To take up development works on its own or on request /advice of the state govt.
- To borrow money from the Govt., Banks or financial institutions for application in the development works/ welfare works of the village and repay the same with/ without interest as the case may be;
- To apply for and receive grant-in-aid, donations, subsidies from the Govt. or any other agencies;
- To provide security for due repayment of the loan received by any permanent resident of the village from the Govt., Banks and financial institutions.
- To lend money from its funds to the deserving permanent resident of the village and to obtain repayment thereof with interest or without interest;
- To forfeit the security of the individual borrower on his default in repayment of loan/ advances to him;
- To enter into any loan agreement with the Govt., Banks and FIs or a permanent resident of the village;
- To realise registration fee for each legislation within its jurisdiction;
- To raise funds for utility servicing within the village by passing a resolution, subject to the approval of the State Govt.;
- To constitute a Village Development Board (VDB)
- To empower certain Acts in the event of epidemic.

The Village Development Boards (VDBs)

The Community Development Programme was introduced in the State since the early fifties. The decentralization concept of achieving "Rural Development through Active Participation

of the Village Community" began to take shape only during the 7th Plan period. A separate VDB, without displacing the traditional VC was first experimented and adopted in Phek District, in 1976 and later in 1980-81 extended to all recognised villages in the state. As is provided for in the Nagaland VCs Act, it is the VC, which forms the VDBs. The power bestowed upon the VCs to establish VDBs in Nagaland dramatically changed the functions and outlook of VCs across the state. As socially embedded institutions VCs have always been people centred delivery mechanisms that responded effectively to the needs of the community.

Over the years, VCs through the VDBs have become an important implementation arm for governmental development programs and have started to play an important role in facilitating livelihood and economic development of the community and the village as a whole. Funds for development flow to the VDBs from the State Plan as grant, as well as from the various Rural Development schemes of the Government of India implemented through the DRDAs. Funds transferred are proportioned as per the recognized households in the village and also as per particular schemes laid down criteria. The VDBs are involved in all phases of developmental activities as a part of their responsibilities. These include receipt of allocation of funds, selection of beneficiaries or schemes, monitoring of progress of works & expenditure and completion of schemes. The book keeping of accounts of all VDB is mandatory, open, and subject to any audit of its account, including by an independent committee appointed by the VC on a regular basis (Nagaland State HDR, 2004).

All residents of the village are members of the General Body of the VDB. Two General Body meetings are held in a financial year, where the Secretary of the Board presents his reports, along with detailed audited financial statements. The Deputy Commissioners, in their ex-officio capacity, are the chairpersons of the VDBs in their respective districts. A VDB is managed by a committee chosen by the Village Council and includes traditional leaders. The maximum total membership of the management committee is fixed at 25 but it should not be less than five. Twenty-five percent of the membership is reserved for women. Youth representation is also compulsory to ensure that any development activity in the village benefits the entire community. The tenure of the Management Committee is three years.

Powers and Duties of the VDB includes:

- Formulation of Village Development Schemes;
- Supervising proper maintenance of water supply, roads, power, forest, education and other welfare activities;
- Helping various Government agencies in carrying out development works in the village;
- Initiating development works on its own or on request by the Government;
- Facilitate borrowing from Government, banks or financial institutions for development and welfare works;
- Authority to receive grant-in-aid, donations and subsidies from Government or other agencies;
- The VDB can provide security for repayment of loan by any permanent resident of the village from the Government, bank or financial institution; it can also forfeit security of borrower on default;
- The VDB can lend money to deserving permanent residents;
- Authority to enter into loan agreements with the Government, bank or financial institutions or a permanent resident of the village.

3.3 Land Ownership and Governance

In the Naga system, historically the land remains under the control of the people through constitutional provisions[35]. As a result, the ownership of land in Nagaland is quite different from the other states of India. Local customary laws govern the land tenure system. Such laws are tribe specific where each tribe or even village has its own customary laws and traditions. The village community owned and regulate the land and its resources according to the traditional customs and practices. The pattern of ownership of land is complex and diverse. Every village has their peculiar system of ownership of land and the laws that regulates it. There are variations in the forms or patterns of traditional institutions and practices vis-à-vis the management and ownership of land among the different groups or tribes[36].

In general, the traditional system of ownership of land in Nagaland is fundamentally of three types, village land, clan/ *khel* land and private land. In the attempt to codify and bring a uniform law in the administration of the village, the Government of Nagaland passed the Nagaland Village and Area Council Act in 1978. It was through this Act that a Village Council was established in every village in Nagaland. According to the Act, "Village Council shall consist of members, chosen by villagers in accordance with the prevailing customary practice and usages." This provision of the Act is important, in the sense that it allows the Village Council to practices their specified customary laws in the village administration. The Village Council will also choose a member as Chairman and a Secretary of the council. The Village Council were given the administration Power and Duties at the local or village level36. The Government owns just about 7% of the total land area.

In recent time, the state government also owned land for the construction of government institutions and for developmental and conservation purposes. Usually Jhum lands are owned by the community, clan and sub-clan but regulated by the respective village councils for deciding the area to be cleared for jhumming each year. A very democratic system is adopted for the allotment of annual jhum plots. For permanent cultivation, gardens and homesteads etc, prior consultation with village authorities, clan elders or with respective owners are usually taken[37].

3.4 Communitization of Public Institutions and Services

Building upon the strong traditional institutions and governance systems, the Nagaland government initiated "Communitization of Public Institutions and Services Act (2002)" which fosters a strategic partnership between the government and the communities. The Act to improve services and ensure peoples' buy-in to public assets as stakeholders delegates management responsibilities for essential services such as health, primary education, power, rural tourism, rural water supply, etc. to the community.

Communitization therefore involves transfer of government assets to the community, empowerment of community through delegation of governmental powers of management and supervision of day-to -day functioning of employees to village committees. It also demands

[35] Customary ownership rights to our land and the special status accorded to the Nagas through the Article 371(A) of the constitution of India
[36] http://dlc.dlib.indiana.edu/dlc/bitstream/handle/10535/2185/George_211601.pdf?sequence=1
[37] https://www.nabard.org/Nagaland/english/Demographic1.aspx

ensuring accountability of government employees posted at the service delivery level to local communities and control of government assets by village committees including the responsibility for maintenance, amelioration and augmentation of assets. As such communitization is based on triple 'T' approach. Trust the user community. Train them to discharge their newfound responsibilities and Transfer governmental powers and resources in respect of management.

Communitization is a partnership between the government and the community. In this partnership, the community becomes the owner of the government institutions and assets and is granted powers and resources to manage the employees and maintain institutions. In other words, it is empowerment, delegation, decentralisation and privatisation at the same time. The move has in many ways become an effective instrument to ensure that the institutions and services set up for the benefit of the community operate efficiently and that the authorities are accountable to the beneficiaries and not only to the government.

Initially the scheme focused on three very important areas: Elementary education, Grass root health services and Electricity management. The experiment evolved from the need to revitalize the massive welfare infrastructure and vast network of delivery services set up by the government which had become ineffective and dysfunctional. It is based on the philosophy of communitization as an alternative to privatization as well as management by government. This philosophy attempts to combine the best of both approaches by substituting the private profit motive with enlightened collective self interest.

Through communitization, essential parameters in elementary education, enrolment, reduction in the dropout rates, the pass percentage as well as the attendance of the teachers in the primary schools marked a quantum rise in Nagaland. So also is the case in the efficiency of the village health service delivery system measured in terms of number of child and adult patients visiting health centres in rural Nagaland, improvement in the staff attendance, visit of the medical officers and even in the staff attitude.

Nagaland Communitization Act 2002- Salient Features

- Boards or committees constituted under the aegis of Village Councils to own and manage the communitized institutions.
- A representative Committee of the community
  - Members are from the user community … the actual stakeholders.
- Assets, powers and management functions of the Government transferred to Committee through MOU.
- *Responsibility of the Committee:*
  - Disbursal of salary, grant of casual leave, control of employees including power to exercise 'no work no pay', maintenance of buildings and assets, purchase of essentials e.g. textbooks, medicines.
- *Responsibility of the Government:*
  - Ensure deployment of health workers, provision of funds for salaries and other grants, provision of technical guidance and support.

'Government to be in assistive, monitoring and regulatory role - A paradigm change'

3.4.1 Communitization in Health Services

Subsequent to the enactment of the "Nagaland Communitization of Public Institutions and Services Act, 2002", the Department of Health and Family Welfare has leveraged the communitization strategy to build public ownership of public health care in the state. Communitization calls for a partnership between the government and the community with the objective of promoting and protecting the health and well-being of the people in the state with the active participation of the community. The community is represented by the various health committees organized at the grassroots level, including the Village Health Committees (VHCs), Urban Health Committees (UHCs), and the Health Centre Management Committee (HCMCs). The health institutions in rural areas were the first to be communitized. As of date, all public health facilities in the state, with the exception of District Hospitals, have been communitized. With the communitization process, the health committees are called upon to exercise their supportive role in the four main areas of (1) administrative, financial and technical management of CHCs, PHCs and SCs; (2) preventive health care; (3) Promotion of indigenous medicine; and (4) mobilization of local resources for improved service delivery. The active involvement of the community in the functioning of the health facilities has resulted in community ownership of the assets in health care service provision created by Government and led to an improvement in the availability of health care personnel, maintenance of health facilities, and availability of medicines[38].

