8TH COMMON REVIEW MISSION

JS (Policy)

Background

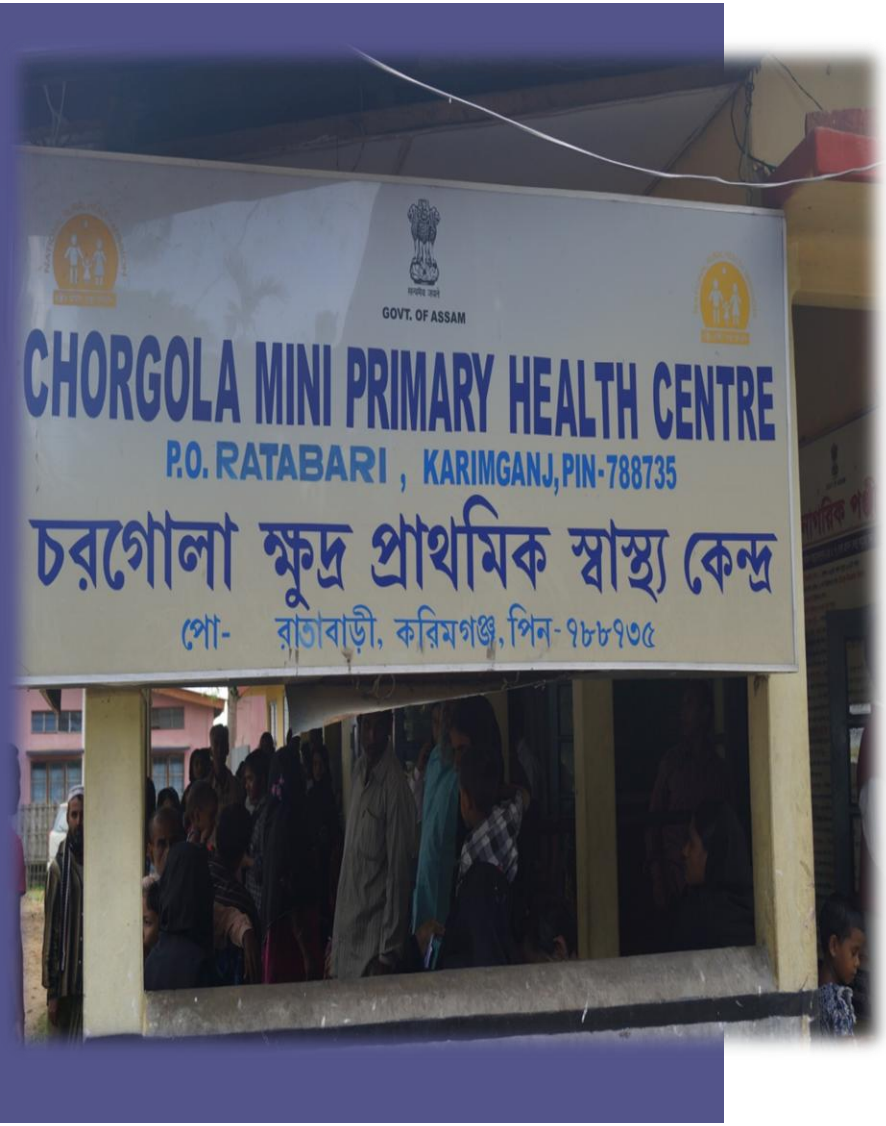
Held between Nov 7-14, Covered a total of 15 states - 9 High Focus States including two North-Eastern States and six Non High Focus States.

A total of 259 members including Government Officials from Planning Commission, Ministry and other related departments, Public Health Experts, Civil Society members, Development Partners representatives, MoHFW Consultants

Terms of Reference

1. Service delivery
2. Reproductive and child health
3. Disease control programmes
4. Human resources and training
5. Community processes and convergence
6. Information and knowledge
7. Health care financing
8. Quality Assurance
9. Drugs, Diagnostics and Procurement & Supply Chain Management
10. National Urban Health Mission
11. Governance and management

TOR 1 : Service Delivery Encouraging Findings



Beneficiaries at PHC

- Adequate number of health facilities as per population norms in most states, except Uttar Pradesh, Uttarakhand, and Bihar.
- Investment in infrastructure responsive to caseloads.
- Increasing trends in OPD load at every level
- Availability of secondary care at district hospitals in most states, except districts in Uttarakhand (Tehri), Chhattisgarh (Jashpur), and Uttar Pradesh (Shravasti)
- Tamil Nadu and Kerala demonstrate relatively better availability of services at SDH/Taluka level as compared to other states
- Laboratory services at sub-district level are available but not comprehensive, Tamil Nadu has a robust system of diagnostics, **Odisha has taken efforts towards integration of laboratory services across various programs and optimise HR utilisation**
- Co-location of AYUSH services in most states
- Utilization of 108 ambulances has picked up over a period of time

