NATIONAL HEALTH MISSION (NHM)
DRAFT OPERATING MANUAL
FOR
PREPARATION AND MONITORING OF
STATE PROGRAMME IMPLEMENTATION
PLANS (PIPs)

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

MSG STRATEGIC CONSULTING PVT. LTD.

October, 2013
<table>
<thead>
<tr>
<th>SL. NO.</th>
<th>CONTENTS</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Key Features of NHM</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Purpose and structure of this manual</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Other relevant guidelines/documents</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>CONCEPTUAL FRAMEWORK AND OVERVIEW OF THE PLANNING AND MONITORING PROCESS</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Key features of the PIP</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Resource allocation criteria for states</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Pilots</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Self-Appraisal of State PIPs</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Overview of the planning and monitoring cycle</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Timeline</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Institutional Arrangements</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>GETTING STARTED</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>State and District level planning teams</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Allocation of resources by State</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Guidelines to Districts/Other spending centres for preparation of DHPs/Respective Plans</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Training of district and/ city planning teams</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>WHERE ARE WE NOW (SITUATION ANALYSIS)?</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Data Collection</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Data Analysis</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Outcome</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>WHERE DO WE WISH TO GO?</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Choice of Indicators</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Basis for setting targets</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>HOW WILL WE GET THERE?</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Progress &amp; Lessons Learnt</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Prioritisation of Strategies</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Innovation and Pilots</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Programme Management Arrangements</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Activities to Implement Strategies</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Internal Consistency</td>
<td>22</td>
</tr>
<tr>
<td>7</td>
<td>WHAT RESOURCES ARE REQUIRED?</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Flexibility in Preparation of Budgets</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Basis for Budget Preparation</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Process of Iteration</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Budget Review</td>
<td>24</td>
</tr>
<tr>
<td>8</td>
<td>WHAT THE STATE NHM PIP SHOULD LOOK LIKE?</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Indicative Contents of State NHM PIP</td>
<td>25</td>
</tr>
<tr>
<td>9</td>
<td>HOW DO WE KNOW WE ARE ON THE RIGHT TRACK? (PROGRAMME MONITORING &amp; REVIEW)</td>
<td>30</td>
</tr>
<tr>
<td>ANNEX No.</td>
<td>ANNEXURE</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td><strong>CHAPTER 1</strong></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td><strong>TECHNICAL STRATEGIES</strong></td>
<td></td>
</tr>
<tr>
<td>1.1a</td>
<td>RMNCH+A</td>
<td></td>
</tr>
<tr>
<td>1.1b</td>
<td>NUHM</td>
<td></td>
</tr>
<tr>
<td>1.1c</td>
<td>Disease Control Programmes</td>
<td></td>
</tr>
<tr>
<td>1.1d</td>
<td>Non Communicable Diseases, Injury and Trauma</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Checklist of Health system initiatives</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Priority RMNCH+A Strategies (5x5 matrix)</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Relevant Guidelines/Documents</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>CHAPTER 4</strong></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td><strong>STATE PROFILE</strong></td>
<td></td>
</tr>
<tr>
<td>4.1a</td>
<td>Demographic &amp; Socio Economic Indicators</td>
<td></td>
</tr>
<tr>
<td>4.1b</td>
<td>Administrative Details</td>
<td></td>
</tr>
<tr>
<td>4.1c</td>
<td>Facility Distance</td>
<td></td>
</tr>
<tr>
<td>4.1d</td>
<td>Public &amp; Private Infrastructure</td>
<td></td>
</tr>
<tr>
<td>4.1e</td>
<td>Support from Development Partners</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td><strong>STATE HEALTH INDICATORS</strong></td>
<td></td>
</tr>
<tr>
<td>4.2a</td>
<td>Goal</td>
<td></td>
</tr>
<tr>
<td>4.2b</td>
<td>Service Delivery</td>
<td></td>
</tr>
<tr>
<td>4.2c</td>
<td>Program</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>CHAPTER 6</strong></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td><strong>CONDITIONALITIES &amp; INCENTIVES</strong></td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td><strong>PROCUREMENT FORMAT</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>CHAPTER 7</strong></td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td><strong>BUDGETING NORMS</strong></td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td><strong>BUDGET FORMATS</strong></td>
<td></td>
</tr>
<tr>
<td>7.2a</td>
<td>Budget Summary</td>
<td></td>
</tr>
<tr>
<td>7.2b</td>
<td>Part I: NRHM + RMNCH plus A Flexipool budget</td>
<td></td>
</tr>
<tr>
<td>7.2c</td>
<td>Part II: NUHM Flexipool budget</td>
<td></td>
</tr>
<tr>
<td>7.2d</td>
<td>Part III: Flexipool for Disease Control Programs budget</td>
<td></td>
</tr>
<tr>
<td>7.2e</td>
<td>Part IV: Flexipool for Non-Communicable Diseases including Injury and Trauma budget</td>
<td></td>
</tr>
<tr>
<td>7.2f</td>
<td>Part V: Infrastructure Maintenance budget</td>
<td></td>
</tr>
<tr>
<td>7.2g</td>
<td>Compiled budget</td>
<td></td>
</tr>
<tr>
<td>7.2h</td>
<td>District wise budget</td>
<td></td>
</tr>
<tr>
<td>7.2i</td>
<td>Committed unspent budget format</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>CHAPTER 8</strong></td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td><strong>PIP SELF APPRAISAL FORMAT</strong></td>
<td></td>
</tr>
</tbody>
</table>
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>APL</td>
<td>Above Poverty Line</td>
</tr>
<tr>
<td>ARSH</td>
<td>Adolescent Reproductive And Sexual Health</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
</tr>
<tr>
<td>BPMU</td>
<td>Block Programme Management Unit</td>
</tr>
<tr>
<td>CH</td>
<td>Child Health</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Care</td>
</tr>
<tr>
<td>DC</td>
<td>Disease Control</td>
</tr>
<tr>
<td>DP</td>
<td>Development Partner</td>
</tr>
<tr>
<td>DPMU</td>
<td>District Programme Management Unit</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FRU</td>
<td>First Referral Unit</td>
</tr>
<tr>
<td>GoI</td>
<td>Government Of India</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HPD</td>
<td>High Priority District</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HRD</td>
<td>Human Resource Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>JSSK</td>
<td>Janani Shishu Suraksha Karyakram</td>
</tr>
<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MAS</td>
<td>Mahila Arogya Samiti</td>
</tr>
<tr>
<td>MCD</td>
<td>Municipal Corporation Department</td>
</tr>
<tr>
<td>MH</td>
<td>Maternal Health</td>
</tr>
<tr>
<td>MMU</td>
<td>Mobile Medical Unit</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry Of Health &amp; Family Welfare</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>NLEP</td>
<td>National Leprosy Eradication Programme</td>
</tr>
<tr>
<td>NPCC</td>
<td>National Programme Coordination Committee</td>
</tr>
<tr>
<td>NPCDCS</td>
<td>National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke</td>
</tr>
<tr>
<td>NPCB</td>
<td>National Programme for Control of Blindness</td>
</tr>
<tr>
<td>NMHP</td>
<td>National Mental Health Programme</td>
</tr>
<tr>
<td>NOHP</td>
<td>National Oral Health Programme</td>
</tr>
<tr>
<td>NPPC</td>
<td>National Programme for Palliative Care</td>
</tr>
<tr>
<td>NPPMBI</td>
<td>National Programme for Prevention and Management of Burn Injuries</td>
</tr>
<tr>
<td>NPPCF</td>
<td>National Programme for Prevention and Control of Fluorosis</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Program</td>
</tr>
<tr>
<td>NUHM</td>
<td>National Urban Health Mission</td>
</tr>
<tr>
<td>NVBDCP</td>
<td>National Vector Borne Disease Control Programme</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
</tr>
<tr>
<td>PIP</td>
<td>Program Implementation Plan</td>
</tr>
<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive Child Health</td>
</tr>
</tbody>
</table>
RKS: Rogi Kalyan Samiti
RMNCH+A: Reproductive Maternal Neonatal Child Health + Adolescent
ROP: Record of Proceedings
SC/ST: Scheduled Castes/Scheduled Tribals
SHC: Sub Health Centre
SHS: State Health Systems
SHSRC: State Health Systems Resource Centre
SIHFW: State Institute of Health and Family Welfare
SPMU: State Programme Management Unit
SRS: Sample Registration System
AHS: Annual Health Survey
DLHS: District Level House Hold Survey
NFHS: National Family Health Survey
HMIS: Health Management Information System
MCTS: Mother and Child Tracking System
IDSP: Integrated Disease Surveillance Programme
TFR: Total Fertility Rate
UH: Urban Health
ULB: Urban Local Body
UPHC: Urban Primary Health Centre
VHSNC: Village Health Sanitation and Nutrition Committee
1. INTRODUCTION

