

8TH COMMON REVIEW MISSION

JS (Policy)



"ESSENTIAL DRUG LIST"			
Sl. No.	Generic Name	Sl. No.	Generic Name
1	Aspirin 100 mg	73	Amoxicillin 250 mg
2	Paracetamol 500 mg	74	Amoxicillin 500 mg
3	Metformin 500 mg	75	Amoxicillin 875 mg
4	Insulin 100 units	76	Amoxicillin 1250 mg
5	Insulin 500 units	77	Amoxicillin 1500 mg
6	Insulin 1000 units	78	Amoxicillin 2000 mg
7	Insulin 1500 units	79	Amoxicillin 2500 mg
8	Insulin 2000 units	80	Amoxicillin 3000 mg
9	Insulin 2500 units	81	Amoxicillin 3500 mg
10	Insulin 3000 units	82	Amoxicillin 4000 mg
11	Insulin 3500 units	83	Amoxicillin 4500 mg
12	Insulin 4000 units	84	Amoxicillin 5000 mg
13	Insulin 4500 units	85	Amoxicillin 5500 mg
14	Insulin 5000 units	86	Amoxicillin 6000 mg
15	Insulin 5500 units	87	Amoxicillin 6500 mg
16	Insulin 6000 units	88	Amoxicillin 7000 mg
17	Insulin 6500 units	89	Amoxicillin 7500 mg
18	Insulin 7000 units	90	Amoxicillin 8000 mg
19	Insulin 7500 units	91	Amoxicillin 8500 mg
20	Insulin 8000 units	92	Amoxicillin 9000 mg
21	Insulin 8500 units	93	Amoxicillin 9500 mg
22	Insulin 9000 units	94	Amoxicillin 10000 mg
23	Insulin 9500 units	95	Amoxicillin 10500 mg
24	Insulin 10000 units	96	Amoxicillin 11000 mg
25	Insulin 10500 units	97	Amoxicillin 11500 mg
26	Insulin 11000 units	98	Amoxicillin 12000 mg
27	Insulin 11500 units	99	Amoxicillin 12500 mg
28	Insulin 12000 units	100	Amoxicillin 13000 mg
29	Insulin 12500 units	101	Amoxicillin 13500 mg
30	Insulin 13000 units	102	Amoxicillin 14000 mg
31	Insulin 13500 units	103	Amoxicillin 14500 mg
32	Insulin 14000 units	104	Amoxicillin 15000 mg
33	Insulin 14500 units	105	Amoxicillin 15500 mg
34	Insulin 15000 units	106	Amoxicillin 16000 mg
35	Insulin 15500 units	107	Amoxicillin 16500 mg
36	Insulin 16000 units	108	Amoxicillin 17000 mg
37	Insulin 16500 units	109	Amoxicillin 17500 mg
38	Insulin 17000 units	110	Amoxicillin 18000 mg
39	Insulin 17500 units	111	Amoxicillin 18500 mg
40	Insulin 18000 units	112	Amoxicillin 19000 mg
41	Insulin 18500 units	113	Amoxicillin 19500 mg
42	Insulin 19000 units	114	Amoxicillin 20000 mg
43	Insulin 19500 units	115	Amoxicillin 20500 mg
44	Insulin 20000 units	116	Amoxicillin 21000 mg
45	Insulin 20500 units	117	Amoxicillin 21500 mg
46	Insulin 21000 units	118	Amoxicillin 22000 mg
47	Insulin 21500 units	119	Amoxicillin 22500 mg
48	Insulin 22000 units	120	Amoxicillin 23000 mg
49	Insulin 22500 units	121	Amoxicillin 23500 mg
50	Insulin 23000 units	122	Amoxicillin 24000 mg
51	Insulin 23500 units	123	Amoxicillin 24500 mg
52	Insulin 24000 units	124	Amoxicillin 25000 mg
53	Insulin 24500 units	125	Amoxicillin 25500 mg
54	Insulin 25000 units	126	Amoxicillin 26000 mg
55	Insulin 25500 units	127	Amoxicillin 26500 mg
56	Insulin 26000 units	128	Amoxicillin 27000 mg
57	Insulin 26500 units	129	Amoxicillin 27500 mg
58	Insulin 27000 units	130	Amoxicillin 28000 mg
59	Insulin 27500 units	131	Amoxicillin 28500 mg
60	Insulin 28000 units	132	Amoxicillin 29000 mg
61	Insulin 28500 units	133	Amoxicillin 29500 mg
62	Insulin 29000 units	134	Amoxicillin 30000 mg
63	Insulin 29500 units	135	Amoxicillin 30500 mg
64	Insulin 30000 units	136	Amoxicillin 31000 mg
65	Insulin 30500 units	137	Amoxicillin 31500 mg
