

Executive Summary

Mid-Term Evaluation of National AYUSH Mission (NAM)

Submitted By

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EXECUTIVE SUMMARY

1. Introduction

Ministry of AYUSH (MoA), Government of India launched National AYUSH Mission (NAM) as a Centrally Sponsored Scheme in financial year 2014-15 for implementation through States/UTs. The basic objective of NAM is to promote AYUSH medical systems through cost effective AYUSH services, strengthen AYUSH educational systems and facilitate the enforcement of quality control of Ayurveda, Siddha, Unani & Homoeopathy (ASU&H) drugs and ensure sustainable availability of ASU & H raw materials by promoting the cultivation and post-harvest processing of medicinal plants.

The guidelines of NAM had mandated third party Mid-Term evaluation after two years of implementation of the scheme. The study was accordingly commissioned by the MoA in early 2017-18 and awarded to M/s Centre for Market Research & Social Development (CMSD), New Delhi. The initial scope defined as per the Terms of Reference and initial discussions with MoA was to cover a period from inception of the scheme upto 30th June 2016. The field work and study was conducted accordingly and findings discussed by CMSD with the senior officials of MoA. During these discussions, it was felt by officials of MoA that the usefulness and effectiveness of the study findings and recommendations would be greatly enhanced if the reference period could be increased and data and information be gathered for scheme's performance upto 31st March 2017 instead of 30th June 2016. Accordingly, CMSD was instructed by the senior officials of the Ministry of AYUSH. The sample was redesigned by CMSD and fieldwork done once again in all the 26 states/UTs of the country so as to capture information about programme implementation upto 31st March 2017 as per the requirement of the Ministry of AYUSH.

The evaluation study is aimed at comprehensive and in-depth impact assessment of four sub components namely: - AYUSH Services, AYUSH Educational Institutions, Quality Control of ASU&H Drugs and Medicinal Plants of the Centrally Sponsored Scheme 'National AYUSH Mission (NAM)' implemented by the Ministry of AYUSH w.e.f. September, 2014.

Both secondary and primary research were undertaken to generate required information. The quantitative data was collected from the target respondents under the study. The qualitative

information was collected through in-depth interviews with the officials involved in implementation of the scheme. The sample size for each of the AYUSH unit/programme for each state was suggested by the MoA right at the outset of the study. The study has been conducted in two phases. Phase I (preliminary phase, for which report has already been submitted in July 2017) and Phase II (final study in details at the conclusion of which this report is being submitted). The findings and recommendations of the mid-term evaluation for the components NAM are summarized in the sections that follow.

2. Institutional and Governance issues

The implementation of NAM is governed at the Central level by the Central Programme Management Unit and at the state level by respective State Programme Management Units (SPMUs or PMUs in short). However, for the purpose of governance, the Mission at State level is governed and executed by a State AYUSH Mission Society. In order to strengthen the AYUSH infrastructure both at the Central and State levels, financial assistance for setting up of the Programme Management Units (PMUs) is being provided under NAM.

i) Utilisation of Funds from 2014-15 to 2016-17: The figures of utilisation have been obtained from the State AYUSH Society (SAS) and duly verified from the entries in the documents pertaining to accounts of the respective State AYUSH society. In many cases, especially for the financial year 2016-17, the figures of utilisation are not yet finally audited figures but an aggregate of the expenditure entries that are intended to be considered for finalization at the level of the respective State AYUSH Societies are available and the figures provided in this report are based on these.

The data given in the table of sanctioned and utilized amount under NAM suggests that Rs. 452.70 crores has been utilised against a released amount of Rs. 694.48 crores. It represents a utilisation percentage of 65.19% for the reference period and for the 24 sample states (As per the sample design for this study, out of the 26 States that were visited, two states, Maharashtra and Tripura were studied only for implementation of Medicinal Plants component of NAM and therefore, their overall figures of funds utilisation for NAM are not included). The amount of funds released annually to the states as well as the percentage of funds utilisation has consistently shown an upward trend with each successive year of NAM

implementation. It is likely that the shortfall observed in percentage of utilization of funds in the initial years maybe due to the time taken for stakeholders to learn about the details of the scheme and to establish mechanisms to implement and monitor the scheme. This process does take some time to get established and therefore, till it happens, the actual implementation of the programme components on the ground does get delayed.

Three categories of states based on their funds utilisation performance

The analysis of the percentage of funds utilisation by the respective states and their categorization has been done in accordance with the criteria evolved in consultations with the senior officials of Ministry of AYUSH.

- a. **A Category States:** Those states which have utilised 75% or above of the funds received from Centre in the period 2014-15 to 2016-17
- b. **B Category States:** Those states which have utilised 40-74.9% of the funds received from Centre in the period 2014-15 to 2016-17
- c. **C Category States:** Those states which have utilised less than 40% of the funds received from Centre in the period 2014-15 to 2016-17

Category-wise classification of States (NAM funds utilisation Period FY 2014-15 to FY 2016-17)

| Category Label | Parameter (Percentage funds utilised with respect to funds released by the Central Government) | Number of States | Names of states with the particular category label |
|-----------------------|---|-------------------------|---|
| A Category | 75% and above of the released funds are utilised | 11 | Haryana, Karnataka, Kerala, Madhya Pradesh (MP), Mizoram, Nagaland, Rajasthan, Sikkim, Tamilnadu (TN), Uttarakhand (UK), Uttar Pradesh (UP) |
| B Category | 40%-74% of the released funds are | 7 | Arunachal Pradesh, Gujarat, Himachal Pradesh (HP) |

| | | | |
|----------------------------|--|----|---|
| | utilised | | Jammu & Kashmir (J&K), Puducherry, Telangana West Bengal |
| C Category | Less than 40% of the released funds are utilised | 6 | Andhra Pradesh (AP), Assam, Goa, Manipur, Odisha, CO-LOCATED Punjab |
| Total Sample States | | 24 | |

Some of the factors that contribute towards the relatively better performance of 'A' category states are can be summarized as follows:

- i) **Making unencumbered land available expeditiously** for construction of AYUSH facilities. The respective state governments of Mizoram, Nagaland and Sikkim have been able to provide land for the construction of Integrated Hospitals, OPDs, and Drug Testing Laboratories in alignment with the release for funds from Ministry of AYUSH, Government of India. This has led to higher and timely utilisation of funds. Thenzawl (Mizoram) and Noklak (Nagaland) already have inaugurated 50 bedded integrated hospitals constructed with NAM funds.
- ii) Faster recruitment of AYUSH staff and filling of vacancies has led to improved performance of 'A' category states. The states which have been able to conclude recruitment of AYUSH personnel in required numbers have been able to perform better. Almost all the A category states have demonstrated the ability to complete the process of recruitment faster than the other.
- iii) The A category states such as Mizoram, Nagaland, Kerala, Uttarakhand, Sikkim, Rajasthan and Madhya Pradesh have **focused on conducting significantly higher numbers of Free Clinic/Health Camps of AYUSH** system for general public. This may have led to improvement in visibility and credibility of AYUSH system resulting in greater demand of AYUSH services from public and higher funds utilisation.
- iv) **Staffing and functioning of Programme Management Units (PMUs) has been relatively better in 'A' category states** as compared to. The better functioning and well-staffed PMUs may have contributed to better coordination and thereby faster implementation of NAM activities.