TOR 1 : Service Delivery- Areas of Concern

- Availability of radiological investigations only at district level in most contexts.
- Range of Diagnostic services is limited at Sub-District level hospital and below
- Assured IPD care at sub-district level is still a challenge in most states
- Time to care approach is yet to set in across the States
- Non-Integration of various models of ambulances leading ineffective utilization
- Under utilization of Mobile Medical Units
- Implementation of Comprehensive evidence based contextualised IEC/BCC plan is lacking
- Grievance redressal mechanisms yet to be established & where available, their effectiveness is limited

TOR 1 : Service Delivery- Recommendations

- Adequate number of evenly distributed facilities need to be strengthened as delivery points/ functional facilities to improve access, equity and affordability
- Inputs – especially infrastructure, training, human resources, funds and supplies to facilities be made responsive to case loads
- Implement MSG decision on Untied Funds- Inter-facility allocation responsive to case loads and usage at facility level
- Address persistent gaps of Specialists and blood banks/ Blood Storage Centres to operationalize adequate number of evenly spread FRUs
- Responsive & Effective grievance redressal mechanisms to be put in place including Toll free Helplines and NGO run Help desks
- Strengthen Performance assessment for improved efficiencies e.g. monitor service delivery such as OPD, lab tests, X-rays per month, referrals etc. for MMUs, Use MMUs for IEC/ BCC

TOR 1 : Service Delivery- Recommendations

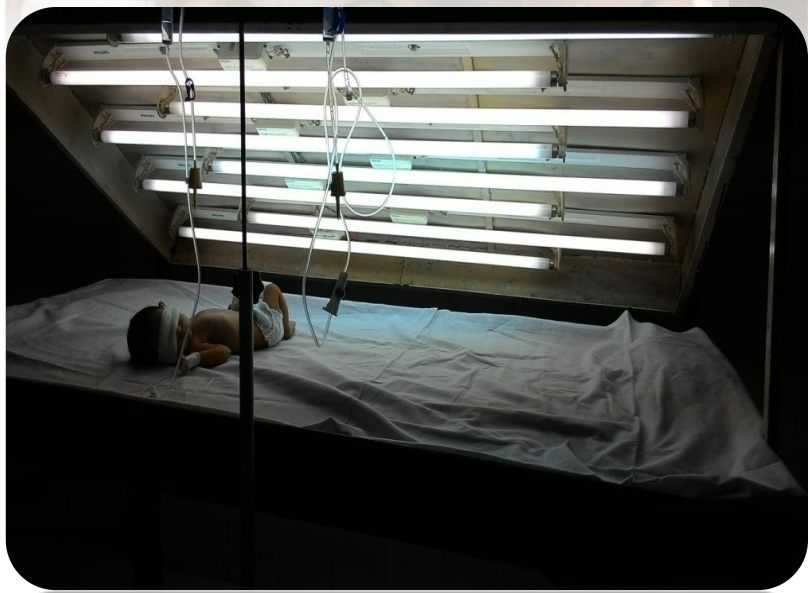
- DHAPs to clearly specify functional public facilities where emergency services would be made available - to match the growing presence of Dial 108 ERS
- Referral transport- Integrate Dial 102 & Dial 108 services and other empanelled services like Janani
  - Ensure call centre based referral transport and GPS fitted ambulances
  - Monitor performance on key parameters such as
    - ❑ Operational cost per month per ambulance
    - ❑ Km travelled (availed) per ambulance per day
    - ❑ no. of trips per ambulance per day
    - ❑ emergency rescues per month per ambulance
    - ❑ No. and % of cases where patient could not be attended at the first health facility destination
    - ❑ % of calls not attended

TOR 2 : RMNCH +A- Encouraging Findings

- Essential commodities as per the RMNCH+A matrix available at majority of the visited states
- JSSK operational in all states, resulting in considerable reduction of OOP
- Increasing trend of institutional deliveries
- Significant increase in the establishment of Facility Based Newborn Care Services throughout the country
- RBSK rolled in most of the States and teams are in place
- Fixed day service approach for sterilization in place in most states, although only upto CHC level
- Adolescent Friendly Health Clinics (AFHCs) established but with low case load
- Home Based Newborn Care for post natal visit found to be satisfactory
- Maternal Death Review systems are in place except Bihar