66	Insulin 31000 units	138	Amoxicillin 32000 mg
67	Insulin 31500 units	139	Amoxicillin 32500 mg
68	Insulin 32000 units	140	Amoxicillin 33000 mg
69	Insulin 32500 units	141	Amoxicillin 33500 mg
70	Insulin 33000 units	142	Amoxicillin 34000 mg
71	Insulin 33500 units	143	Amoxicillin 34500 mg
72	Insulin 34000 units	144	Amoxicillin 35000 mg
73	Insulin 34500 units	145	Amoxicillin 35500 mg
74	Insulin 35000 units	146	Amoxicillin 36000 mg
75	Insulin 35500 units	147	Amoxicillin 36500 mg
76	Insulin 36000 units	148	Amoxicillin 37000 mg
77	Insulin 36500 units	149	Amoxicillin 37500 mg
78	Insulin 37000 units	150	Amoxicillin 38000 mg
79	Insulin 37500 units	151	Amoxicillin 38500 mg
80	Insulin 38000 units	152	Amoxicillin 39000 mg
81	Insulin 38500 units	153	Amoxicillin 39500 mg
82	Insulin 39000 units	154	Amoxicillin 40000 mg
83	Insulin 39500 units	155	Amoxicillin 40500 mg
84	Insulin 40000 units	156	Amoxicillin 41000 mg
85	Insulin 40500 units	157	Amoxicillin 41500 mg
86	Insulin 41000 units	158	Amoxicillin 42000 mg
87	Insulin 41500 units	159	Amoxicillin 42500 mg
88	Insulin 42000 units	160	Amoxicillin 43000 mg
89	Insulin 42500 units	161	Amoxicillin 43500 mg
90	Insulin 43000 units	162	Amoxicillin 44000 mg
91	Insulin 43500 units	163	Amoxicillin 44500 mg
92	Insulin 44000 units	164	Amoxicillin 45000 mg
93	Insulin 44500 units	165	Amoxicillin 45500 mg
94	Insulin 45000 units	166	Amoxicillin 46000 mg
95	Insulin 45500 units	167	Amoxicillin 46500 mg
96	Insulin 46000 units	168	Amoxicillin 47000 mg
97	Insulin 46500 units	169	Amoxicillin 47500 mg
98	Insulin 47000 units	170	Amoxicillin 48000 mg
99	Insulin 47500 units	171	Amoxicillin 48500 mg
100	Insulin 48000 units	172	Amoxicillin 49000 mg
101	Insulin 48500 units	173	Amoxicillin 49500 mg
102	Insulin 49000 units	174	Amoxicillin 50000 mg
103	Insulin 49500 units	175	Amoxicillin 50500 mg
104	Insulin 50000 units	176	Amoxicillin 51000 mg
105	Insulin 50500 units	177	Amoxicillin 51500 mg
106	Insulin 51000 units	178	Amoxicillin 52000 mg
107	Insulin 51500 units	179	Amoxicillin 52500 mg
108	Insulin 52000 units	180	Amoxicillin 53000 mg
109	Insulin 52500 units	181	Amoxicillin 53500 mg
110	Insulin 53000 units	182	Amoxicillin 54000 mg
111	Insulin 53500 units	183	Amoxicillin 54500 mg
112	Insulin 54000 units	184	Amoxicillin 55000 mg
113	Insulin 54500 units	185	Amoxicillin 55500 mg
114	Insulin 55000 units	186	Amoxicillin 56000 mg
115	Insulin 55500 units	187	Amoxicillin 56500 mg
116	Insulin 56000 units	188	Amoxicillin 57000 mg
117	Insulin 56500 units	189	Amoxicillin 57500 mg
118	Insulin 57000 units	190	Amoxicillin 58000 mg
119	Insulin 57500 units	191	Amoxicillin 58500 mg
120	Insulin 58000 units	192	Amoxicillin 59000 mg
121	Insulin 58500 units	193	Amoxicillin 59500 mg
122	Insulin 59000 units	194	Amoxicillin 60000 mg
123	Insulin 59500 units	195	Amoxicillin 60500 mg
124	Insulin 60000 units	196	Amoxicillin 61000 mg
125	Insulin 60500 units	197	Amoxicillin 61500 mg
126	Insulin 61000 units	198	Amoxicillin 62000 mg
127	Insulin 61500 units	199	Amoxicillin 62500 mg
128	Insulin 62000 units	200	Amoxicillin 63000 mg
129	Insulin 62500 units	201	Amoxicillin 63500 mg