- v) **Having a separate Department of AYUSH at the state level helps make performance better:** States like Kerala, Rajasthan, and Haryana have a separate department of AYUSH as distinct from Department of Health and Family Welfare. It helps in channelizing the funds better for AYUSH activities.
- vi) **Appointment of separate Drug Controller for AYUSH in the state:** The appointment of separate drug controller for AYUSH in the state characterizes most of the A category states. It might be leading to availability of better quality AYUSH medicines in the state and better enforcement.

ii) **Reason for low utilisation of funds and low absorption capacity of State AYUSH**

Societies:Main reasons cited by the respective State AYUSH Societies for lower utilisation of funds are as follows:

- Delay in receipt of funds from the treasury of their respective state.
- Lumping of funds into large installments which are released very late into the financial year by Ministry of AYUSH thus making it difficult for the State AYUSH Society to approve and disburse for the projects proposed for the same year.
- Delays caused because the process of procurement when carried out as per central guidelines with existing institutional mechanism at state level takes a long time.
- Lack of human resources, especially those who are formally qualified and experienced for project appraisal and management in general and that in the health sector in particular. There also is a lack of professionals in SASs who have formally qualification or are otherwise competent to handle marketing and communication. This limits the outreach and acceptability of the AYUSH initiatives among the targeted groups of individuals and organisations.
- Lack of infrastructure with SASs, especially in relation to computers and office equipment, leads to compromise in performance of the SASs.
- The State Governments often have other priorities and alternative uses of funds received from centre as NAM funds. This might be leading to funds diversion and resulting in delays in release of funds by State Governments to SASs for implementation of NAM.

- The coordination and communication between SMPBs and their respective SASs is poor in almost all the states barring a few exceptions like Telangana, AP and Rajasthan, and it leads to poor and delayed implementation of Medicinal Plants Component of NAM because in the absence of appropriate and timely inputs from SMPBs, the SASs on their own are not able to accord adequate importance to Medicinal Plants component in the state.

iii) Speed of flow of funds : In order to analyse the speed of funds flow, the SASs were contacted and information of certain sample sanction letters were picked up randomly for three financial years, 2014-15, 2015-16 and 2016-17. The items mentioned in respective SAAPs were studied in combination with the information about the dates of fund transfer from one stage to another in the process from SAAP submission to funds disbursement to local units by SAS. Averages, maximum and minimum durations were recorded for each state in order to bring out the actual situation and identify bottlenecks.

Based on the sample of sanctions chosen from SASs for this exercise, the average time duration of release of installment by MoA after the receipt of SAAP is 158 days for the country as a whole. The average time taken by SASs to complete the process of withdrawing the money from the respective state treasury is 187 days (or more than six months). The transactions that were observed showed that the minimum time taken from Central funds to reach the beneficiary unit is 158 days and the maximum is 490 days.

Transfer of installment of funds from State AYUSH Society to beneficiary units/beneficiaries takes anything between 30-100 days depending on the project and the state. The transfer of funds from SAS to nodal agency for Medicinal Plants takes almost similar time or even more, depending on the state. Once the SASs receive the funds from State treasury, they are able to disburse it to final beneficiary (if all processes are complied with) in an average period of 106 days and to SMPB in 125 days.

During 2016-17, the average of the time observed for all state AYUSH societies combined for receipt of first installment was 174 days and for second installment was 252 days (from beginning of financial year i.e. 1st April 2016). It is important to note that the time taken for receipt of funds has reduced significantly with respect to average time taken in 2014-15 and

2015-16 which is 251 days for first receipt of first installment and 331 days for second installment. It is observed that even though the major part of the time is taken by transfer of funds from State Treasury to State AYUSH Society due to procedural delays at State level, there also is some scope for expediting funds transfer from Centre to States.

- iv) Adherence to procurement guidelines:** Officials in all the State AYUSH Societies reported that they follow Central Procurement Guidelines despite local demands to deviate from the procedure to suit local requirements. A total of 17 out of 23 States reported that they exclusively followed central procurement guidelines for procurement of medicines and six states reported that they also comply with respective State Procurement Guidelines and rules in addition to the Central Procurement Guidelines.
- v) Awarding of Civil works:** The delay in awarding civil works was cited by all the states and the delay sometime extended to as much as one year. The detailed procedures involved at each stage were often cited as the reason for the delay. The states which have a special designated agency for executing health infrastructure projects such as Telangana, Andhra Pradesh, and Karnataka are able to execute the civil construction projects relatively faster.
- vi) Monitoring and review:** Almost all the states have proposed their own version of monthly monitoring and review mechanism wherein the field units are required to report on their performance parameters such as that related to patients, medicines, civil and other works in the specified formats. However, an actual enquiry about the reporting system suggested that the field units in most of the states are submitting their reports irregularly or in an incomplete manner. The problems that were cited at the state level were shortage of manpower that was skilled in proper reporting method, lack of motivation, non-prioritisation of reporting over operational responsibilities as well as lack of IT infrastructure, poor internet connectivity in the rural and remote locations, difficulty in recording Aadhaar Card numbers at field unit level, etc. It is pertinent to note here that the irregularity in data submission and lack of completeness in data submitted may be affecting the NAM implementation adversely. There are only 12 State AYUSH Societies which reported that the monthly reports were being received regularly and completely.
- vii) Submission of Utilisation Certificates (UCs):** The performance of the State AYUSH Societies in submitting UCs has a scope for improvement. In the past, most of the State AYUSH Societies were unable to submit UCs in a timely manner. The submission of UCs

has improved significantly in 2016-17 due to facilitating as well as close monitoring actions taken by the Ministry of AYUSH in 2016-17. There still are 12 states who have not submitted any UC so far. Among the states which had submitted the UC, many reported that the acceptance of the UCs by Ministry of AYUSH (MoA) remained to be concluded. This issue needs sustained attention and intervention from Ministry of AYUSH. It was discovered during fieldwork that there is a very limited in-house competence and skill available with State AYUSH Societies for preparation of UCs. Many SASs have outsourced this responsibility to the CAs. During the survey, we found many instances of lack of ownership for submission of UCs within the State AYUSH Societies.

