MINISTRY OF HEALTH & FAMILY WELFARE

Guidelines for Preparation of Annual Programme Implementation Plan National Rural Health Mission

2013-14

NATIONAL RURAL HEALTH MISSION

GUIDELINES FOR PREPARATION OF STATE PROGRAM IMPLEMENTATION PLANS: (2013- 14)

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FOREWORD

I express my appreciation for all the States and Union Territories which have been striving to achieve the priorities set by NRHM. We have come a long way since 2005. The national MMR has reduced from 254/100000 live births in 2004-06 (SRS) to 212/100000 live births in 2007-09 (SRS), an average reduction of 14 points per year. The national infant mortality rate has also declined from 58 /1000 (SRS 2005) live births in year to 47 (SRS 2010), while TFR at 2.5 (SRS 2010) has improved from 2.9 (SRS 2004). However, there is a lot that remains to be achieved.

As you are aware, we are anticipating an increase in funding under the Mission. States/ UTs may thus plan their activities for 2013-14 expecting a 30 % increase over the Resource Envelope for 2012-13. However, at the onset of planning process for 2013-14, every State would have to think over two critical questions: Are our strategies & are they efficient? As I keep emphasizing, more money for health must lead to more health for money.

Based on our interaction with the States we have made some changes in the PIP process and PIP documentation. This year the planning process is being initiated early, so that the States have ample time to plan and approvals are conveyed well in advance. The format of PIP is being changed this year. Instead of lengthy write-ups the plan for 2013-14, could basically be a work-plan with budget as guidelines would demonstrate.

With the ultimate aim of moving closer to Universal Health Coverage, certain priority areas have been identified for focused attention. Strengthening Sub Centres as the first port of call & plugging gaps based on Census 2011, focus on scale up of referral transport services to ensure that universal response time does not exceed 30 minutes, case load based augmentation of facilities with special attention to nurses and other allied health professionals, universal access to free generic medicines in government health facilities, strengthening District Hospitals and higher allocation to high focus districts are among the areas that have been identified.

Utmost emphasis this year should be placed on institutionalising mechanisms for supportive supervision and monitoring at all levels. Budgets should be planned envisaging integrated monitoring systems as monitoring seems to be the weakest link in our programme.

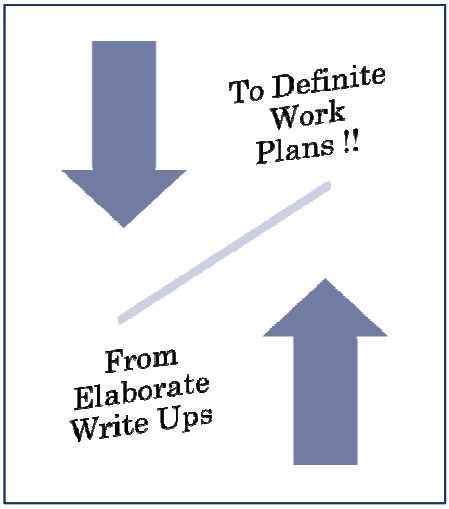
The NRHM framework envisages a decentralized planning process involving concerned stakeholders at all levels and the PIP planning process for the year 2013-14 must also ensure this bottom up approach in formulating the plans. Community oversight should also be strengthened.

I am sure that under the able leadership of State Health Secretaries, the Mission Directors and their teams would come up with PIPs which would address the State priorities and further the cause of 'Health for All'.

Anuradha Gupta
Additional Secretary & Mission Director (NRHM)

1. GUIDING PRINCIPLES FOR PIP 2013-14

1.01 At the juncture of moving on to the next plan period and learning from our past experience, this year we move towards bringing in more systemic reforms, focus on the priority areas set last year and also make some changes in the planning process.



1.02 Based on the feedback received from various quarters especially the States, the format of the Project Implementation Plans (PIPs) is being modified this year. The annual plan for 2013-14 would be a precise and cogent work-plan and budget in excel format with specific basic information. There would be no elaborate write -ups. The budget sheet provided as part of this guideline has columns for the approved budget for 2012-13, and progress made, wherein state indicates physical achievement and expenditure against last year's targets (April- October 2012). The subsequent columns are for 2013-14 budget. The State should specifically mention whether a particular activity is a continuation of an activity from previous year or a new activity. If it is a continuation; a brief description of progress/challenges or underlying reasons for last year's poor performance (if applicable) should be given. In case of new activity the State should provide the justification. The State also needs to fill in all the annexes that have been hyperlinked in the budget sheet.

1.03 This document contains guidelines for preparation of PIP for the Reproductive & Child Health Programme including Immunization and the Mission Flexible Pool Component. For disease control programmes including NVBDCP, RNTCP, NIDDCP, IDSP, NLEP and NPCB, separate guidelines would follow.

1.04 Though the budget format would remain the same, in order to provide the senior policy makers a snap-shot of entire budget, the second sheet of the budget is linked in such a way that the same budget would also be available as per natural heads such as HR, infrastructure, procurement, training, IEC etc.

1.05 The state PIP must reflect key guiding principles of RCH and NRHM especially:

- An explicit pro-poor focus through identification of vulnerable groups/high focus districts with relatively poor performance against RCH II indicators and ensuring that their needs are met. This would mean concentrating resources (staff, medical supplies, closer supervision, etc) to areas with the worst health outcomes and the greatest need. In 2010-11 GoI identified 264 high focus districts in the entire country. The State needs to ensure that High focus districts get at least 30% more than a non-high focus State i.e. HF get a weightage of 1.3 against 1 for non high focus.
- Ideally the NRHM PIP should be a subset of the holistic State PIP wherein funds from all sources should be reflected.

- The PIP should make commitments to deliver results in terms of goals i.e. MMR, IMR and TFR as well as underlying outcomes such as institutional delivery, full immunisation, contraceptive prevalence rate and unmet need. Expenditure is a necessary but not sufficient condition to achieving improved performance on outcomes. The targets set in 2012-13 (now a part of Administrative Approval / Record of Proceedings (RoP) 2012-13 for each State/U.T) would apply unless the State communicates a change explicitly. The targets need to be broken down into quarterly targets so that quarterly monitoring is possible and corrective steps (wherever needed) can be taken.
- National guidelines are given to all states based on evidence and learning from the programmes across the states. However we appreciate the State context and local peculiarities which requires adaptation. State innovations are much encouraged.
- Prioritization of initiatives as per the need of the State is a must, given multiple needs in health sector and limited resources. E.g. the state will need to first operationalize facilities in high focus districts and those having adequate patient load.
- States are requested to use the survey (DLHS etc.) as well as HMIS data in planning. High focus states (for which district wise AHS data is available) are expected to use AHS data in their DHAPs.
- States must specify a minimum of 10% of the funds allocated to districts as genuinely untied i.e. districts have the freedom to prepare their own schemes in response to local conditions. In the past, most states preferred to run state schemes and districts were essentially expected to plan for implementation of these schemes. While this approach has the advantage of administrative convenience, the purpose of giving districts flexibility to develop their own strategies in accordance with local conditions is defeated. Thus there is need to operationalize this intervention. Budget for the proposals received due to this flexibility must be reflected under the head New Initiatives (F.M.R - B.18) attaching the details in the annexures.
- NRHM must take a 'systems approach' to Health. It is expected that States would take a holistic view and work towards putting in place policies and systems in several strategic areas so that there are optimal returns on investments made under NRHM. For effective outcomes, a sector wide implementation plan is desirable. Some of the key strategic areas/management imperatives in this regard are given in Annex-1.

2. KEY CONDITIONALITIES AND INCENTIVES

2.01 The key conditionalities agreed and enforced during the year 2012-13 would remain applicable in 2013-14:

- Rational and equitable deployment of HR with the highest priority accorded to high focus districts and delivery points.
- Facility wise performance audit and corrective action based thereon.
- Non-compliance with either of the above conditionalities may translate into a reduction in outlay upto 7 ½% and non-compliance with both translating into a reduction of upto 15%.
- Gaps in implementation of JSSK may lead to a reduction in outlay upto 10%.
- Continued support under NRHM for 2nd ANM would be contingent on improvement on ANC coverage and immunization as reflected in MCTS.
- Vaccines, logistics and other operational costs would also be calculable on the basis of MCTS data.

2.02 Initiatives in the following areas would draw additional allocations by way of incentivisation of performance:

- Responsiveness, transparency and accountability (upto 8% of the outlay). b) Quality assurance (upto 3% of the outlay).
- Inter-sectoral convergence (upto 3% of the outlay).
- Recording of vital events including strengthening of civil registration of births and deaths (upto 2% of the outlay).
- Creation of a public health cadre (by states which do not have it already) (upto 10% of the outlay).
- Policy and systems to provide free generic medicines to all in public health facilities (upto 5% of the outlay).

Note:

Rational and equitable deployment would include posting of staff on the basis of case load, posting of specialists in teams (e.g. Gynaecologist and Anaesthetist together), posting of EmOC/ LSAS trained doctors in FRUs, optimal utilization of specialists in FRUs and above and filling up vacancies in high focus/ remote areas.