TOR 2 : RMNCH +A- Areas of Concern

- Follow up of infants discharged from SNCU/NBSUs and referral linkages weak
- Sub-optimal utilization of Nutritional Rehabilitations Centres except Telangana, MP and Tamil Nadu
- PPIUCD services yet to gain momentum
- OOPE under JSSK still persists especially on drugs, diet & Transport in majority of states
- JSSK- benefits of entitlements for sick infants still to be realized;
- Line listing of severely anaemic pregnant women and use of MCTS to track service delivery poor.
- Quality of care esp. ANC care in terms of Hb estimation, BP measurement, abdominal examination, urine albumin unsatisfactory



TOR 2 : RMNCH +A-Recommendations

- Focus on Quality of care especially in ANC services
- Prioritize identification of high risk pregnant women and line listing of anemic women and their pro-active follow up
- Strategic and meticulous planning needed for strengthening primary and secondary level care newborn services
  - FBNC- focus on quality, adherence to protocols, building capacities through partnerships with medical colleges etc.
  - Referral link between home based and facility based newborn care needs strengthening
  - Capture all maternal and child deaths, Child Death Review must be initiated for evidence based corrective actions
- Speed up implementation of DEICs under RBSK; make birth screening and school level screening more comprehensive with good two-way referral systems,
- Focus on quality of trainings under RBSK
- Logistics and supply of IFA Tablets under NIPI to be strengthened
- Counseling skills of RMNCH+A/FP/Adolescent/ICTC counselors to be enhanced and multi-skilled
- Establish MTP services in all 24X7 facilities in time-bound manner
- Focused expansion of PPIUCD services to all delivery points

TOR 3 : Disease Control Programs – Key Observations

- Malaria showing a declining trend in a number of states
- States like Kerala and Punjab need to strengthen active and passive surveillance and work towards elimination of Malaria
- In RNTCP, most of the states are showing satisfactory performance
- Program Management of Drug Resistant TB (PMDT) well established with adequate service provisioning
- Good Nikshay Registration status seen in Tamil Nadu, Odisha, Uttar Pradesh, West Bengal, Chandigarh and Assam, but improved use of data needed.
- IDSP - Surveillance units established in all states/districts- improvement in reporting status,
- Leprosy - Bihar, Uttar Pradesh, Chandigarh, Chhattisgarh, Madhya Pradesh, Mizoram and Odisha need to pay more attention to programme aspects
- NPCB - implemented in all the visited states. School based eye screening programme reported from Kerala, Odisha, Tamil Nadu, Telangana and Uttarakhand.
- NPCDCS- well-functioning NCD clinics seen in Tamil Nadu and Kerala. Programme is still evolving in other states visited

TOR 3 : Disease Control Programs - Recommendations

- Need for better utilization of IDSP data.
- District health plans to spell out the continuity of care for Communicable Diseases and NCDs across facilities providing primary, secondary and tertiary levels of care to be organized.
- NVBDCP-IEC/BCC for engagement with migrant population
  - vacant posts to be filled on priority basis
  - Reorientation/training to LTs/MPWs/ASHA etc
- RNTCP: improving collaboration and engagement with private providers for TB notification
  - NIKSHAY data entry to be done at every PHC through Pharmacist /DEO /any staff available
- Plan for establishment of primary care for NCDs- both screening and follow up on doctor/specialist initiated drugs; access to drugs at PHC level

TOR 4 : Human Resources Encouraging Findings

- Innovative measures to streamline recruitment adopted by some states (e.g. web-enabled procedures, decentralized recruitments and direct walk-in interviews)
- Absorption of contractual staff into the regular cadre initiated in a couple of states, e.g. Tamil Nadu and Rajasthan
- Implementation of online Human Resource Management Information System (HRMIS) initiated by some states, but needs strengthening across all states
- Couple of states have set up skill labs and introduced baseline skill assessment tests
- States like Bihar, Rajasthan, Mizoram and Chandigarh have implemented Clinical Establishment Act. Orissa, Tamil Nadu are in the process

TOR 4 : Human Resources -Areas of Concern

- Vacancies of HR particularly specialists remain a critical issue
- Performance Monitoring of facilities and regular/ contractual HR poor
- Training plans in place but implementation slow with little district level involvement in training need assessment
- Initial steps to introduce performance appraisal systems in a few states - yet to be linked to performance based incentives and salary increments

