Training Module on

“Budget/ PIP Preparation”

April, 2014

Learning Objective of the Module

The aim of this training module on "Budget/PIP Preparation" is to help the finance and accounts staff to develop an understanding of the following:

- ✓ Importance of Programme Implementation Plan (PIP)
- ✓ Steps involved in preparation and approval of State PIPs
- ✓ Concept of District Health Action Plan and its purpose
- ✓ NHM PIP guidelines circulated to states and its requirements
- ✓ Broad contents of the PIP and the important aspects to be included
- ✓ Role of finance and accounts staff in the preparation of PIPs/ DHAPs

Table of Contents

Introduction to PIP

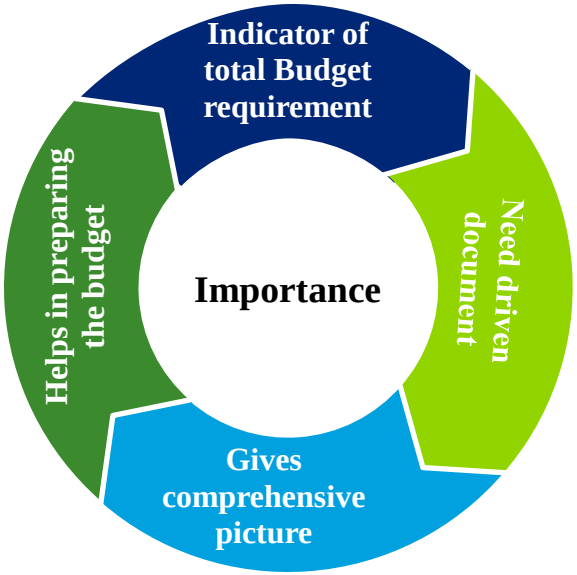
Introduction to PIP

What is Programme Implementation Plan?

State Programme Implementation Plan is a document to be prepared by States annually which helps them in identifying and quantifying their targets required for programme implementation for the proposed year. The documents are then finalized in the NPCC (National Programme Coordination Committed) meeting for Administrative approval , Resource envelope is created and accordingly conveyed to the state. On finalization of the budget in the NPCC Meeting, it becomes an Official document available in the Ministry's site for general viewing.

Importance of Programme Implementation Plan

- Indicator of the total budget requirement of the state for carrying out the programme activities and helps in planning before commencement of the year



- For each programme component, the unit cost is fixed which helps in budgeting for the programme division and consolidation of the programme budget for the State.

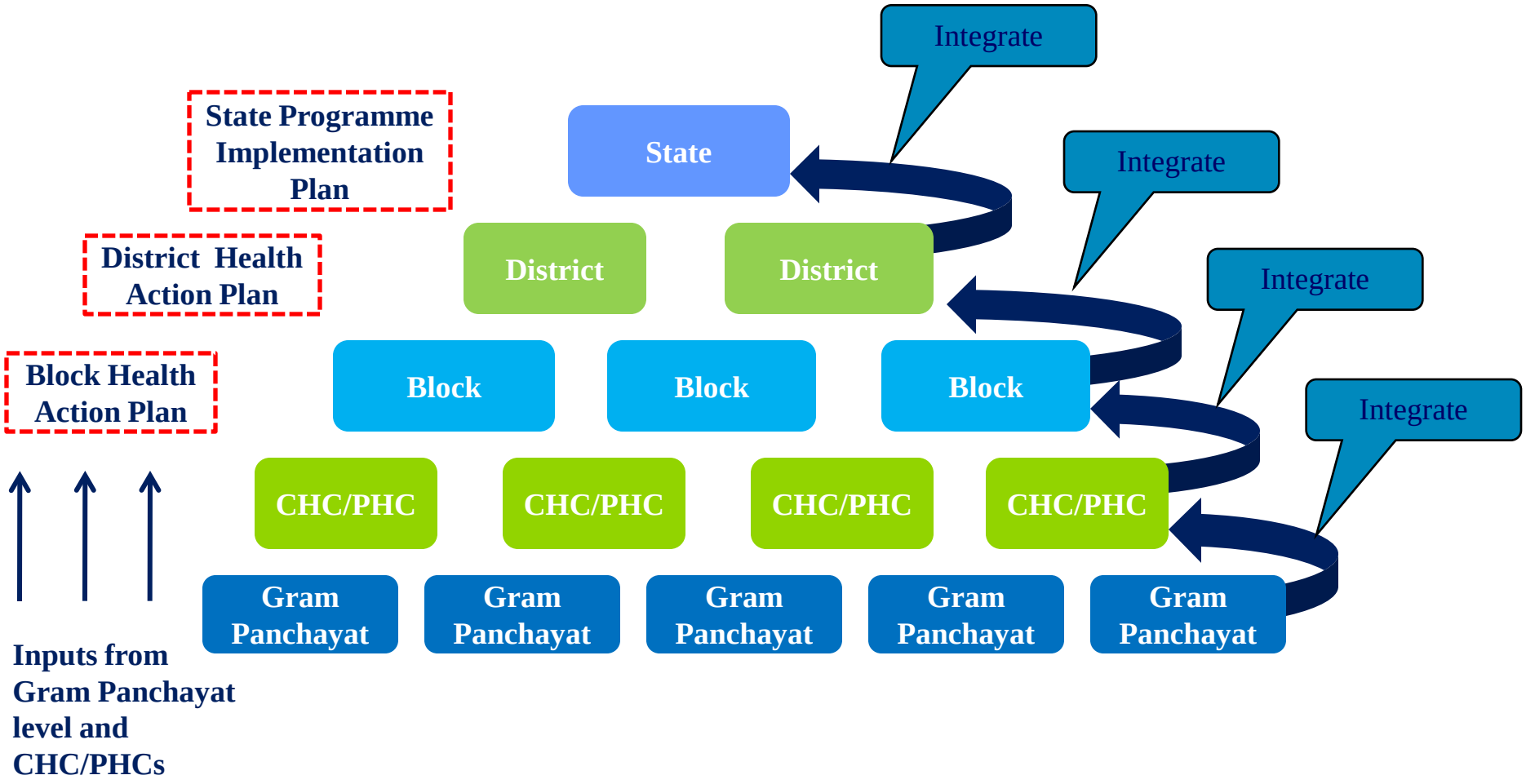
- Need driven document prepared by consolidating information from various District Health Action Plans (DHAPs) submitted by districts under the State.
- DHAPs contain inputs on the needs of the districts in terms of programme implementation and hence the funds required for the same.