130	Insulin 63000 units	202	Amoxicillin 64000 mg
131	Insulin 63500 units	203	Amoxicillin 64500 mg
132	Insulin 64000 units	204	Amoxicillin 65000 mg
133	Insulin 64500 units	205	Amoxicillin 65500 mg
134	Insulin 65000 units	206	Amoxicillin 66000 mg
135	Insulin 65500 units	207	Amoxicillin 66500 mg
136	Insulin 66000 units	208	Amoxicillin 67000 mg
137	Insulin 66500 units	209	Amoxicillin 67500 mg
138	Insulin 67000 units	210	Amoxicillin 68000 mg
139	Insulin 67500 units	211	Amoxicillin 68500 mg
140	Insulin 68000 units	212	Amoxicillin 69000 mg
141	Insulin 68500 units	213	Amoxicillin 69500 mg
142	Insulin 69000 units	214	Amoxicillin 70000 mg
143	Insulin 69500 units	215	Amoxicillin 70500 mg
144	Insulin 70000 units	216	Amoxicillin 71000 mg
145	Insulin 70500 units	217	Amoxicillin 71500 mg
146	Insulin 71000 units	218	Amoxicillin 72000 mg
147	Insulin 71500 units	219	Amoxicillin 72500 mg
148	Insulin 72000 units	220	Amoxicillin 73000 mg
149	Insulin 72500 units	221	Amoxicillin 73500 mg
150	Insulin 73000 units	222	Amoxicillin 74000 mg
151	Insulin 73500 units	223	Amoxicillin 74500 mg
152	Insulin 74000 units	224	Amoxicillin 75000 mg
153	Insulin 74500 units	225	Amoxicillin 75500 mg
154	Insulin 75000 units	226	Amoxicillin 76000 mg
155	Insulin 75500 units	227	Amoxicillin 76500 mg
156	Insulin 76000 units	228	Amoxicillin 77000 mg
157	Insulin 76500 units	229	Amoxicillin 77500 mg
158	Insulin 77000 units	230	Amoxicillin 78000 mg
159	Insulin 77500 units	231	Amoxicillin 78500 mg
160	Insulin 78000 units	232	Amoxicillin 79000 mg
161	Insulin 78500 units	233	Amoxicillin 79500 mg
162	Insulin 79000 units	234	Amoxicillin 80000 mg
163	Insulin 79500 units	235	Amoxicillin 80500 mg
164	Insulin 80000 units	236	Amoxicillin 81000 mg
165	Insulin 80500 units	237	Amoxicillin 81500 mg
166	Insulin 81000 units	238	Amoxicillin 82000 mg
167	Insulin 81500 units	239	Amoxicillin 82500 mg
168	Insulin 82000 units	240	Amoxicillin 83000 mg
169	Insulin 82500 units	241	Amoxicillin 83500 mg
170	Insulin 83000 units	242	Amoxicillin 84000 mg
171	Insulin 83500 units	243	Amoxicillin 84500 mg
172	Insulin 84000 units	244	Amoxicillin 85000 mg
173	Insulin 84500 units	245	Amoxicillin 85500 mg
174	Insulin 85000 units	246	Amoxicillin 86000 mg
175	Insulin 85500 units	247	Amoxicillin 86500 mg
176	Insulin 86000 units	248	Amoxicillin 87000 mg
177	Insulin 86500 units	249	Amoxicillin 87500 mg
178	Insulin 87000 units	250	Amoxicillin 88000 mg
179	Insulin 87500 units	251	Amoxicillin 88500 mg
180	Insulin 88000 units	252	Amoxicillin 89000 mg
181	Insulin 88500 units	253	Amoxicillin 89500 mg
182	Insulin 89000 units	254	Amoxicillin 90000 mg
183	Insulin 89500 units	255	Amoxicillin 90500 mg
184	Insulin 90000 units	256	Amoxicillin 91000 mg
185	Insulin 90500 units	257	Amoxicillin 91500 mg
186	Insulin 91000 units	258	Amoxicillin 92000 mg
187	Insulin 91500 units	259	Amoxicillin 92500 mg
188	Insulin 92000 units	260	Amoxicillin 93000 mg
189	Insulin 92500 units	261	Amoxicillin 93500 mg
190	Insulin 93000 units	262	Amoxicillin 94000 mg
191	Insulin 93500 units	263	Amoxicillin 94500 mg
192	Insulin 94000 units	264	Amoxicillin 95000 mg
193	Insulin 94500 units	265	Amoxicillin 95500 mg