The Village Health Committee has 3 Village Council Member, Member Secretary of VDB, 2 Mahila Swasthya Sangh members, 1 Anganwadi Worker,1 dhai, Pastor. The Member Secretary of the VHC is the senior most Health staff in the facility.

3.5 Civil Society in Nagaland

A major strength that contemporary Naga society has inherited is the 'social capital' that has stemmed out of traditional institutions and practices. There is strong social bonding and community spirit, and absence of caste and social discrimination. In Nagaland there are two distinct type of civil society organization: (a) one which largely works on social concern, and (b) those who also work in the developmental aspect of the population.

a. Civil Society Organizations largely working on social concerns

Civil society in Nagaland is characterised by a range of organisations and networks. A number of civil society organizations linked with different tribes (or cutting across the tribes) do exist and largely work in the welfare approach and also voice their tribal identity to be recognised by the formal system of governance. Majority of them have evolved out of social concern and work at State and district levels. They have been acting in public interest and exerting pressure on the Government on issues of public importance, and at times assisting in governance. Example of these are e.g. Naga *Hoho* (and other tribal *hohos*), Eastern Naga Peoples' organisation, Naga Student Federation, Naga Mother's Association (NMA), Nagaland Baptist Church Council (NBCC).

[38] An Impact Evaluation Study on Communitization in the Heath Sector, 2009. Department of Health and Family Welfare, GoN

Naga civil society, particularly the Churches based on gospel truth, have been instrumental in bringing about the ceasefire and peace talks. However, over the last decade and a half Naga women across tribes and neighbouring states, based on their common experiences of sufferings over decades of armed violence, emerged as a formidable non-violent force in Naga society. The collective efforts of Churches and Women organizations having been able to bring all factions for reconciliation also ensure continuation of the processes through constant vigil and persuasion; they have created their own safe space and legitimacy in the society. (Nagaland State HDR, 2004).

The Church today enjoys overwhelming influence over the Naga population. Its reach effectively extends to every village in the State. It has played vital roles in peace building in the long history of conflict and insurgency in Nagaland. Church organisations continue to work for peace, like the Nagaland Baptist Church Council (NBCC) through its Peace Affairs Committee. The recent coming together of the different church denominations under the Nagaland Christian Forum (NCF) and joining issue on the question of peace in the State has been a significant development. Since first introducing education, the churches have continued to contribute very significantly to education, health and human resource building in Nagaland. The women's and youth wings and other structures within the Church have been involved in social activities aimed at empowering the society. Different churches also have their frontal organisations involved in welfare and development of the people. (Nagaland State HDR, 2004).

b. Civil society organizations that are also working on developmental aspects

NGOs working largely in rural development are few in Nagaland. Organization like Eleutherous Christian Society (ECS) from Tuensang, Rongmai Baptist Association (RBA) from Peren, Phom Baptist Christian Association (PBCA) from Longleng, North East Network (NEN) from Phek, Hill Area Development Society (HADO) from Dimapur, Chakhesang Women Welfare Society (CWWS) from Phek, and North East Initiative Development Agency (NEIDA) are some of the examples. Some of these organizations also work in the area of health.

3.6 Current System of Grievance Redressal and Conflict Resolution

The Government of Nagaland had launched an online public grievance redressal system 'E-MODOP', for the people through which they can seek redressal of their grievances and keep the government officials informed of their problems. The system designed in such a manner that citizens can submit their grievances online. Upon successful submission, a unique grievance number is generated and provided to the complainant. It further stated that each department will have a Nodal Officer to handle the grievances and the concerned department on receipt of the grievance will pass appropriate orders for redressal of the grievance along with fixing a time limit for the redressal. These orders and the time limit will be updated on the Website and the citizens can actually track action taken of the grievance with the help of their unique grievance number[39]. However there are issues of its online efficient functioning and also availability of reliable internet services across the state. The Personnel and Administrative Reform (P&AR) Department (Govt of Nagaland) has also developed a manual for grievance redressal[40].

[39] http://www.igovernment.in/igov/news/29134/nagaland-launches-online-grievance-redressal
[40] http://nlsic.gov.in/chapter/Persnl&admi_reforms.htm

At the village level, the Village Council is the supreme authority (with both civil and judicial powers and also dealing with customary laws) to redress any grievances that may arise. At the district level, the judicial and executive powers in the district are currently exercised by the Deputy Commissioner. At the state level, a separate bench of the Guwahati High Court at Kohima provides an easier and closer access to the higher justice systems.

In addition, each of the department has their own public grievance redressal mechanism at the state level. The department of Health and Family Welfare in Nagaland also has a grievance redressal mechanism set up at state, district and health facility level (vide Government order no. HFW-28/B-20/2013 dated 24th October 2013)[41].

3.7 Law and Order Situation in Nagaland

Historical Context

The Naga Hills have been an area of continued resistance as they had long been isolated from outside cultures. The development of a spirit of nationalism and sense of a common identity are relatively new concepts among the Naga people. According to their traditions, each village was an independent republic. Initially, they wanted to be free from all outside domination. Modern education, together with Christian missions, contributed to the politicization of Naga ethnicity. In 1918, a group of educated Nagas (from present Nagaland) formed Naga Club (name changed to Naga National Council post World war-II). On 14 August 1947, the day before India gained independence from British rule, the Nagas were the first ethnic group from the northeast to declare their territory an independent state, not belonging to the new nation led by Angami Zapu Phizo with the Naga National Council (NNC). Under Phizo, the NNC declared their independence from the British on 14 August 1947, a day before India. In May 1951, the NNC claimed that 99% of the tribal people supported a referendum to secede from India, which was summarily rejected by the government in New Delhi. By 1952, the NNC, composed primarily of Nagaland Nagas, led a guerrilla movement. India responded by crushing it with their armed forces[42].

The State of Nagaland was formed on December 1st, 1963, as the 16th State of the Indian Union. The State consists of seven Administrative Districts, inhabited by 16 major tribes along with other sub-tribes.

The relentless endeavour of the peace process, actively supported by the church leaders and the liberal help and patronage of the State Government, finally resulted in an agreement for Cessation of Fire signed by the then Governor on behalf of the Government of India, the Peace Mission and members of the NNC underground government. The ceasefire was widely welcomed in Nagaland. Since then, there have been various peace talks and periods of uncertainty, but the ceasefire broadly remain in force with some interruptions in between[42].

Current status

The entire area of the States of Nagaland continues to be excluded from the Protected Area Regime notified under Foreigners (Protected Area) Order, 1958[43].

[41] http://nrhmnagaland.in/programmes_file_path/Public%20Grievance%20Redressal%20Mechanism.pdf
[42] http://en.wikipedia.org/wiki/Naga_people
[43] Annual Report 2013-14, Ministry of Home Affairs, Government of Nagaland

The violence in Nagaland has been mainly in the form of inter-factional clashes between different groups. The major insurgent groups operating in the State of Nagaland are the factions of National Socialist Council of Nagaland (NSCN) which came into being in 1980 following the failure of the 1975 Shillong Accord. These insurgent groups are NSCN (IM) led by IsakSwu and Th. Muivah, NSCN(K) led by S.S. Khaplang, a Naga from Myanmar and a new faction formed in June, 2011, NSCN/KK led by Khole-Kitovi. Though various steps have been taken by the Government from time to time to control insurgency, the NSCN factions continue to indulge in factional violence and other violent/illegal activities affecting normal life in the State (MHA, GoI, 2013-14).

Now, the Eastern Naga People Organization (ENPO), an apex body of six Naga tribes, has raised the demand for creation of a separate State comprising the four eastern districts of Nagaland (Mon, Tuensang, Kiphire and Longleng) and two districts (Tirap and Changlang) of Arunachal Pradesh, with a special status within the Indian Union (MHA, GoI, 2013-14).

National Socialist Council of Nagaland NSCN (IM) and NSCN (K), the major outfits of Nagaland, are in ceasefire agreement with the Government of India. NSCN/K split into two outfits namely NSCN/K and NSCN/KK. Shri Ajit Lal, Chairman, JIC has been appointed Government of India's representative for Naga peace talks, has been holding dialogue with NSCN (IM)[44]. A Ceasefire Monitoring Cell (CFMC) overlooks the entire process. Over the last seven years the violence profile in Nagaland suggests a downward trend and presented in the table below.

Table (14): Details of Violence Profile in Nagaland during the last seven years (as on 31.03.2014)

Years	Incidents	Extremists arrested	Extremists killed	Extremists surrendered	Security Forces killed	Civilians killed
2007	272	98	109	4	1	44
2008	321	316	140	4	3	70
2009	129	185	15	6	-	16
2010	64	247	5	12	-	-
2011	61	267	8	-	-	7
2012	151	275	66	4	-	8
2013	145	309	33	1	-	11
2014 (upto 31.03.2014)	17	63	3	--	--	--

Source: Annual Report 2013-14, Ministry of Home Affairs, Government of India

This is a good sign as it reflects the success of not only the cease-fires between the Government of India and the NSCN (IM) and the NSCN (K) in place since 1997 and 2001 respectively, but also the success of efforts for peaceful reconciliation between the two armed

[44] Annual Report 2013-14, Ministry of Home Affairs, Government of India

groups by Naga civil society actors like the Naga Hoho (Tribal Apex Council) and the Forum for Naga Reconciliation[45] (FNR)[46] till date.