- Gives comprehensive picture by taking inputs from various programme divisions (like Maternal Health, Child Health, Family Planning Services, Immunization etc.) who prepare their achievable physical targets for the year on the basis of annual population or other determining factors

Planning and Approval Process of PIPs

Bottom Up Approach

A bottom up approach is followed for preparing the State PIP wherein the inputs are taken from block, cities, CHC/PHC and Village level to prepare a District Health Action Plan (DHAP). These DHAPs are then consolidated to prepare a State PIP.



PIP preparation - Key Steps

GoI

State

1. *Communication of guidelines and timelines for preparation of PIP to states*
   - *Resource envelope more or less would be same as per last year budget, unless specfic instruction for increase /decrease has been communicated by GOI.*

6. *Submission of draft State PIP to GoI*
   - *For finalizing State PIP, an action plan meeting should be held between the State and district officials to approve or disapprove their requirements after discussion*
   - *Each programme division at the states approves/ disapproves its respective targets*

District

2. *Communication on resource allocation to the Districts*
   - *Resource allocation to be determined based on population of the district and other determining factors. A weightage of 1.3 to high priority districts and 1.0 to the other districts needs to be given subject to state's suitability.*

5. *Preparation and Submission of District Health Action Plans to the State*
   - *For finalizing DHAP, an action plan meeting should be held between the district and block officials to approve or disapprove their requirements after discussion*

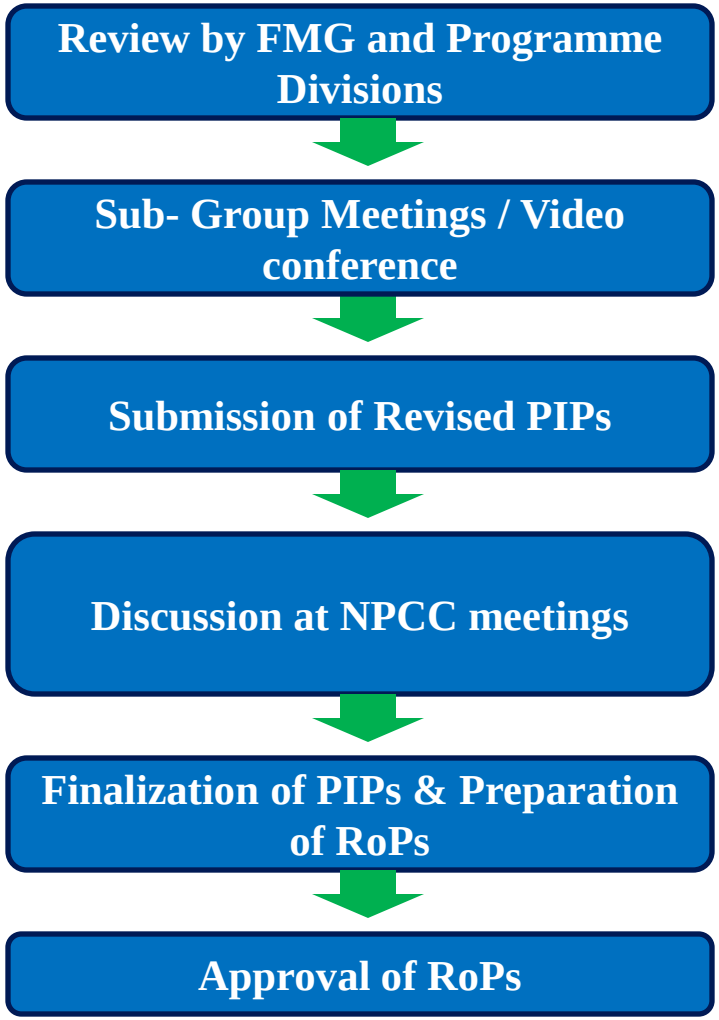
Block

3. *Districts intimate blocks to submit Block Action Plans*

4. *Preparation of Block Action Plans and Submission to the respective districts*
   - *Inputs to be taken from CHCs/ PHCs, ASHAs, Village Gram Panchayats etc.*

PIP Approval – Key Steps

Following are the steps involved in the finalization of PIPs after their submission to the Center by the States:



After submission of PIPs by the states to the GoI, the FMG and respective programme divisions at GoI level review them in detail.