TOR 4 : Human Resources -Recommendations

- Develop a comprehensive State HR policy with emphasis on recruitment procedures, robust retention strategies and rational deployment of human resources
- Establish and strengthen HR cells to streamline HR management
- Strengthen training and develop systems of supportive supervision for skill based activities
- Develop a transparent policy for postings and transfers to ensure equitable availability in remote, rural and underserved areas
- Service Rules, particularly in relation to specialists, need to be aligned to HR need- Facility Wise positions of specialists to be created which could be filled up by them only either through regular or contractual employees.
- Separate cadres for clinical specialists and public health professionals with dedicated career progression pathways
- More seats for government doctors in medical colleges particularly in those disciplines where greater shortage of specialists exists.

TOR 4 : Human Resources Recommendations

- Policy for retention and motivation of staff - Higher/differential payments for hard and remote areas particularly for specialists that are in short supply.
- Use NHM for topping up remuneration of regular specialists in hard areas
- Establish and strengthen Human Resource Management Information Systems (HRMIS) for robust HR management, training needs assessment, performance management, promotions, postings and transfers
- Link HRH database/ HRIS to facility HMIS to facilitate rational deployment
- Ensure quality in recruitment through rigorous selection, competency assessment and decent remuneration
- Establish/ improve performance appraisal systems with good contracts design for performance measurement.
- Institute Standard Treatment Guidelines (STG) and base assessment of training needs, training plans and performance on the STGs.
- Develop training capacity in high focus states by revitalization of existing institutions and leveraging of partnerships with other state level institutes specially medical colleges and schools of public health for training, technical support and mentoring

TOR 5 : Community processes- Encouraging Findings

- ASHA recognised as 'The most prominent face' and backbone of the community based interventions under NHM
- Pace of training increased in UP and Rajasthan but loss of momentum noted in MP and Bihar because of trainer attrition
- ASHA's role in disease control programmes especially malaria and leprosy also appreciated in West Bengal, Odisha, and Tamil Nadu.
- Average incentive in the range of Rs. 1500-2000 pm through electronic transfer or direct bank transfer.
- Social security measures implemented in Chhattisgarh, Assam and Odisha.
- Chhattisgarh, Madhya Pradesh and Odisha also support ASHA admission in ANM courses
- In Kerala ASHAs play a key role in Palliative Care (under leadership of Gram Panchayat Nurse) and NCDs. Kerala's initiatives on Palliative Care and Mental Health, are integrated with the PRI.

TOR 5 : Community processes- Areas of Concern

- Delays in selection of ASHAs against the targets noted in UP, Rajasthan, Bihar, WB and Mizoram
- ASHA- Mechanisms of payment, drug logistics, supportive supervision and performance assessment remain a challenge.
- Low level of HBNC skills in states of MP, WB, and Bihar -delay in provision of HBNC kit observed.
- Restructuring of VHSNCs as per the new GOI guidelines reported only in UK, Punjab and Rajasthan
- Training of VHSNC members in many states except Odisha and Chhattisgarh continue to be adhoc affecting VHSNC functionality
- No specific mechanisms for monitoring of VHNDs seen in most states except WB and MP
- Convergence seen only at the level of FLWs in most states while inter department convergence continue to be a challenge at block/district level

TOR 5 : Community processes - Recommendations

- States to prioritize the selection of ASHA and household allocation to ensure full population coverage
- Weak skills and poor performance highlight need to improve training quality, post training assessments, refresher trainings, and ongoing field level mentoring - need for continuous refresher training even where “training is completed”
- Adhoc training systems to be replaced by institutionalized mechanisms for ongoing training - certification process provides an opportunity for states to initiate this process
- NIOS certification of ASHAs and Creating career opportunities by supporting participation in nurse education programmes.
- ASHAs and ASHA facilitators to be sensitized to reach the most marginalised and vulnerable.
- Build and strengthen the support structures to create a viable structure
  - Support staff at all levels to be sensitized to their roles, and provided with support by their district counterparts.
  - In non high focus states, existing staff need to be strengthened to undertake this additional task through training and monetary/non monetary incentives.