[45] FNR an organization comprising the churches and the civil society groups, which was established in February 2008, had a role to play in bringing about an end to violence.
[46] file:///C:/Users/R%20B%20Verma/Downloads/IB-NortheastIndia2009.pdf

4.0 THE CURRENT PROJECT:

The project aims to contribute to overall health sector development in the state. The project development objective (PDO) is *to improve health services and increase their utilization by communities in targeted locations in Nagaland*. The key result areas of the project include:

- Increase in utilization of basic health services, such as immunization, antenatal care and outpatient consultations (disaggregated by gender). This is intended to reflect the results of the range of activities in different areas supported by the project.
- Improvement in HNP-related behaviours by targeted communities (i.e. hygiene, breastfeeding and weaning practices, care and nutrition of pregnant mothers). This is an indicator of the results of project support to community-level activities, which will include mobilization to improve health, nutrition and hygiene-related behaviours.
- Increase in availability at targeted health facilities of reliable electricity, safe water supply and adequate sanitation. This is intended to reflect results of investments to improve conditions in health facilities.
- Planned human resource and supply chain management are functional. This is intended to reflect results of project support to development of key components of the government health system.

The Key components of the project are:

Component 1: Community action for health and nutrition. This component will support community engagement and management of health services, as well as to community-implemented investments with an impact on HNP services and outcomes. This is intended to contribute to improved management and delivery of local health services as well as increased community awareness and knowledge leading to greater utilization of health services and health-related behaviours. The component will support capacity-building of Village Health Committees as well as provide results-based financial resources for the community to make investments to improve HNP services and in other areas with the potential to affect HNP outcomes. Training and ongoing support to Village Health Committees will improve their capacity to oversee and manage health services as well as to manage implementation of project-financed investments. The project will support increased representation by women and foster the involvement of women's self-help groups. Grants to Village Health Committees will be disbursed on the basis of measurable (and verified) results in matters that have an impact on health and nutrition. Examples include: increase in the number of children fully immunized in the community, increase in the number of households who practice safe hygiene behaviours, increase in knowledge of good nutritional practices and other care for pregnant women in the community, etc.

In turn, Village Health Committees will be empowered to use the grants and other available resources (i.e. from other government programs) for investments that are priorities for their communities and which have potential impacts on health and nutrition. Examples could be improving community water supply, improving sanitation facilities, investing in health and

nutrition service infrastructure and equipment, incentivizing health and nutrition workers, mobilizing the community to improve health and nutrition-related knowledge and behaviours, etc.

Component 2: Health system development. This component will support improvements in the management and delivery of health services, including both targeted and system-wide investments.

Sub-component 2.1 Investments to improve conditions at targeted health facilities. The project will finance investments to improve conditions for staff and patients in targeted health facilities, with the intention of contributing to improved staff motivation better quality services and resulting greater demand for services. Investments will be made in off-grid electricity supply, water supply and sanitation in targeted health facilities. Investments in off-grid power solutions will be adapted to the needs of each facility to assure a basic level of functioning (i.e. lighting and high priority equipment). In larger facilities, (Primary Health Centres, Community Health Centres and District Hospitals) solar energy technology will be needed, while smaller facilities, particularly Sub-Centres, will only require battery and inverter systems that can be charged by the grid when it is available. Peak energy needs (i.e. for some types of equipment such as x-ray machines) cannot be met by off-grid solutions and so a combination of power from the grid and existing diesel generation sets will be used. Detailed technical assessment of each targeted facility will be done to inform implementation by a contracted supplier that will ensure supply and installation of equipment, repairs and maintenance, and necessary training. Training of health workers and Village Health Committees will foster their involvement and support for ongoing operations and maintenance.

Implementation of water and sanitation investments in health facilities will be decentralized to Village Health Committees. Financing of these investments is additional to the results-based grants under Component 1, but the same implementation, support and monitoring mechanisms will be used. Technical support contracted at the state level will provide guidance to Village Health Committees on implementation of water and sanitation investments, starting with detailed technical assessment of each targeted health facility. Improvements will include setting up roof- and rain-water harvesting and storage, making repairs and improving piped water connections (most of which are linked to springs or streams that serve the entire community), and improving toilets and sanitation infrastructure. Implementation by Village Health Committees will foster local ownership of the investments, crucial to sustained operation and maintenance.

Sub-component 2.2 Health system management. The project will support development of key state-level components of the health system intended to improve the management and effectiveness of government health services in Nagaland. Development of the health supply chain management system will include improving planning and ordering, procurement, quality assurance, stock management, distribution, storage, and reporting and information systems. Along with required policy and process improvements, including adoption of standard operating procedures, investments will encompass training, equipment and warehouse improvements. The project will also support investment in information and communications technology (ICT) systems to improve management and delivery of health services. On the basis of an integrated platform, priority systems adapted to the Nagaland context will be developed, including ICT applications for supply chain, financial and human resource management. Program management applications will be designed to improve existing reporting and monitoring, notably in order to reduce the reporting burden on front-

line health workers, while a helpline will be established in order to support both health workers and patients. The project will also contribute to addressing health human resource constraints, including improving human resource management and supporting implementation of a health human resource strategy for the state that is currently under development. The project will support improvements in medical waste management. The project may intervene on other systemic components of the government health system as needs arise during the course of implementation, and will also contribute to addressing priority gaps in health service delivery in targeted locations that cannot be filled through community action under Component 1 or from other sources.

This component will also support rigorous monitoring and evaluation in order to ensure that lessons learned, notably on the community-level initiatives under Component 1, but also including health service and system development under Component 2, are captured. The required capacity to manage the project, as well as technical assistance and studies/evaluations needed during the course of implementation, will also be supported.

4.1 Key Stakeholders

The primary stakeholders of the Project include the community as the main beneficiary, communitization groups of the targeted health facilities, the village level institutions i.e. Village Councils, Village Development Boards, Communitization group of water supply and sanitation, and Communitization group of power/ electricity of the villages associated with the target health facilities.

The Department of Health and Family Welfare (DoHFW) is the implementing stakeholder of the project.

The secondary stakeholders will include other line departments such as Public Health Engineering Department (PHED – responsible for providing safe drinking water and sanitation), Department of Rural Development (responsible for various rural development programmes in the state), Department of Urban Development (responsible for urban development programmes and systematic infrastructure development), Department of Social Welfare (responsible for implementation of schemes aimed at upliftment of vulnerable and weaker sections and schemes related to nutrition of women and children especially the ICDS and Mid day meal programmes), and Directorate of Women Resource Development (responsible for upliftment of women in Nagaland).

4.2 Potential Social Impacts of the Project

Review of activities proposed suggests no adverse social impact on the Tribal people of the state. The likely benefits include better and enhanced health care services across different parts of the state and across different tiers of health care facility. This will in turn help reduce morbidity, enhanced institutional service from health care facilities, and reduction in health expenditure and loss of income.

The likely social benefit will include:

- Better equipped health care facilities especially in remote areas to and ensure improved health care services to rural population especially the women and children.

- Enhance and improved service delivery due to availability reliable electricity, safe water supply and adequate sanitation.
- Increased availability necessary human resource, improved supply chain management, better planning and monitoring system to lead to better health outcomes.
- Given that, the various project interventions will be coordinated and focused on specific targeted health facilities and the communities they serve it will help maximize the impact in those areas.

4.3 Key Risk and Mitigation Measures

There is no major social risk to the project activities. In absence of availability of private sector health care facilities in rural and remote areas (including urban areas), dependence on public health facilities is very high and hence there has been least amount of disruption by any activity including those related to insurgency in the past.

Tradition and customary law play a pivotal role in determining gender equations in Naga society. The traditional governing system are male centric and does not allow women to participate in traditional gatherings. However, in order to mitigate the same and meet the requirement of various Government of India programmes (that suggests a certain level of women participation), separate institutions were formed like Village Development Board (VDB) under the aegis of Village Council (VC) for all developmental programmes and a prescribed number to women members are allowed to be part of the VDB. Similar is the case will all the communitization groups including the one for health facilities. However, in order to ensure that women take an active part in the programme, both men and women, and traditional institutions may need to be sensitised on gender issues.

The project activities envisaged suggests that planned civil works will be limited to the existing footprint of health facilities and will not entail any private land acquisition or resettlement. However, in case of a chance find, a Resettlement Policy Framework is set out in the subsequent section of this Document as a part of the Social Management Framework.

4.4 Stakeholder Consultations

Stakeholder consultations were carried out in multiple phases. Consultation with various stakeholder groups (in addition to various staff members at DH&FW and other Govt departments) was done during the primary visits especially with staffs at Sub-Centre, PHCs, CHCs and District Hospitals; members of community groups including members of women societies and members of village councils at different places.


Discussion with Women SHG members in Tuensang

The primary consultation was carried out by TA team on communitization[47] with community involving focus group discussions and semi-structured interviews with a range of stakeholders in 4 districts (Phek, Dimapur, Tuensang and Kiphire). Primary stakeholders included communitization groups (mainly Village Health Committees) as well as general community members including village level institutions (village councils and VDBs), traditional women's groups, and SHG's.