- viii) Programme Management Unit:** The PMU was not found to be functional in Maharashtra as of March 2017. There are 12 states reporting staff strength of 1-3 members and 4 states reporting staff strength of more than 6 members. There are 17 SPMUs where State Programme Manager is in place.
- ix) NAM programme has been slow in picking up momentum:** Due to the delay in receipt of funds by the State AYUSH Societies in most states/UTs, there has been a delay in implementing different components of NAM. The performance has improved significantly in 2016-17 as far as the ground level progress is concerned. The backlog of low fund utilisation in earlier periods is getting cleared now with the support under NAM reaching AYUSH Units and the beneficiaries and delivering the benefits. It is likely that with the guidance of MoA, the capacity of the states for implementing NAM has improved in 2016-17 as compared to earlier years.
- x) Difficulty in recruiting and deputing suitable human resources:** States/UTs are finding it a challenge to recruit human talent especially those who have formal qualification, competence and experience in project management, social marketing, information, education and communication. In almost all the cases, the progress of NAM has been hampered due to absence of qualified professionals.

II. AYUSH Services

Collocation of AYUSH facilities with the units that deliver Allopathic system: Many reports about healthcare delivery system in India have maintained the view that India's current healthcare system is not sustainable for its 1.25 billion population. An estimated 600 million people in India, many in rural locations, have little or no access to good quality healthcare at

affordable cost. India also faces a critical shortage of trained health professionals such as doctors, nurses, and allied healthcare workers. The National Policy on Indian Medicine Systems and Homeopathy-2002 envisaged integration of traditional systems of Medicines practiced in India with modern system of medicine and into healthcare delivery. The government is also considering a holistic healthcare system that is universally accessible, affordable, and which dramatically reduces out-of-pocket health expenditures. National Health Mission (NHM), the bedrock of India's healthcare delivery system, seeks to provide accessible, affordable and quality healthcare to every Indian. It is towards this end that integration of traditional systems of medicine (represented by AYUSH) with modern system and thereby into the healthcare delivery system is implemented.

National AYUSH Mission has several components which are aimed at promoting improved accessibility of affordable, quality healthcare as well as medical pluralism by integrating AYUSH into the state health services system and mainstreaming of AYUSH with allopathy. It has been envisaged primarily by co-locating AYUSH services like AYUSH OPD in PHCs, AYUSH IPD in CHCs and AYUSH wing in District Hospitals. Towards this end, the personnel of AYUSH are often utilised for National Health Mission (NHM) activities as well as for involvement in Crosspathy/Cross referrals at the health facilities.

Under the National Health Mission (NHM), financial and technical support is provided to States/UTs for strengthening their healthcare systems, including for mainstreaming of AYUSH, based on the requirements posed by the States/UTs in their Programme Implementation Plans (PIPs). Similarly, under National AYUSH Mission (NAM) financial support is provided to States/UTs for better access to AYUSH services through co-location of AYUSH facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs), upgradation of the exclusive AYUSH hospitals and dispensaries as per the requirement projected by them in their State Annual Action Plans (SAAPs).

i) Co-located OPD in PHC: Out of a universe of 1794 PHCs which were planned (as per respective SAAPs) to receive recurring funds for co-located AYUSH OPD, 449 PHCs (existing and proposed) were visited by the survey teams and out of 25 PHCs, which were planned to receive non-recurring funds for co-located OPD, 7 OPDs (existing and proposed)

were visited during the fieldwork. During the survey it was observed that in many states, most of the PHCs share the facilities between AYUSH and Allopathy. Non-sharing of the facility is an exception. It is common in many states to use the AYUSH manpower for NHM activities.

In one month cycle, the number of patients who came for the AYUSH treatment and the patients cured remain highest in the Rajasthan, followed by Punjab. In the reporting OPDs, none of the patients in Haryana, Himachal Pradesh and Uttarakhand discontinued the AYUSH treatment and the state of Punjab has the highest number of patients who are continuing the AYUSH medication. Nearly 60% of the AYUSH OPD patients received relief within a reasonable time.

- ii) Co-located IPD in CHC:** Out of a universe of 521 CHCs which were planned (as per respective SAAPs) to receive recurring funds for co-located AYUSH IPDs, 131 CHCs spread over 12 states were visited by the survey teams and out of 25 CHCs which were planned to receive non-recurring funds for co-located IPDs, 7 CHCs in three states were visited during the fieldwork. The common diseases treated in IPDs of CHCs are Arthritis, diabetes, hypertension, chronic nervous disorder, joint pain, gas, geriatric issues, rheumatic disorders, gastric disorders, skin infections. Among the special cases attended to, it was reported that special diseases such as Autism, Mental Retarded, Hemipleg, Bell Palsy, CP Child, Renal calculus, fatty liver were treated with AYUSH. On a monthly basis, the states reported that about 60% of the patients were cured in AYUSH IPDs.

It was observed in all the sample states except four states (Manipur, Haryana, Punjab and Uttarakhand) that most of the AYUSH IPDs in CHCs were functional and their condition was good. In the four states mentioned, there were more than 40% IPDs where there was scope for improvement. The behaviour of Staff in almost all the cases was good as endorsed by the patients who were interviewed. It was also noticed that there was significant level of interaction between AYUSH Doctors and Head of Allopathy section.

It was observed that in majority of IPDs, cleanliness & hygiene in AYUSH IPDs was good. Separate section for male & female were not seen in most of the IPDs in CHCs and Panchkarma facility was yet to start in most of the visited CHC-IPD centers. It was observed that in most of the IPDs (74%) there is no separate dispensary and the counter for

AYUSH medicines is in the same dispensary as that for Allopathy. AYUSH doctors received their salary from NHM.

During the interaction with the patients in the hospital, it was observed that AYUSH Doctors were present regularly in the hospital. A separate signage for AYUSH section in CHCs was also observed in almost all the CHCs.

iii) Colocated AYUSH wing in district hospital: Out of a universe of 320 AYUSH Wings in District Hospitals (DHs) which were planned (as per respective SAAPs) to receive recurring funds, 80 AYUSH wings were visited by the survey teams and out of 10 AYUSH Wings, which were planned to receive non-recurring funds for co-location with DHs, 5 AYUSH Wings were visited during the fieldwork.

Training has been conducted for certain staff. Haryana and Sikkim conducted training of Medical Officers on 'Mainstreaming of AYUSH'. Sikkim conducted 'Skilled Birth Attendant' programme. Other training programmes conducted by states include Haryana (Panchkarma, General awareness, public outreach, and school health programme), Sikkim (NLEP, NPCDCS, and SMHA), Mizoram (Training of Medical officers on IUCD 2015) and Madhya Pradesh (Homeopathy software and I.H.M.S.).