Pre- appraisal/ sub group meetings / video conferences are held with state officials to discuss their demand of the budget as per the targets decided, compare d with previous year's achievements.

Based on the suggestions, PIPs are revised.

NPCC meetings are held at MoHFW or discussion on the PIPs where each State makes a proposal through presentation. These meetings have representatives from each division to approve/ disapprove the targets and inappropriate proposals.

Suggestions made in the NPCC are incorporated in the form of Record of Proceedings (RoPs) and PIPs are finalized.

The AS&MD approves the RoPs and sends them to the states by 31st March of the year.

Key Timelines- Preparation & Approval of PIPs

Activity	*Timeline*
Communication of Resource envelope to States by GoI	**October**
Communication of resource envelope to districts/other agencies by states	**October**
Preparation of District/ City and other plans by state level agencies	**November**
Preparation of state PIPs, approval by State Health Mission/ Society and submission to MoHFW	**December**
Appraisal and approval of PIPs by MoHFW	**January - March**

Key Features of the NHM PIP

Key changes under NHM PIP planning

- ✓ **National Health Mission** launched, subsuming all health programs of GoI
  - ❖ urban and rural
  - ❖ communicable and non-communicable diseases
  - ❖ technical and system strengthening
  - ❖ infrastructure
- ✓ **3-year perspective plan/ PIP** for the period 2014-15 to 2016-17
- ✓ Flexible pools have changed – now we have **5 pools**
- ✓ **Resource allocation norms** provided for some major budget heads
- ✓ **Budgeting norms** provided for various activities

Key Features

- ✓ Each state will 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.

- ✓ Each year the PIP will need to be updated by 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.

Key Features (contd…)

- ✓ State Program Implementation Plans (PIPs) will now consist of following five parts:
  - ➢ PART I: NRHM and RMNCH+A (including immunization) Flexipool;
  - ➢ PART II: NUHM Flexipool;
  - ➢ PART III: Flexipool for Communicable Disease Control Programs;
  - ➢ PART IV: Flexipool for non-communicable diseases including injury and trauma;
  - ➢ PART V: Infrastructure Maintenance
- ✓ State PIPs would be an aggregate of district/ city health action plans. City Plans for the first year to be submitted as a part of the NHM State PIP.
- ✓ Procurement requirement for items to be supplied by centre should also be included.
- ✓ State governments are required to contribute 25% under NHM, except for special category states, wherein state contribution would be 10%.
- ✓ States have to maintain a minimum of 10% annual increase in health budget.
- ✓ States are required to carry out a self-appraisal as part of the PIP preparation process

Resource Allocation Criteria

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-à-vis the population) funds.
- ✓ Under NUHM priority should be given to cities having higher percentage of slum population.
- ✓ 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 (30 minutes of walking distance), secondary care (upto 2 hours reach time) and referral linkage between primary and secondary care.
- ✓ Prioritise facilities with higher caseloads (deliveries, OPD/IPD services) for further development; all others should maintain or redeploy existing staff.

Resource Allocation Criteria

- ✓ 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%.
- ✓ Programme management costs should not exceed 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 state level.
- ✓ Up to 5% of the NHM resource envelope may be used as Grants in aid to NGOs at various levels
- ✓ Up to 5% of state resource envelope may be allocated towards capacity building.
- ✓ Up to 10% of district allocation should be earmarked for schemes developed by districts / cities