Performance parameters must include OPD/ IPD/ normal deliveries/ C- Sections (wherever applicable).

3. FOCUS AREAS

RCH FOCUS AREAS

3.01 Following are the general areas of focus across reproductive, maternal, neonatal, child and adolescent health on which the State needs to focus. The focus areas are a continuation from the last year (2012-13) and the main points are being reiterated here for sake of convenience.

1. Operationalizing Delivery Points

3.02 Gaps in the identified delivery points to be assessed and filled through prioritized allocation of the necessary resources in order to ensure quality of services and provision of comprehensive RMNCHA +(Reproductive Maternal Neonatal Child Health and Adolescent Health) services at these facilities. The vacancies should be filled up on priority basis, HR posted in delivery points to be trained in all requisite skills and prioritised for any training programme e.g. all Medical Officers and Staff Nurses, positioned in FRUs/DH and 24x7 PHCs should be prioritised for F-IMNCI training so that they can provide care to sick children with diarrhoea, pneumonia and malnutrition.

3.03 These delivery points then must be branded and positioned as quality RMNCHA + 24x7 Service Centres within the current year.

3.04 The targets for different categories of facilities are:

A) All District Hospitals and other similar district level facilities to provide the following services:

- 24*7 service delivery for CS and other Emergency Obstetric Care.
- 1^{st} and 2^{nd} trimester abortion services.
- Facility based MDR.
- Essential new-born care and facility based care for sick newborns. Special Newborn care Units (SNCU) for care of the sick newborn should be established in all District Hospitals. All resources meant for establishment of SNCUs should be aligned in terms of equipment, manpower, drugs etc. to make SNCUs fully operational.
- Family planning and adolescent friendly health services
- RTI/STI services.
- Functional BSU/BB.

B) CHCs and other health facilities at sub district level (above block and below district level) functioning as FRUs to provide the same comprehensive RMNCHA+ Services as the district hospitals.

C) 24*7 PHCs and Non FRUs to provide the following services:

- 24*7 BEmOC services including conducting normal delivery and handling common obstetric complications.

- 1st trimester safe abortion services. (MVA upto 8 weeks and MMA upto 7 weeks)
- RTI/STI services.
- Essential new-born care and facility based care for sick newborns. NBSUs being set up at FRUs should be utilised for stabilization of sick newborns referred from peripheral units. Dedicated staff posted at NBSU must be adequately trained and should have the skills to provide care to sick newborns.
- Family planning
- Adolescent health services

D) All identified SCs/ facilities will:

- Conduct Delivery by SBAs.
- Provide IUD Services
- Provide Essential New born care services.
- Provide ANC, PNC and Immunization services.
- Provide Nutritional and Family planning counselling.
- Conduct designated VHND and other outreach services.

2. Essential Drug List

A) To formulate an Essential Drug List (EDL) for each level of facility viz. SC, PHCs, CHCs, DHs, and Medical colleges.

B) Ensure timely procurement and supply linked to case load.

C) The EDL should include drugs for maternal and child health, safe abortion services, and RTI/STI.

3. Capacity Building

A) Delivery points to be first saturated with trained HR. High focus/ remote areas to be covered first.

B) Shortfall in trained human resource at delivery points particularly sub centres and those in HFDs/ tribal/ remote areas to be addressed on priority.

C) Training load for skill based trainings to be estimated after gap analysis.

D) Certification /accreditation of the training sites is mandatory.

E) Training plan to factor in reorientation training of HR, particularly for those posted at non-functional facilities and being redeployed at delivery points. Orientation training of field functionaries on newer interventions e.g. MDR.

F) Performance Monitoring during training/post-deployment need to be ensured

G) Specific steps to strengthen SIHFW/ any other nodal institution involved in planning, implementation, monitoring and post training follow up of all skill based trainings under NRHM.

4. High Focus Districts

A) The State should prioritize activities for the HF districts and develop and operationalise the identified facilities as delivery points.

B) At least 25% of all sub centres under each PHC to be made functional as delivery points in the HFDs.

C) In the 12 high focus states pre service nursing training should be planned with the State nursing cell which if not present should be made functional. At least one state Master Nodal centre should be created and planned to be made functional.

3.05 Given below are specific component wise focus areas for all programmes.

Maternal Health

3.06 Key components under maternal health include:

A) **Implementing free entitlements under JSSK**

- JSSK entitlements to be ensured to all pregnant women and sick newborns accessing public health facilities.
- Drop back to be ensured to at least 70% of pregnant women delivering in the public health facilities.
- Effective IEC and grievance redressal to be ensured.

B) **Centralized Call Centre and Assured Referral**

- To ensure availability of a centralized call centre for referral transport at State or district level as per requirements along with GPS fitted ambulances.
- Response time for the ambulance to reach the beneficiary not to exceed 30 minutes.

C) **Strengthening Mother & Child Tracking System**

- State level MCTS call centre to be set up to monitor service delivery to pregnant women and children MCTS to be made fully operational for regular and effective monitoring of service delivery including tracking and monitoring of severely anaemic women, low birth weight babies and sick neonates.

D) **Tracking severe anaemia**

- All severely anaemic pregnant woman (2% of the anaemic pregnant woman) to be tracked and line listed for providing timely treatment of anaemia followed by micro birth planning.

E) JSY implementation:

- JSY guidelines to be strictly followed and payments made as per the eligibility criteria.
- No delays in JSY payments to the beneficiaries and full amount of financial assistance to be given to the beneficiary before being discharged from the health facility after delivery.

- All payments to be made through cheques and preferably into bank/ post office accounts.
- Strict monitoring and physical (at least 5%) verification of beneficiaries to be done by state and district level health authorities to check malpractices.
- Grievance redressal mechanisms as stipulated under JSY guidelines to be activated at the district and state levels.
- Accuracy of JSY data reported at the HMIS portal of MOHFW to be ensured besides furnishing quarterly progress reports to the Ministry within the prescribed timeframe.

Child Health

3.07 Focus areas under child health includes:

A) Facility Level Care

- All the delivery points must have a functional Newborn Care Corner (NBCC) consisting of essential equipment and staff trained in NSSK. All staff must be trained in a 2 days NSSK training for skills development in providing Essential Newborn Care.
- SNCUs are referral centres with provision of care to sick new borns in the entire district and relevant information must be given to all peripheral health facilities including ANM and ASHA for optimum utilisation of the facility. Referral and admission of out born sick neonates should be encouraged and monitored along with inborn admissions.
- Nutrition Rehabilitation Centres (NRCs) are to be established in District Hospitals (and/or FRUs), prioritising tribal and high focus districts with high prevalence of child malnutrition. The optimum utilisation of NRCs must be ensured through identification and referral of Severe Acute Malnutrition cases in the community through convergence with Anganwadi workers under ICDS scheme (refer to guidelines on NRCs).
- In order to reduce the prevalence of anaemia among children as a preventive measure, all children between the ages of 6 months to 5 years must receive Iron and Folic Acid tablets/ syrup (IFA) (as appropriate) for 100 days in a year. This should be ensured at the facility and during field visits. School health teams can in addition assess children below 6 years of age at AWCs. Accordingly appropriate formulation and logistics must be ensured and proper implementation and monitoring should be emphasised through tracking of stocks using HMIS.
- Availability of ORS and Zinc should be ensured at all sub-centres and with ASHAs. Use of Zinc should be actively promoted along with use of ORS in cases of diarrhoea in children.

B) ANM & ASHA Training

- All ANMs are to be trained in IMNCI.
- All ASHA workers are to be trained in Module 6 & 7 (IMNCI Plus) for implementing Home Based New-born Care Scheme. The ASHA kit and incentives for home visits should be made available on a regular basis to ASHAs who have completed round 1 of training in Module 6.
- At least two health care providers should be trained in 'Lactation Management' at District Hospitals and FRUs; other MCH staff should be provided 2 days training in IYCF and growth monitoring. In order to promote early and exclusive breastfeeding, counselling of all pregnant and expectant mothers should be ensured at all delivery points and breastfeeding initiated soon after birth.

C) Monitoring and Review

- Infant and Under-fives Death Review must be initiated for deaths occurring both at community and facility level.
- Line listing of newly detected cases of SAM and Low birth weight babies must be maintained by the ANM and their follow-up must be ensured through ASHA.
- Data from SNCU, NBSU and NRC utilisation and child health training programmes (progress against committed training load) must be sent on a regular basis to the Child Health Division, MoHFW.