TOR 5 : Community processes - Recommendations

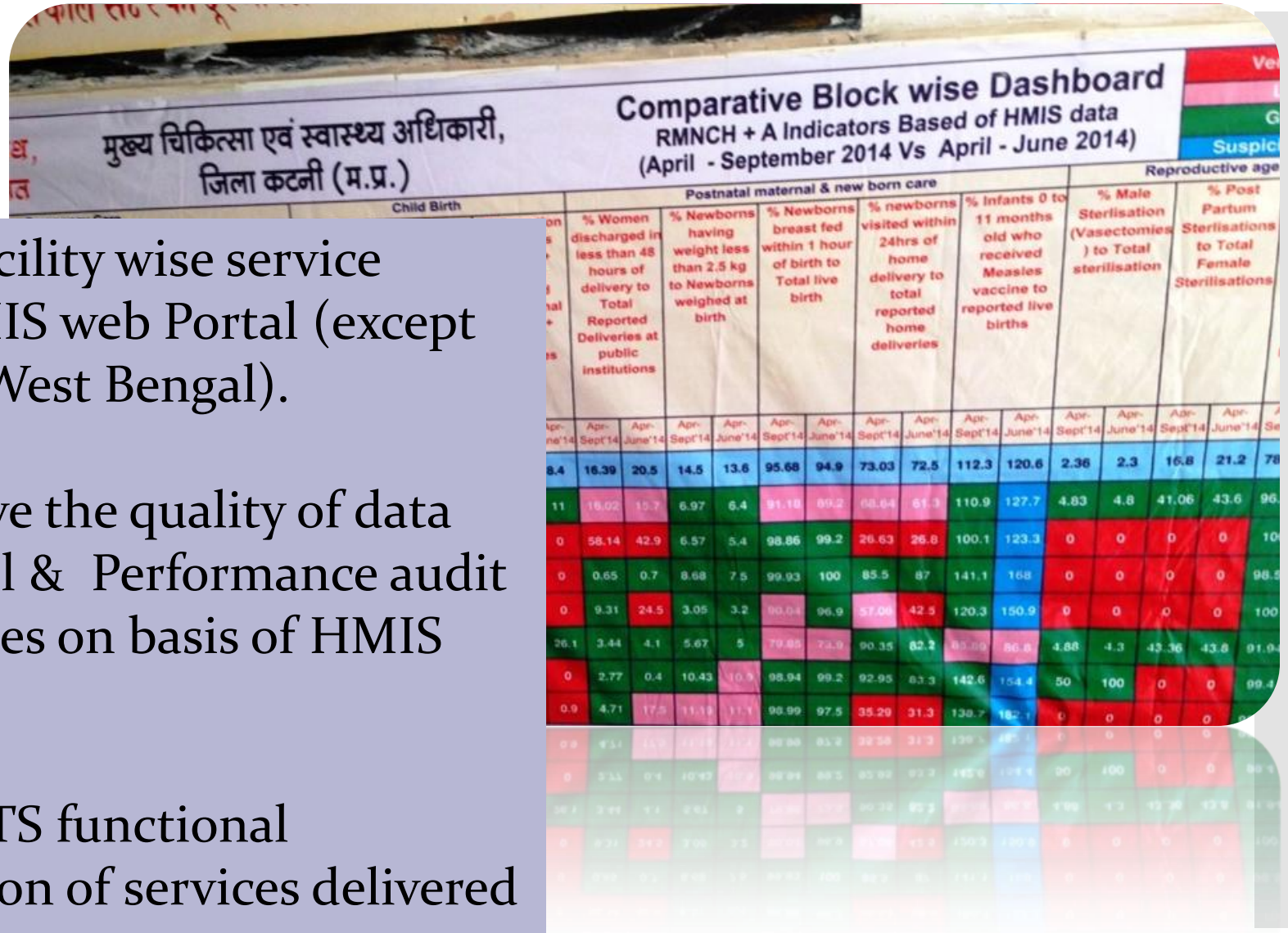
- States must ensure provision of kits, drugs and communication material to ASHAs
- In non high focus states like Kerala and Tamil Nadu where ASHA is an underused human resource, states must plan to engage ASHA in chronic diseases and palliative care linked to certification in a set of relevant skills
- Engaging representatives of Panchayati Raj institutions in health committees at various levels needs action by the Departments of Health and Rural Development/PRI.
- Building capacity of VHSNC requires support from NGOs and other training institutions
- ASHA support structures to support VHSNCs to:
  - monitor and facilitate access to all health and health related public services
  - organize local collective action for health promotion
  - Undertake community monitoring of health care facilities
  - Ensure convergence

TOR 6 - Information and knowledge - Encouraging Findings

- All the states visited report facility wise service delivery information into HMIS web Portal (except for Tamil Nadu and Kolkata-West Bengal).