Overview of State NHM PIP Planning Process

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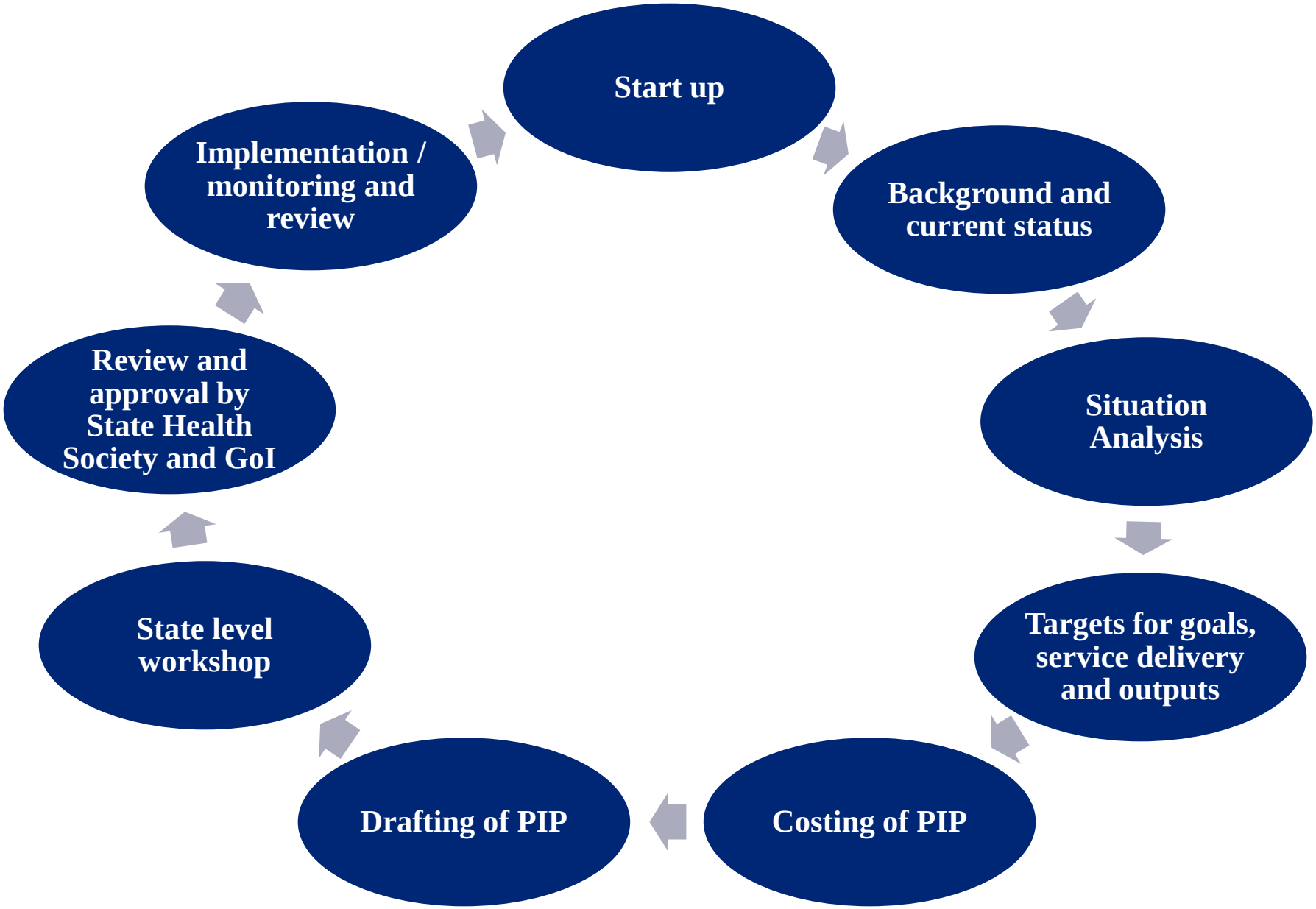


Overview of State NHM PIP Planning Process (contd…)

The PIP planning process will start with 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.

Key stages include:

- ✓ Preparation of district/ city plans (also prepare facility plans for high volume facilities)
- ✓ State level situation analysis
- ✓ Setting of targets for goals, service delivery, outputs and corresponding strategies and activities
- ✓ Budgeting 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
- ✓ Subsequent costing of the PIP in order to ensure that the PIP is within the financial envelope
- ✓ State NHM PIP will be drafted and a state level workshop will be conducted.
- ✓ Presentation of PIP to the respective State Health Society and the NPCC, MoHFW after incorporating feedback and making appropriate modifications to the PIP
- ✓ Implementation of the approved PIP which will result in 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.

Institutional Arrangements

Institutional Arrangements

The following institutional arrangements should be 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)
- ✓ 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.
- ✓ 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.
- ✓ 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.

Budgeting Norms

NRHM/ RMCHH+A

Untied funds for facilities

- ✓ Untied funds, funds for RKS and untied maintenance facility level funds will be merged into a single untied grant to the facility.
- ✓ The current annual allocation under NRHM per SC (Rs. 20,000) and per PHC (Rs. 1.75 lakhs) would remain the same.
- ✓ The annual untied fund amount per CHC would be increased from the current Rs. 2.5 lakhs to Rs. 5.0 lakhs, and for a DH it would be increased from the current Rs. 5 lakhs to Rs. 10 lakhs.
- ✓ Funds admissible for different levels of facilities like SC, PHC, CHC, SDH would be pooled according to the category of facility, at the district level and allocated to individual facilities based on utilization of funds, case loads, range of services, keeping equity considerations in mind.
- ✓ The sub-center would continue to receive its untied fund, with additional allocation of untied funds to sub-centers providing midwifery services, and/or handling larger caseloads and those that have special difficulties to overcome.

VHSNC

- ✓ Expenditures upto Rs 10,000 per VHSNC, but to flow according to utilisation and needs, with an increase of ceiling by 10% per year. The total funds for VHSNC in a district will be pooled.

NRHM/ RMCHH+A

ASHA

- ✓ Support per ASHA upto Rs 16,000 per year, excluding drugs and incentives. This is subject to a 5% increase per year.
- ✓ ASHA to earn at least Rs. 1000 per month, subject to a range of specified activities.
- ✓ Incentives may be appropriately designed for a range of activities, based on the complexity of tasks undertaken by the ASHAs.