BACKGROUND

1.01 The National Rural Health Mission (NRHM) was launched in 2005 and during the period 2005-06 to 2013-14, States\(^1\) prepared Program Implementation Plans (PIPs) on an annual basis. The PIPs went through a formal process of appraisal each year by MoHFW and with subsequent approval, States commenced implementation. With the advent of the National Urban Health Mission (NUHM) in the first quarter of 2013-14, separate NUHM PIPs are being prepared by States for the period September 2013-March 2014. The preparation of the NRHM and NUHM PIPs are governed by the respective Implementation Frameworks\(^2\), with detailed guidance provided to states in the form of operating manuals/guidelines, which were revised on an annual basis. Non Communicable Diseases (NCDs) have been incorporated for the first time.

1.02 The National Health Mission (NHM) now subsumes NRHM and NUHM, which have been designated as Sub-Missions (of NHM). NHM would be guided by a separate Implementation Framework\(^3\); and both NRHM and NUHM Frameworks for Implementation will continue to guide the NRHM and the NUHM in so far as they are not inconsistent with any of the provisions of the NHM framework. Similarly, detailed guidelines have been prepared for various Communicable and Non-Communicable Disease Control Programmes that would guide these programmes within the NHM framework. NUHM will cover all the state capitals, all district headquarters, towns, other cities & towns with a population more than 50,000. Other smaller towns will continue to be covered under NRHM.

KEY FEATURES OF NHM

1.03 NHM envisages “Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people’s needs, with effective inter-sectoral convergent action to address the wider social determinants of health”\(^4\). To attain the above vision, NHM would seek to:

Range and delivery of services

- Prioritize achievement of universal coverage for Reproductive Maternal, Newborn, Child Health and Adolescents (RMNCH+A) services, National Disease Control and Non Communicable Diseases programmes in rural and urban areas.
- Go beyond maternal and child survival to ensuring quality of life for women and children.
- Expand focus from child survival to development of all children 0-18 years through a mix of Community, Anganwadi and School based health services.
- Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in urban slums.
- Strengthening existing health care system to address the rising burden of Non-

\(^1\) Also refers to union territories throughout this document
\(^2\) Refer NRHM Implementation Framework, 2006 and NUHM Implementation Framework, May 2013
\(^3\) NHM Framework for Implementation, Version 5.2, Draft, August 7, 2013
Communicable Diseases

- Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health care services.
- Converge with Ministry of Women & Child Development and other related Ministries for effective prevention and reduction of under-nutrition in children aged 0-3 years and anaemia among children, adolescents and women and provision of safe drinking water and sanitation.

Equity

- Plan for differential financial investments and technical support to states, districts and cities, with higher proportions of vulnerable population groups, including urban poor and destitute, and with difficult geographical terrain that face special challenges to meeting health goals.
- Ensure increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers.
- Address shortages of skilled workers in remote, rural areas, urban slums, and other under-served pockets through appropriate monetary and non-monetary incentives.
- Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities where-ever necessary.

Health system strengthening

- Support and supplement state efforts to undertake sector wide health system strengthening through the provision of financial and technical assistance; incentivize States to undertake health sector reforms that lead to greater efficiency and equity in health care delivery.
- Improve Public Health Management by encouraging states to create public health cadre, and strengthening/ creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures.
- Support states to develop a comprehensive strategy for human resources in health, through policies to support improved recruitment, retention and motivation of health workers to serve in rural, remote tribal and underserved areas, improved workforce management, achievement of IPHS norms of human resource deployment, development of mid level care providers and creation of new cadres with appropriate skill sets, and in-service training.
- Empower the ASHA to serve as a facilitator, mobilizer of community level care.
- Ensure Quality Assurance for improved credibility of public health services.
- Strengthen Health Management Information Systems as an effective instrument for programme planning and monitoring, supplemented by annual district level surveys and a strong disease surveillance system.
- Ensure universal registration of births and deaths with adequate information on cause of death, to assist in health outcome measurements and health planning.
- Create mechanisms to strengthen Behaviour Change Communication efforts for

---

5 Universal provision of free consultations, free drugs and diagnostics, free emergency response and patient transport systems
preventive and promotive health functions, action on social determinants and to reach the most marginalized.

- Mainstream AYUSH, so as to enhance choice of services for users and learning from and revitalizing local health care traditions.
- Develop effective partnerships with the not-for-profit, Non Governmental Organizations in all aspects of health care and with the for-profit, private sector to bring in additional capacity where needed to close gaps or improve quality of services.
- Establish Accountability Frameworks at all levels for improved oversight of programme implementation and achievement of programme goals. The mechanisms for accountability shall range from participatory community processes like Jan Sunwais/Samwads, Social Audit through Gram Sabhas and professional independent concurrent evaluation.
- Implement pilots for Universal Health Coverage (UHC) in selected districts in both EAG and non-EAG states to test approaches and innovations before scaling up.

**Program management**
- Continue to strengthen (1) Program management structures at state, district, city, block and facility levels(2) Involvement of Panchayati Raj Institutions (PRIs) /Urban Local Bodies (ULBs) representatives in the governance and oversight of health services and (3) People’s organizations such as the Village Health Sanitation and Nutrition Committees (VHSNC) and Mahila Arogya Samitis (MAS) for convergent inter-sectoral planning and monitoring.
- Build state, district and city capacity for decentralized outcome based planning and implementation, based on varying diseases burden scenarios, and using a differential financing approach. There will be a focus on results and performance based funding including linkage to caseloads.
- Enable integrated facility development planning which would include infrastructure, human resources, drugs and supplies, quality assurance, and effective Rogi Kalyan Samitis (RKS).
- Incentivize good performance of both facilities and providers.
- Create a District Level Knowledge Center within each District Hospital to serve as the hub for a range of tasks that inter alia includes, provision of secondary and selected elements of tertiary care, being the site for skill based training for all cadres of health workers, collating and analyzing data and coordinating district planning.