Utilisation of AYUSH personnel for NHM activities: AYUSH personnel are regularly utilised for NHM activities in all states. The School Health Programme, the Immunization programme, Village Health Nutrition Day (VHND) are all assisted by AYUSH personnel. Apart from these roles, the AYUSH personnel are used in the role of sector medical officer, Polio Programme, SMHA and Family Planning & Yoga Camps in various states. There were also many instances reported (could not be verified through observation) where AYUSH Medical officers were utilised for routine administrative activities rather than healthcare activities by Medical officer/ Incharge of the health unit where AYUSH facility was co-located.

Salient Observations related to Collocation of AYUSH facilities: It was observed during the pan-India fieldwork that, the strategy of Collocation of AYUSH facilities with Allopathy has helped AYUSH system to gain a certain degree of visibility among public in general and patients

in particular. However, the current provisions and guidelines of the system of Health Delivery in the country tend to suggest significant primacy of Allopathic system over the AYUSH system, even in the co-located units. Due to this implied primacy of Allopathic system, it was observed that the AYUSH system very often gets perceived as inferior and a very limited option to Allopathy in the co-located units.

There is no distinct cadre for personnel associated with AYUSH system. Due to this gap, all the AYUSH personnel in co-located units have to report to the Unit Head/Incharge, who invariably happens to be a doctor from the allopathic system. Since the head of the Unit is trained solely in allopathic system of health delivery, he often has low awareness of the importance and requirements of the AYUSH system. Moreover, the parameters used to assess his performance do not place any demands on him to grant adequate importance to AYUSH system and personnel. They very often tend to treat AYUSH personnel including doctors as weak subordinates. The personnel trained to deliver AYUSH system of health services at the co-located units are very often deployed by Unit Incharge for administrative activities and not for providing health and medical care through AYUSH system.

As per the current provisions, the salaries and remuneration of personnel associated with AYUSH system are lower than those of corresponding personnel trained in allopathic system. These salaries are provided from the budgetary resources of National Health Mission rather than from the National AYUSH Mission. There is no arrangement for providing government residential accommodation for AYUSH doctors even if they are posted at remote co-located Units. Such a predominance of Allopathic system leads to the dilution of the impact of National AYUSH Mission in promoting AYUSH system as a comparable option.

Kerala is the only state which has implemented delivery of AYUSH health services without relying on collocation of AYUSH with Allopathy. The state has opted only for numerical expansion and upgradation of standalone AYUSH units. This strategy has been successful in Kerala because of two contextual characteristics that are unique to Kerala. One, a relatively more educated and evolved health services recipient as compared to other states and two, a long tradition of Yoga, Ayurveda, Siddha, Naturopathy and Homeopathy. Such unique contextual conditions are not prevalent in any of the other states of India.

Mechanisms other than Collocation of AYUSH services:

In addition to the co-location in PHCs, CHCs and District Hospitals (DHs), there also are initiatives which promote independent existence and expansion of AYUSH services. Such initiatives involve upgradation of AYUSH hospitals, upgradation of AYUSH dispensaries and supply of genuine and good quality AYUSH medicines to dispensaries and other health establishments. The range of initiatives under the head of 'AYUSH Services' is meant to work in tandem and create a positive image of an effective system of healthcare in the minds of intended individuals so that they willingly exercise their healthcare option when the need so arises.

iv) Upgradation of Standalone AYUSH hospital: Out of a universe of 361 Upgraded AYUSH Hospitals which were planned (as per respective SAAPs) to receive recurring funds, 91 Upgraded AYUSH Hospitals were visited by the survey teams and out of 57 upgraded AYUSH hospitals which were planned to receive non-recurring funds 15 upgraded AYUSH hospitals were visited during the fieldwork. These were spread over 10 states/UTs. The success rate of sample upgraded AYUSH hospitals in terms of patients cured is 68.01%, 27.85% of the patients were continuing their treatment and 4.09% patients had dropped out. On the average monthly basis, the report from Gujarat indicates that highest, that is 75% of the patients were cured.

v) Upgradation of Standalone AYUSH dispensaries: Out of a universe of 6082 Upgraded AYUSH dispensaries which were planned (as per respective SAAPs) to receive recurring funds, 1521 Upgraded AYUSH dispensaries were visited by the survey teams and out of 915 upgraded AYUSH dispensaries which were planned to receive non-recurring funds 229 upgraded AYUSH dispensaries were visited during the fieldwork. These were spread over 12 states/UTs. The overall success rate of AYUSH treatment was 57% whereas the balance continue their treatment barring a small number, who dropped out. Out of the sampled states, the dispensary in Kerala happened to have maximum number of patients coming in for AYUSH medication followed by those in Rajasthan and Telangana.

vi) Supply of essential drugs at AYUSH hospitals and AYUSH dispensaries: Out of a universe of 1193 AYUSH hospitals and 13601 AYUSH dispensaries which have had assistance under NAM for purchase of essential drugs, 42 hospitals and 312 dispensaries

have been sampled and contacted during the fieldwork in consultation with respective AYUSH societies which had proposed these (as per respective SAAPs) to receive NAM funds for essential drugs purchase. These were spread over 14 states/UTs.

vii) Positive impact of AYUSH facilities as stated by the stakeholders: Some amount of awareness among public about preventive health practices and instances of treatment of chronic diseases through AYUSH were mentioned by the officials in the states where AYUSH OPDs, IPDs, and AYUSH Wings have been co-located. It was observed during the fieldwork that the co-located AYUSH facility is specially preferred by women and the elderly. Women also bring children for treatment.

viii) Scope of AYUSH services varies from state to state: The current implementation of AYUSH services has been conceived as co-location, upgradation and supply of essential drugs in the NAM guidelines. However, Kerala is the only state where co-location has not been done and the focus has been on standalone AYUSH facilities/ health units. It has led to mixed outcomes, some positive (increased visibility, improved usage of AYUSH facilities and manpower) and some not so positive (less than optimal access, narrow base of patients limited mostly to women and the elderly).

III. Findings regarding 50 bedded integrated AYUSH Hospital component

i) Difficulty in site identification and notification for land acquisition: The data gathered during fieldwork makes it evident that except for Nagaland (where one hospital is constructed in Noklak), this component of the scheme has picked up only in recent months for the other states. In almost all the cases, the progress of this component was hampered right at the first step comprising identification of the site and followed by land notification and acquisition related issues. In almost all the cases, the announcement of establishment of hospital as well as its inclusion in SAAP proposals has been done without having clarity about the exact location of the hospital. This has led to a situation where financial approval, allocation and disbursement of funds from MoA has materialized but, without the expected physical progress.