A total of 12 Sub-centres, 7 PHCs, 2 Village Health Committee, 6 Village Councils, 5 Village Development Boards, along with 18 discussions with general community members, traditional women's groups, and SHG's were conducted.

The findings from the consultations reconfirmed the secondary review that community involvement has clearly delivered improvements in service delivery in the health sector and is well appreciated and understood across the state. However, it was felt that it is not yet delivering to its full potential; much of this is because of the lack of training and capacity building. Also, there seemed to a general lack of any structured interaction with the general community in the catchment area of these committees. While some committees reported the use of the platform of the Church to convey anything if and when they needed to, these interactions were generally one sided as well as unstructured in terms of their frequency and topics of discussion. The community engagement and functioning of the communitization groups can further be strengthened by (a) training and capacity building of the communitization groups, and building awareness level of village level institutions and as well as the community, (b) improving monitoring system, (c) helping develop systematic community engagement plan by the communitization groups including women.

In addition to above, a prior informed stakeholder consultation workshop was organised with various stakeholders to share the draft findings of environmental and social assessment and draft management plan to seek their views and suggestions. The consultation workshop was attended by participation from various stakeholder groups included Secretary Health and Family Welfare, senior officials from DH&FW, Member Secretary from Nagaland Pollution Control Board (NPCB), member of Environmental Advisory Board of NPCB, CEOs of Kohima Municipal Corporation (KMC) and Dimapur Municipal Corporation (DMC), staffs from KMC involved in Bio-Medical Waste Management (BMWM), Chairman of Village Health Committee Vishvema, members from civil society organizations and colleges from World Bank. Minutes of the same has been presented in Annexure –I of this report. Presented below are the key highlights and suggestions from the consultation workshop.

[47] Community Engagement for health and nutrition outcomes: An assessment of existing efforts and potential way forward. By Oxford Policy Management & Entrepreneur's Associates (2014)

SOCIAL MANAGEMENT FRAMEWORK

5.0 SOCIAL MANAGEMENT FRAMWORK

Given that Nagaland is predominantly inhibited by schedule Tribe population with about 86.5% of the state population are tribal population. Eight out of eleven districts have more than 90% tribal population, with another two over 80% and only one district (Dimapur) have 59% of tribal population, any benefit accrued from the proposed project will largely benefit tribal population and hence broadly align to World Bank Policy on Indigenous People (OP 4.10).

However, it may be useful to attempt for a more inclusive approach with gender and empowering community while implementing proposed activities under the project. In line with that, the proposed project has already identified incentivising communitization groups for better management of health care facilities and any innovations done in this direction through a dedicated component of the project "Community action for health and nutrition".

The project activities envisaged suggests that planned civil works will be limited to the existing footprint of health facilities and will not entail any land acquisition or resettlement. However, in case of a chance find, a reporting procedure is also presented in the subsequent section for any need that may arise at a later stage.

The Social Management Framework (SMF) has been developed in order to address the social issues that may arise as a result of any activities proposed under the project. The SMF contains the following sections:

(a) Resettlement Policy Framework,
(b) Tribal Development Plan,
(c) Gender and Social Inclusion Guidelines,
(d) Implementation Arrangements

5.1 Resettlement Policy Framework (RPF)

5.1.2 Justification for triggering OP/BP 4.12 related to Involuntary Displacement and land Acquisition

Component 2 of the project entail financing investments in off-grid electricity supply, water supply and sanitation in targeted health facilities and support medical waste management as well as meet priority requirements for improving municipal waste management in several urban areas of the state. Though the project activities envisaged so far does not require any land acquisition and associated involuntary resettlements, however, in case of 'chance find', a detailed process to be followed along with reporting procedure is presented in the subsequent section.

Given that 93% of the land is owned by community and being managed through the traditional customary laws, when needed for public interest or Government, normally the land will be either purchased or donated by the community, private owners, and the local self government. In rare cases, land is acquired. Though there are legal provisions made under the Nagaland Land (Requisition and Acquisition) Act, 1965, often, the practice adopted by the Government is to buy land or get donation from the community. Based on possibilities of

'chance find', OP/BP 4.12 has been triggered for the project. At the time of project preparation, the location of the subprojects and the possibility and scope of land acquisition and involuntary displacement were not known at the level of each sub-project, it has been decided to prepare a Resettlement Policy Framework (RPF), which is the appropriate and designated tool for such a situation. The RPF will define roles, responsibilities, procedures to guide the preparation of the individual Resettlement Action Plans (RAPs) during implementation for the sub-projects that will cause involuntary displacement and mandatory land acquisition of land owned or used by individuals, families or other entities.

The World Bank Policy and requirements as stated in OP/BP 4.12 provides the guidelines to be followed. The World Bank OP/BP 4.12 details issues of involuntary resettlement, emphasizing the severe economic and environmental risks involved if unmitigated. The World Bank Policy Objectives urge that involuntary resettlement be avoided whenever possible. If unavoidable, the displaced persons need to:

- Share in project benefits;
- Participate in planning and implementation of resettlement programs;
- Be assisted in their efforts to improve their livelihoods and standards of living or at least to restore them, in real terms, to pre – displacement levels or to levels prevailing prior to the beginning of project implementation, whichever is higher.

The World Bank Policy covers direct economic and social impacts that both result from Bank – assisted investment projects. This covers taking of land which may result in relocation or loss of shelter, assets, access to assets or loss of income resources or means of livelihood whether or not the affected persons must move to other locations.

Objectives of RPF

The primary objective of this RPF is to provide better standard of living to the project affected persons or at least restore their standard of living to that of before project. The specific objectives are:

- Avoid or minimize involuntary resettlement where feasible, exploring all viable alternative project designs.

- Assist displaced persons in improving their former living standards, income earning capacity, and production levels, or at least in restoring them.

- Encourage community participation in planning and implementing resettlement.

- Provide assistance to affected people regardless of the legality of land tenure.

The following guidelines will be followed during implementation:

5.1.3 Legal and Administrative Framework

5.1.3.1 The Constitutional Provision – Article 371-A

The Article 371 (A) of the constitution gives special constitutional status to Nagaland and the Naga customary law[48] and procedure, including with regard to ownership of land and its resources, an overriding supremacy over the national statutes.

The Article 371-A of the Constitution of India regarding special status of Nagaland includes "*Notwithstanding anything in this Constitutions, (a) no Act of Parliament in respect of (i) religious or social practices of the Nagas, (ii) Naga customary law and procedure, (iii) Administration of civil and criminal justice involving decisions according to Naga customary law, (iv) Ownership and transfer of land and its resources shall apply to the State of Nagaland unless the Legislative Assembly of Nagaland by resolution so decides…..*".

As a result, the ownership of land in Nagaland is quite different from the other states of India. Local customary laws govern the land tenure system. Such laws are tribe specific where each tribe or even village has its own customary laws and traditions. The traditional system of ownership of land in Nagaland is fundamentally of three types, village land, clan/ khel land and private land. The village community owned and regulate the land and its resources according to the traditional customs and practices.

5.1.3.2 The Nagaland Village and Area Council Act (1978)

Village Council is the apex governing body at the village level in Nagaland. In order to restore the esteem of the traditional village authority systems, the Government codified the powers and functions of the Village Councils, recognising the traditional village bodies like the *Putu Menden* of the Aos, through the Nagaland Village and Area Councils Act, 1978. It was through this Act that a Village Council was established in every village in Nagaland. Village Council members are chosen by villagers in accordance with the prevailing customary practices. Hereditary Village Chiefs, Gaonburas and Angs shall be ex-officio members with voting right. The Village Council meets once every three months or more frequently if requisitioned by one-third of the members.

The Special Powers of the Village Council includes powers to maintain law and order and administer justice within the village limits in accordance with the customary laws and usages as accepted by the canons of justice established in Nagaland. Section 15(1) of the Village Council Act provides that 'the village shall … have full powers to deal with internal administration of the village'. The Councils act as the village courts in accordance with the powers entrusted under the Rules for Administration of Justice and Police in Nagaland, 1937. In disputes between villages, two or more Village Councils can settle the dispute in a joint session.

[48] Customary Laws: There is no universally accepted definition of a customary law. It can be described as a set of rules through which a tribe practises its culture and expresses its worldview. It is "an established system of immemorial rules which had evolved from the way of life and natural wants of the people, the general context of which was a matter of common knowledge, coupled with precedents applying to special cases, which were retained in the memories of the chief and his counsellors, their sons and their sons' sons, until forgotten, or until they became part of the immemorial rules…". It governs a person's marriage, divorce, inheritance, child custody, etc as well as community relations such as tenurial rights over forests, lands, water bodies and other natural resources.

5.1.3.3 Communitization of Public Institutions and Services Act (2002)

Building upon the strong traditional institutions and governance systems, the Nagaland government initiated "Communitization of Public Institutions and Services Act (2002)" which fosters a strategic partnership between the government and the communities. The Act to improve services and ensure peoples' buy-in to public assets as stakeholders delegates management responsibilities for essential services such as health, primary education, power, rural tourism, rural water supply, etc. to the community. Initially the scheme focused on three very important areas: Elementary education, Grass root health services and Electricity management.