- As observed, efforts to improve the quality of data uploaded in HMIS Web Portal & Performance audit of the districts and the facilities on basis of HMIS data are underway .

- Efforts by States to make MCTS functional appreciable. Real time updation of services delivered via USSD gateway in process.



TOR 6 - Information and knowledge -Areas of Concern

- Major issues - number of reporting formats and ambiguity in the reporting formats maintained at the facilities especially in case of secondary and tertiary care settings having high footfalls.
- GoI has introduced Integrated Village wise RCH registers. However, ANMs have not been properly trained to use these.
- Errors in manual compilation of the data by the ANM/frontline health worker and Multiple IT application for reporting with minimal or no interoperability
- Use of data by the states to close the gap in service delivery still poor.
- Contribution from the private facilities and medical colleges in HMIS minimal.

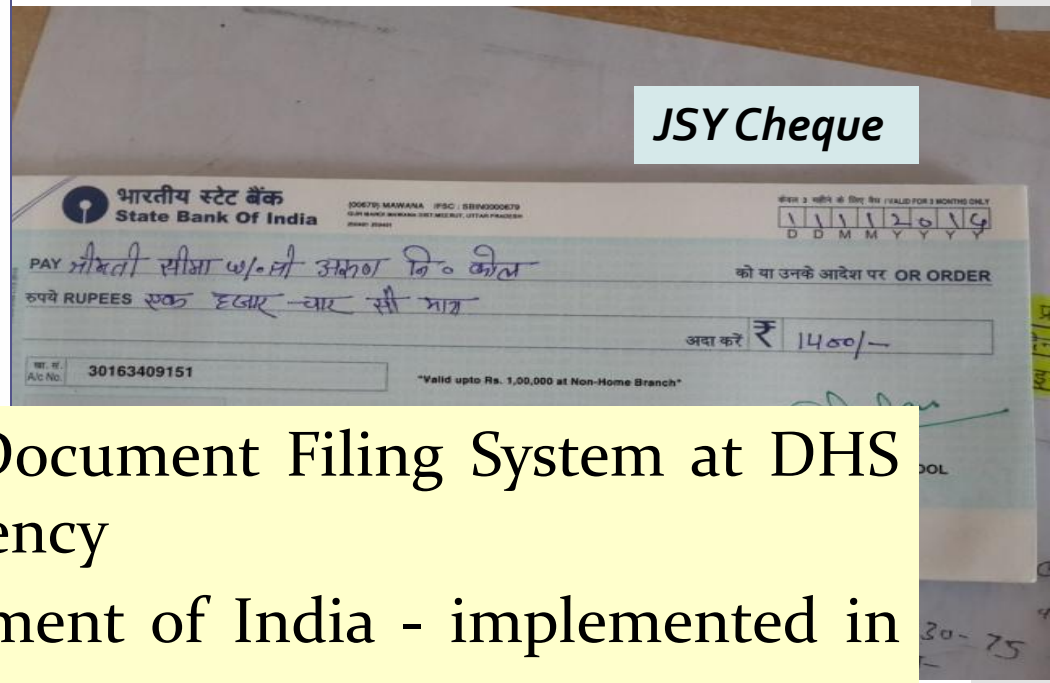
TOR 6 - Information and knowledge - Recommendations

- Integration of HMIS and MCTS essential.
- Information sources related to non-communicable diseases, communicable diseases and cause of death reporting to be strengthened.
- Various Health IT systems to accommodate local data requirements - all functioning in silos and should be integrated and made interoperable.
- Data collection and recording formats to be standardized following basic semantic standards to provide quality input in all reporting systems.
- Skype based video conferencing being set up in Adilabad district of Telangana to follow up with Service delivery and reporting at the facility (PHCs) – may be scaled up
- Clear set of guidelines on institutional framework for effective functioning of SHSRCs and SIHFWs to be set up.
- USE MCTS+ Integrate information systems e.g. MCTS should be used for civil birth registration plus birth certificates within 24 hours of birth, by WCD for monitoring nutrition status child-wise and delivery of services to target group, also School education
- Use MCTS not only for tracking delivery of services , but also IEC/ BCC, monitoring services, proactively identifying high risk pregnancies and children

TOR 7 Health Care Financing: Encouraging Findings

No. G-27017/21/2010-NRHM (F)
Government of India
Ministry of Health & Family Welfare

Sub: Guidelines regarding integration of State and District Health Societies- Opening of a Group Bank account linked to the sub-