- ii) **Delay by the State Governments in tendering and awarding of contract:**In the few states, where the hospital projects have progressed beyond site selection and DPR, there have been instances of prolonged delays in issuing of Tender notices, evaluation of tenders and awarding of the contracts. States such as West Bengal and Sikkim have experienced delays such as these at the State level.
- iii) **Delay by the State Governments in notifying the posts of the doctors and other staff for the AYUSH hospitals:** There has been little progress in the states approving and notifying the posts of the doctors and staff for the proposed AYUSH hospital. This has also led to poor utilisation of funds provided for this component.

IV. Findings regarding Public Health Outreach component

There were 20 states that were visited by the fieldwork team for collecting first hand data about Public Outreach component since the other states had not been sanctioned any funds for this component. Receipt of funds under NAM for Public Health Outreach has been reported by nine states. Deducing from the data, the first year (2014-2015) shows the highest amount of utilization of grants with Rs. 86.95 lakhs. There is a constant decrease in the amount of utilization in the succeeding years with Rs. 41.50 lakhs in the second year and Rs. 27.15 Lakhs in the third year. Rajasthan, Madhya Pradesh, Nagaland and Andhra Pradesh have negligible or low activity under this NAM component. Public Health Outreach activities, wherever carried out, have been reportedly induced positive outcomes such as creating awareness among people on maintenance of health, treatment of diseases, and promotion of health, and have also made people aware of locally available medicinal plants and home remedies. It has been extended to various initiatives like the development of more community leaders working for the system, particularly reported in the state of Sikkim. The interest of people towards AYUSH was drawn through IEC materials and camps held at various places in various states. Moreover, another notable advance in regards to decrease in disease burden was reported. Kerala reported its success of no dengue cases status in 2015-16 after the intervention of the scheme and Himachal Pradesh has reported decrease in disease burden. Most states have revealed that AWWs, ANMs, ASHA and Village Health Workers were involved in the programme.

Scope of Public Health Outreach is unclear and non-standard: It was observed during the fieldwork that the current scope of what should or should not be included in this component has not been specified and leaves room for different interpretations.

V. Findings regarding Behaviour Change Communication (BCC) component

Out of the 24 States/UTs, where funds for BCC were approved at any time during three financial years 2014-15, 2015-16, 2016-17, data was collected first hand from 15 States. Among the 15 sample states surveyed as per the TOR, nine states are reported to have taken up Behaviour Change Communication (BCC) in the period under study. Out of the total states which reported to have used at least one strategy, print media including pamphlets, booklets & leaflets is seen to be the most common strategy as adopted by nine states.

The implementation of this component lacks pan India standardization and is open to personal interpretation of the officers in charge who often are not experts in media and communication. In almost all the cases, the progress of this component has been hampered due to the absence of any ‘communication’ specialist/professional/expert in the AYUSH implementation machinery. This leads to a compromise not only in achievements of outcomes but also leads to poor design of communication mix.

VI. Findings regarding AYUSH Gram component

The activities of AYUSH Gram as reported in the three states have included screening. The highest number of people screened is 25000, which is in Kerala. Recommendation of home remedies during the activities, involvement of ASHA workers, ANMs, AWWs were reported in the states of Kerala and Telangana, while Mizoram reported otherwise. All the three states involved NGOs in the activities undertaken as part of AYUSH Gram component.

Difficulty in identification and notification of villages for AYUSH Gram: The data gathered makes it evident that this component of the scheme has picked up only in the last few months of Financial Year 2016-17. Except for some developments in Kerala, Mizoram and Telangana from among the surveyed states, the activity regarding establishment of the AYUSH Gram in all the other states has been very slow. When the reasons for the delay and relatively slow progress were investigated, it was found that in almost all the cases, the progress of this component was

hampered because of lack of clarity about norms and criteria for identification of the villages for AYUSH Gram intervention. In almost all the cases, announcement of establishment of AYUSH Gram in the respective states as well as inclusion in SAAP proposals has been done without having clarity about the criteria to be used for location of the AYUSH Gram within the state as well as agreement with the respective village community/leadership. This has led to a situation where financial approval, allocation and disbursement of funds from MoA has happened but, the physical progress of the work at the ground level has lagged behind in the states.

Positive impact of AYUSH Gram as stated by the stakeholders: In Telangana, the farmers of the targeted villages had no interest in Yoga prior to AYUSH Gram intervention. However, with the help of NGOs and school teachers, AYUSH personnel have been able to motivate them towards AYUSH system, Awareness of AYUSH programme has been created and those who have benefitted have spread the word in other villages about the AYUSH and Yoga camps. In Kerala, the programme has created and informed people about the system and there has been mass participation in promotion of AYUSH system.

AYUSH Gram Component faces certain challenges: Some of the administrative guidelines specified in the NAM framework are in conflict/at variance with the guidelines issued by the State Governments for this component. This creates confusion and delays in implementation right from the initial stages. The nodal officers have not received any specific training for implementing this component and there is lack of continuity and stability in terms of availability of qualified AYUSH medical officers in the areas for leading this component.

Definition of AYUSH Gram is unclear and non-standard: The current definition of AYUSH Grams is open-ended and leaves room for different interpretations. This leads to confusion and disputes during choice of candidate villages as well as determining the mix of interventions that can be /should be implemented in the villages once chosen.

VII. Findings regarding School Health Programme component

There were 10 states that were visited to check School Health Programme. From the states that were surveyed, there are three states reporting utilisation of grant received for School Health programme (SHP), these are Sikkim, Manipur and Gujarat.

Difficulty in recruiting and deputing suitable person: In almost all the cases, the progress of this component has been hampered due to the absence of any ‘School Health Programme’ specialist/professional/expert in the AYUSH implementation machinery. This has led to poor utilisation of funds allotted and disbursed by MoA till 31st March 2017. The officers in the State AYUSH Society have not received any specific training for implementing this component and that may be leading to poor utilisation of resources and lack of effectiveness.

Scope of School Health Programme is unclear and non-standard: The current scope of what should or should not be included in this component has not been specified very clearly and it leaves room for vastly different interpretations. This may be leading to dilution of impact.

Delays in appointment of Nodal officers: The identification and deployment of nodal officers is delayed in all the states. This is hampering the implementation of the programme.

VIII. Findings regarding Wellness Centre component

Out of the data from the states shown above, there were 18 states that were visited by the fieldwork team for collecting data. From the states that we surveyed, there are twelve states reporting receipt of funds under the component of wellness center. Four out of 12 states reported that new OPD was constructed for wellness center while eight states reported that an existing OPD was changed for wellness center. From the states that we surveyed, there are seven states reporting that they have facility of Yoga hall. Beside yoga hall, the old age care was found in Himachal Pradesh & Pondicherry states/UTs respectively.