1.04 An overview of NHM health infrastructure and institutions of governance has been provided in Exhibit 1.01. For detailed descriptions of NHM refer to NHM Framework for Implementation, Version 5.2, Draft, August 7, 2013.
EXHIBIT 1.01: OVERVIEW OF NHM HEALTH INFRASTRUCTURE AND INSTITUTIONS OF GOVERNANCE

PURPOSE AND STRUCTURE OF THIS MANUAL

1.05 This Manual is intended to be a user-friendly tool to assist states in preparation of planning and monitoring of NHM state PIPs. Target groups for this manual include:

- State NHM Mission Director and health managers at state and district levels;
- SPMU and DPMU staff; and
- Members of the team constituted for preparation and monitoring of PIPs.

Structure of this Manual

1.06 An overview of the structure of this Manual is provided in Exhibit 1.02. Chapter 2 sets out the conceptual framework for planning and key underlying principles. It also provides an overview of the planning and monitoring process along with the time frame. Chapter 3 i.e. ‘Getting started’ addresses the composition of planning teams at state and district levels and allocation of funds to districts / other agencies. Chapter 4 i.e. ‘Where are we now’ deals with the current status and situation analysis leading to identification of key issues adversely affecting performance. While Chapter 5 (Where do we wish to go) covers setting of targets for goals and service delivery, Chapter 6 looks at
‘How will we get there’ in terms of strategies, activities and corresponding costs. The approach to budget preparation is addressed in Chapter 7. The drafting of the PIP including a detailed contents page and subsequent review and approvals are addressed in Chapter 8. Monitoring and review i.e. ‘How will we know if we have arrived’ is covered in Chapter 9.

**OTHER RELEVANT GUIDELINES / DOCUMENTS**

1.07 This manual should be seen together with guidance provided in:

- Technical strategies promoted by MoHFW; these have been listed separately for RMNCH+A, NUHM, Disease control programmes and Non-communicable diseases in Annex 1.1a to 1.1d respectively.
- Systems approach to health; key initiatives have been summarized in Annex 1.2.
- Priority RMNCH+A Strategies (5x5 matrix); refer Annex 1.3.
- Various guidelines/ other documents provided by MoHFW; listed in Annex 1.4.
- The state ROP for 2013-14, which provides a road map for priority action in various programme areas.
2. CONCEPTUAL FRAMEWORK AND OVERVIEW OF THE PLANNING AND MONITORING PROCESS

2.01 This manual is a tool for preparation and monitoring of the state NHM PIP. This chapter sets out the conceptual framework in terms of key features and underlying principles, the planning and monitoring process and institutional arrangements.

KEY FEATURES OF THE PIP

2.02 State Programme Implementation Plans (PIPs) will now consist of the following five parts: PART I: NRHM plus RMNCH+A (including immunization) Flexipool; PART II: NUHM Flexipool; PART III: Flexipool for Disease Control Programmes; PART IV: Flexipool for non-communicable diseases including injury and trauma; and PART V: Infrastructure Maintenance. There will be a separate financial envelope tied to Parts I to IV within which every State will have the flexibility to allocate funds across different strategies/activities in line with local conditions and within broad national priorities.

2.03 Each state should prepare a three year perspective plan / PIP for the period 2014-15 to 2016-17. The three year plan would have a results framework broken down by year in terms of key indicators i.e. goals, outcomes, outputs and process. On an annual basis, States are to update the PIP by way of providing:

- Progress in the last year/ lessons learnt and changes proposed;
- Detailed action plan including activities, agencies/ persons responsible and timeline, by quarter;
- Quarterly targets for outcomes and outputs (to be based on the web based HMIS); and
- Detailed quarterly budgets linked to physical outputs.

The perspective plan for 2014-2017 will also have the detailed quarterly targets and budget for the first year, 2014-15.

2.04 Ideally the NHM annual PIP should be a component of the state Department of Health and Family Welfare’s annual plan. At a minimum, the NHM PIP should capture all sources of funds.

2.05 Procurement requirement for items to be supplied by centre are to be included as a part of the PIP.

2.06 State PIPs would be an aggregate of district/ city health action plans. DP supported activities (as a part of RMNCH+A Intensification and Harmonization of efforts in High Priority Districts) would be reflected in district/ state PIPs. City Plans for the first year to be submitted as a part of the NHM State PIP.

2.07 State governments are required to contribute 25% under NHM, except for NE states, Jammu & Kashmir and HP, wherein state contribution would be 10%. Further, states have to maintain a minimum of 10% annual increase in health budget.

---

6 The erstwhile, RCH, Mission Flexi-pool and Immunization components of PIPs.
7 Refers to direct budgetary support to states.
RESOURCE ALLOCATION CRITERIA FOR STATES

2.08 States should adhere to the following resource allocation criteria:

- At least 70% of funds should be allocated to districts. High priority districts to be allocated 30% more (vis-a-vis the population) funds.
- Tribal population / areas and vulnerable groups to receive special attention.
- Construction / upgrading of facilities should along with other parameters be determined by time to primary health care i.e. no more than 30 minutes of walking distance, and secondary care services including C-section and blood transfusion are available within two hours of any habitation\(^8\) with an assured referral transport system connecting the two. In hard to reach areas, Mobile Medical Units (MMUs) should be used to provide primary healthcare services on a regular basis.
- Not more than 33% of total state resource envelope should be allocated for infrastructure in EAG states; for other states, the corresponding figure is 25%.
- Prioritise facilities with higher caseloads (deliveries, OPD/OPD services) for further development\(^9\); all others should maintain or redeploy existing staff.
- Annual untied amount is proposed to be doubled for CHCs and District Hospitals; but this should be reallocated based on need/case loads.
- Up to 5% of state resource envelope may be allocated towards capacity building.
- Programme management costs should not account for more than 5.5% of the total annual work plan; however in small states and union territories this may increase to no more than 10%.
- For technical assistance at the State and District level, up to 2% of the state annual work plan may be allocated.
- The cost of monitoring including MIS should be no more than 1% of total NHM funds.
- Up to 10% of the total NHM resource envelope may be used to fund innovations at the state level.

PILOTS

2.09 States to propose the following low cost and scalable pilots in 2-3 districts which are at present not covered under regular PIP:

- Universal health coverage to reduce out of pocket expenditure and ensure universal access to assured services of quality.
- Development of: 1) District Hospital to provide most secondary care services; 2) the District Training and Education Center; and 3) the District Public Health Resource Centre which would provide the technical inputs, support and handholding for planning, for epidemiology and data analysis, and for knowledge management.

\(^8\) Either by establishing new centres and/or purchase of services from private sector
\(^9\) By way of meeting IPHS norms/Quality of care standards established as per national guidelines, greater allocation of untied funds as well as drugs and diagnostic services (the earlier Maintenance, RKS and Facility grants would be replaced by a single untied fund linked to patient load- if feasible, on a cost per unit or type of treatment basis).
SEFS- APPRAISAL OF STATE PIPS

2.10 As a part of this manual, appraisal criteria for PIPs has been provided. States are to carry out self-appraisal as a part of the PIP preparation process.

OVERVIEW OF THE PLANNING AND MONITORING CYCLE

2.11 An overview of the planning and monitoring process for state NHM PIPs is schematically shown in Exhibit 2.01. The starting point is the constitution of the state, district and city planning teams, allocation of flexible and other funds to districts and state level /other agencies (SIHFW, IEC bureau, M&E, logistics, urban local bodies, etc) and training of their respective planning teams. Districts/ ULB share envisaged to prepare their respective PIPs in accordance with the prescribed guidelines; state level “spending agencies” would need to prepare plans for their functions/support to districts/cities. The State may also use the formats recommended for State PIP for districts.