BCC

- ✓ Funds will be provided based on specific plans while retaining the earlier norm of ceiling at Rs 10 per capita.

MMU

- ✓ The existing cap of five per district can be relaxed based on the area, difficult terrain, size of population, tribal and LWE areas, which are underserved.
- ✓ Norms for capital and operational expenditure will be suitably revised from time to time based on Consumer Price Index (CPI) and range of services provided.

M&E

- ✓ 1% of the NHM funds – of which resource 20% may be used at the national level, 30% at the State level and the rest at district level and below.

NRHM/ RMCHH+A

Grant in aid to NGOs

- ✓ Upto 5% of the NHM budget (of resource envelope of state) to be used to support NGOs for a range of activities. This 5% could overlap with other activities like ASHA and VHSNC training etc.

Technical Assistance

- ✓ Upto 2% of the annual work plan - includes establishment and consultant costs in SHSRC and operational research and studies and knowledge partnerships at the state and district levels.

Capacity Building

- ✓ Upto 5% of the resource envelope for costs of resource teams and institutions at all levels for capacity building.

Program Management Unit

- ✓ Upto 5.5 % of the total Annual Work Plan for that year, calculated on the basis of the total State PIP. For small states and UTs this amount could be increased to 10%.

Innovation fund and support for disaster management

- ✓ Upto 10% of the resource envelope would be used to fund innovations at the state level. Disaster response related interventions would be supported based on fund availability.

Planning & Mapping

- ✓ Indicative unit costs are as following:
  - ➢ Rs.15 L/city for planning/mapping of Metro cities
  - ➢ Rs.10 L/city for planning/mapping of cities with 1 million plus population
  - ➢ Rs.5 L/city for planning/mapping of cities with 1- 10 L population
  - ➢ Rs. 2L/town for planning/mapping of towns with 50,000- 1 L population

Training & Capacity Building

- ✓ Indicative unit costs are as following:
  - ➢ Orientation of Urban Local Bodies (ULB): Rs.5 lakhs for metros, Rs.3 lakhs for million+ cities, Rs.1 lakh for other cities above 1 lakh and Rs.0.5 lakhs for smaller towns below 1 lakh
  - ➢ Training of ANM/paramedical staff: Maximum Rs.5000 per ANM (for entire training package)
  - ➢ Training of Medical Officers: Maximum Rs.10,000 per MO (for entire training package)
  - ➢ Selection & Training of ASHA: Maximum Rs.10,000 per ASHA (for entire training package)

Strengthening of Health Services

- ✓ Indicative unit costs are as following:
  - ➢ Outreach services/camps/UHNDs: Maximum Rs.10,000 per session/camp
  - ➢ Salary support for ANM/LHV: Maximum Rs.12,500 pm for ANM; Maximum Rs.15,000 pm for LHV
  - ➢ Mobility support for ANM/LHV: Rs.500/m
  - ➢ Renovation/up-gradation of existing facility to UPHC: Rs.10 lakhs per UPHC
  - ➢ Operating cost support for running UPHC (other than untied grants and medicines & consumables): Rs.20 lakhs per year per UPHC
  - ➢ Untied grants to UPHC: Rs.2.50 lakhs per year per UPHC
  - ➢ Medicines & Consumables for UPHC: Rs.12.50 lakhs per year per UPHC
  - ➢ Untied grants for UCHC: Rs.5 lakhs per year per hospital

Community Processes

- ✓ Indicative unit costs are as following:
  - ➢ MAS/community groups: Rs.5000 per year per MAS
  - ➢ ASHA (urban): Approx. Rs.2000 pm per ASHA

Format for Self-assessment of State PIP against Appraisal Criteria

Format for Self-assessment of State PIP against Appraisal Criteria

Sr. No.	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 a chartered accountant/Finance manager reviewed the budget in detail? Has the State ensured that there is no double budgeting under any head? Has the State ensured adherence to all the costing norms laid down under NHM? Have the 'new activities' and 'activities to be continued' clearly marked?	
3	Has the district wise resource envelop conveyed to the districts? Has the State ensured that high priority districts get at least 30% more (i.e. HPD to be given a weightage of 1.3 Vs. 1.0 against non high focus)?	
4	Has the state ensured that each of the components given in 5x5 matrix for RMNCH+A has been addressed in PIP?	
5	Is the budget consistent with stated components/ objectives, strategies and activities? Would the proposed phasing of activities lead to targeted increase in delivery/ utilisation of services?	
6	Has the PIP spelt out the strategy and activities for assuring quality of service delivery at public facilities? Has the State taken steps to ensure establishment and functioning of quality assurance committees in the districts?	
7	Are the supportive supervision structures at state and district / sub-district levels consistent with expertise required for programme strategies?	
8	Has the State reported progress on the conditionalities and incentives given in 2013-14?	
9	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, across the sections?	
10	Has the State ensured that the HR sheet and infrastructure sheet given in annexure filled accurately?	
11	Has the State taken steps to plan and ensure monitoring of districts on the basis of activities and budget proposed in the PIP?	