Subsequent to the enactment of the "Nagaland Communitization of Public Institutions and Services Act, 2002", the Department of Health and Family Welfare has leveraged the communitization strategy to build public ownership of public health care in the state. Communitization calls for a partnership between the government and the community with the objective of promoting and protecting the health and well-being of the people in the state with the active participation of the community. The community is represented by the various health committees organized at the grassroots level, including the Village Health Committees (VHCs) at Sub-Centre level, Urban Health Committees (UHCs) at dispensary level, and the Health Centre Management Committee (HCMCs) at PHC and CHC level.

5.1.3.4 Resettlement Principles According to World Bank OP/BP 4.12

The World Bank requirements are detailed in OP/BP 4.12. The directives outline the following principles:

1. Involuntary resettlement should be avoided where feasible or minimized by exploring alternative project designs. If not feasible to avoid resettlement, resources are to be provided to enable the displaced persons to share in the project benefits;
2. The population to be affected by the project are those who may lose as the consequence of the project, all or part of their physical and non – physical assets including homes, farms, productive land, properties, income earning opportunities, social and cultural relations and other losses that maybe identified in the process of resettlement;
3. All population impacted by the project should be consulted and given the opportunity to participate in planning and implementing resettlement programs;
4. All population affected by the project are entitled to be compensated for their lost assets and incomes at full replacement cost and assisted in their efforts to improve their livelihoods and standards of living to pre – project standards;
5. All affected population are equally eligible for compensation and rehabilitation assistance, irrespective of tenure status, social or economic standing and without any discrimination;
6. The World Bank policies stipulate that displacement or restriction of access to resources must not occur before necessary measures for resettlement are put in place. This includes provision of compensation and other assistance required for relocation prior to displacement to new sites with adequate facilities. For compensation purposes, preference should be given to land – based strategies for displaced persons

whose livelihoods are land – based with land equivalent to the advantages of the land taken. If land is not available, options built around opportunities for employment should be provided in addition to cash compensation for land and other assets lost. In case of land – based livelihoods, cash payment may be appropriate if the land taken is a small fraction of the affected asset and the residual is economically viable particularly, if active market for land exists and the displaced persons have the opportunity to use such markets. Cash compensation should be sufficient to replace the lost land and other assets at full replacement cost in local markets.

7. In all cases, the displaced persons and host communities receiving them are to be provided with timely and relevant information, consulted on resettlement options and offered opportunities to participate in planning, implementing and monitoring resettlement and appropriate mechanisms for grievance redress are established. It is also important that in resettlement sites or host communities, public services and infrastructure are provided and measures are to be taken to the extent possible to preserve the social and cultural institutions. Special measures are to be taken to protect socially and economically vulnerable groups and people living in extreme poverty.

5.1.3.5 Land Acquisition, Rehabilitation and Resettlement Act, 2013

Land acquisition in India is currently governed by "The Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013", which came into force from 1 January 2014. Till 2013, land acquisition in India was governed by Land Acquisition Act of 1894. However, the act 'The Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013' to be applicable to Nagaland is yet to be decided by a resolution of the Nagaland Legislative Assembly." And hence, till then the "Nagaland Land (Requisition and Acquisition) Act, 1965" will be applicable.

Given that the current Nagaland Land (Requisition and Acquisition) Act, 1965 may be replaced by the new Act over time with resolution of the Nagaland Legislative Assembly, the process details mentioned are aligned to the "The Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013" (LARRA 2013). The current 2013 Act focuses on providing not only compensation to the land owners, but also extend rehabilitation and resettlement benefits to livelihood looser from the land, which shall be in addition to the minimum compensation. The Act also introduced changes in the land acquisition process, including a compulsory social-impact study, which need to be conducted before an acquisition in made.

However, given that the requirement of land will be very small for any extension of existing health facility beyond its exiting footprint, it is suggested that an ***outright purchase of land will be initiated based on willing seller willing buyer principle***.

5.1.4 Key Steps in Implementing RPF

5.1.4.1 Screening of Activities

There shall be a quick screening of all civil works in order to ascertain the nature and extent of resettlement impacts and kind of mitigation measures required as per the RPF. The purpose of screening is twofold:

- To ensure that activities that are likely to cause significant negative environmental or social impacts are not supported

- To ensure that all supported activities are in accordance with the laws, regulations of the Government and with the safeguard policies of the World Bank.

Responsibility for Screening

Chief Medical Officer (CMO) at the district level will be responsible for undertaking the screening and suggesting mitigation measures as suggested under the SMF.

When the Screening will be done

The screening is proposed to be done at the time when Draft Plans for undertaking the project activities are ready and a draft final set of activities has been identified for the health care facility.

Preparing RAPs: Based on the screening outcomes, resettlement action plans (RAP) will be prepared setting out the steps for land taking, if required, and for relocating any households affected due to the project. This will involve activities through census survey of impacted households and in consultation with the affected people. The RAP shall be disclosed and implemented by the District Administration on behalf of the Project. The key implementation steps are discussed below.

5.1.4.2 Land Taking Options

- The process of land taking through purchase or donation and rehabilitation assistance will be paid before displacement.

- Land value will be determined in consultation with the owners and with reference to the Act

- The PMU/ District implementation Unit (DIU) will provide information to the concerned community and the affected people regarding the implementation of the RPF and entitlements.

Depending on the additional land required for the health facility, the DoHFW, GoN, as a first step, would try and secure public lands (if available) under different tenure systems where feasible and available. And then go for outright direct purchase. The government has decided not to apply land acquisition to obtain land required for the project.

Direct Purchase: GoN has experience of direct purchase of private lands for public purposes and will adopt this method, on a willing seller and willing buyer basis, to avoid delays. The steps for direct purchase will require following steps as being followed by the Govt of Nagaland:

- Step-1: DoHFW, GoN will identify the land required for any project activities
- Step-2: DoHFW through Commissioner (General Administration) requests Deputy Commissioner of the concerned district to initiate direct purchase
- Step-3: Deputy Commissioner through their Revenue officer will hold consultation with the concerned land owners to solicit their consent regarding purchase of land,
- Step-4: Once basic agreement regarding land purchase is reached, Deputy Commissioner through their Revenue officer will liaison with land record and survey officer and Village/ Town Council for joint measurement and Zamabandi (in principal agreement to sell).
- Step-5: Valuation of land and assets: Any physical structure, tree, crop etc on the land will be valued by the respective line department representative e.g. PWD for building, horticulture or forest department for trees (based on type of trees), Agriculture department for crops etc., whereas the land shall be valued by the revenue department.
- Step-6: A basic price will be worked out with considering the value of land and assets, such as physical structure, tree, crop etc. based on replacement value using existing/market prices
- Step-7: Revenue officer will further liaison for Price negotiation with the land owner
- Step-8: Sale deed will be done and payment will be made with Village council Chairman/ representative being witness to it.
- Step-9: All necessary documentation shall be made and the title of land thus purchased shall be transferred in favour of the Project implementing agency.

While purchasing land, as a rule it will be ensured that the land is free of any encumbrances.

5.1.4.3 Common Property Resources

Common property resources (CPRs) like grazing lands, places of worship, places of heritage value, burial grounds, water points, community wells, bore wells for drinking water, roads, path ways, community meeting places, wood lots, etc. are categorized under this heading. In case of CPRs, the resources will be restored to an acceptable level at an appropriate place as agreed with the community/ Village Council. Community will be fully involved in their replacement. This will also be done through the office of concerned Deputy Commissioner or under her/ his supervision.

5.1.4.4 Relocating Squatters

The squatters will be identified involving Village Councils (VC)/ Town Council/ ULBs and Revenue Officer/ representative from the Deputy Commissioner's office. Post identification, a social screening survey will be done to ascertain socio-economic status of the affected person(s) through extensive consultations with project affected families and will be compensated as per entitlement matrix presented below.

5.1.4.5 Entitlement Matrix

This Entitlement Matrix is developed giving various entitlements for all categories of PAPs, in the light of impacts borne by them. The Right to Fair Compensation and Transparency in Land Acquisition and Resettlement Act 2013 though not applicable has been kept as a reference point. This Matrix will be used as a guide for designing Resettlement Action Plans for sub-projects. All the families will be entitled to two broad categories of assistance; (1) compensation for land loss; and (2) livelihood (rehabilitation) assistance for starting some income generation activity, which may include the purchase of lands, as decided by the PAF. The livelihood assistance in the matrix are rather indicative (as they are average figures), whereas, the actual assistance will relate to, at the minimum restoring, if not enhancing the pre-land loss income levels. The amounts given in the Entitlement matrix are for the current year and may be revised by the government appropriately every year to neutralize inflation and with reference to the whole sale price index and consumer price index. Details related to the entitlements are presented in the matrix below.