2.12 As shown in Exhibit 2.01, key stages include preparation of district/ city plans; a state level situation analysis followed by setting of targets for goals, service delivery, outputs and corresponding strategies and activities. Budgeting would start with appropriate provisions for ongoing national schemes/ initiatives like JSY, JSSK, RBSK and entitlement related provisions such as for sterilisation, ASHA incentives and such compensation for HR that is proposed to be continued and for which the GOI has not put restrictions. The subsequent costing of the PIP would be an iterative activity in order to ensure that the PIP is within the financial envelope. Once the state NHM PIP has been drafted, a state level workshop should be conducted. With feedback incorporated, and appropriate modifications made into the PIP, states should then present it to the respective State Health Society and the NPCC, MoHFW. Implementation of the approved PIP should lead to improvement in outcomes and hence favorably impact the current situation (analysis). This would then be the starting point for the planning process in the subsequent year.

2.13 On a quarterly basis, each state will prepare a variance analysis report (based on web based HMIS) against the plan/ targets/ expenditure for the reporting quarter no later than the end of the month following the quarter. A copy of the above quarterly variance analysis reports are to be sent to MoHFW.
EXHIBIT 2.01: OVERVIEW OF STATE NHM PIP PLANNING PROCESS

Start Up
- State level planning team constituted
- Allocation of funds to districts
- District/City/ULB planning guidelines disseminated
- District staff trained

Background and current status
- Demographic and socio-economic features
- Health outcomes and service utilization
- Public health infrastructure; Human
- Private and NGO health services/ infrastructure
- DP (donor assisted) programmes
- Institutional arrangements and organizational development
- Programme finances

Situation Analysis
- RMNCH +A;
- Health Systems/NRHM Initiatives;
- Urban;
- Disease Control Programmes; NCD.

Targets for goals, service delivery and outputs; corresponding strategies and activities

Costing of PIP

Drafting of PIP

State level workshop

Implementation / monitoring and review

Review and approval by State Health Society, and GoI
**TIME LINE**

2.14 The targeted time frames for the above process are as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimation of resource envelope to states by GoI</td>
<td>October</td>
</tr>
<tr>
<td>Intimation of resource envelope to districts/other agencies by states</td>
<td>October</td>
</tr>
<tr>
<td>Preparation of District/ City and other plans by state level agencies</td>
<td>November</td>
</tr>
<tr>
<td>Preparation of state PIPs, approval by State Health Mission/ Society and</td>
<td>December</td>
</tr>
<tr>
<td>submission to MoHFW</td>
<td></td>
</tr>
<tr>
<td>Appraisal and approval of PIPs by MoHFW</td>
<td>January - March</td>
</tr>
</tbody>
</table>

**INSTITUTIONAL ARRANGEMENTS**

2.15 It is expected that the following institutional arrangements (refer Exhibit 2.02) are in place at the state level:

- State Health Mission and State Health Society headed by the State Chief Minister and State Chief Secretary respectively.
- The State Health Mission/Society has been expanded to include Minister(s) in charge of Urban Development and Housing & Urban Poverty Alleviation, and Secretaries in charge of the Urban Development and Housing & Urban Poverty Alleviation departments.
- Mission Director NRHM to be re-designated as Mission Director National Health Mission (NHM) and shall look after the work of NRHM and NHM both.
- Appointment of Additional Mission Director, NUHM (especially for big states)

2.16 The State Program Management Unit (SPMU) has been appropriately strengthened to address NHM requirements, in particular, setting up an Urban Health Cell within State Health Society/SPMU. The constitution and functioning of the SPMU and Executive Committee of the SHS shall be such that there is no hiatus between the Directorate of Health and Family Welfare services and the SPMU.

2.17 The District Health Society and the District Programme Management Unit (DPMU) has also been appropriately expanded to cater to NHM requirements, in particular the NUHM sub-mission.
2.18 City Urban Health Societies will also have to be put in place in the mega cities and other large cities/ corporations, where the responsibility of implementing NUHM is handed over to respective ULB.

EXHIBIT 2.02: INSTITUTIONAL ARRANGEMENTS
3. GETTING STARTED

3.01 This chapter covers preplanning activities including formation of the state, district and city level planning teams, allocation of funds to districts, ULBs and other “spending centres”, dissemination of district / city planning guidelines and training of district planning teams.

STATE AND DISTRICT LEVEL PLANNING TEAMS

3.02 The State Programme Management Unit (SPMU) together with the Urban cell is primarily responsible for coordinating the preparation of the state NHM PIP and its final drafting. A state level PIP preparation team should be constituted with representatives from RMNCH+A technical divisions, Urban health, disease control programmes and non-communicable diseases, finance and M&E.

3.03 Similarly the District Programme Management Units (DPMUs) would have the primary responsibility for development of District Health Plans and city NUHM plans; in the case of metros, large ULBS, wherein the responsibility for NUHM is primarily with the concerned city, the CPMU would take the lead in preparation of the City NUHM Plan.

3.04 The NHM Mission Director should formally (through an order) establish planning teams at state, district and city levels.

ALLOCATION OF RESOURCES BY STATE

3.05 Allocation of resources to districts, cities and other spending centres (e.g. SIHFW, state level activities) is an extremely important decision. This should be in line with the criteria provided in chapter 2 of this Manual. In particular, at least 70% of funds under NRHM – RCH flexible pool should be allocated to districts; high priority districts of the state to be allocated at least 30% more funds per capita as compared to average of non-high priority districts of the state. Under NUHM, priority should be given to cities having higher percentage of slum population. The SPMU should prepare a tentative allocation and subsequent to approval the necessary order should be passed. The outcome of the above exercise is that each district / city and state level “spending centers” should be informed of their respective annual NHM allocation for the 3 year period: 2014-15 to 2016-17.

GUIDELINES TO DISTRICTS/ OTHER SPENDING CENTRES FOR PREPARATION OF DHPs/ RESPECTIVE PLANS

3.06 Key steps include:

- Make necessary modifications to this Manual, taking into account state specific conditions.
- Provide detailed formats to districts for preparing their respective plans, such that they can be easily consolidated into the state PIP. In particular, states may wish to review the structure and formats provided for the state PIP; and subsequently prepare corresponding formats for the district plans.
- Districts should be urged to prepare facility plans for high volume facilities. The facility plans should also take onto account funds available from untied grant(s).
- While states may wish to provide districts and cities with a standard menu of strategies and activities for adoption, upto 10% of the district allocation should
be earmarked for schemes to be developed by districts/cities. This is extremely important.

- Indicate criteria and process of appraisal of district plans. States may wish to take into account the criteria to be adopted for state PIPs.
- Similarly, for other spending centres such as SIHFW/state level functions, states may wish to develop a format for their plans such that these are amenable to easy consolidation into the state PIP.

**TRAINING OF DISTRICT AND CITY PLANNING TEAMS**

3.06 The above guidelines to districts together with a copy of key documents should be sent to each district/spending centre. Subsequently, a one-day workshop should be held in order to:

- Explain the key features of the guidelines.
- Explain the criteria and process for approval of district plans.
- Clarify any doubts/concerns.
- Agree timeframe.
4. WHERE ARE WE NOW (SITUATION ANALYSIS)?