D) Immunisation

- A dedicated State Immunisation Officer should be in place. District Immunisation Officer should be in place in all the districts. The placement of ANMs at all session sites must be ensured. For sub centres without ANMs, special strategy should be formulated.
- The birth dose of immunisation should be ensured for all newborns delivered in the institutions, before discharge. Daily Immunisation services should be available in PHCs, CHCs, SDHs/DHs.
- State must prepare a detailed district plan for Intensification of Routine Immunization with special focus on districts with low coverage.
- List of beneficiaries must be available with ANM and ASHA and a village wise list of beneficiaries should be available with ASHA after each session. MCTS should be made full use of for generating due lists for ANMs, sending SMS alerts to beneficiaries and maintaining actual service delivery.
- The immunisation sessions must be carried out on a daily basis in District Hospitals and FRUs/ 24x7 PHCs with considerable case load in the OPD.
- Cold chain mechanics must be placed in every district with a definite travel plan so as to ensure that at least 3 facilities are visited every month as a preventive maintenance of cold chain equipment. The paramedic person instead of a clerical staff should be identified as the Cold Chain Handler in all cold chain points and their training must be ensured along with one more person as a backup.

- It has been observed that the coverage of DPT 1st booster and Measles 2nd dose to be given at the age 18 months is less than 50% across the country. Therefore coverage of DPT 1st booster and measles 2nd dose must be emphasised and monitored.
- District AEFI Committees must be in place and investigation report of every serious AEFI case must be submitted within 15 days of occurrence.
- Rapid response team should be in place in priority districts of the states to identify pockets of low immunization coverage and to respond to any threat of polio.
- Special micro plans are to be developed for inaccessible, remote areas and urban slums. The micro plans developed under polio programme must be utilised and special focus should be given to the migrant population (Refer to guidelines).

Family Planning

3.08 Target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; promoting 'children by choice' in the context of reproductive health.

A) Strengthening spacing methods

- Increasing number of providers should be trained in IUCD 380A.
- Fixed Day IUCD services should be strengthened at facilities .Focus should be on IUCD services at sub-centers for at least 2 fixed days a week.
- Introduction of Cu IUCD 375 at all levels.
- Delivering of contraceptives at homes of beneficiaries (in pilot states/ districts).

B) Emphasis on post-partum family planning services

- Strengthening Post-Partum IUCD (PPIUCD) services at least at DH level with Post-partum sterilisation (PPS) made available.
- Post-Partum Centres at women & child hospitals at district levels with high case load should be facilitated with counsellors.

C) Strengthening sterilization service delivery

- Pool of trained service providers providing minilap, lap & NSV should be created at facilies.
- Operationalizing FDS centres for sterilisation by holding camps to clear back log should be focussed upon.

D) Strengthening quality of service delivery:

- QACs should be strengthened for monitoring adherence to following existing protocols/ guidelines/ manuals and monitoring of FP Insurance.
- BCC/ IEC tools to be developed highlighting benefits of Family Planning specially on spacing methods
- Focus on using private sector capacity for service delivery by exploring PPP availability.

Adolescent Health

3.09 Following are the focus areas for adolescent health**:**

1) **Setting up of AH cell**

- A unit for adolescent health at state level with a nodal officer supported by preferably four consultants one each for ARSH, SHP, Menstrual hygiene and WIFS; one nodal officer (rank of ACMHO) for all the components of Adolescent Health at district level to take care of Adolescent health programme including the SHP.

2) **Adolescent Reproductive Sexual Health (ARSH) Programme**

A) **Clinics**

- Number of functional clinics at the DH, CHC, PHC and Medical Colleges (dedicated days, fixed time, trained manpower).
- Number of clinics integrated with ICTCs
- Quarterly Reporting from the ARSH clinics to be initiated to GoI.
- Establish a Supportive supervision and Monitoring mechanism.

B) **Outreach**

- Utilisation of the VHND platform for improving the clinic attendance.
- Demand generation in convergence with SABLA and also through Teen Clubs of MOYAS.

C) **Capacity Building/Training:**

- Calculation of the training load and development of training plans/ refresher trainings.
- Deployment of trained manpower at the functional clinics.

3) **School Health Programme**

- GoI Guidelines including terms of reference of stakeholders adapted by States and operational plan in place.
- School health committee with diverse stakeholders beyond the health department; this committee with representation of academia will be responsible for implementation and monitoring of the programme.
- Involvement of nodal teachers from schools in the programme (Screening and communication - preventive and promotive) is to be ensured.
- Height / weight measurement and BMI calculation should be part of School Health Card.
- All children in government and government aided schools should be covered.
- The programme should focus on three Ds- Deficiency, Disease and Disability.
- Referral of children must be tied up and complete treatment at higher facilities to be ensured.

- An effort should be made to have dedicated teams with adequate provision for mobility for school health. The teams should also conduct health check- ups for children below 6 years at AWCs.

4) **Menstrual Hygiene Scheme (MHS)**

- Formation of State and district level steering committees.
- Training / re-orientation of service providers(MOs, ANMs, ASHAs)
- Monthly meeting with BMO.
- Regular feedback on quality of sanitary napkins to be sent to GoI
- Identification of appropriate storage place for sanitary napkins.
- Mechanism of distribution of SN right upto the user level.
- Reporting and accounting system in place at various levels.
- Utilizing MCTS for service delivery by checking with ASHAs and ANMs about supply chain management of IFA tabs and Sanitary napkins.
- Distribution of Sanitary Napkins to school going adolescent girls to be encouraged in schools and preferably combined with Weekly Iron Folic Acid Supplementation (WIFS).

5) **Weekly Iron and Folic Acid Supplementation programme (WIFS)**

- Procurement policy in place for procurement of EDL including IFA and deworming tablets.
- Establish "Monday" as a fixed day for WIFS.
- Plan for training and capacity building of field level functionaries of concerned Departments (i.e. Department of Women and Child Development and Department of Education) and plan for sensitization of programme planners on WIFS.
- Ensure that monitoring mechanism as outlined in the operational framework (shared with the states during the National Adolescent Health Workshop) are put in place and being executed across levels and departments.

Urban RCH

3.10 Key components under urban health include:

- Carry out a comprehensive third party evaluation of UHCs/ NGO performance including an assessment of reasons for low expenditure and gaps in implementation. State to clearly lay down challenges in implementation and actions taken to overcome them.
- State to share findings of GIS mapping and surveys to identify pockets of urban slums etc. as most states have undertaken this activity but have not used the data for planning in the previous PIPs.
- Adequacy of urban health centres to be assessed and states should provide clear justifications in case there is a proposal for increase.
- Data on performance to be used as an indicator in planning for 2013-14.

- Staffing at UHCs to be linked to case load.
- Performance of UHCs/NGOs to be monitored against targets

Tribal Health

3.11 Key components under tribal health include:

- States to clearly map out tribal areas and pockets which are hard to reach before planning activities for 2013-14.
- State to closely monitor progress (physical, expenditure) on all health activities in notified tribal areas.
- On a quarterly basis, a progress report, including constraints faced and action proposed to be sent to MoHFW.
- Any additional staffing proposed needs to be substantiated with performance and case load data
- The States shall focus on health entitlements of vulnerable social groups like SCs, STs, OBCs, minorities, women, disabled, migrants etc.

PNDT

3.12 The mission of PNDT program is to improve the sex ratio at birth by regulating the pre-conception and prenatal diagnostic techniques misused for sex selection and the guiding principle followed is deterrence for unethical practice sex selection to ensure improvement in the child sex ratio. Key components under PNDT include:

A) **Strengthening programme management structures**:

- Appointment of Nodal officer
- Strengthening of Human resource
- Formation of PNDT Cell at state and district level

B) **Establishment of statutory bodies under the PC&PNDT Act**

- Constitution of 20 member State Supervisory Board) with reconstitution every three years (other than ex-officio members). This board should have four meetings in a year
- Notification of three members Sate Appropriate Authority and constitution of 8 member State Advisory Committee and reconstitution in every 3 years with at least 6 meetings in a year
- Notification of District Appropriate Authorities and constitution of 8 member district Advisory committees; to be reconstituted every 3 years. It should have at least 6 meetings in a year

C) **Strengthening of monitoring mechanisms**

- Monitoring of sex ratio at birth through civil registration of birth data
- Formulation of Inspection and Monitoring committees

- Increasing the monitoring visits
- Review and evaluation of registration records
- Online availability of PNDT registration records
- Online filling and medical audit of form- Fs
- Ensure regular reporting of sales of ultrasound machines from manufactures
- Enumeration of all Ultrasound machines and identification of un-registered ultrasound machine
- Ensure compliance for maintenance of records mandatory under the Act
- Ensure regular quarterly progress reports at state and district level

D) **Capacity building and sensitisation of program managers**

- Appropriate Authorities
- Advisory committee members
- Nodal officers both State and District

E) **Sensitisation and Alliance building with**

- Judiciary
- Medical Council / associations
- Civil society

F) **Development of BCC/ IEC/ IPC Campaigns highlighting provisions of PC& PNDT Act and promotion of Girl Child with special focus on the districts with very adverse sex ratio.**

G) **Convergence for Monitoring of Child sex Ratio at birth**

Human Resources

3.13 Key components under HR include:

- A comprehensive HR policy to be formulated and implemented; to be uploaded on the State NRHM website too.
- Underserved facilities particularly in high focus districts/ areas, to be first strengthened through contractual staff engaged under NRHM. Similarly high case load facilities to be supplemented as per need
- All appointments under NRHM to be contractual; contracts to be renewed not routinely but based on structured performance appraisal
- Decentralized recruitment of all HR engaged under NRHM by delegating recruitment process to the District Health Society under the chairpersonship of the District Collector/ Rogi Kalyan Samitis.
- Preference to be given to local candidates to ensure presence/availability of service providers in the community. Residence at place of posting to be ensured.