194	Insulin 95000 units	266	Amoxicillin 96000 mg
195	Insulin 95500 units	267	Amoxicillin 96500 mg
196	Insulin 96000 units	268	Amoxicillin 97000 mg
197	Insulin 96500 units	269	Amoxicillin 97500 mg
198	Insulin 97000 units	270	Amoxicillin 98000 mg
199	Insulin 97500 units	271	Amoxicillin 98500 mg
200	Insulin 98000 units	272	Amoxicillin 99000 mg
201	Insulin 98500 units	273	Amoxicillin 99500 mg
202	Insulin 99000 units	274	Amoxicillin 100000 mg
203	Insulin 99500 units	275	Amoxicillin 100500 mg
204	Insulin 100000 units	276	Amoxicillin 101000 mg
205	Insulin 100500 units	277	Amoxicillin 101500 mg
206	Insulin 101000 units	278	Amoxicillin 102000 mg
207	Insulin 101500 units	279	Amoxicillin 102500 mg
208	Insulin 102000 units	280	Amoxicillin 103000 mg
209	Insulin 102500 units	281	Amoxicillin 103500 mg
210	Insulin 103000 units	282	Amoxicillin 104000 mg
211	Insulin 103500 units	283	Amoxicillin 104500 mg
212	Insulin 104000 units	284	Amoxicillin 105000 mg
213	Insulin 104500 units	285	Amoxicillin 105500 mg
214	Insulin 105000 units	286	Amoxicillin 106000 mg
215	Insulin 105500 units	287	Amoxicillin 106500 mg
216	Insulin 106000 units	288	Amoxicillin 107000 mg
217	Insulin 106500 units	289	Amoxicillin 107500 mg
218	Insulin 107000 units	290	Amoxicillin 108000 mg
219	Insulin 107500 units	291	Amoxicillin 108500 mg
220	Insulin 108000 units	292	Amoxicillin 109000 mg
221	Insulin 108500 units	293	Amoxicillin 109500 mg
222	Insulin 109000 units	294	Amoxicillin 110000 mg
223	Insulin 109500 units	295	Amoxicillin 110500 mg
224	Insulin 110000 units	296	Amoxicillin 111000 mg
225	Insulin 110500 units	297	Amoxicillin 111500 mg
226	Insulin 111000 units	298	Amoxicillin 112000 mg
227	Insulin 111500 units	299	Amoxicillin 112500 mg
228	Insulin 112000 units	300	Amoxicillin 113000 mg
229	Insulin 112500 units	301	Amoxicillin 113500 mg
230	Insulin 113000 units	302	Amoxicillin 114000 mg
231	Insulin 113500 units	303	Amoxicillin 114500 mg
232	Insulin 114000 units	304	Amoxicillin 115000 mg
233	Insulin 114500 units	305	Amoxicillin 115500 mg
234	Insulin 115000 units	306	Amoxicillin 116000 mg
235	Insulin 115500 units	307	Amoxicillin 116500 mg
236	Insulin 116000 units	308	Amoxicillin 117000 mg
237	Insulin 116500 units	309	Amoxicillin 117500 mg
238	Insulin 117000 units	310	Amoxicillin 118000 mg
239	Insulin 117500 units	311	Amoxicillin 118500 mg
240	Insulin 118000 units	312	Amoxicillin 119000 mg
241	Insulin 118500 units	313	Amoxicillin 119500 mg
242	Insulin 119000 units	314	Amoxicillin 120000 mg
243	Insulin 119500 units	315	Amoxicillin 120500 mg
244	Insulin 120000 units	316	Amoxicillin 121000 mg
245	Insulin 120500 units	317	Amoxicillin 121500 mg
246	Insulin 121000 units	318	Amoxicillin 122000 mg
247	Insulin 121500 units	319	Amoxicillin 122500 mg
248	Insulin 122000 units	320	Amoxicillin 123000 mg
249	Insulin 122500 units	321	Amoxicillin 123500 mg
250	Insulin 123000 units	322	Amoxicillin 124000 mg
251	Insulin 123500 units	323	Amoxicillin 124500 mg
252	Insulin 124000 units	324	Amoxicillin 125000 mg
253	Insulin 124500 units	325	Amoxicillin 125500 mg
254	Insulin		

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.