4.01 The situation analysis should lead to:

- An understanding of the current status of health in the State (RMNCH+A, NRHM Initiatives/health systems, urban health, communicable and non communicable diseases), including variations across divisions/districts/cities, BPL, tribal populations, and vulnerable groups.

- Identification of key issues and gaps affecting delivery and utilisation of health services. Some of the key challenges would be outcome or program specific, whereas others would be cross-cutting/health systems linked. Typically these could be a combination of inadequate reach or access, poor quality, indifferent health seeking behaviour, lack of accountability/organizational capacity, shortage/sub-optimal utilization of funds and inequity (poverty, gender, geographical).

- Prioritisation over the next three years in terms of:
  
  - Geographic areas for greater attention—(a) while HPDs have already been identified in the context of RMNCH+A, these may need to be revisited vis-à-vis prevalence of communicable diseases and NCDs and within districts, there could be some blocks which need special attention; (b) tribal areas typically have much poorer health indicators; and (c) phasing of cities/towns for urban health.
  
  - Programmes, for instance a state with high TFR would need to pay greater attention to family planning.

  - Service delivery, examples include facilities to be operationalised as per IPHS guidelines; areas/target population to be covered by MMUs/outreach; partnerships with private sector etc.

  - Specific health system issues such as redeployment of HR, quality assurance, regulation etc.

DATA COLLECTION

4.02 The starting point is to collect state level data(current and trends) vis-a-vis the national average in terms of:

**Background of the State**

- **Demographics**: Current (2011 Census) population broken down by rural/urban, age, sex, SC/ST, vulnerable groups, sex ratio, age at marriage, etc

- **Socio-economic indicators** like proportion of BPL/APL, per capita income, school enrolment, drop-out and literacy rates; percentage of population with access to clean drinking water and improved sanitation

- **Administrative divisions**: districts, blocks, villages, cities with population distribution

**Health Status**

- **Programme/Health outcomes**: current status and trends for:
  
  - RMNCH+A: MH, CH, Immunization, FP, AH, RBSK, Tribal, PNDT, vulnerable groups
  
  - Urban Health
• Disease Control: RNTCP, NVBDCP, NLEP
• Non Communicable Diseases: NPCDCS, NPCB, NMHP, NTCP, NOHP, NPPC, NPPMBI and NPPCF
(To the extent possible look for a break down by rural/urban, tribal, HPDs, cities, SC/ST, BPL, etc.).
• Health infrastructure and service availability: (again broken down by district/ city, tribal areas to the extent possible) in terms of:
  • Average time to care for primary and secondary services
  • Public health infrastructure (district/ civil hospitals, CHCs/FRUs, PHCs/UPHCs, SHCs; MMUs etc.): assessment of shortfall/ mismatch and extent to which these are fully operationalized (based on IPHS norms)
  • Private and NGO health services, including total number disaggregated by size and staff availability that are currently providing or having the potential to provide NHM services.
  • DP (donor assisted) programmes in the state (objectives, outputs, key activities, funds, etc.)
• Health systems: Current status and key issues in terms of:
  • Human resources availability and shortfall (include both regular and contractual staff)
  • Training: Total numbers trained by staff category and type of training programme; shortfall; status of SIHFW and district training institutions
  • Other HRD aspects (staff productivity; performance appraisal system, etc.)
  • Emergency/referral transport
  • IEC/ BCC
  • Procurement and logistics
  • Quality assurance (facilities and outreach services)
  • Monitoring and evaluation including HMIS and MCTS
  • Partnerships with donors, non-profit or private sector
  • Convergence
  • ASHA/ community processes
  • Program management
  • Assessment of institutional capacities including for ULBs
  • Detailed organization structure and staffing both directorate and PMU at state, district/ city and block levels
  • Supportive supervision
  • Financial management including trends in expenditure and utilization of funds
  • Others (refer Annex 1.2 for a menu of health systems related issues and aspects to be addressed)

4.03 While the above is a long list of areas, in particular address priority RMNCH+A strategies indicated in Annex 1.3 (5x 5 matrix).

4.04 Both quantitative and qualitative sources of data would need to be tapped. The former would include Census, SRS, AHS/DLHS, NFHS, HMIS, MCTS, IDSP, etc. Qualitative sources include discussions with a wide range of stakeholders including NGOs, experts, etc.
4.05 The above data collection would typically be carried out by both the state and district planning teams, since certain types of data is likely to be available only at the district level.

DATA ANALYSIS

4.06 Typically data collection and analysis takes place simultaneously and quite often the latter would lead to requirement of additional data. Nevertheless for the sake of convenience, data analysis has been shown as a sequential activity.

4.07 It would be useful to present data in the form of tables/ graphs etc as this would facilitate analysis. Formats with indicators and sources of data have been provided in Annex 4. The State should supplement/ add to these.

4.08 For each item, systematically consolidate district wise data. Reconcile these figures with state level data wherever this is available or judgmentally. This reconciliation is necessary in order to ensure sanctity of the reported figures. Apart from providing the consolidated state level figures, analyze variations across districts and appropriately group districts/ cities. While HPDs have already been identified vis-à-vis RMNCH+A, certain other districts may also need to be prioritized on the basis of prevalence of communicable and non-communicable diseases.

4.09 Try and identify common core issues to be addressed across districts and issues, which are category, or district specific. This should lead to a set of common interventions across all districts and some category/ district specific interventions. Hiring of contractual staff and JSSK are examples of the former; whereas staff in less developed districts may need to be incentivized.

4.10 The above analysis of district/city plans should lead to identification of issues to be primarily addressed by the State and those that need to be addressed at the district/ sub-district levels. Development of a separate public health management cadre, preparation of training materials, training of district level trainers, strengthening HMIS and procurement systems are all examples of the former; whereas improved supervision and in service training of ASHAs and ANMs would be under the purview of districts. In districts with localized issues, develop a district specific scheme.

OUTCOME

4.11 As mentioned earlier, the outcome of the situation analysis is prioritisation over the next three years in terms of:

- Geographic areas for greater attention—(a) while HPDs have already been identified in the context of RMNCH+A, these may also need to be prioritized on the basis of prevalence of communicable diseases and NCDs; (b) tribal areas typically have much poorer health indicators; and (c) phasing of cities/ towns for urban health.
- Programmes, for instance a state with high TFR would need to pay greater attention to family planning.
- Service delivery, examples include facilities to be operationalised as per IPHS guidelines; areas/target population to be covered by MMUs/ outreach; partnerships with private sector etc.
- Specific health system issues such as redeployment of HR, quality assurance, regulation etc.
5. WHERE DO WE WISH TO GO?

5.01 This chapter sets out some suggestions for setting targets for goal, service delivery and programme (output, process) indicators.

CHOICE OF INDICATORS

5.02 A list of indicators (and format for setting targets) have been provided in Annexes 4.2a, 4.2b and 4.2c for goal, service delivery and programme (output, process) respectively. States should review the choice of indicators and ensure that performance of all disease control programmes and non-communicable diseases are reflected.

BASIS FOR SETTING TARGETS

- In order to ensure that the targets are realistic, states may wish to consider the following:
- Past trends in performance
- Likely impact of strategies/activities which could lead to accelerated improvement; in order to estimate the likely impact, try and obtain data from experiences elsewhere.
- Where possible carry out ‘back of the envelope’ cross-checks. For example, a projected increase in institutional delivery could be converted to absolute increase in number of institutional deliveries and this could be tallied with deliveries in the previous year/capacity in the public/accredited private sector facilities.
- High priority districts may wish to target outcomes achieved by average/best districts in the state. The best districts in the state could set themselves targets in line with performance of better districts in other states. District wise targets should then be consolidated for the state as a whole and compared with the better/best performing states in the country, before a final determination of the target is made.
- Setting targets should be linked to resource allocation and hence, this would be an iterative process.
6. HOW WILL WE GET THERE?