Positive impact of Wellness centres as stated by the stakeholders: Some amount of awareness about preventive health practices through AYUSH were claimed by the officials in the states where implementation of this component has taken place.

Scope of Wellness centres is non-standard: The current scope of what should or should not be included in this component has not been clearly specified and it leaves room for different

interpretations by different officials. This might be leading to inconsistency of impact across different states.

IX. Findings regarding Quality Improvement component

During the course of the fieldwork there were 12 states from where the survey team obtained responses about the State AYUSH Drug Controller's office. In the other states in our list, there was no separate Drug Controller assigned for AYUSH system. There are Nine out of 12 states where 'Certificate of pharmaceutical products' is granted to eligible pharmacies. 'Unit WHO GMP practice' and 'Free sale certificate' are the other two common certificates that are offered by five states in each case. There are certain certificates which are offered only in one state each.

- i) Absence of Government Analyst and inadequate number of Drug inspectors in ASU&H Drug control framework:** As per the provisions of the Drug and Cosmetics Act 1940, Government has to appoint Government Analysts and Drug inspectors for controlling the process and product quality of ASU&H drugs and to enforce quality standards in the state. Our fieldwork indicated that this has not been done in most states. The drug inspectors are in short numbers and this may be the cause of suboptimal enforcement of drug control for AYUSH system in almost all the states.
- ii) Quality Improvement and Control under NAM has been funded recently in many states:** The release of funds to SASs has got delayed in the first two years of NAM implementation. Therefore, it was found that the impact of this component is yet to acquire significance in most states.
- iii) Difficulty in recruiting and deputing suitable person:** States/UTs which have applied for funding under this component are finding it difficult to recruit qualified personnel especially for the quality control laboratories. This has led to sub-optimal functioning of laboratories and slowdown in testing activities. There also is a problem in recruiting Drug Inspectors as per the numerical and qualification norms. The salaries being offered under NAM for qualified quality testers (of different streams) and drug inspectors are lower than general expectations in the market. In almost all the cases, the progress of this component has been hampered due to absence of quality and inspection professionals in the AYUSH implementation machinery. This leads to a compromise not only in achievements of

outcomes but also poor quality maintenance. This has led to poor utilisation of funds allotted and disbursed by MoA till 31st March 2017.

X. Findings regarding Educational Institution component

i) The fund utilisation towards AYUSH Educational Institutions has been at a low level:

Due to the delay in release of funds to the institutions in most states/UTs, there has been delay in utilizing the funds in AYUSH Educational Institutions component. The impact of this component is diffused and unless measures for assessment of impact are pre-decided and the baseline data is collected accordingly, the impact of NAM on stakeholders will be difficult to assess.

Positive impact of AYUSH Educational Institutions component as stated by the stakeholders: The Principals, the Librarians, the students and the teachers when contacted during the field survey did mention that even though the assistance received under NAM was less than what they needed, there is certainly some augmentation of institute's/ college's resources and this may be causing some positive impact.

SUGGESTIONS & RECOMMENDATIONS

- i) **NAM must be continued as an essential part of health delivery:** The improvement in rate of fund utilisation with passage of time, leads us to suggest that the scheme be continued with increased allocation for not only project implementation but also for improvement in capacity building of institutions connected with NAM in the states.
- ii) **The co-location of AYUSH facilities need to be continued with due importance to adequate space, furniture & equipment, signage, personnel, training of personnel and provision for medicines.**
- iii) **Performance Categorisation of States should be used to improve performance:** The present study has used the formula jointly developed by MoA and CMSD to categorise the states into A, B and C category. There are six C category states (Andhra Pradesh (AP), Assam, Goa, Manipur, Odisha and Punjab) but, three of these have already initiated actions towards performance enhancement. Leaving these aside, the states which are categorized as C and in which actions towards improvement are not clearly evident (Assam, Goa and Odisha), MoA must take actions to remedy the situation by holding discussions and

understanding the actual challenges. Based on the actual challenges, state specific action plan must be drawn up to speed up the process of NAM implementation in these states.

- iv) **Improve the speed of fund transmission upto beneficiary stage:** There have been attempts to improve the speed of funds transmission from MoA to States, but there still is considerable scope for improvement the speed and steps of the process. The deadline for communicating resource pool to states and receipt of SAAP can be advanced further. Possibility to be explored to release first installment to states by May 31st of the year. This will catalyse better utilisation.
- v) **Possibility of approval for recurring items before meeting of Mission Directorate to approve SAAP:** Possibility must be explored for approving the funds for recurring items, prior committed items in the respective state's SAAP before the formal discussions of SAAP in the respective state Mission Directorate meeting at the MoA. It may be considered that a certain percentage (we suggest this to be 60%) be processed for release to the States irrespective of discussions. Balance can be processed after the approval in the Mission Directorate meeting.
- vi) **Planning for utilisation of unspent balances with the states must be done soon:** The data collected during the fieldwork seems to suggest that a balance of over Rs. 242 crores is lying unspent with the sample 24 states/UTs on account of previously released funds for NAM. It is suggested that a time-bound process must be implemented to utilise the unspent balances either for the items for these are earmarked or even for revised items after considering them under the due process.
- vii) **Improving the Monitoring:** The integrity of the data obtained by the respective State AYUSH Societies with the existing monitoring system may be doubtful because it is merely a consolidation of data furnished by field units who are severely constrained due to lack of qualified and motivated manpower and absence of IT systems for furnishing accurate and timely data. Therefore, the reliability of the data may be compromised even if the regularity is not. This area needs immediate attention from MoA. There should be significant investment by MoA in providing funds and knowhow to states for deployment of trained manpower and modern computers at field units and district level to ensure that accurate data related to performance of the programme is furnished in a timely manner.