- Digitalized office procedures through Digital Document Filing System at DHS has enhanced financial and administrative efficiency
- New banking guidelines issued by the Government of India - implemented in most of the states
- Most States accounted for and utilized interest earned on unspent balances as per guidelines of GOI.
- Maintenance of the records of book of accounts under NHM guidelines satisfactory

TOR 7 Health Care Financing- Areas of Concern

- Key posts of the Director still vacant in Bihar, Chhattisgarh, Kerala and Uttrakhand.
- Vacant Positions and insufficiently trained staff adversely affect the financial management
- Delays observed in transfer of funds from SHS to DHS
- Underutilization of funds found in several states
- Some states not submitting the Statutory Audit and Concurrent Audit Report on time, delay is caused due to late appointment of the Auditor.
- In most of the states, physical progress is not captured in the Financial Monitoring Report (FMR) along with financial progress.

TOR 7 Health Care Financing- Recommendations

- Shortage of Human Resources and their appropriate training for financial management and accounting at the state and district level to be addressed on priority basis.
  - Create more regular posts in the area of financial management, as consistent with a long term strategy.
  - Ensure regular annual training of about one week to all those at state, district and block level in charge of accounting and financial management functions
  - Ensure access to guidelines at the periphery to enable shared understanding of programmes
  - Establish a regular schedule of supportive supervisory visits by directorate and program management staff using checklists and follow up action plans
- State to due importance to the PFMS and use the same for tracking of availability and underutilization of funds at each level.
- States to submit timely the Statutory Audit Report and Selection of Blocks/Facilities for Concurrent Audit to be on rational basis.
- Health facilities below district to report physical as well as financial progress on monthly basis.
- As the public health care system is moving towards achieving universal health coverage, the state governments should plan to wave off user charges for all those attending public facilities.

TOR 8 Quality Assurance- Key Observations

- States taking initiatives in implementation of NHM QA operational guidelines
- States need to formulate Road-map for Quality Assurance and identify Number and type of facilities.(Punjab, Chandigarh, Assam, Uttarakhand, Chhattisgarh, Mizoram, Telangana, & Rajasthan as well as Tamil Nadu have not yet identified the facilities they will be taking up for certification under the NQAS)
- Reconstitution of State as well as District Quality Assurance Committees not initiated in many states.
- States like Punjab, Uttarakhand, Chhattisgarh, Rajasthan, Mizoram, and Telangana, Chandigarh, Tamil Nadu, and Madhya Pradesh- yet to streamline the 5 types of trainings recommended in the Operational Guidelines
- Proper Management of Bio Medical Waste - a Concern in many states
- Hygiene and Sanitation – an area which needs attention in all states.
- States like Punjab, Chandigarh, Assam, Uttrakhand, Chattisgarh, Mizoram, Telangana & Rajasthan as well as Tamil Nadu -not yet identified the facilities for certification under the NQAS

TOR 8 Quality Assurance- Recommendations

- Quality Assurance, facility wise performance audit and supportive supervision must be taken as a priority.
  - Implementation of BMW management to be linked to the planning and practice of comprehensive infection prevention plans.
  - Public/ Patient to be central. Seek and value their feedback on services
- Trainings (Internal Assessor, Service Provider, Awareness Training, External Assessor as well as Thematic Trainings to be streamlined and conducted by states
- States to accelerate the implementation of QA activities in time-bound manner. Currently most of the activities are in the planning phase
- Road map for improving quality assurance services need to be developed through a participatory approach with due handholding of the districts
- Reconstitution of state and district quality assurance committees to be done on priority basis.

TOR 9 - Drugs, Diagnostics and Procurement & Supply Chain Management

- Tamilnadu and Rajasthan have robust system of Procurement, storage and distribution. Other states gradually catching up.
- **KEY AREAS OF CONCERN:**
  - Multiple channels of procurement,
  - States' share for drugs quite low as compared to NHM.
  - Non availability of essential drugs at facilities-Frequent stock outs and also expired drugs.
  - Lack of availability/adherence to STG and EDL. Prescription by Brand names, No Prescription Audits.
  - Poor Quality Control mechanism for Drugs.
  - Lack of scientific storage (Warehouses) and distribution system.
  - No Drug & Therapeutic Committees at State/District/Facility level. No reporting and analysis of Adverse Drug Reaction.
  - IT based solutions (Software) either not developed or Non-functional or not meeting the requirements of the state with real time tracking.
  - Several districts are without single US facility.