PROGRESS & LESSONS LEARNT

6.01 In order to move towards the targets set in Chapter 5, a review of the range of strategies encompassing RMNCH+A, NRHM initiatives/health systems disease control programmes and non-communicable diseases are necessary. States may wish to critically examine the implementation of these strategies and the extent of achievement vis-à-vis targets set for various indicators and the road map provided in the state ROP for 2013-14. This process should lead to decisions regarding strengthening some strategies and perhaps discarding others. For example, limited progress against outcomes in hard to reach areas may require interventions such as increasing MMU coverage, incentivizing doctors and nurses to work in those areas, multi-skilling of doctors, strengthening delivery points and/or operationalisation of facilities in accordance with IPHS guidelines etc. In case of pilots that are considered to be successful, states may wish to consider a stringent evaluation followed by possible replication across the state.

6.02 In particular, states are expected to address the priority strategies (5x5 matrix) listed in Annex 1.3.

6.03 In case of under utilisation of funds, examine reasons (time-consuming procedures, insufficient delegation of powers, etc) and identify appropriate solutions. Also examine reasons for delays in reporting back of expenditures and identify corrective steps to be taken. This will not only improve timely and accurate reporting of utilisation, but also allow matching of physical and financial progress.

6.04 NHM annual PIP should contain activity details (one pager for each activity) indicating brief summary of the activities and its financial costing along-with FMR Code. The description should be drafted separately for each activity in word format along-with all other Annexure and Budget sheet. An indicative format is provided in Exhibit 6.01.

PRIORITISATION OF STRATEGIES

6.05 Strategies should be prioritized such that the key challenges identified as a part of the situation analysis are addressed. The following table highlights a few examples:

<table>
<thead>
<tr>
<th>No of Units*</th>
<th>Cost per unit</th>
<th>Total Cost</th>
<th>FMR code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note* - Attach separate sheet for the detail components and tentative cost of each component e.g. if Labour Rooms are to be created - unit cost of the LR is to be indicated, however different components of LR and its tentative cost is to be annexed.

---

10 For convenience, technical strategies for RMNCH+A, NUHM, Disease control programmes and Non-communicable diseases are listed in Annex 1.1a to 1.1d respectively; Systems related initiatives in Annex 1.2 and Priority RMNCH+A Strategies (5x5 matrix) in Annex 1.3.

11 Refer to underlying budget formats (annex 8) for guidance on indicators which would provide a more detailed understanding of the current situation.
**EXHIBIT 6.02: INDICATIVE CHALLENGES AND POSSIBLE STRATEGIES**

<table>
<thead>
<tr>
<th>Constraints</th>
<th>Possible RMNCH+A, Urban Health or Disease specific response</th>
<th>Possible Health System Response</th>
</tr>
</thead>
</table>
| Poor access to primary healthcare services in terms of distance to public facility | • MMU and outreach services  
• Engage private/non-profit healthcare providers | • Revise plans for upgrading and/or constructing new facilities based on location. |
| High out of pocket expenditure | • Cashless transactions at facilities for health services and drugs on the EDL list | • Address bottle necks to ensure adequate drug supply  
• Monitoring and supervision |
| Poor health seeking behavior | • IPC through ASHAs and ANMs  
• Specific IEC/BCC campaigns  
• Coordination with other departments—education and women and child development | • Mechanisms to ensure convergence with other departments |
| Poor staff motivation | • Intervention specific Incentives/disincentives for health workers | • HR policy as well as recruitment, training and management systems in place  
• Development of Public Health Cadre |

**Conditionalities and Incentives**

6.06 In order to catalyse systemic changes and accelerate implementation of high impact interventions, MoHFW has instituted a system of conditionalities and incentives:

*Conditionalities*

- Rational deployment of HR with the highest priority accorded to high priority districts and delivery points.
- Facility wise performance audit and corrective action based thereon.
- Performance Measurement system set up and implemented to monitor performance of regular and contractual staff.
- Baseline assessment of competencies of all SNs, ANMs, Laboratory technicians to be done and corrective action taken thereon.
- Gaps in implementation of JSSK.

*Incentives*

- Responsiveness, transparency and accountability.
- Quality assurance.
- Inter-sectoral convergence
- Recording of vital events including strengthening of civil registration of births and deaths
- Creation of a public health cadre.
- Policy and systems to provide free generic medicines to all in public health facilities
- Timely roll out of RBSK.
- Adopting Clinical Establishment Act 2010 as per State’s/UT’s requirement, to
regulate the quality and cost of health care in different public and private health facilities.

- Increase in State annual health budget.
- Implementation of nurse practitioner model.

States are expected to provide an implementation plan with quantifiable targets for the above. Refer to Annex 6.1 for format.

**INNOVATIONS AND PILOTS**

6.07 In order to address state / district specific concerns/ gaps, upto 10% of the financial envelope could be used for innovative strategies. For each such innovation, states should prepare a separate note articulating, the problem to be addressed, objectives, description of approach and activities, management arrangements, costs and method of evaluation.

6.08 States are also advised to conduct the following pilots in 2-3 districts:

- Universal health coverage to reduce out of pocket expenditure
- Development of:
  - District Hospital to provide most secondary care services;
  - District Training and Education Center; and
  - District Public Health Resource Centre which would provide the technical inputs, support and handholding for planning, for epidemiology and data analysis, and for knowledge management.

As in the case of innovations, a detailed concept note would be required.

**PROGRAMME MANAGEMENT ARRANGEMENTS**

6.09 In order to obtain a clear understanding of the programme management arrangements, states should provide detailed organisation charts for the Department of Health and Family Welfare at the state, district/city and sub district levels including position of the state and district/city programme management units.

6.10 As far as possible, states should ensure that the proposed organization structure is consistent with NHM goals and strategies and key functions, in particular, dedicated staff / nodal officers should be in place for the priorities listed in Annex 1.3.

**ACTIVITIES TO IMPLEMENT STRATEGIES**

6.11 For each strategy, revisit the activities in terms of identifying implementation bottlenecks. Where necessary, revisit/ prepare standard operating procedures clearly articulating person responsible and time frame. Subsequently, it may be necessary to provide for training and improved supportive supervision.

**Procurement Planning**

6.11 In order to facilitate necessary supply of centrally procured items, effective planning by states is a must. To this end, states are expected to estimate expected stocks of centrally procured items as at March 31, 2014 and project requirements. A format including indicative list of centrally
procured items is provided in Annex 6.2. States should ensure that the projected requirement is in line with its strategies and targets.

INTERNAL CONSISTENCY

6.12 States should try and ensure internal consistency within the NHM PIP such that the goal, outcomes, outputs, activities, work-plan and costs are all systematically linked with each other. For instance, in order to reduce MMR, increasing institutional deliveries is a key strategy for which functional facilities (24 x 7 PHCs, FRUs) and emergency and referral transport would be one of the key outputs. This involves activities such as training and posting staff, strengthening infrastructure and staff supervision. These activities should then be listed in the State PIP, along with an estimation of costs. This approach should lead to a systematic assessment of activities and costs required for improving each outcome and the overall goal.