- Quality of HR to be ensured through appropriate qualifications and a merit- based, transparent recruitment process.
- Vacant regular posts to be filled on a priority basis: at least 75% by March 2013.
- It has been observed that contractual HR engaged under NRHM i.e. Specialists, Doctors (both MBBS and AYUSH), Staff Nurses and ANM are not posted to the desired extent in inaccessible/hard to reach areas thereby defeating the very purpose of the Mission to take services to the remotest parts of the country, particularly the un-served and under-served areas. It must therefore be ensured that the remotest Sub-Centres and PHCs are staffed first. Contractual HR must not be deployed in better served areas until the remotest areas are adequately staffed. No Sub-Centre in remote/difficult to reach areas should remain without any ANM. No PHC in these areas should be without a doctor. Further, CHCs in remote areas must get contractual HR ahead of District Hospitals. Compliance with these conditionalities will be closely monitored and salaries for contractual HR dis-allowed in case of a violation.
- Details of facility wise deployment of all HR engaged under NRHM to be displayed on the State NRHM web site.
- For SHCs with 2 ANMs, demarcation /division of population and job clarity to be ensured between the two, population to be covered to be divided between them. Further, one ANM to be available at the sub-centre throughout the day while the other ANM undertakes field visits; timings for ANM's availability in the SHC to be notified.
- AYUSH doctors to be more effectively utilised e.g. for supportive supervision, school health and WIFS.
- All contractual staff to have job descriptions with reporting relationships and quantifiable indicators of performance.
- Performance appraisal and hence increments of contractual staff to be linked to progress against indicators.
- Staff productivity to be monitored. Continuation of additional staff recruited under NRHM for 24/7 PHCs/FRUs/SDH, etc , who do not meet performance benchmarks, to be reviewed by State on a priority basis.
- All performance based payments/ difficult area incentives should be under the supervision of RKS/ Community Organizations (PRI).

Programme Management

3.14 Key components under programme management include:

- A full time Mission Director is a prerequisite. Stable tenure of the Mission Director should also be ensured.
- A regular full time Director/ Joint Director/ Deputy Director (Finance) (depending on resource envelope of State), from the State Finance Services (not holding any additional charge outside the Health Department) must be put in place, considering the quantum of funds under NRHM and the need for financial discipline and diligence.

- Regular meetings of state and district health missions/ societies.
- Key technical areas of RCH to have a dedicated / nodal person at state/ district levels; staff performance to be monitored against targets and staff sensitised across all areas of NRHM such that during field visits they do not limit themselves only to their area of functional expertise.
- Performance of staff to be monitored against benchmarks; qualifications, recruitment process and training requirements to be reviewed.
- Delegation of financial powers to district/ sub-district levels in line with guidelines should be implemented.
- Funds for implementation of programmes both at the State level and the district level must be released expeditiously and no delays should take place.
- Evidence based district plans prepared, appraised against pre determined criteria; district plans to be a "live" document. Variance analysis (physical and financial) reports prepared and discussed/action taken to correct variances.
- Supportive supervision system to be established with identification of nodal persons for districts; frequency of visits; checklists and action taken reports.
- Remote/ hard to reach/ high focus areas to be intensively monitored and supervised.
- An integrated plan and budget for providing mobility support for supportive supervision to be prepared and submitted for review/approval; this should include allocation to State/ District and Block Level

Health System Strengthening

3.15 The additionalities under NRHM have budget codes starting with B. Though the pool would be same for the sake of convenience the FMR heads have been kept the same.

ASHA

3.16 Key components under ASHA include:

- Clear criteria for selection of ASHA
- Well-functioning ASHA support system including ASHA days, ASHA coordinators
- Performance Monitoring system for ASHAs designed and implemented (including analysis of pattern of monthly payments; identification of non/under-performing ASHAs and their replacement; and reward for well performing ASHAs). State to report on a quarterly basis on ASHA's average earnings/ range per month.
- Timely replenishment of ASHA kits.
- Timely payments to ASHAs and gradual shift towards electronic payment.
- Detailed data base of ASHAs to be created and continuously updated; village wise name list of ASHA to be uploaded on website with address and cell phone number.

Untied Funds/ RKS/ AMG

3.17 Key components under untied funds/RKS/AMG include:

- Timely release of untied funds to all facilities; differential allocation based on case load.
- Funds to be utilized by respective RKS only and not by higher levels.
- Review of practice of utilising RKS funds for procurement of medicines from commercial medical stores and accordingly revisit guidelines for fund utilisation by RKS.
- Well-functioning system for monitoring utilization of funds as well as purposes for which funds are spent.
- Plan for capacity building of RKS members developed and implemented.
- RKS meetings to take place regularly.
- Audit of all untied, annual maintenance grants and RKS funds.
- The State must take up capacity building of Village Health & Sanitation Committees Rogi
- Kalyan Samitis and other community/ PRI institutions at all levels.
- The State shall ensure regular meetings of all community Organizations/ District / State Mission with public display of financial resources received by all health facilities.
- The State shall also make contributions to Rogi Kalyan Samitis.

New Constructions/ Renovation

3.18 Focus areas infrastructure- new construction/renovation include:

- Prioritization of construction of sub-centres as they are to the first port of call.
- Priority should next be given to delivery points and facilities in high focus districts with a view to reduce the disparity in access.
- Works must be completed within a definite time frame. For new constructions upto CHC level, a maximum of two years and for a District Hospital a maximum period of 3 years is envisaged. Renovation/ repair should be completed within a year. Requirement of funds should be projected accordingly. Funds would not be permissible for constructions/ works that spill over beyond the stipulated timeframe.
- Standardized drawing/ detailed specifications and standard costs must be evolved keeping in view IPHS.
- Third party monitoring of works through reputed institutions to be introduced to ensure quality.
- Information on all ongoing works to be displayed on the NRHM website.
- Approved locations for constructions/ renovations will not be altered.
- All government health institutions in rural areas should carry a logo of NRHM in English/ Hindi & Regional languages as recognition of support provided by the Mission.

Procurement

3.19 Key components under procurement include:

- Strict compliance of procurement procedures for purchase of medicines, equipments etc as per state guidelines.
- Competitive bidding through open tenders and transparency in all procurements to be ensured.
- Only need based procurement to be done strictly on indent/requisition by the concerned facility.
- Procurement to be made well in time & not to be pushed to the end of the year.
- Carry out an audit of equipment procured in the past to be carried out to ensure rational deployment.
- Annual Maintenance Contract (AMC) to be built into equipment procurement contracts.
- A system for preventive maintenance of equipment to be put in place.

Mobile Medical Unit (MMU)

3.20 Plan for MMU should focus on:

- Route chart to be widely publicised
- GPS to be installed for tracking movement of vehicles.
- Performance of MMUs to be monitored on a monthly basis (including analysis of number of patients served and services rendered).
- MMUs to be well integrated with Primary Health Care facilities and VHND.
- Engagement with village panchayats / communities for monitoring of services
- AWCs to be visited for services to children below 6 years of age
- AWCs to maintain record of services rendered
- Service delivery data to be regularly made available in public domain on NRHM website.
- A universal name 'Rashtriya Mobile Medical Unit' to be used for all MMUs funded under NRHM. Also uniform colour with emblem of NRHM (in English/ Hindi & Regional languages), Government of India and State Government to be used on all the MMUs.

Referral Transport

3.21 Key components under referral transport include:

- Free referral transport to be ensured for all pregnant women and sick neonates accessing public health facilities.
- Universal access to referral transport throughout the State, including transport to difficult and hard to reach areas, to be ensured.
- A universal toll free number to be operationalized and 24x7 call centre based approach

to be adopted.

- Vehicles to be GPS fitted for effective network and utilization.
- Rigorous and regular monitoring of usage of vehicles to be done.
- Service delivery data to be regularly put in public domain on NRHM website.