Entitlement Matrix		
Impact Type	Entitled Entity	**Entitlements**
Impact on land and structure due to expansion of health care Infrastructure in existing villages	- Community – for village/ clan land - Private land owners	• Direct Purchase of land with payment of replacement cost as agreed with the land loser on willing seller willing buyer basis, or through voluntary donation as per norms provided in this RPF • Reimbursement of all necessary costs involved in land purchase including any fees, taxes, stamp duties and other charges levied, as applicable under the relevant laws, by the government/ borne by the land loser
Loss of residential structures of squatter	- Affected Family	• Provision of a housing unit as provided to beneficiaries government supported social housing schemes (Rajiv Awas Yojana (RAY) in urban areas and Indira Awas

Entitlement Matrix		
Impact Type	Entitled Entity	**Entitlements**
		Yojana in rural areas) with government bearing all costs • One time rehabilitation assistance of INR 12000 • All necessary cost for fees, taxes, stamp duties and other charges, as applicable under the relevant laws, incurred are to be borne by the government • Right to salvage material from demolished structure and frontage etc
Loss of Commercial structures of squatter	- Affected Family	• Cost of the structure lost due to the project • Subsistence Grant of INR 50,000/- to the displaced poor and vulnerable families losing livelihood due to the project • One time grant of Rs. 25,000/- to artisans, and small traders
Unforeseen/ Unanticipated Impacts		Any unforeseen/ unanticipated impacts due to the sub-projects will be documented and mitigated based on the spirit of the principle agreed upon in this framework

5.2 Gender and Social Inclusion Framework

The Gender and social inclusion approach under NMHP would be to consider the vulnerability factors and make effort to address them. Gender and social inclusiveness will be across cutting theme in the operational guidelines, training modules, reporting system etc.

5.2.1 Specific Acts and policies related to Women empowerment

Recognizing the need to accelerate the empowerment process of women, while also acknowledging the fact that women are now accepted agents of development, during 2003-04, the "*Directorate of Women Resource Development"* was created out of the bifurcation of the erstwhile Department of Social Security & Welfare. With the overall objective of balancing the gender divide, the Department aims at the uplift of women and facilitates her self-dependency while continuing to protect and safeguard her rights and privileges. This directorate has entered into a partnership with apex women Hohos in all the districts. The partner NGOs have been instrumental in implementing various schemes of the department. The main thrust of the department was to encourage and strengthen women-cantered self-help groups (SHGs). The primary focus of the department is (1) to better the socio-economic status of women, (2) to safeguard the rights of women, (3) to provide support services to women for social and economic upliftment.

Government of Nagaland in its endeavour towards empowerment and upliftment of Naga women has already enacted the Nagaland State Women Empowerment Policy 2007, Nagaland Municipal (first amendment) Act 2006 for reservation of seats for women in Municipal and Town Councils and also enacted Domestic Violence Act 2005 for protection of women from domestic violence.

a. Nagaland State Women Empowerment Policy 2007
- for women SHGs

b. Women seat reservations under Nagaland Municipal (first amendment) Act 2006
- Training cum Protection Centre – for rural women and school dropout girls
- Support to Training and Employment Programmes (STEP)
- Working Women Hostel
- Swadhar – for women rehabilitation and shelter
- Nutrition Programme for Adolescent Girls

c. Domestic Violence Act 2005
- protection of women from domestic violence

5.2.2 Gender and Social Inclusion Issues in Health Sector

It is important to address the healthcare inequalities and related implications among different population groups and availability of these services. These may emerge from economic reasons (Ex: people living below the Poverty Line i.e. BPL category), socio-cultural reasons (different tribes/ sub-tribes living especially the backward tribes), geographic reasons (i.e. inclusive of backward districts), gender reasons, and special vulnerable groups such as women headed households, female migrant workers etc.

According to rules laid out under the Communitization of Public Institutions and Services Act (2002), the Village Health Committee (VHC) is constituted with Chairman of Village Council (as Chairman of the VHC), 3 Village Council Members, Secretary of Village Development Board (VDB), 2 Mahila Swasthya Sangh members (women members), 1 Anganwadi Worker, 1 dai (Traind Birth attendant), 1 Pastor of village church, and the Senior most Health staff at the facility. Similarly, the Health Centre Managing Committee (HCMC) for CHC and PHC have members from Village Councils of all the constituent villages, and two senior most employee of the health centre, Medical Officer, Chief Medical Officer (CMO) of the district and a pastor from the local church.

The impact study conducted by the Directorate of Health and family Welfare in 2009 suggests that overall there has been more than 25% participation of women in the communitization groups put together. However this varies across facility to facility and in some case it is very high (higher than the no. of men) and in some case very low.

The component-1of the proposed project i.e. Community action for health and nutrition, is already built in the project to address the women and community participation and capacity development and proposes to support increased representation by women and foster the involvement of women's self-help groups. However, it is further proposed that special emphasis to be made for gender inclusion while detailing out component-1.

5.2.3 Key GSI Measures

The key activities under gender and social inclusion framework will include:

(a) Addressing gender and social inclusion

- In order to ensure that women take an active part in decision making and gender concerns are dealt properly, both men and women, and traditional institutions are to be sensitised on gender issues especially in the villages associated with targeted facilities.
- It is also proposed that the project implementing unit at the health facility level must have at least one women active member in the decision making group.
- Awareness generation among general community regarding roles and responsibilities of VHCs (and HCMCs at PHC and CHCs) to be done in the associated villages of the target facilities.
- An incentive system in the project implementation shall be built to villages and institutions showing substantial progress in gender inclusion.
- Special capacity building and awareness raising activities will be undertaken targeting women members at the community levels
- Special awareness raising activities will be undertaken to raise awareness on gender equality and social inclusion issues at the community level.
- Priority will be given to hiring women as community mobilization staff in the Project
- The communitization process will promote social harmony and inclusion of all members of the communities in the preventive and curative health initiatives through IEC and outreach activities involving village health committees and village councils.

5.3 Tribal Development Plan

Introduction: About 86.5%[49] (93% in rural areas) of Nagaland's population is tribal belonging to 16 tribes with many sub-tribes and clans. Each tribe has its distinct socio-cultural practices and exhibit strong bondage.

When Nagaland was carved out of Assam to be a separate State, certain areas from other regions were also included in the newly formed State. Tuensang district was part of North East Frontier Agency (NEFA), which later was included in Nagaland and form a part of Eastern Nagaland region. The areas in Eastern Nagaland, the Mon and Tuensang districts (now Tuensang district further divided into Longleng, Tuensang and Kiphire) were classified as 'Un-administered Areas' during the colonial period. This structural demarcation during the colonial period also led to the continuation of this region being categorized as the 'Backward Areas'[50].

The State has identified Mon and Tuensang districts as well as Meluri subdivision in Phek, Bhandari in Wokha, Peren in Kohima and Pughoboto in Zunheboto as its backward areas. These areas were 'traditionally' remote and inaccessible. Present Mon and Tuensang districts were also part of the 'un-administered areas' during the British period[51].

Amongst the Naga tribes as many as nine tribes have been declared as educationally and economically backward tribes by the state Government. This is largely caused by disparities and other related development activities which contributes to the backwardness of some tribes in Nagaland. This is also evident from the HDI.

In terms of education and Christianization process, Naga tribes in Eastern Nagaland were late receivers of Western religion and education, as compared to other tribes in Nagaland. On the whole, the level of socio-economic development in the western regions of Nagaland is higher than in the eastern side. This is because proximity to Assam provides better connectivity while on the Myanmar side accessibility still presents formidable problem. Eastern Nagaland lags behind in every aspect in comparison to other districts in the state[20, 21].

Nagaland is not a classless society in contemporary times; it is far more stratified and socially different from one tribe to another. The state has significant role in employment generation and up-liftment of the disadvantaged sections but benefits are not distributed evenly leading to economic inequality among the people[20].

Presently there are 16 major tribes each having a specific geographical area and out of which Six-inhabiting Eastern Nagaland-are considered backward tribes in Nagaland. The six tribes are Khiamniungan, Chang, Phom, Sangtam, Konyak, and Yimchunger. Another three tribes

[49] As per Census 2011

[50] Khiamniungan, T. Longkoi 2014. Inequality in Nagaland: A Case Study Of 'Advanced' and 'Backward' Tribes. OIDA International Journal of Sustainable Development 07:02 (2014). Ontario International Development Agency. ISSN 1923-6654 (print) ISSN 1923-6662 (online) Available at http://www.ssrn.com/link/OIDA-Intl-Journal-Sustainable-Dev.html

[51] Govt of Nagaland (2004). State Human Development Report 2004. Department of Planning and Coordination, Govt. of Nagaland

Chakhesang/Pochury, Zeliang living in Phek district and Sumis of Kiphire District are considered as backward tribes[20, 21].

These are further reflected in access to basic infrastructure and other developmental indicators reflected from various districts. The four districts namely Mon, Tuensang Longleng and Kiphire are ranked much lower than the rest of the districts. In order to address the concern, the Government had set up Development of Under-Developed Areas (DUDA) for up-liftment of the six most backward tribes. In addition, the Nagaland service rules notified by Personnel and Administrative Reforms Department, Government of Nagaland have made 25% reservations in Government jobs for the 6 backward living in four eastern districts and relatively lower rate of reservation 2%-6% for the remaining three tribes[52].

Nagaland is one of the 11 special category states that receive budgetary assistance from the central government in the form of 90% grants and 10% loans. These states are given special permission to use up to 20% of central assistance for meeting the 'non plan gap,' which is unexpected expenditure at the time of budget approval (North Eastern Council, 2009). The state is highly dependent on Central assistance to meet the budget requirement. An analysis of annual plan of 2013-14 and 2014-15 suggests that for many of the development schemes, state has been unable to contribute 10% of their share (in part or full) and hence unable to fully leverage the 90% funds provided by Centre.