Key Conditionalities & Incentives

Key Conditionalities

Rational and equitable 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 regular and contractual staff
Baseline assessment of competencies of all SNs, ANMs, LTs to be done and corrective action taken thereon
Gaps in implementation of JSSK

Key Conditionalities & Incentives

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

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

District Health Action Plans (DHAPs)

District Health Mission

A District Health Mission has been constituted at the district level which is responsible for planning, implementing, monitoring and evaluating progress of the programme at District level. Some of the key activities which are carried by the District Health Mission:

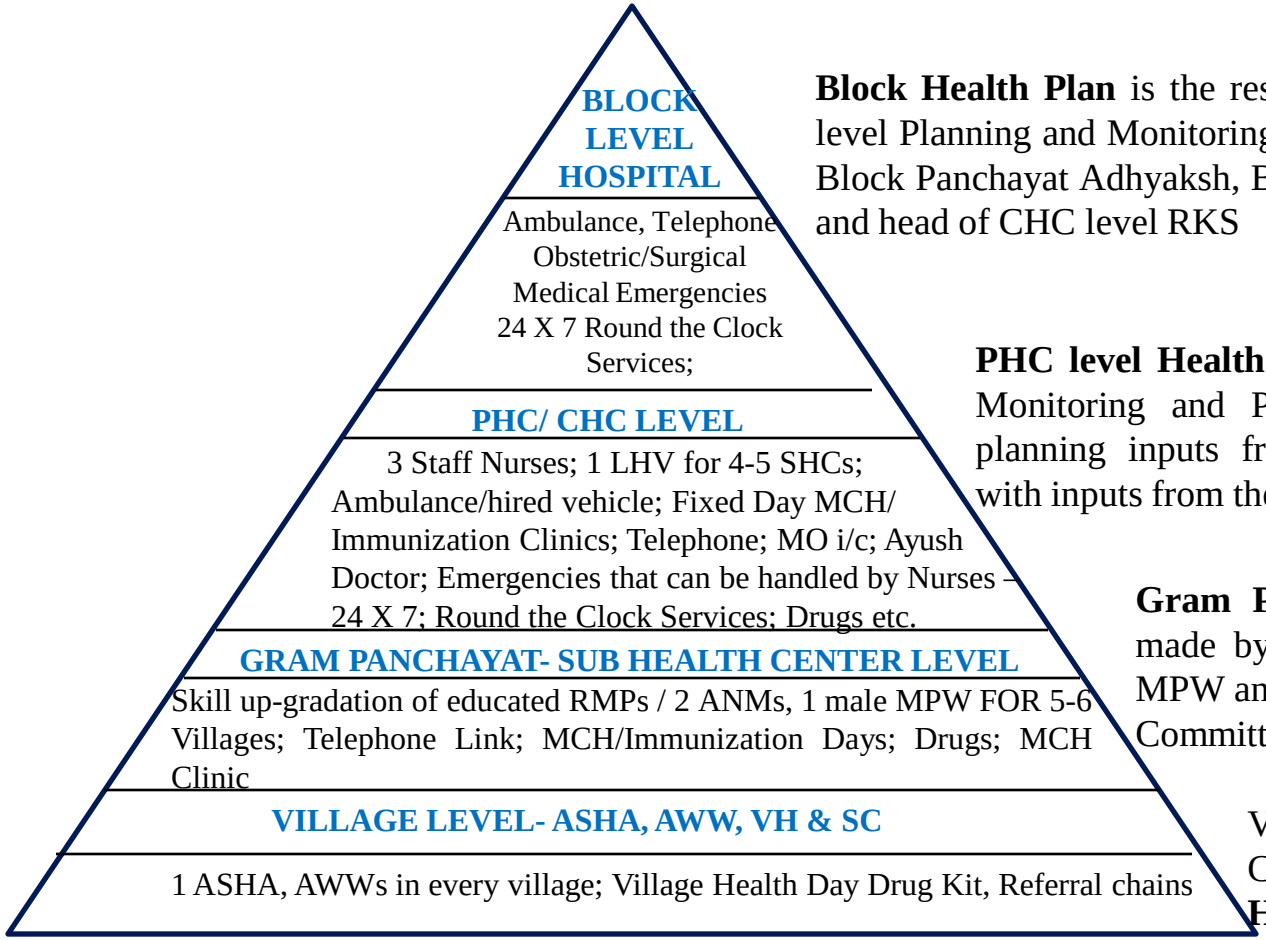
- ✓ Preparation of annual action plans for the district called District Health Action Plan (DHAP)
- ✓ Suggest district specific interventions
- ✓ Carry out health facility surveys and supervision of household surveys
- ✓ Timely disbursement of all claims made
- ✓ Arrange for technical support to the block teams and support sub district level implementing units

- ➢ ***Particularly in planning, the District Health Mission is responsible for the preparation of DHAP which is done by constituting a Planning team responsible for providing overall guidance and support to the planning process.***

- ➢ ***A DHAP depicts the need at sub district level units for programme implementation in terms of infrastructure, HR, procurement, various schemes running etc. and provides an overall budget required to execute those activities.***

Planning Process at Sub-District Level

- ✓ Planning process under NRHM is supposed to follow a bottom up approach wherein inputs are taken from implementing levels to form Block Health Plans which are aggregated and consolidated to form DHAPs
- ✓ This requires setting up of planning teams and committees at different levels- Village, Gram Panchayat (Sub Health Center), PHC (Cluster level), CHC/ Block Level and District level.