Mainstreaming of AYUSH

3.22 Key focus areas under AYUSH include:

- State to co-locate AYUSH in district hospitals and provide post graduate doctors for at least two streams: Ayurveda and homoeopathy (or Unani, siddha,Yoga as per the local demand). Panchakarma Unit should also be considered.
- OPD in AYUSH clinics will be monitored along with IPD/OPD for the facility as a whole.
- The AYUSH pharmacist/compounder to be engaged only in facilities with a minimum case load.
- Adequate availability of AYUSH medicines at facilities where AYUSH doctors are posted to enable them to practice their own system of Medicine without difficulty.
- At CHCs and PHCs any one system viz., Homeopathy/Ayurveda/ Unani/Sidha to be considered depending on local preference.
- At CHC/PHC level, Post-Graduate Degree may not be insisted upon.
- District Ayurveda Officer should be a member of District Health Society in order to participate in decision making with regard to indent, procurement and issue of AYUSH drugs.
- Infrastructure at facilities proposed to be collocated would be provided by Department of AYUSH.
- Those PHC/CHC/Sub-Divisional hospitals which have been identified as delivery points under NRHM should be given priority for collocation of AYUSH as these are functional facilities with substantial footfalls.
- AYUSH medical officers should increasingly be involved in the implementation of national health programmes and for the purpose of supportive supervision and monitoring in the field. They should be encouraged to oversee VHND and outreach activities and in addition programmes such as school health, weekly supplementation of iron and folic acid for adolescents, distribution of contraceptives through ASHA, menstrual hygiene scheme for rural adolescent girls etc.
- AYUSH medical officer should also be member of the RKS of the facility and actively participate in decision making.
- AYUSH doctors first need to be provided under NRHM first in the remotest locations and only thereafter in better served areas.

IEC/BCC

3.23 Key components under IEC/BCC include:

- Comprehensive IEC/ BCC strategy to be prepared. IPC given necessary emphasis and improved inter-sectoral convergence particularly with WCD.
- Details of activities carried out to be made available /displayed on the website

A basic template for States to use to draw up their IEC plan is given in Annex-7

Monitoring and Evaluation (HMIS)/MCTS)

3.24 Key components under monitoring & evaluation include:

- Data is uploaded, validated and committed; data for the month available by the 15th of the following month.
- Uploading of facility wise HMIS data by the first quarter of 2012-13.
- Facility based HMIS to be implemented. HMIS data to be analysed, discussed with concerned staff at state and district levels and necessary corrective action taken.
- Program managers at all levels use HMIS for monthly reviews.
- MCTS to be made fully operational for regular and effective monitoring of service delivery including tracking and monitoring of severely anaemic women, low birth weight babies and sick neonates.
- Pace of registration under MCTS to be fast tracked to capture 100% pregnant women and children
- Service delivery data to be uploaded regularly.
- Progress to be monitored rigorously at all levels
- MCTS call centre to be set up at the State level to check the veracity of data and service delivery.

4. STRUCTURE OF THE PIP FOR 2013-14

4.01 PIP for 2013-14 would consist of:

1) A cover letter by State Mission Director- confirming/summarizing
   - Targets and road maps in the last year's booklet remain the same
   - Self appraisal by the State
   - Priorities of the State
   - Budget proposed under main heads
   - New initiatives/innovations
2) Budget format in excel with tables for requisite information necessary for approval- budget sheet provides progress columns
3) Annexure:
   - Criteria for Self-appraisal
   - State Resources and Other Sources of Funds

Detailed budgeted head wise explanation

4.02 The FMR heads of the budget have been kept as per last year. However, some of the budget heads have been divided into further subheads. This has been done to provide a clearer picture of what goes into each activity as generally more than one activity is budgeted under one head. In case the State needs more rows for activities not shown in budget sheet it may budget it in 'Others' row and provide its detail in the remarks column. In case more space is required State may add a word document with the specified FMR code or give details in annexure. We have also added a column for committed unspent which needs to be filled with the most recent data the State has.

4.03 The State needs to provide unit of measure, unit cost and quantity for the activities proposed. In case the unit cost/rate cannot be defined for an activity, the State may propose a lump-sum. The targets should be cumulative and as per the budget proposed. The progress against the PIP should be as per October, 2012 and should be uniform across.

ANNEX 1

MANAGEMENT IMPERATIVES

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED
PUBLIC HEALTH PLANNING & FINANCING		
1.	Planning and financing	Mapping of facilities, differential planning for districts / blocks with poor health indicators; resources not to be spread too thin / targeted investments; at least 10% annual increase in state health budget (plan) over and above State share to NRHM resource envelope; addressing verticality in health programmes; planning for full spectrum of RCH services; emphasis on quality assurance in delivery points
2.	Management strengthening	Full time Mission Director for NRHM and a full-time Director/ Jt. Director/ Dy. Director Finance, not holding any additional responsibility outside the health department; fully staffed programme management support units at state, district and block levels; training of key health functionaries in planning and use of data. Strong integration with Health & FW and AYUSH directorates
3.	Developing a strong Public Health focus	Separate public health cadre, induction training for all key cadres; public health training for doctors working in health administrative positions; strengthening of public health nursing cadre, enactment of Public Health Act
HUMAN RESOURCES		
4.	HR policies for doctors, nurses paramedical staff and programme management staff	Minimising regular vacancies; expeditious recruitment (eg. taking recruitment of MOs out of Public Service Commission purview); merit –based and transparent selection; opportunities for career progression and professional development; rational and equitable deployment; effective skills utilization; stability of tenure; sustainability of contractual human resources under RCH / NRHM and plan for their inclusion in State budget

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED
5.	HR Accountability	Facility based monitoring; incentives for both the health service provider and the facility based on functioning; performance appraisal against benchmarks; renewal of contracts/ promotions based on performance; incentives for performance above benchmark; incentives for difficult areas
6.	Medical, Nursing and Paramedical Education (new institutions and upgradation of existing ones)	Planning for enhanced supply of doctors, nurses, ANMs, and paramedical staff; mandatory rural posting after MBBS and PG education; expansion of tertiary health care; use of medical colleges as resource centres for national health programmes; strengthening/ revamping of ANM / GNM training centres and paramedical institutions; re-structuring of pre service education; developing a highly skilled and specialised nursing cadre
7.	Training and capacity building	Strengthening of State Institute of Health & Family Welfare (SIHFW)/ District Training Centres (DTCs); quality assurance; availability of centralised training log; monitoring of post training outcomes; expanding training capacity through partnerships with NGOs / institutions; up scaling of multi skilling initiatives, accreditation of training
STRENGTHENING SERVICES		
8.	Policies on drugs, procurement system and logistics management	Articulation of policy on entitlements of free drugs for out / in patients; rational prescriptions and use of drugs; timely procurement of drugs and consumables; smooth distribution to facilities from the district hospital to the sub centre; uninterrupted availability to patients; minimisation of out of pocket expenses; quality assurance; prescription audits; essential drug lists (EDL) in public domain; computerised drugs and logistics MIS system; setting up dedicated corporation eg: TNMSC
9.	Equipments	Availability of essential functional equipments in all facilities; regular needs assessment; timely indenting and procurement; identification of unused/ faulty equipment; regular maintenance and MIS/ competitive and transparent bidding processes

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED
10.	Ambulance Services and Referral Transport	Universal availability of GPS fitted ambulances; reliable, assured free transport for pregnant women and newborn/ infants; clear policy articulation on entitlements both for mother and newborn; establishing control rooms for timely response and provision of services; drop back facility; a prudent mix of basic level ambulances and emergency response vehicles
11.	New infrastructure and Maintenance of buildings; sanitation, water, electricity, laundry, kitchen, facilities for attendants	New infrastructure, especially in backward areas; 24x7 maintenance , plumbing, electrical, carpentry services and round the clock power back up; cleanliness and sanitation; upkeep of toilets; proper disposal of bio medical waste; drinking water; water in toilets; electricity; clean linen; kitchens, facilities for attendants
12.	Diagnostics	Rational prescription of diagnostic tests; reliable and affordable availability to patients; partnerships with private service providers; prescription audits, free diagnostics for pregnant women and sick neonates
COMMUNITY INVOLVEMENT		
13.	Patient's feedback and grievance redressal	Feedback from patients; expeditious grievance redressal; analysis of feedback for corrective action
14.	Community Participation	Active community participation; empowered PRIs; strong VHSNCs; social audit; effective Village Health & Nutrition Days (VHNDs), strengthening of ASHAs, policies to encourage contributions from public/ community
15.	IEC	Comprehensive communication strategy with a strong behaviour change communication (BCC) component in the IEC strategy; dissemination in villages/ urban slums/ peri urban areas
CONVERGENCE, COORDINATION & REGULATION		
16.	Inter Sectoral convergence	Effective coordination with key departments to address health determinants viz. water, sanitation, hygiene, nutrition, infant and young child feeding, gender, education, woman empowerment, convergence with SABLA, SSA, ICDS etc.