Tribal Development Plan:

The Bank Operational Policy on Indigenous People 4.10 has been triggered as Scheduled Tribes form an overwhelming majority of the state's population.

The Bank Operational Policy 4.10 on Indigenous People aims to ensure that tribal people:

- Benefit from **prior, informed consultation** and participation in Bank projects that affect them
- Get full respect for their dignity, human rights and cultural identity in the development process
- Do not suffer (by avoiding/mitigating potentially adverse effects caused by developmental activities)
- Receive culturally compatible economic and social benefits

Given that overwhelming majority of the beneficiaries are tribal, the above principles and concerns have been mainstreamed into the Project Design with the following steps taken and planned to be taken. The TDP has a two-fold focus: (a) integrating into the project design and implementation cultural sensitivity to the tribal communities of Nagaland, their unique socio-cultural heritage, traditional institutions, etc., and accordingly designing the community-based implementation architecture through consultation and participation and (b) paying special attention to the needs of the backward tribal communities in specific regions.

- The Project has been prepared with holding a series of free, prior, informed consultations held with the primary stakeholders at different levels, details of which have been provided in the annex.

[52] Govt of Nagaland (2011). Notification No. RCBT-5/87 (PI-II), 2011. Personnel and Administrative Reforms Department, Govt of Nagaland

- The Project has set out a well-defined institutional framework for continued consultation with and active participation of tribal communities through the communitization mechanism.
- A Resettlement Policy Framework has been prepared to identify and address any adverse impacts of the Project activities, which is provided in this document
- In respect of the backward tribes, an adequate number of health facilities to be taken up for improvement under this Project in the Eastern Nagaland districts mainly Mon, Longleng, Tuensang, Kiphrie and Phek districts.
- Special emphasis and allocation on training and capacity building along with some additional benefit will be given to the target facilities and staffs/ community involved in the backward region.

Tribal Development Plan Matrix

Principle/ Concern	Steps Taken	Measures Planned	Responsibility
Free, Prior, Informed Consultation	Already held at community levels, Consultation framework provided in SMF	Communitization framework provides for continuous consultation	PIU/CHC/PHC/Sub-Centres
Participation	Project Design sensitive to community participation for	Culturally sensitive communitization strategy	PMU/ PIUs
Communication		Community Disclosure of Project related information	PIUs, CHC, PHC, Sub-Centres
Culturally compatible benefits		Culturally sensitive Information, Education and Communication (IEC) strategy for better outreach	PMU/PIUs
Special vulnerabilities of backward tribes		Coverage of health facilities from backward districts in Project	PMU
Meeting differential information needs		a. Special thrust on IEC and training in backward tribal areas b. special incentives to staff in far flung backward tribal areas	PMU

5.4 Consultation Framework

Stakeholder consultations were carried out in multiple phases in preparation of SMF. This included consultations with various staff members at DH&FW and other Govt departments; staff members and members of communitization groups at Sub-Centre, PHCs, CHCs and District Hospitals; members of community groups including members of women societies (members of traditional women's groups and SHG's) and members of village councils, VDB at different villages visited – it also involved focus group discussions and semi-structured interviews with a range of stakeholders in 4 districts (Phek, Dimapur, Tuensang and Kiphire).

As mentioned in the earlier section 4.4, the stakeholder consultation was carried out at 12 Sub-centres, 7 PHCs, 2 Village Health Committee (VHCs), 6 Village Councils (VCs), 5 Village Development Boards (VDBs), along with 18 discussions with general community members, traditional women's groups, and SHG's were conducted. The consultation carried out informed the social assessment and development of SMF as well as shaping the project component on Community action for health and nutrition.

The component-1 of the project "Community action for health and nutrition" has already built in mechanism for community actions and consultations at the village level. The Village Health Committees will be given result based financing to support activities with impacts on health and nutrition to be implemented at the community level. This will have consultations at least two times if not more with other village level institutions and community at large while receiving the fund for community action and at the end discussing the results of the actions.

Consultations will also proposed at each of the Working groups which will have members from various state government departments, including Women and Child Development, Public Health Engineering, Renewable Energy, Information Technology, Planning, Finance and others as relevant. The project proposes to have four working groups: (i) community mobilization; (ii) water and sanitation, (iii) off-grid energy; and (iv) project management. The working groups will support the Department of Health and Family Welfare in planning, implementation and management of project activities that require coordination across sectors.

At the apex level, the Project Executive Committee and Project Steering Committee will take note of the recommendations from these consultations and make necessary changes in the programme implementation and suggests necessary actions to be taken by PMU.

5.5 Implementation Arrangements

Institutional arrangements to manage and implement the Social management framework will be set up at PMU at the state level.

- An officer at the PMU will be made as Nodal officer (Consultant) for Communitization and IEC who will be responsible for implementation of the SMF
- PMU will take steps as required to augment the implementation capacity at PMU and PIU/District levels with regard to gender and social inclusion and land acquisition (if required) and management of TDP issues.
- Every district will have a nodal officer (Consultant) appointed for planning and implanting SMF measures and report the same to the PMU on a monthly basis
- PMU will set guidelines for appointing social mobilization coordinators at the field level with appropriate area of coverage and execute the same

5.6 Monitoring Arrangement

It is the responsibility of the project to conduct regular monitoring of the SMF. The nodal officer for M&E at PMU will be responsible for monitoring of the SMF. The monitoring results will indicate the appropriateness of mitigation measures.

The SMF implementation plan will be included as part of the Annual Action Plan of the project and monitored monthly through a format designed by Nodal Officer for M&E in consultation with Nodal officer for SMF at the state level. The monthly progress will be collated at the district level by the District level facilitator and further at the state level.

Feedback from community on SMF implementation will also be collected through the monthly progress report format and will be collated and presented by PMU.

PMU will prepare an annual report on SMF implementation and share it with State Government and the World Bank.

5.7 Disclosure

The Right to Information Act, 2005 provides for setting out the practical regime of right to information for citizens to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority, the constitution of a Central Information Commission and State Information Commissions and for matters connected therewith or incidental thereto. The process for obtaining information and details of designated officials shall be posted on the DH&FW website.

State Level

PMU shall disclose this entire SMF and all Safeguards related documents and mitigation plans at DoHFW websites. Given that English is official language in Nagaland and also popular among local community, the disclosure will be in English. The Resettlement Policy Framework will be disclosed along with the entitlement framework to the concerned village community even though this is a part of this SMF document.

District Level

District level facilitator will ensure and arrange to disclose the final versions of the SMF in English along with Resettlement Policy Framework and Entitlement Matrix in to the concerned community.

Disclosure by the World Bank at the Info shop

The World Bank will disclose this SMF along with Social Assessment at the infoshop for downloading and reference by interested parties.

5.8 Grievance Redressal Mechanism

The existing grievance redressal mechanism set up at state, district and health facility level (vide Government order no. HFW-28/B-20/2013 dated 24th October 2013) by the department of Health and Family Welfare. GoN is adequate (see details in Annex-II) and there is no special mechanism to be set up for the project. The contact details of the concerned officer at state, district and health facility level will also be disclosed at the DoHFW website.

5.9 Budget

A separate sub-component for community empowerment has been proposed for the current project along with budgetary provision. Hence, further provision of capacity building on SMF and monitoring are being proposed under this.

5.10 Revision/ Modification of SMF

The SMF is an "up-to-date" or a "live document" enabling revision, when and where necessary. Unexpected situations and/or changes in the project or sub-component design would therefore be assessed and appropriate management measures will be incorporated by updating the SMF to meet the requirements of applicable legislations and Bank safeguards policies. Such revisions will also cover and update any changes/modifications introduced in the legal/regulatory regime of the country/ state. Also, based on the experience of application and implementation of this framework, the provisions and procedures would be updated, as appropriate in consultation with the World Bank and the DH&FW, Govt. of Nagaland. Any changes to the SMF will required to be cleared by the Bank.

ANNEX I: MINUTES OF STAKEHOLDER CONSULTATION WORKSHOP

Stakeholder Consultation Workshop on Environment and Social Management Framework for Nagaland Multisectoral Health Project

Venue: ISDP Conference Hall, Directorate of Health and Family Welfare, Kohima
Date: 28th February 2014

Participants: Participation from various stakeholder groups included Secretary Health and Family Welfare, senior officials from DH&FW, Member Secretary from Nagaland Pollution Control Board (NPCB), member of Environmental Advisory Board of NPCB, CEOs of Kohima Municipal Corporation (KMC) and Dimapur Municipal Corporation (DMC), staffs from KMC involved in Bio-Medical Waste Management (BMWM), Chairman of Village Health Committee Vishvema, members from civil society organizations and colleges from World Bank. A detail list of participants is enclosed herewith.

The Proceedings of the Workshop

The workshop was initiated by Mr. Angami (Secretary Health and family Welfare) and Dr. Nandira Changkija by introducing the World Bank project and going over the presentation on ESMF. This followed by discussions on issues and practice related to Bio-medical waste management in the state, and seeking views and suggestions on how to further improve upon the bio-medical waste management (BMWM) practices. The key points emerged from the workshop includes as follows:

- Member Secretary from NPCB mentioned that there are three main stages of BMWM i.e. segregation and handling (of biomedical waste); transportation (in colour coded vans); safe disposal. As a demo project with KMC, a disposal site was setup and BMW are collected from all the registered facilities including NHAK and private facilities in Kohima. The CEO-KMC also mentioned that to BMW being received by them are not segregated and hence poses a challenge while disposing.