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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.

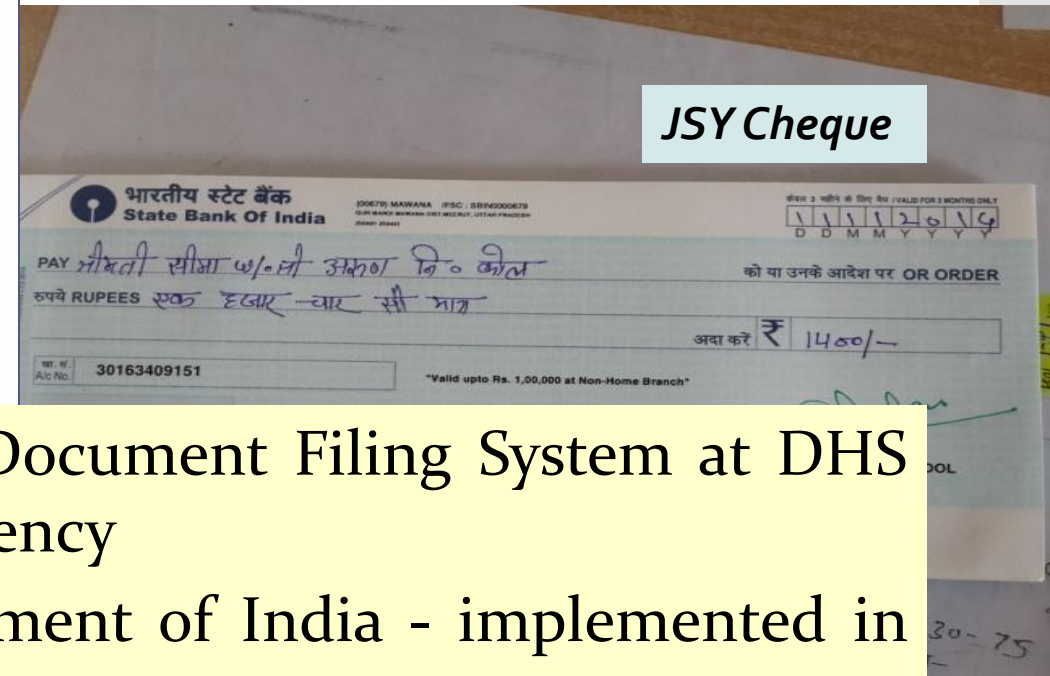
- Integration of HMIS and MCTS essential.
- Information sources related to non-communicable diseases, communicable diseases and cause of death reporting to be strengthened.
- Various Health IT systems to accommodate local data requirements - all functioning in silos and should be integrated and made 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

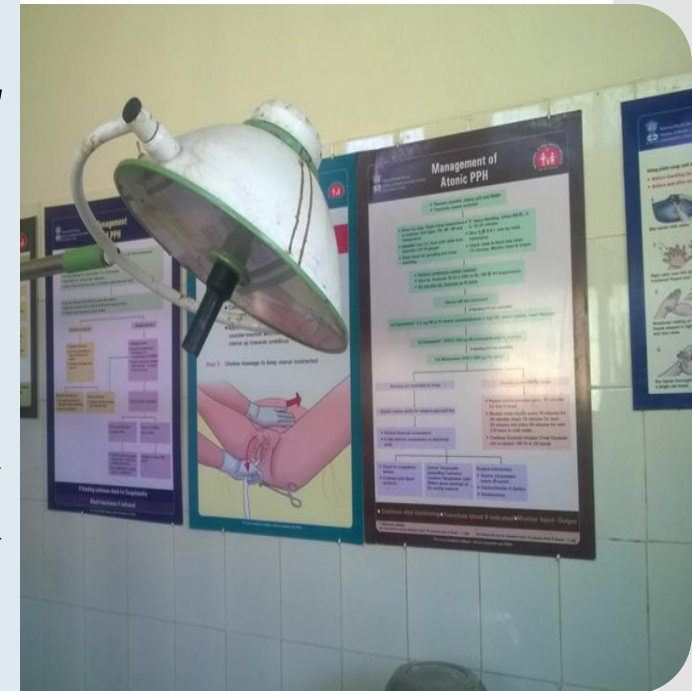
- Shortage of Human Resources and their appropriate training for financial management and accounting at the state and district level to be addressed on priority basis.
 - Create more regular posts in the area of financial management, as consistent with a long term strategy.
 - Ensure regular annual training 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, Uttarakhand, Chhattisgarh, 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