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED
17.	NGO/ Civil Society	Mechanisms for consultation with civil society; civil society to be part of active communitisation process; involvement of NGOs in filling service delivery gaps; active community monitoring
18.	Private Public Partnership (PPP)	Partnership with private service providers to supplement governmental efforts in underserved and vulnerable areas for deliveries, family planning services and diagnostics
19.	Regulation of services in the private sector	Implementation of Clinical Establishment Act; quality of services, e.g. safe abortion services; adherence to protocols; checking unqualified service providers; quality of vaccines and vaccinators, enforcement of PC-PNDT Act
MONITORING & SUPERVISION		
20.	Strengthening data capturing, validity / triangulation	100% registration of births and deaths under Civil Registration System (CRS); capturing of births in private institutions; data collection on key performance indicators; rationalising HMIS indicators; reliability of health data / data triangulation mechanisms
21.	Supportive Supervision	Effective supervision of field activities/ performance; handholding; strengthening of Lady Health Visitors (LHVs), District Public Health Nurses (DPHNs), Multi Purpose Health Supervisors (MPHS) etc.
22.	Monitoring and Review	Regular meetings of State/ District Health Mission/ Society for periodic review and future road map; clear agenda and follow up action; Regular, focused reviews at different levels viz. Union Minister/ Chief Minister/ Health Minister/ Health Secretary/ Mission Director/ District Health Society headed by Collector/ Officers at Block/ PHC level; use of the HMIS/ MCTS data for reviews; concurrent evaluation
23.	Quality assurance	Quality assurance at all levels of service delivery; quality certification/ accreditation of facilities and services; institutionalized quality management systems

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED
24.	Surveillance	Epidemiological surveillance; maternal and infant death review at facility level and verbal autopsy at community level to identify causes of death for corrective action; tracking of services to pregnant women and children under MCTS
25.	Leveraging technology	Use of GIS maps and databases for planning and monitoring; GPS for tracking ambulances and mobile health units; mobile phones for real time data entry; video conferencing for regular reviews; closed user group mobile phone facility for health staff; endless opportunities- sky is the limit!

ANNEX 2

BROAD STRUCTURE OF COVERING LETTER FROM STATE

Sub: - Submission of NRHM PIP of 'state name' for fiscal year 2013-2014.

With reference to above cited subject the Project Implementation Plan (PIP), NRHM for the year 2013-14 is enclosed, as per the guidelines given by MoHFW, GoI.

We affirm that the targets and road maps of the state, for the year 2013-14 remains the same (In case there is change in targets, State to provide the following table) as given in the RoP booklet 2012-13.

GOALS: INDICATOR	INDIA		STATE Trend (*year & source*)			STATE TARGETS		
	Current status	RCH II/ NRHM (2014) goal				2012-13	2013-14	2014-15
Maternal Mortality Ratio (MMR)	212 (SRS 07-09	<100						
Infant Mortality Rate (IMR)	47 (SRS 2010)	<30						
Neonatal Mortality Rate (NMR)	33 (SRS 2010)							
Early NMR	25 (SRS 2010)							
Under 5 Mortality	59 (SRS 2010)							
Total Fertility Rate (TFR)	2.5 (SRS 2010)	2.1						

The proposed State NRHM Budget is Rs.----- crores. The break up for the same is as per the following table.

Part	Head	Budget 2013-14 (Rs. in Crores)
A	RCH Flexible Pool	
B	NRHM Flexible Pool	
C	Immunization (from RCH Flexible Pool)	
D	NIDDCP	
E	IDSP	
F	NVBDCP	
G	NLEP	
H	NPCB	
I	RNTCP	
J	Direction & Administration	
K	PPI Operation Cost	

The provisional committed balance is Rs. ----- crores and the uncommitted unspent balance is Rs. ---- Crores (as per the FMR and Statement of Fund position on .....2012).

We are submitting the PIP after self appraisal of the state activities as specified in the Annex no.---- . Through this we have also been able to arrive at priority areas for our State as following:

1.
2.
3.
4.
5.

Further, for the year 2013-14 State intends to take up following new initiatives/innovations:

1.
2.
3.

ANNEX 3

FORMAT FOR SELF ASSESSMENT OF STATE PIP AGAINST APPRAISAL CRITERIA

	CRITERIA	**REMARKS** ***{Yes (Y) or No (N)***
1.	Has the state PIP been reviewed in detail by a single person to ensure internal consistency? If yes, by whom?	
2.	Has the State ensured that there is no double budgeting under any head?	
3.	Has a chartered accountant/Finance manager reviewed the budget in detail?	
4.	Has the district wise resource envelop conveyed to the districts? Has the State ensured that HF districts get at least 30% more (i.e. HF to be given a weightage of 1.3 Vs 1.0 against non high focus)?	
5.	Have DHAPs been prepared for all districts (as a minimum for all high focus)? If not, for how many?	
6.	Are the supportive supervision structures at state and district / sub-district levels consistent with expertise required for programme strategies? Are job descriptions including person specifications, delegation of powers and basis for assessment of performance in place?	
7.	Has the State taken steps to ensure establishment and functioning of quality assurance committees in the districts?	
8.	Have the 'new activities' and 'activities to be continued' clearly marked?	
9.	Has the State ensured that the HR sheet and infrastructure sheet given in annexure filled up accurately?	
10.	Has the State ensured that the statistics used in PIP (e.g. number of facilities DH/FRU etc., HR in each category, population etc.) have their source mentioned and are consistent throughout the document?	

ANNEX 4

STATE RESOURCES AND OTHER SOURCES OF FUNDS FOR HEALTH SECTOR

In order to get a complete picture of the resources available for the health sector, the State should clearly indicate the resources available from the State Government and from other sources for the Health Sector and the details of the activities for which these funds would be utilized. Amount received or likely to be received from each source and the activities for which it is to be utilized along with outcomes of the same should be indicated in this chapter.

Sr. No.	Source of Fund/ Name of Development Partner	Activity for which funds expected to be received	Amount Expected in 2013-14

ANNEX 6

DETAILED BUDGETED HEADWISE EXPLANATION

The FMR heads of the budget have been kept as per last year. However, some of the budget heads have been divided into further subheads. This has been done to provide a clearer picture of what goes into each activity as generally more than one activity is budgeted under one head.

In case the State needs more rows for activities not shown in budget sheet it may budget it in 'Others' row and provide its detail in the remarks column

Following rows in the budget sheet and FMR from 2013-14 has been made non-operational/frozen (coloured in the budget sheet in light grey) to avoid duplication/redundancy. This means that for 2012-13, if the State had budgeted any amount under this head they may book the expenditure for it; however, for next year i.e. 2013-14 state should not plan any budget under these FMR heads:

A.1.1.1	Operationalise FRUs
A.1.1.2	Operationalise 24x7 PHCs
A.1.1.5	Operationalise sub-centres
A.1.2	Referral Transport
A.2.9	Incentive to ASHA under child health
A.9.1	Strengthening of existing Training Institutions (SIHFW, ANMTCs, etc.)
B.4.4	Logistics management/ improvement

There are other heads in budget format under which all the above items can be budgeted.

The blank rows have been given for states to add state specific activities. Please use these only after you ensure that the existing heads cannot accommodate the activity.

FMR code	Budget Head	Explanation
A.1.1	Operationalize facilities	The head has sub heads for FRU, 24x7 and sub-centres have been frozen. In case a state has an activity which pertains to these heads it may budget it under other activities. For Safe abortion services, and RTI/STI services all the miscellaneous expenses which cannot be put under HR, procurement, training etc should be put here. Cost of mapping exercise, prioritization exercise, District Level Committee (DLC)formation, DLC meeting etc should be put here. Kindly mention the number of facilities to be operationalized under each category.
A.1.2	Referral transport	Referral transport under this head is frozen. Referral transport for JSSK is to be budgeted under MH A.1.7.5 and CH A.2.10

FMR code	Budget Head	Explanation
A.1.3.1	Outreach camps	Outreach camps to be restricted only to areas without functional health facilities
A.1.4	JSY	The column for institutional deliveries should be a sum of rural and urban deliveries. In case the State has contracted in specialists for C-section on per case basis or engaged private providers for C-section, it should be budgeted under FMR code 1.4.2 c JSY incentive for ASHA is to be budgeted under MH, rest all the incentives for ASHA are to be budgeted under ASHA in part B.
A.1.7	JSSK	Under MH, budget for pregnant women. State should budget for drugs and consumables in A.1.7.1, diagnostic in A.1.7.2, blood transfusion in A.1.7.3, Diet in A.1.7.4 (for calculation of diet charges – all normal deliveries to be budgeted for 3 days and C-sections for 7 days). JSSK budget has to be calculated on the basis of number of normal deliveries and c-sections. A.1.7.5 would have the budget for referral transport which is inclusive of home to facility, inter-facility and drop back. Any other JSSK activity may be specified under A.1.7.6
A.2.1	IMNCI	Planning activities for all IMNCI activities including F-IMNCI and planning for pre-service IMNCI activities in medical colleges, nursing colleges, and ANMTCs to be budgeted here. Cost of training HR, Procurement is to be budgeted under training.
A.2.2	Facility based newborn care	Separate rows given for SNCU, NBSU and NBCC. Operating costs to be budgeted here. Costs other than HR, infrastructure, procurement, training, IEC to be budgeted
A.2.5	Care of sick children and severe malnutrition	Budget for Nutritional Rehabilitation Centres, Malnutrition treatment centres, CDNCs except HR, training, infrastructure, procurement, IEC to be budgeted here.
A.2.10	JSSK (for sick neonates up to 30 days)	Drugs and consumables, diagnostics and provision of free referral transport for sick neonates to be budgeted here
A.3.1.6	Accreditation of private providers to provide sterilization services	State may budget the sterilizations (male & female) to be done in private facility @ Rs.1500 as prescribed
A.3.2.4	Social marketing of contraceptives	This head would include the budget for delivery of contraceptive by ASHA at door step