Block Health Plan is the responsibility of the Block/ CHC level Planning and Monitoring committee which constitute of Block Panchayat Adhyaksh, BMO. NGO/CBO representative and head of CHC level RKS

PHC level Health Plans are made by the PHC Health Monitoring and Planning committee which facilitate planning inputs from Panchayat representatives along with inputs from the community.

Gram Panchayat level health plans are made by Gram Panchayat Pradhan, ANM, MPW and few Village Health and Sanitation Committees

Village Level Health and Sanitation Committee will be responsible for **Village Health Plans**

Activity components shown in the PIP Planning process may be changed, as per the needs of the state

District Health Action Plan Guidelines

- ✓ Detailed guidelines have been formulated for the Preparation of DHAPs, namely "***Broad Framework for Preparation of District Health Action Plans***" These are available online on http://www.nrhm.gov.in

- ✓ For purposes of NHM planning, DHAPs to follow State PIP formats and norms.

Role of Finance and Accounts Staff

Role of Finance and Accounts Staff

State level

Various divisions like Maternal Health, Child health, Family Planning, Immunisation etc. decide on their respective targets under various pools. In preparation of PIP , following is the role of the Finance and Accounts division at the state level:

- ✓ Calculate the budget for various schemes and prepare consolidated budget sheet for each of the programs
- ✓Check the rates cost units and calculations of budgets and finally consolidate the budget.
- ✓Check that the budget is proposed as per GOI guidelines and based on the achievable targets.
- ✓Check that the abstract sheets are duly filled.
- ✓Check the key priority areas of the budget proposed are duly supported by logical interventions.
- ✓In case, the state is planning to take any new initiatives , the costing for those activities is estimated and provided in the PIP (in prescribed format).

Role of Finance and Accounts Staff

District Level

Following points need to be considered by DAM in preparation of DHAP:

- ✓ Detailed guidelines on preparation of DHAP should be thoroughly understood and followed
- ✓ Coordinate collection of necessary inputs for planning at the sub-district level
- ✓ Budget should be prepared on the basis of actual Physical vs. Financial Mapping
- ✓ Ensure arithmetic accuracy of the PIP / Budget calculations
- ✓ Budget should be classified as per the guidelines / formats
- ✓ Ensure timely preparation and submission of the DHAP to the state
- ✓ Comments should be provided on the following aspects:
  - ➢ Delegation of Financial and Administrative Power (From DHS to HSC/VHSNC)
  - ➢ Frequency of Meetings (DHS/RKS) and compliances of Action Taken Report
  - ➢ Uploading of FMR on HMIS portal
  - ➢ Registration Status of DHS and RKS
  - ➢ Mode of Fund Transfer from DHS to Blocks/CHC/PHC (e-Banking /e-transfer/ Manual)

Role of Finance and Accounts Staff

- ✓ As part of the PIP, Following should be reported w.r.t Financial Management systems:
  - ➢ Comments on accuracy and completeness in maintenance of Books of Accounts.
  - ➢ Mode of maintaining of Books of Accounts (Manual/ Computerised)
  - ➢ If computerised (Tally /Tally ERP-9/ Tally ERP-9-Customised Version/ Any other web based accounting software)
  - ➢ Process of transferring fund to VHSNCs and sub-centres
  - ➢ Process of receiving funds from State
  - ➢ Process of distributing funds from DHS to Blocks/CHC/PHC
  - ➢ Comments on timeliness of Statutory Audit completion
  - ➢ Comments on status of Implementation of Concurrent Audit at DHS ,
  - ➢ Comments on Quality of Concurrent Audit, whether it is adequate to improve the internal control system.
  - ➢ Timeliness of MIS reporting.
  - ➢ Release reconciliation from DHS to Blocks/CHC/PHC
  - ➢ Comments on Monitoring & Evaluation Tool adopted by the DHS
  - ➢ Comments on diversion of funds from one pool to another under NHM.
  - ➢ Disclosure of likely unspent balance of Committed and Uncommitted liability
  - ➢ Comments on Age wise analysis of Advances.
  - ➢ Comments on timeliness for Quarterly e-TDS filing

Budget Format

PIP Budget Format

PIP Budget Format

Self Assessment

Self Assessment

1. Arrange the following in the order of occurrence:
   i. Submission of draft State PIPs to the Center
   ii. Discussion on PIPs in NPCC meetings
   iii. Approval of RoPs and approved RoPs sent to states
   iv. Sub group meetings / Video conference for discussion on state PIPs

   a. i-ii-iv-iii
   b. i-iv-ii-iii
   c. iv-i-ii-iii
   d. ii-i-iv-iii

2. By when should the first draft of the state PIP be sent to the center?
   a. 15th February
   b. 30th January
   c. 15th January
   d. 31st December