- viii) **Investment in Computerisation:** The current level of computerization at ground level is low. The states cite lack of resources. However, lack in this area is hampering the NAM implementation severely. It may be considered by MoA to provide funds to augment computerization from District Level upwards by supporting hardware, software and human resources. It will certainly improve monitoring and reporting and will speed up funds flow and its better and timely utilisation towards better NAM implementation.
- ix) **Establish Independent Department of AYUSH in each state with district and block level structure:** All the evidence gathered with respect to programme implementation so far suggests that the present system of State AYUSH Society to units can be improved upon in terms of monitoring and reporting as well as identification and implementation of project. It is suggested that all the states must establish a separate department of AYUSH which must have an implementation and monitoring personnel/setup at block level as well as at the district level. It should be similar to most of the other major developmental interventions of the government.
- x) **Establish District Level AYUSH mechanism:** There is a need to have DPM unit at district level with a minimum number of two personnel; District Programme Manager and District HMIS Personnel. MoA must explore the possibility of providing funds for District Level Programme Units.
- xi) **Measures should be taken to improve absorption capacity of State Governments:** Many of the state governments/ SASs were found to be lacking in their absorption capacity for the funds allocated to them under NAM. The same needs to be tackled from the PUSH side where adequate investments has to be made in filling up all sanctioned posts, engaging individuals and organisations with better managerial qualification and experience so that the project cycle is managed systematically. PULL side changes will involve improving the genuine demand for AYUSH services by improving social marketing, outreach and IEC activities. Professionals who are competent in this area must be hired. Material support in terms of better IT infrastructure, better access to ground level data and more investment in effective IEC activities and material will go a long way in improving absorption capacity of the states.
- xii) **Capacity building in the area of Management:** Increased funds should be earmarked and massive drive is suggested to improve the managerial skills of project implementing

professionals. This is a significant area of gap that was observed. The training of AYUSH doctors, Paramedics, Pharmacists, PMU personnel in areas of better work management practices, planning, project management, communication must be included and encouraged. It should be taken up as a continuous improvement activity for quality improvement in NAM delivery.

- xiii) **PMU Staff qualification to be spelt out clearly:** Telangana, AP, Jammu & Kashmir and MP have suggested that specifying the qualifications of PMU staffs would do a lot to the overall implementation of the scheme. State AYUSH Societies should be made to comply with the proper eligibility qualifications for recruiting PMU staff.
- xiv) **Scope of SAAP needs to be locally relevant and designed bottom up:** The current scope of what should or should not be included in the SAAP is largely dictated by top-down processes. This has sometimes led to the mismatch between state's requirements and the plan actually approved by the Ministry of AYUSH. This situation needs to be remedied by making the process bottom-up from aggregation of local needs culminating into a formulation of SAAP. If a robust consultative process is added to it, then the state and national priorities can be linked.
- xv) **Decentralisation of NAM proposal to implementation:** The slow pick up of the programme, the relatively lower utilisation of the funds even at present, lower offtake of AYUSH services even when provided. Large amount of unspent balances lying with state governments and State AYUSH Societies in most states may be due to some extent of misalignment with respect to the exact requirements of beneficiaries. In order to address this situation, DECENTRALISED PLANNING must take place when the SAAP is being formulated. It is suggested that the local level CBOs and NGOs must be involved actively in NAM activities and it is their suggestions along with that of community members which must form an important input into SAAP. The village and urban self-government institutions must be co-opted into the formulation of proposals from SAAP. The SAAP must be an aggregate of such proposals after these are screened properly.
- xvi) **SMPB mandatorily must interact with its respective SAS:** The coordination between SAS with their respective SMPBs is mostly done through meetings. There are 16 states mentioning it among its method of coordination. However, in seven out of these 16 states, these meetings are infrequent and far between and there is no regularity. The

relatively poor interaction and communication between SMPBs and their respective SASs has a negative impact on implementation of medicinal plant component of NAM. In most such cases, it was the SMPB which mostly interacted with NMPB rather than its State's SAS. This needs to be remedied. If possible, the SAS and SMPB should be situated in close proximity (the interaction was better in those states where they were located close to each other) if possible. It should be made a mandatory part of activities of the SAS and SMPB that they meet once a month regularly and the minutes of such a meeting are sent to CPMU at Ministry of AYUSH early in the month. The CPMU must include the receipt of formal minutes of such monthly meeting as a performance that must be monitored for the SAS and SMPB. If possible, CPMU can specify a simple tabular format for recording minutes of such meetings. The lack of communication between SAS and SMPB needs urgent attention by specifying this as a performance parameter of the SAS as well as the SMPB that should be monitored at Central level and the must form a part of State's performance assessment.

xvii) **Strengthen the AYUSH health delivery in co-located units:** There is no other state other than Kerala which has unique characteristics that help impart visibility to AYUSH. Therefore, states other than Kerala have to rely on co-location to make AYUSH visible and credible. Therefore, it is suggested that co-location of AYUSH with Allopathic Units be continued but changes should be introduced.

The salaries for the AYUSH doctors and other staff should be provided through National AYUSH Mission and not through National Health Mission. The unit level, the district level and block level AYUSH manpower as recommended in the previous sections must report to the respective AYUSH doctor of their level. In effect, it is recommended to create a distinct cadre for AYUSH personnel. The salaries and remuneration of AYUSH doctors and other associated staff should be reviewed and revised upwards and brought to reasonable levels in comparison with salaries and facilities enjoyed by Allopathic doctors and staff. National AYUSH Mission must have funds provision for constructing residential accommodation for AYUSH doctors and paramedical staff at Unit level so as to encourage talent AYUSH professionals to join the government to provide health services at local level, especially in remote and underserved/unserved locations. Acceptance of the aforementioned recommendations will enable the AYUSH system to

establish its distinctive importance without losing the mainstreaming advantage that comes from co-location.

- xviii) **Explore possibility of stipulating state government undertaking for unencumbered land availability and possession for AYUSH Hospitals, Educational institutions, laboratories and pharmacies:** The possibility should be explored by MoA for stipulating that the respective state governments while submitting the proposal(s) for integrated AYUSH Hospital, Educational institution, Drug Testing Laboratory or Pharmacy should also submit an undertaking along with the proposal that the land/building(s) meant for the proposed project is available with the State Government and such land/buildings are free from any kind of encumbrances. The State Government should furnish the record of right/ownership right of the land proposed for 50 bedded integrated AYUSH Hospital, Educational institution, Drug Testing Laboratory or Pharmacy. The State Government should furnish the details of creation of regular posts/commitment towards filling up of regular posts for the proposed facility.
- xix) **Scope of Public Health Outreach should be standardised:** There should be clear cut guidelines specified by Mission Directorate for the elements of Public Health Outreach component of NAM. We suggest that a group of officials and experts be constituted for this purpose to evolve the detailed guidelines for Public Health Outreach so that this intervention is standardized across the country. It should take into account regional variations such as North East, tribal areas, etc. and factor these into the criteria that is finally arrived at.
- xx) **Engagement of trained and experienced ‘Extension and advocacy’ professional to lead the Public Health Outreach component:** It is suggested that in order to improve the quality of outcomes and increase the effectiveness of Public Health Outreach, the services of a formally trained and experienced extension and advocacy professional/expert must be taken. The State AYUSH Societies must engage such a professional to lead the component right from the design stage, through implementation and till the time the feedback is obtained. The professional should have a formal degree in Social Work or in Rural Management and should have at least five years of experience in extension work in the community. Such a person can be given a retainership contract in accordance with the rules

of State Government/ State AYUSH Society. This engagement is likely to have a great impact.