FMR code	Budget Head	Explanation
A.4.1	Adolescent services	This head would include adolescent services at health facilities as well as outreach activities
A.4.2	School Health Programme	All components of school health except procurement, training etc to be budgeted. This includes budget related to preparing detailed operational plan for dedicated School Health Programme across districts and cost of plan meetings with Department of education and ICDS for pre-school children (6 month to <6 years) registered with Anganwadi centres and other miscellaneous expenses. Mobility support for school health teams to be budgeted under 4.2.3 and referral support to students referred for further treatment to health facilities to be budgeted under 4.2.4
A.4.3.1	Menstrual Hygiene	Costs other than HR, procurement of sanitary napkins and training to be budgeted
A.5	Urban RCH	All components of urban health including HR is to be budgeted under this head. HR as an exception is budgeted here as in many States the urban health is looked after by Urban local bodies to whom the entire Urban RCH budget is given.
A.6	Tribal Health	HR if any in addition to normative HR can be added here; part-time HR to be clearly demarcated.
A.7	PNDT activities	Support to PNDT cell would include operating costs but the budget for consultants is to be budgeted under Programme management. Mobility cost under PNDT activity is for inspection and has been kept separate to allow greater flexibility to the PNDT cell
A.8	Human Resources	All the HR except AYUSH, PPP/ NGOs, ASHA, HMIS, MCTS, IEC/ BCC Bureaus, Regional Drug Warehouses, IDW wing, SHSRC to be budgeted under A.8. HR in this head, are service delivery personnel including field supervisors such as LHVs. Each category of staff to be budgeted separately. State to clearly indicate the place/level of posting DH, FRU, CHC etc. Kindly make sure that the salary budgeted is the salary for the entire year 2013-14.
A.9	Training	All the training programme recommended, have been given separate rows. In case State has other training programmes it is to be budgeted in the Others category. For each of the training programme specify the total number of batches as well as the batch size. In case separate row for ToT or refresher training is not available, please budget and mention the kind of

FMR code	Budget Head	Explanation
		training in the remarks column. The head for strengthening of training institutes is to be used for budgeting for components other than HR and infrastructure.
A.10	Programme Management	All the personnel not engaged in direct service delivery, including programme managers to be budgeted here. Support staff like peons, office attendant etc. (except DEO, programme assistants) for each level State, district, block to be budgeted under separate head provided. Strengthening (Others) should include regional programme management units, hospital managers etc (if any). Category of staff to be clearly mentioned. FMR head 10.7 should give the total mobility costs at State, district, block and others. This includes mobility cost of programme officers as well as consultants/contractual personnel. To implement effective supportive supervision, State needs to prepare monthly comprehensive supportive supervision and monitoring plan for all supervisory cadres. Supportive supervision for MH, CH, FP, AH (including ARSH, WIFS, SHP and MHS) should be conducted from the budget provided under this head, State is thus requested to project a lump-sum budget for supervision/ Monitoring at various levels i.e. National, State, Districts and Block. However, Mobility Support for Immunization, PC-PNDT Cell, ARSH & ICTC counselors, quarterly review meetings for immunization, review and workshop of RCH/ NRHM and support for review meetings for HMIS & MCTS should be reflected under separate sub-heads as per the budget sheet. State may also budget the cost of committee formation under the Clinical Establishment Act, meetings, and their mobility under the heads of programme management.
A. 11	Vulnerable Groups	This head would include planning for such groups (other than urban slums and tribals) who are considered vulnerable in the State e.g. migrants, salt pan workers etc.
B.1	ASHA	All costs for ASHA to be budgeted under this head. Performance incentive to ASHA under RCH also to be

FMR code	Budget Head	Explanation
		budgeted here except JSY incentives which are to be budgeted under JSY & FP head. Many of the heads have been sub- divided into several sub-heads to bring in clarity in planning. State to provide break up accordingly.
B.4 B.5	Hospital Strengthening New constructions/renovation and setting up	This head includes all proposals related to the civil work/ construction of health facilities such as MCH wings (at DH/DWHH/SDH/CHC)/ District Hospitals/ Sub-Divisional Hospitals/ CHC/ PHC/ SC (including for AYUSH if any), Training Institutes (Including SIHFW, ANMTC/GNMTC) and Drugs Warehouses. Further, each head is sub-categorization into 5 different sub-heads i.e. completely new/rented to own building, Additional Building/ Major up gradation of existing structures, Repair/Renovation, Spill over of ongoing works (specify which instalment) and Staff quarters along with the timeline for completion. All other cost such as HR (except HR for infrastructure development wings), equipments and drugs should be booked under the respective Human Resource, Equipments and drugs heads. State to provide the supporting information such as OPD/IPD load etc. as per the infrastructure sheet which is hyperlinked to the budget sheet. B.4 should include budget for upgradations only and should not include budget for IPHS upgradation, procurement and other hospital strengthening activities. All new constructions are to be included in B-5 only.
B.7	Health Action Plans	Budget for planning process to be included under this head. District Health Action Plans (DHAPs) to be aggregation of block plans and village health plans. All the requirements of the facilities in a particular district should be reflected in the DHAP.
B.10	IEC /BCC NRHM	Funds for IEC/ BCC at State, District and Block level may be budgeted under this head. All forms of communication including Mass Media, Mid Media and IPC should be used to convey IEC messages on all technical interventions and programmes. States may thus project for all three types of communication under this head. Budget for conducting health melas in parliamentary constituencies should be included under this head. Printing of other Material for MH (MCP cards/ registers /Safe Motherhood Booklet/Partographs) and Adolescent Health (including

FMR code	Budget Head	Explanation
		MHS, WIFS, SHP &ARSH) etc should be budgeted under the heads given.
B.11	Mobile Medical Units (Including recurring expenditures)	States to budget for capital and operational costs for Mobile Medical Units under this head. This head is divided into capex and opex for regular MMUs and capex and opex for special MMUs such as dental MMUs, mobile mammography vans, mental health MMUs and smaller vans etc. Cost for HR of Mobile Medical Units should be included under the operational cost. States to calculate and specify the per trip operational cost (excluding the capital cost). Kindly specify whether the MMU is run in a PPP mode or by the State/ District Health Mission.
B.12	Referral Transport	All ambulance services including basic ambulances under the 102 network as well as advanced ambulances under the 108 EMRI network are to be budgeted under this head. States to specify the type of ambulance i.e ALS/ BLS, the helpline number i.e. 102/ 108 etc. Capital costs and operational costs are to be budgeted separately. EMRI ambulances are to be budgeted under this head, clearly outlining the number of years the EMRI has been operational and the percentage of operational costs given under NRHM in the previous years. States to calculate and specify the per trip operational cost (excluding the capital cost). All HR for ambulances whether outsourced or under contract with State/ District Health Missions should also be projected under the operational cost of this head. Setting up and operational costs including HR for Call Centres should also be budgeted for under this head. State should take care to avoid duplication in budget in MH A.1.2, JSSK, and CH A.2.10.3
B.13	PPP/NGO	All the PPPs are to be budgeted under this head. There is specific rows for Outsourcing of services.
B.14	Innovations	All State Specific Initiatives/ Innovations to be included under this head. All technical HR required for implementation of State Specific initiatives/ Innovations are to be reflected under general HR head and programme management HR to be included under the head Strengthening (others) in programme management. State is requested to use the annex for new initiatives wherever needed. In case there is a

FMR code	Budget Head	Explanation
		need to share necessary data or explanation please add a sheet with FMR code number and activity clearly specified.
B.15/B.15.1 /B.15.2/15.3	Planning, Implementation and Monitoring/Community monitoring/Quality Assurance/Monitoring & Evaluation	Operational Costs for HMIS and MCTS should be reflected here. Other E- governance projects such as Hospital Management Software's, other IT initiatives should be included under this head. NRHM has a key mandate to provide good quality health services through Quality Assurance (QA). Quality Assurance means maintenance of a desired level of quality in a service especially by means of attention to every stage of the process of service delivery. State needs to elaborate upon constitution of Quality Assurance Cell at State level and Quality Assurance Committees at district level. Details about Quality Assurance plan including details on ToRs, goals, objective and time frame monitorable targets, process and outcome evaluation methods. Details on development of any indigenous plan for quality improvement for facility based care or adoption of any existing standards e.g. ISO, IPHS, FFH, etc. Details about the types and purpose of Quality Assurance training with no. of batches and batch size. Development of guidelines and formats for Quality Assurance. Monitoring plan including calendar for visits. Summary on State achievement against the set goals in previous years to be provided. We have added a row (B15.2.4) where the State may budget for review meetings at state, district and block levels.
B.16	Procurement/Procurement of equipments/drugs and supplies	This head would include budget for drugs and consumables for all Maternal Health (including RTI /STI drugs and consumables including and, Drugs for Safe Abortion), Child Health, Family Planning, Adolescent Health (Including ARSH, WIFS, School Health Programme and Menstrual Hygiene Programme), Urban RCH initiatives as well as general drugs and supplies for OPD & IPD. Budget for guaranteed availability of free generic drugs at all public health facilities (as per the Essential Drug List (EDL) of States) should be included under this head. Drugs for co-located AYUSH facilities may also be included under this component.