6.13 Further, projected institutional deliveries in the public sector should be reconciled with capacity (in public and accredited facilities); JSY and JSSK costs should be inline with projected institutional deliveries and so on.
7. WHAT RESOURCES ARE REQUIRED

7.01 This chapter sets out suggestions for budget preparation in terms of the basis/underlying assumptions and the level of detailing required including formats.

FLEXIBILITY IN PREPARATION OF BUDGETS

7.02 As mentioned in Chapter 2, there would be separate financial envelopes for PART I: NRHM plus RMNCH+A (including immunization) flexipool; PART II: NUHM flexipool; PART III: Flexipool for Disease Control Programmes; PART IV: Flexipool for non-communicable diseases including injury and trauma; and within each pool, every State will have the flexibility to allocate funds across different strategies/activities in line with local conditions.

7.03 However, there are some caveats and states are expected to adhere to the resource allocation criteria stipulated in para 2.8 (chapter 2) of this manual. Further, budgeting norms for specific activities have been provided in Annex 7.1.

BASIS FOR BUDGET PREPARATION

7.04 The starting point for budget preparation is to cost each strategy/activity identified in chapter 6. Please note:

- As far as possible, estimate the quantity of work to be carried out in each quarter for 2014/15 and for the whole remaining two years 2015/16 and 2016/17.
- For each activity, estimate the rate or unit cost. Annex 7.1 provides norms for selected activities.
- Where a quantity and rate cannot be estimated, states can estimate a lump sum amount; but this should be the exception.
- The same strategies and activities should be used for the detailed budgets indicated in the State PIP.

7.05 Use the following formats to prepare budgets:

- Budget Summary (See Annex 7.2a)
- Part I: NRHM + RMNCH plus A Flexipool budget (See Annex 7.2b)
- Part II: NUHM Flexipool budget (See Annex 7.2c)
- Part III: Flexipool for Disease Control Programmes budget (See Annex 7.2d)
- Part IV: Flexipool for Non-Communicable Diseases including Injury and Trauma budget (See Annex 7.2)
- Part V: Infrastructure Maintenance budget (See Annex 7.2f)
- Compiled budget (See Annex 7.2g)
- District wise budget (See Annex 7.2h)
- City wise budgets under NUHM
- Committed unspent budget format (See Annex 7.2i)
- In addition, Annex 7.2b and 7.2c have underlying work sheets.

---

12 As mentioned in chapter 2, State government is expected to contribute 25% under NHM, except for NE states, Jammu & Kashmir and HP, wherein state contribution would be 10%. Further, states to maintain a minimum of 10% annual increase in health budget.

13 The erstwhile, RCH, Mission Flexi-pool and Immunisation components of PIPs.
The above formats are self explanatory. For convenience, efforts have been made to retain the existing budget heads and codes to the extent possible; however, this has resulted in some inconsistencies between the text of the Manual and the budget codes.

**PROCESS OF ITERATION**

7.06 Budget preparation is a process of iteration, particularly as allocations under NHM flexi pools will not be sufficient to meet all state requirements. Once a first cut of the budget has been prepared, this would need to be extensively discussed within the State Planning Team and the State NHM Director in order to:

- Re-visit and agree priorities. Please note that the allocation of funds should be in-line with the situation analysis. For example, if a district has a very high incidence of TB, then greater emphasis on ensuring detection at the primary healthcare level is likely to give faster results. Similarly, if the sex ratio is a major cause for concern, then greater allocation to implementation of the PNDT Act/other measures is necessary.
- Identify other sources of funds.
- Scale down targets for outcomes.

7.07 Typically the budget would need to be reworked several times before consistency between the situation analyses, targeted outcomes, strategies, work plan and allocation of funds is achieved.

**BUDGET REVIEW**

7.08 Once the budget has been finalised, an in-depth independent review of the budget should be carried out by a chartered accountant to ensure internal consistency and accuracy of figures.
8. WHAT THE STATE NHM PIP SHOULD LOOK LIKE?

8.01 This chapter sets out an indicative structure of the NHM state PIP. States are expected to follow the structure to the extent possible:

### INDICATIVE CONTENTS OF STATE NHM PIP

*Letter of transmittal including the state’s own assessment of the extent to which criteria for appraisal of the state PIP has been met. Use appraisal criteria checklist provided in Annex 8.1 of this Manual*

<table>
<thead>
<tr>
<th>1. SUMMARY (upto 5 pages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a minimum, indicate:</td>
</tr>
<tr>
<td>• Where we are now and where do we wish to go by 2016/17 in terms of indicators (use formats specified in Annex 4.2a and 4.2b).</td>
</tr>
<tr>
<td>• Key challenges</td>
</tr>
<tr>
<td>• How do we propose to tackle key challenges; in particular, spell out health systems strengthening/ sector reform and innovations</td>
</tr>
<tr>
<td>• How much will it cost (use budget summary format in Annex 7.2a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PROCESS OF PLAN PREPARATION (1 page)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief overview of the steps taken to prepare the PIP including consultations/workshops held at the state, district and block level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. CURRENT STATUS &amp; SITUATION ANALYSIS (upto 10 pages)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1 Background:</strong></td>
</tr>
<tr>
<td>• <strong>Demographics:</strong> Current (2011 Census) population broken down by rural/urban, age, sex, SC/ST, vulnerable groups, sex ratio, age at marriage, etc and trends (use table in Annex 4.1a)</td>
</tr>
<tr>
<td>• <strong>Socio-economic indicators</strong> like proportion of BPL/APL, per capita income, school enrolment, drop-out and literacy rates; percentage of population with access to clean drinking water and improved sanitation (use table in Annex 4.1a)</td>
</tr>
<tr>
<td>• <strong>Administrative divisions:</strong> Districts, blocks, villages, cities with population distribution (use table in Annex 4.1b)</td>
</tr>
<tr>
<td>• <strong>Health Infrastructure and Service availability:</strong> again broken down by district/city; tribal areas to the extent possible in terms of:</td>
</tr>
<tr>
<td>• Average time to care for primary and secondary services (use table in Annex 4.1c)</td>
</tr>
<tr>
<td>• Public health infrastructure (district/ civil hospitals, CHCs/FRUs, PHCs/UPHCs, SHCs, MMUs etc.): Assessment of shortfall/ mismatch and extent to which these are fully operationalized (based on IPHS norms) (use table in Annex 4.1d)</td>
</tr>
<tr>
<td>• Private and NGO health services, including total number disaggregated by size and staff availability that are currently providing or having the potential to provide NHM services.</td>
</tr>
</tbody>
</table>
3.2. Detailed theme-wise current status and situation analysis:

- Health systems: Current status and key issues in terms of:
  - Human resources availability and shortfall (include both regular and contractual staff) (use format provided in budget worksheet)
  - Training: Total numbers trained by staff category and type of training programme; shortfall; status of SIHFW and district training institutions (use format provided in budget worksheet).
  - Other HRD aspects (staff productivity; performance appraisal system, etc.).
- Emergency/referral transport
- BCC
- Procurement and logistics
- Quality assurance
- Monitoring and Evaluation Including HMIS and MCTS
- Partnerships with donors, non-profit or private sector
- Convergence
- Community processes
- Program management
  - Detailed organization structure and staffing both directorate and PMU at state, district/city and block levels
  - Supportive Supervision
- Financial management including trends in expenditure and utilization of funds
- Programme/Health outcomes: current status, trends and key challenges for:
  - RMNCH+A: MH, CH, Immunization, FP, AH
  - Urban Health
  - Disease Control: NTCP, NVBDCP, NLCP
  - Non Communicable Diseases: NPCDCS, NPCB, NMHP, NTCP, NOHP, NPPC, NPPMBI and NPPCF

To the extent possible by include HPDs/cities, rural/urban, SC/ST, vulnerable groups, etc. As a minimum, this should be in terms of indicators listed in Annex 2.2a to 2.2c.