- xxi) **Conducting training and preparing training material for ASHA/ANM/school teachers/Anganwadi workers should be made mandatory part of BCC intervention:** The States/UTs, where this component is approved for implementation must ensure that they conduct training of ASHAs/ANMs/school teachers/Anganwadi workers from the target areas of BCC during the implementation of the component. This will lead to better awareness generation and information dissemination.
- xxii) **Scope of BCC should be standardised:** There should be clear cut guidelines specified by Mission Directorate for the BCC material content and format. The criteria should reflect a combination of need for the communication and high chances of its adoption by the target audience. We suggest that a group of officials and experts be constituted for this purpose to evolve the detailed guidelines for BCC so that AYUSH material is standardized across the country. It should take into account regional variations such as North East, tribal areas, etc. and factor these into the criteria that are finally arrived at. It must be insisted that BCC proposal by states must be submitted along with the details of communication proposed to be produced as well as the method by which it will be disseminated.
- xxiii) **Engagement of trained and experienced ‘Communication’ professional to lead the BCC component:** It is suggested that in order to improve the quality of outcomes and increase the effectiveness of BCC, the services of a formally trained and experienced communication professional/expert must be taken. The State AYUSH Societies must engage such a professional to lead the BCC component right from the design stage, through production and distribution and till the time the feedback is obtained. The professional should have a formal degree in Mass Communication or in Visual communication and should have at least five years of experience in communication design, production and distribution. Such a person can be given a retainership contract in accordance with the rules of State Government/ State AYUSH Society. Once the communication professional is engaged, it will have a great impact.

- xxiv) **Conducting training of ASHA/ANM/school teachers/Anganwadi workers should be made mandatory part of AYUSH Gram intervention:** The States/UTs, where this component is approved for implementation must ensure that they conduct training of ASHAs/ANMs/school teachers/Anganwadi workers from the AYUSH Grams on AYUSH during the implementation of the programme. This will lead to better outcomes.
- xxv) **Better awareness of beneficiaries must be ensured:** The topic of AYUSH should be included in awareness programmes at schools of AYUSH Grams; people availing AYUSH services at the camps must be educated about the need to come for follow-up checkups at Primary Health Centres.
- xxvi) **Definition of AYUSH Gram should be standardised:** There should be clear cut eligibility criteria based on demographic, geographic and physical and social infrastructure, health status related measures that should be specified by Mission Directorate for the villages that can be considered for AYUSH Grams. The criteria should reflect a combination of need for AYUSH intervention and high chances of its adoption in the candidate villages. We suggest that a group of officials and experts be constituted for this purpose to evolve the eligibility criteria for AYUSH Gram villages. It should take into account regional variations such as North East, remoteness, forest, SC/ST, etc. and factor these into the criteria that is finally arrived at. It must be insisted that AYUSH Grams proposal by states must be submitted along with the actual data of those villages that acts as an evidence for their eligibility. Depending on the village level data and therefore the category of such villages, combination of a set of standardized interventions along with some sub component of flexible interventions (depending on local context) is implemented in each of the villages.
- xxvii) **Scope of School Health Programme should be standardised:** There should be clear cut guidelines specified by Mission Directorate for the elements of School Health Programme Component of NAM. We suggest that a group of officials and experts be constituted for this purpose to evolve the detailed guidelines for School Health Programme so that this intervention is standardized across the country. It should take into account regional variations such as North East, tribal areas, etc. and factor these into the criteria that are finally arrived at. It must be insisted that School Health Programme

proposal by states must be submitted along with the details of elements proposed to be implemented as well as the locations where these will be carried out.

- xxviii) **Engagement of trained and experienced ‘Extension and advocacy’ professional to lead the School Health Programme component:** It is suggested that in order to improve the quality of outcomes and increase the effectiveness of School Health Programme, the services of a formally trained and experienced extension and advocacy professional/expert must be taken. The State AYUSH Societies must engage such a professional to lead the component right from the design stage, through implementation and till the time the feedback is obtained. The professional should have a formal degree in Social Work or in Education and should have at least five years of experience in extension work in the community. Such a person can be given a retainership contract in accordance with the rules of State Government/ State AYUSH Society. This engagement is likely to have a great impact.
- xxix) **Scope of Wellness Centres should be standardized:** There should be clear cut guidelines specified by Mission Directorate for the elements of this Component of NAM. We suggest that a group of officials and experts be constituted for this purpose to evolve the detailed guidelines for Wellness centres so that this intervention is standardized across the country. It should take into account regional variations such as North East, tribal areas, Kerala, etc. and factor these into the criteria that are finally arrived at. During this exercise all the states should be involved in giving inputs.
- xxx) **Engagement of trained and experienced quality testing and inspection professionals like drug analyst and drug inspectors to man the Quality Improvement and Control component:** It is suggested that in order to improve the quality of outcomes and increase the effectiveness of Quality Improvement and Control, the salaries and terms of engagement for competent people qualified in different streams of AYUSH pharmaceutical testing and inspection services must be reviewed. The state must appoint competent, qualified and experienced Government Drug analysts and also immediately recruit adequate number of Drug Inspectors as per the norms given in the act, rules and the guidelines specified. This will contribute significantly to improving quality of ASU&H medicines and increase the faith of general population in AYUSH system.

- xxxi) **Expansion and Construction of hostels may be assisted under NAM:** There is a serious shortage of proper hostels and hostel rooms in the educational institutions. The possibility must be explored to support construction of hostels and addition of hostel rooms in good educational institutions of AYUSH which need this facility. It will help attract talented students.
- xxxii) **Standards of AYUSH Educational Institutions should be firmly enforced:** As part of the NAM assistance, the improvement in quality standards of the institutes as well as the education within these institutes must be supported with funds. There must be an attempt to shortlist some of the notably good institutes and other institutes may be supported with funds to come upto their standards using these as benchmarks.
- xxxiii) **Explore possibility of supporting Educational Visits, sessions by notable AYUSH practitioners in the educational institutes:** In order to improve the educational avenues of students, activities like educational visits and lectures by eminent practitioners may be funded at institute level.
- xxxiv) **Success factors identified for certain states must be replicated to other states:** There are certain factors which have been identified for the relative success of NAM in certain states. These factors are regular coordination between SMPB and SAS, fully staffed Programme Management Unit, better monitoring system between field units and SAS, Presence of district level AYUSH machinery and rigorous process followed during formulation of SAAP and regular communication with CPMU. These need to be replicated in relatively lower performing states.