TOR 9 - Recommendations

- Free Drugs & Diagnostics - clear articulation of a policy for free essential drugs and diagnostics, wherein at least the conditions listed in the assured primary health care services are provided free of cost.
  - Robust procurement systems, IT backed supply chain management systems, quality assurance mechanisms, STGs, sensitization of doctors and prescription audits e.g. TNMSC, RSMC
  - Formulation of Differential Essential Drug List-customized and updated
  - Procurement through transparent process (preferably e-tendering)
  - Warehouses at strategic locations and as per norms
  - Ensure free diagnostic services
  - Examine and build capacity for procuring, installing and maintaining bio-medical equipment – Follow GoI guidelines on Biomedical Equipment Maintenance .
  - Report on Adverse Drug Reactions and Patient counseling
- Establishment of an autonomous centralized procurement agency in large states

TOR 10- National Urban Health Mission – Key Observations

- Most states are in the preparatory phase, as they received budgets for the first year and utilization of funds is ineffective.
- Pace of implementation is better in state of Kerala, while it is at a slow pace in states such as UP, Chhattisgarh, Bihar and Uttaranchal
- Planning & mapping of slums and other areas in the cities completed in states like Kerala and Odisha; in process in many other CRM states.
- Facilities mapping done in Punjab, Rajasthan, MP, Chandigarh, Uttaranchal, Odisha ; in process in other states such as Mizoram.
- In many states, service delivery structures of UPHCs created, along with the strengthening of the existing structures in the earmarked/ identified cities.
- Recruitment of Medical Officers, Staff Nurses, and ANM s underway in most CRM states.
- Involvement of the urban local bodies (ULBs) in the implementation of the program initiated in varying degrees across states - to a greater extent in Kerala and Odisha and less in Chhattisgarh, Bihar, and Telangana etc.

TOR 10- NUHM - Recommendations

- Ensure existing urban health care infrastructure and systems are seamlessly integrated with those that are being introduced with NUHM funding, and strengthen them in terms of comprehensive, need-based coverage of services, delivery, staff/HR, drugs and equipment
- Roll out of components and activities of NUHM need to be expedited and strengthened in all CRM states.
- States should leverage the flexibility in NUHM for implementing customized services through innovations, PPPs and collaborations with local stakeholders.
- In many states service delivery (outreach services) is required to be strengthened.
- Recruitment of staff to the management units at the state, districts and service delivery facilities including ASHAs, on the basis of the situation assessment and gap analysis, needs to be fulfilled in many states.
- Convergence mechanisms with all related departments are required to be in place in all states, except in Kerala, which is in a better position.
- Orientation and involvement of Urban Local Bodies (ULBs) activity needs a push in all states.
- States are required to organize capacity building of recruited staff to enable them to carry out program activities.

TOR 11 - Governance and Management

- States like Bihar, Rajasthan, Mizoram and Chandigarh implement CEA. Orissa, Tamil Nadu in process
- Structures for monitoring and supervision weak in many states.
- Communities not fully aware of the NHM facilities/services being provided, hence not in a position to demand services.
- Programme Management Units functional at different levels, but many of the sanctioned positions are lying vacant.
- RKS constituted in several states although not all are active.
- Mechanisms for social audit such as Jansamvad, public meetings at villages and accountability measures for health need to be expanded


Thank You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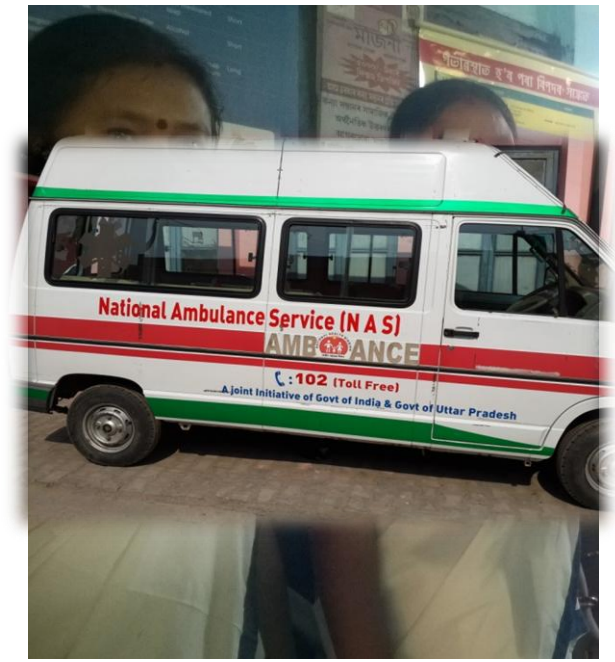
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