- The member secretary from NPCB mentioned that from rural areas (for CHCs, PHCs and SCs) given the low quantity of bio-medical waste and problem of electricity supply in the health facilities, it will not be cost effective to install incinerators. Hence it is best that they use the deep burial rather than incineration.

- The Director Health mentioned that, the BMWM system started in 2010-11 in Nagaland with proposal for installation of incinerators and distribution of colour coded bins to district hospitals and facilities with high case loads. Based on the experiences so far, day-to-day operations and management of the installations are far more difficult. The segregation of the waste is one of the most important aspects and if not done at source the remaining efforts become futile.

- The current set of incinerators installed in four district hospitals including NHAK and Dimapur district hospitals are not-functional or partially functional because of various reasons including its location (being near to residential areas), small and congested operational area among other problems. Director health mentioned that initially these incinerators were to be located as common facility for the district under the jurisdiction of municipal bodies, but with paucity of time to spend fund allocated to it, decision of locating it to district hospital was taken. Also running cost of a 50-70Kgs capacity incinerator is about Rs.70, 000 per month and many facilities as well as municipal bodies will have difficulties in funding for the same.

- It was felt by many participants that capacity building and training of the health care professionals, nurses, technical staffs and other staffs at the health facilities are important on BMWM, and in addition, the front line workers of the health facilities and municipal bodies may need to be trained as well. Community may need to be also sensitized with the risk and management of BMW.

- Though the EMP plans for periodic monitoring and internal and external audits, it was felt by some participants that there should be ownership of BMWM at facility level and someone at the facility level should ensure that it is followed and do day-to-day monitoring. It was also felt by some of the participants that a committee involving representation from DH&FW, Municipal Corporations and NPCB may be useful to monitor at the state level and take things forward.

- The CEO of KMC and DMC and other stakeholders including from NPCB feel that at district headquarter level, there should be common disposal facility to be developed with municipal bodies and preferably under their control so that they can do the collection (using bio-medical waste collection vans), institute user charges, and take the operational and management responsibility of running the incinerator and ensuring safe disposal of other hazardous wastes as per norms laid out by the government.

- CEO of KMC also mention that they have got 94 acres of land for solid waste dump, and DMC though have issues with existing dumping ground but are in process of developing new site which are allocated to them. Both CEOs from KMC and DMC felt that they can earmark some part of the dumping ground specific for BMWM and ready to take responsibility of running common BMW disposal system.

- The member secretary of NPCB also mentioned that each of the facilities generating BMW need to be registered with NPCB. And by that manner, NPCB will also help in identifying the right choice of location for incinerator and other BMW disposal locations and may undertake training.

- On the social management framework, participants felt that there are good provisions laid out under the Communitization Act, however, utilising them for better gender and community participation has been not always up to the desired mark and there is a lot of scope to improve upon by finding ways for enhanced community participation.

- The project team felt that it was quite commendable to see the enthusiasm of the stakeholder groups as most of the stakeholder were willing to collaborate and improve upon the bio-medical waste management system in the state. And as mentioned in the

proposed World Bank project, support for filling the gaps can be provided from the project for better management of bio-medical waste.

- On the social safeguard the project team informed the stakeholders that a complete sub-component under the project is dedicated to improve the community empowerment (the details of which are being developed by the technical team).

Key suggestions to take forward

- Common BMW disposal facilities to be developed at district headquarter level involving municipal bodies.

- A committee involving representation from DH&FW, Municipal Corporations and NPCB may be setup for monitoring of BMWM at the state level.

- A scientific study to be conducted to find suitable mechanism of bio-medical waste management at different levels of health care facilities (suitable to local situation and quantum to bio-medical waste).

- Capacity building of all health personnel and staffs of Municipal bodies involved (or to be involved) in bio-medical waste management need to be trained properly.

- Members of the community groups also needs to be sensitized with the risk involved and importance of bio-medical waste management

- On Social Management Framework, follow the provisions laid out under the Communitization Act, and develop mechanism for better gender and community participation along with their training and capacity building.

List of Participants

Meeting of Stakeholder Consultation on Environment and Social Management Framework for Nagaland Multi-Sectoral Health Project

Date: 28th Feb. 2014
Venue: IDSP Hall

Sl. No	Name	Designation & Deptt/Institution	Contact no. & Email address	Signature
1.	SHRI BELU ANGAMI	Secretary H&FW	9436000129	
2.	Ganesh Sharma	Liaison officer DMC	9436430966 sharmaganesh1965@gmail.com	
3.	Dr R. Rose	SPO NHMB. Member Expert Appraisal Team on Country	9856070109.	
4.	Dr Avino	CMO Kohima	9436011851	
5.	Dr Joyce Angami	Kekhrie Foundation	drjoyceangami1@yahoo.co.in 9436011068	
6.	Nallrongbuolie	Sr. Sanitation Inspector	9402481869.	
7.	PELHOUTSEILIE	Asst. sanitation Inspector	9856244019	
8.	ARVO	Sardar	9436069291	
9.	Thomas Malingmei	Sardar.	9615045506	
10	KUSOVIL JOHN	M.Secy, NPCB npcb2@yahoo.com	9436003731	
11	Zakiekhotuo Kiso	J.A.O. KMC	9436001089 zakiekhotuokiso@yahoo.com	
12	Elizabeth Ngully	CEO, KMC ceokmc-ngl@nic.in	9436009224	
13	Patrick MULLEN	World Bank	pmullen@worldbank.org	
14	Anirlk Nayan	World Bank		
15	Dr. Kika	DD NRHM	9436006134	
16	RANJAN B. VERMA	WORLD BANK	9313370682	

ANNEX -II: Grievance Redressal Mechanism of DoHFW, GoN

GOVERNMENT OF NAGALAND
HEALTH & FAMILY WELFARE DEPARTMENT
NAGALAND::KOHIMA

Dated, Kohima the 24th Oct 13

NOTIFICATION

No: HFW-28/B-20/2013 : In continuation of earlier Notifications, the Public Grievance Redressal Mechanism of the Department is hereby reorganised as mentioned below for handling grievance redress and to strengthen the grievance redress machinery in order to make the administration more responsive to the needs of the people.

A. State Level Public Grievance Redressal Committee and State Nodal Officer of Public Grievances:

1. The Principal Director : Chairman.
2. The Director (Health) : Member & State Nodal Officer of Public Grievances.
3. The Director (Family Welfare) : Member
4. The Mission Director (NRHM) : Member
5. The Project Director : Member
6. The Additional Drugs Controller : Member Secretary

B. District Level Public Grievance Redressal Committee and District Nodal Officer of Public Grievances:

1. The Chief Medical Officer : Chairman
2. One Representative of the District Administration not below the rank of Additional DC. : Member
3. One Representative of the Tribal Women Hoho : Member
4. Deputy CMO : Member Secretary & District Nodal Officer of Public Grievances.

C. Health Facility Level (For District Hospitals, TB Hospitals, Mental Hospitals, Community Health Centres and Primary Health Centres only) Public Grievance Redressal Committee and Health Facility Level Nodal Officer of Public Grievances:

1. Medical Officer In-Charge of the Health Facility : Chairman
2. One Representative of the Local Administration : Member
3. One Representative of the Local Tribal Women Hoho : Member
4. Nursing Staff In-Charge : Member
5. One Senior Doctor : Member Secretary& Health Unit Nodal Officer of Public Grievances

NB: The Committee is authorised to co-opt upto to a maximum of 2 members from the members of the fraternity or civil societies on issue or case based for effective disposal of Complaints/Grievances.

D. Terms of Reference of various Grievance Redressal Committees and Nodal Officer of Public Grievances & Procedure for Filing and Handling of Complaints are given in Annexure: I.

E. The existing Grievance Redressal Committees shall be subsumed under the above mentioned Committees respectively.

(SENTIYANGER IMCHEN)
Commissioner & Secretary to the Govt of Nagaland

No: HFW-28/B-20/2013

Dated, Kohima the 24th Oct'13

Copy to:

1. The Special Secretary to the Hon'ble Chief minister, Nagaland for kind information.
2. The P.S to Hon'ble Minister of Health & Family Welfare, Nagaland, Kohima for information.
3. The P.S. to the Chief Secretary, Nagaland, Kohima for information.
4. The Principal Director, Directorate of Health & Family Welfare, Nagaland, Kohima for information.
5. The Mission Director, NRHM Department of Health & Family Welfare, Nagaland, Kohima for information.
6. The Deputy Commissioner & Chairman District Health Society
   Dimapur/ Kiphire/ Kohima/ Longleng/ Mokokchung/ Mon/ Peren/ Phek/ Tuensang/ Wokha/ Zunheboto for information.
7. The Chief Medical Officer
   Dimapur/ Kiphire/ Kohima/ Longleng/ Mokokchung/ Mon/ Peren/ Phek/ Tuensang/ Wokha/ Zunheboto for information.
8. Office Copy / Guard File

(SENTIYANGER IMCHEN)
Commissioner & Secretary to the Govt of Nagaland