3.3. Key priorities and phasing

4. MAJOR GOALS, OBJECTIVES & TARGETS

Realistic goals, objectives and targets to be set for:

4.1 RMNCH+A: MH, CH, Immunization, FP, AH

4.2 Urban Health

- Any ASHA engaged in cities/towns covered under NUHM would be budgeted in NUHM.
- Any town having a population of less than 50,000 which is not a state capital or district headquarter town would be treated as rural and will be budgeted under RCH-NRHM
- Maternity homes which provide referral/FRU level services may be treated as UCHCs and specialists engaged in those institutions may be budgeted under RCH.

4.3 Communicable Diseases: NVBDCP, NLEP, RNTCP
4.4 Non Communicable Diseases: NPCDCS, NPCB, NMHP, NTCP, NOHP, NPPC, NPPMBI and NPPCF
Use formats provided in Annex 2.2a to 2.2c.

5. RMNCH+A: STRATEGIES, ACTIVITIES AND CORRESPONDING COSTS

Targets for underlying indicators, strategies, activities and costs for:

- MH including JSY, JSSK, Maternal Death Review, Safe Abortion Services, Line listing and follow-up of severe anemic women etc.
- CH including HBNC, IYCF, SNCU, NBCC, NBSU, Management of Diarrhoea, Management of ARI, Infant Death Audit etc.
  - Immunization
  - FP including Terminal limiting methods, PPIUCD, Door step delivery of contraceptive by ASHA, Family planning indemnity scheme etc.
  - AH including Adolescent friendly health clinics (AFHC), Menstrual hygiene, WIFS etc.
  - RBSK

5.7 Others

5 HEALTH SYSTEMS: STRATEGIES, ACTIVITIES AND CORRESPONDING COSTS

- Human resources
- Training
- Other HRD aspects (staff productivity; performance appraisal system, etc.)
- Community processes
- ASHA including ASHA incentive (including MH, CH, FP and AH) etc.
- VHSNC
- Emergency/referral transport
- BCC
- Procurement and logistics including ASHA drug kit, HBNC kit etc.
- Quality assurance
- Programme Management
- Financial management
- SHRC
- Monitoring and evaluation, which should include:
  - Key indicators for measuring progress (a list of indicators has been provided in Annex 2.2a to 2.2c)
  - Steps for strengthening M&E systems, in terms of data collection, analysis and use, interoperability of different information systems etc.
  - Program risks and mitigation strategies
  - Partnerships with donors, non-profit or private sector
  - Convergence with Departments of Education, Women and Child Development, Rural Development etc.
  - Innovations
  - Others (please specify)

6 URBAN HEALTH: STRATEGIES, ACTIVITIES AND CORRESPONDING COSTS

Targets for underlying indicators, strategies, activities and costs
• Number of Cities/ towns
• Cities proposed to be taken up
• Slum population
• Human Resources
• Training
• Infrastructure including UPHCs and CHCs
• Infrastructure managed by:
  ✓ State Government
  ✓ Municipal Corporation / Urban Local Bodies
  ✓ Facilities functioning on PPP mode
  ✓ Any Other
• Outreach Services
• Community processes
• ASHA including ASHA incentive (including MH, CH, FP and AH) etc
• MAS
• IEC/ BCC
• Procurement and logistics including ASHA drug kit, HBNC kit etc.
• Quality assurance
• Programme Management
• Financial management
• Monitoring and evaluation, which should include:
  ✓ State and City Level Indicators (a list of indicators has been provided in Annex 2.2a to 2.2c)
• Innovations
• Public Private Partnership
• Convergence with Departments of Education, Women and Child Development, Urban Development etc
• Others (please specify)

7 COMMUNICABLE DISEASE: STRATEGIES, ACTIVITIES AND CORRESPONDING COSTS

Targets for underlying indicators, strategies, activities and costs for:
• NVBDCP
• NLEP
• RNTCP

8 NON COMMUNICABLE DISEASES: STRATEGIES, ACTIVITIES AND CORRESPONDING COSTS

Targets for underlying indicators, strategies, activities and costs for:
• NPCDCS
• NPCB
• NMHP
• NTCP
• NOHP
• NPPC
• NPPMBI
• NPPCF
9 STATUS OF CONDITIONALITIES & INCENTIVES

State to provide baseline, progress in 2013-14 and targets for 2014-15, 2015-16 and 2016-17 (Use format in Annex 6.1)

10 INFRASTRUCTURE MAINTENANCE

State to provide details of staff in terms of numbers, compensation, deployment etc. (Use format in Annex 7.2f).

11 BUDGET

11.1 Basis and assumptions
11.2 Key features (Use formats in Annex 7.2)

ANNEXES

- A: Self appraisal of state PIP against appraisal criteria (refer Annex 2.1 of this Manual)
- B/1: Targets for Goals (refer Annex 4.2a)
- B/2: Targets for Service Delivery (refer Annex 4.2b)
- B/3: Program (outputs, process) targets (refer Annex 4.2c)
- C: Plan for Conditionalities and incentives (Annex 6.1)
- D: Requirement of centrally procured items (refer Annex 6.2)
- E: Budget formats (Annex 7.2a to 7.2i)
- F: City Health plans (under separate cover)

8.02 The primary responsibility for ensuring an internally consistent PIP rests with the State Program Manager. Subsequent to preparation of the first draft of the PIP, a state level one-day workshop should be held in order to share key features of the PIP especially the situation analysis and strategies and to obtain feedback/suggestions.

8.03 Apart from key departmental staff, participants at the workshop should include elected representatives, NGOs and experts as well as representatives from related departments such as Department of Women and Child Development, School Education Department, Water and Sanitation, Housing and Urban Poverty Alleviation, Rural Development and Urban Development, labor welfare and Environment.

8.04 Subsequently, the NHM PIP should be presented, discussed and agreed with the State Health Society prior to submission to MoHFW.
9. HOW DO WE KNOW WE ARE ON THE RIGHT TRACK?
(PROGRAMME MONITORING & REVIEW)

9.01 States may wish to carry out the following to improve programme monitoring:
- Establish a system of supportive supervision
- Monthly reviews based on data available in the HMIS and MCTS
- Establish district and facility score cards
- Review AHS data (available on an annual basis) and reconcile figures with data available in the HMIS

9.02 In addition, on a quarterly basis, states would be expected to report holistically against the commitments in the PIP in terms of:
- Achievement against key outcomes/outputs
- Physical achievement vis-à-vis the activities specified in the State PIP; and corresponding expenditure against each activity
- Variance analysis: If the targeted outcomes/outputs have not been met, the reasons for the shortfall; corrective action planned/taken and, if necessary a modification in the targets

The quarterly report (outcomes, physical progress with financial expenditure) should show achievement in percentage terms against the activities specified in the state PIP. The report together with the variance analysis indicating corrective action, as well as a brief description of key achievements should be sent to MoHFW in the month following the reporting quarter.