FMR code	Budget Head	Explanation
		Equipments for Maternal Health (including equipments for Blood Banks/ BSUs other than supported by NACO and equipments of MVA /EVA for Safe Abortion services), Child Health, Family Planning (e.g. NSV kits, IUCD kits, minilap kits, laparoscopes etc.), ARSH Clinics, School Health Programme, IMEP, AYUSH facilities, training institutes and all other equipments for strengthening of hospitals should be included under this head. Budget for diagnostic facilities for all (Except JSSK for PW and Neonates) including RPR kits and Whole blood finger prick test for HIV, general diagnostic facilities should be included here. Even if diagnostic facilities are provided in PPP mode/ outsourced to private laboratories, the budget for the same will be reflected under this head.
B.19	New Initiatives	All initiatives that are being introduced for the first time in the current year are to be included under this head. Initiatives continuing from last year or previous years are to be included under innovations. All technical HR required for implementation of New Inititatives are to be reflected under general HR head and programme management HR to be included under the head Strengthening (others) in programme management. States are encouraged to include innovation under Adolescent Health such as peer educators.
B.20	Research ,Studies, Analysis	State may budget any evaluation or implementation research under this head
B.22	Support Services	As the National Disease Control Programmes under NRHM are strait-jacketed with very specific guidelines they are unable to respond to State-Specific needs. Thus, activities of the NDCPS that are not included under their respective heads should be budgeted under this head. State may use a separate excel sheet for details.
C	Immunization	Immunization: Immunization is one of the most cost effective interventions for disease prevention. This head includes cost of Alternative Vaccine Delivery, development of micro plan for Immunisation at sub-centre & block level, Red/Black plastics bags, Hub Cutter/ Bleach/Hypochlorite solution/ Twin bucket,

FMR code	Budget Head	Explanation
		Safety Pits, Operational Cost for Teeka Express, Measles SIA, JE Campaign and maintenance cost for cold chain equipments. Pulse Polio Immunization (PPI) to be reflected separately under this head. The Ministry is also desirous to introduce vaccine insulated vans, under brand name "Teeka Express" which is a specially designed vehicle with logo of NRHM and Immunization along with key messages pertaining to immunization. This branding will be uniform across the country to provide visibility and demand generation. It will be used at the peripheral level for delivery of vaccine from last storage point to outreach session sites.
E	Infrastructure Maintenance	From the current year onwards, State/ UT Governments are expected to project in detail, funds required via the treasury route (also known as the Infrastructure Maintenance scheme). As per the letter issued in 2012, henceforth these funds can only be used for claiming salaries of Staff employed under the institutions set up under this head. All other maintenance, procurement and miscellaneous costs are to be borne by the State/ UT Governments. States are thus expected to include in the budget sheet, details of the number and categories of Staff employed under Family Welfare Bureaus at State & District level, Urban family Welfare Centers (UFWCs), Health Posts (Urban Revamping Scheme), ANM/LHV training Schools, Basic Training Schools of Multi-Purpose Health Workers (Male) and Health & Family Welfare Training Centres (HFWTC). Apart from the salary of 1st ANM and 1/6th salary of LHV per Sub-Centre to be reimbursed via the treasury route should also be budgeted for under this head.

For the HR sub-categories the state will have to gather data beforehand. It is also a pre-requisite for the conditionalities for which HR data base has to be created

A.10.7.4 Other Supportive Supervision costs may include cost of field visits for teams for Clinical Establishment Act

ANNEX 7

BASICS OF MEDIA PLAN – TEMPLATE FOR STATE IEC PIPs

Media outreach plan should ideally comprise of:

(A) MACRO LEVEL -

1. Situation analysis – i.e. identifying State specific issues that need to be addressed for conducting an information, education campaign or a behaviour change campaign. While there could be pan India concerns like popularising the national programmes funded/initiated (new or ongoing) by Central Government Ministry of Health and Family Welfare or pressing social behaviour concerns like that of addressing issue of adverse child sex ratio; popularising need for routine immunization, population stabilization, breast feeding, hand washing etc. Thus the State IEC plans would need to begin with identifying issues to be addressed and consequently identifying the focus groups to be addressed for these concerns.

2. Second stage of strategic design for communication plan – identifying users, content and medium - The method and scope – the medium of messaging – be it mass media, print, electronic, new social media, interpersonal communication method, etc and their extent of use would again depend on the need/subject identified, focus group to be addressed, as also work done in the past – identifying a baseline and availability of resources – financial and human resources at hand.

3. After content identification and content development – message to be conveyed and the manner in which it would be given – implementation i.e. dissemination of the material/campaign thus developed is of vital importance to ensure reaching out to the people for whom the scheme, message is meant for.

   It is advisable to make use of all existing channels like particularly the Doordarshan(DD) and All India Radio(AIR) given their wide reach particularly in remote areas. Other available local State television and radio channels also need to be utilized but keeping in mind the assessment of their cost & reach.

   For interpersonal communication associating the Directorate of Field publicity(DFP) and Song and Drama Division(S&DD) is advisable as supplementary efforts of distt and block level programme IEC personnel. Coordinating with Public Information Campaigns(PICs) periodically organised by local offices of Press Information Bureau, GOI and 'Swasth Bharat' programme of MoHFW on DD and AIR and Inter-Media Publicity Co-ordination Committees set up at all the State Capitals and Union Territories as per the directives of Ministry of Information and Broadcasting, GOI (IMPCC) would also be helpful fora to spread messages.

   Spreading messages through district/block level, programme/IEC personnel is definitely required but it is ideal if they can work in coordination with existing structures as mentioned above. For print and electronic, emphasis on communicating through vernacular would be preferable than English medium. While prototypes developed by

centre/ development partners identified by central/State department would serve as useful guides, these would need to be tweaked to local requirements.

(B) MICRO LEVEL – each State PIP

State PIPS can have following components and financial implications for each worked out as per local rates/funds availability/past utilization pattern

1. Messages to be conveyed for - for example for JSSK, WIFS, Menstrual Hygiene Scheme, Intensification of Routine Immunization, population stabilization, adverse child sex ratio, PC&PNDT Act, etc and other local public health challenges

2. Getting messages through

    a) print (for literates) - medium of newspaper advts – particularly in vernacular papers with wide local reach, fliers, pamphlets, folders, flipcharts, booklets,etc
    b) Outdoor publicity (reaches all sections of society) through - hoardings, banners, electronic billboards; hoardings in govt hospitals, govt premises such as railway stations, post offices; bus/local public transport panels including on NRHM MMU vehicles; wall paintings
    c) Audio video spots on local TV and radio channels including the operational community radios in the area; cinema slides
    d) Organising events – exhibitions on major religious occasions, health melas, participation in DFP campaigns, S&DD programmes, PIB's PICs
    e) DD and AIR – Swasth Bharat programme and other news based/current affairs programme to be coordinated with local station directors
    f) Coordinating activities with Inter-Media Publicity Co-ordination Committees set up at all the State Capitals and Union Territories as per the directives of Ministry of Information and Broadcasting, GOI to identify themes for co-ordinated multi-media publicity and to prepare a common brief for all the local media in consultation with State authorities on all-important subjects as they arise. The senior most officer among the local Central Media Heads is the Chairperson of the Committee. All local Principal Officers of Central Media Units, State Director of Information/Public Relations/Publicity, Defence Public Relations Officers and Publicity Officers of Public Sector Undertakings are the members of IMPCC. The basic purpose of establishing the Inter Media Publicity Coordination Committees is to effectively coordinate the publicity efforts of various Central Government Media Units as well as to achieve coordination with the State Government on common themes so as to achieve maximum projection of development programmes and achievements through media set up.

3. Best practices in the State can be showcased with press tours – journalists through PIB New Delhi or regional offices can be briefed about best practices. Press releases should be issued for general official information sharing – has no financial implication when done through concerned regional/branch PIB office

4. The Mobile Medical Units can also be used to spread messages through short films on video like that of ORS use, breast feeding and utilising other such prototype material made by programme divisions with development partners such as UNICEF, UNFPA etc

5. Capacity building workshops for IEC personnel – ideal to have IEC personnel at district and block level to coordinate at grass root level, coordinating with ASHAs, ANMs, local doctors, local opinion makers

6. Use of new media in specific local context – use of web advertising, linking with official and other prominent programme based websites, facebook of for example diabetic group, alcoholics anonymous, etc, mobile messaging utilising MCTS database

7. Impact assessment surveys to help design next communication plan

8. Other such matters as decided by local programme managers given their domain knowledge

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