Self Assessment

3. What is the ceiling for amount to be spent on civil works in high focus states and other states respectively?
   a. 25%, 33%
   b. 23%, 35%
   c. 33%, 25%
   d. 35%, 23%

4. Programme Management has to kept within what ceiling?
   a. 10.5%
   b. 5.5%
   c. 12.5%
   d. 15%

Self Assessment

5. What is the central and state contribution to the total amount released to the state?
   a. 75:25
   b. 90: 10
   c. 85:15
   d. 80:20

6. Which all activities come under the purview of the role of state finance and accounts staff in preparing the state PIP?
   a. Consolidating the budget for all activities/ components
   b. Preparing a summary budget under various functional heads
   c. Formulate unit costs for all the activities
   d. All of the above

Annexures

Annexure I – Management Imperatives

Microsoft Word Document

Thank You

Annexure V

MANAGEMENT IMPERATIVES

S. NO.	STRATEGICAREAS	ISSUESTHAT NEEDTOBEADDRESSED
PUBLICHEALTHPLANNING&FINANCING		
1.	Planning and financing	Mapping of facilities, differential planning for districts / blocks with poor health indicators; resourcesnottobespreadtoothin /targeted investments;atleast 10% annualincreaseinstate healthbudget(plan)over andaboveStateshareto NRHMresourceenvelope;addressing verticalityin health programmes; planning for full spectrum of RCHservices;emphasis onqualityassurancein deliverypoints
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
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
HUMANRESOURCES		
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

S. NO.	STRATEGICAREAS	ISSUESTHAT NEEDTOBEADDRESSED
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 upgradationofexistingones)	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.	Trainingandcapacitybuilding	Strengthening of State Institute of Health & Family Welfare (SIHFW)/ District Training Centres (DTCs); qualityassurance;availabilityof centralisedtraining log;monitoring ofposttrainingoutcomes;expanding trainingcapacitythrough
STRENGTHENINGSERVICES		
8.	Policies on drugs, procurement system and logisticsmanagement	Articulationofpolicyonentitlementsoffreedrugs for out/inpatients;rationalprescriptionsanduse of drugs; timely procurement of drugs and consumables;smooth distributiontofacilitiesfrom thedistricthospitaltothe subcentre;uninterrupted availabilitytopatients; minimisation of outofpocket expenses;qualityassurance;prescription audits; essential drug lists(EDL)in publicdomain; computeriseddrugsand logistics MIS

S. NO.	STRATEGICAREAS	ISSUESTHAT NEEDTOBEADDRESSED
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
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;
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
COMMUNITYINVOLVEMENT		
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

S. NO.	STRATEGICAREAS	ISSUESTHAT NEEDTOBEADDRESSED
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.
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
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.

S. NO.	STRATEGICAREAS	ISSUESTHAT NEEDTOBEADDRESSED
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/
23.	Quality assurance	Quality assurance at all levels of service delivery; quality certification/ accreditation of facilities and services; institutionalized quality management systems
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
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-

Course Module on Budget/PIP Preparation

Session Title: Budget / PIP Preparation			Session-at-a-glance	
Session learning objectives	**Session Structure**	**Teaching Method Used**	**Teaching Material used**	**Time Required**
Learning Objective: The participants will be able to understand in detail the concept of PIP and its preparation & approval process. The module elaborates on the revised framework of PIP preparation including key highlights of revisions made, key contents of PIP and most importantly, the chapter on Financial Management. It elaborates further on some of the key concepts and instructions to be considered in the preparation of PIPs and estimation of budgets. Modulealso includes process of preparation of District Health Action plans & its contents,areas of improvement for states in making PIPs more effective and certain priority actions suggested by ASMD in the planning process (2011-12). **Materials Required :**	**Key Teaching Point 1**: - Introduction to PIP and its importance **Key Teaching Point 2**: - Planning and approval process of PIP along with Key timelines **Key Teaching Point 3**: Revised framework of PIP and key concepts/ instructions **Key Teaching Point 4:** District Health Action Plan **Key Teaching Point 5:** Role of Finance and Accounts Staff in the preparation of State PIPs	**Instructional and Participative**	Slide 2 and 3 Slides 4-5 Slides 6-10 Slides 11-22 Slides 23-27 Slides 27-32	05 mins 05 mins 25 mins 40 mins 15 mins 10 mins

Session Title: Budget / PIP Preparation			Session-at-a-glance	
Session learning objectives	**Session Structure**	**Teaching Method Used**	**Teaching Material used**	**Time Required**
1. Slides **2. Self Assessment** **Reference Material:** **1. PIP guidelines for FY 2013-14** **2. Revised Operating manual for preparation and monitoring of RCH II and immunization components of NRHM State PIPs** 3. **Guidelines on Preparation of District Health Action Plans**	**Key Teaching Point 6:** Areas of improvement for states in making PIPs more effective &priority actions listed for 2013-14 **Self Assessment**	**Individual Attempts by participants**	Slides 33-37 Participants should attempt the section individually within the give timeframe followed by an open house discussion by the trainer on the queries. Slides 43-46	10 mins 10 mins
			TOTAL TIME REQUIRED	2 hrs