# REPORT ON ANALYSIS
# OF PLANNING PROCESS UNDER NRHM
# (DRAFT)

**August, 2009**

**Public Health Planning**

**National Health Systems Resource Centre**

## ABBREVIATIONS

| | | |
|---|---|---|
| ANC | : | Antenatal care |
| ANM | : | Auxiliary Nurse Midwife |
| AMG | : | Annual Maintenance Grant |
| ARI | : | Acute Respiratory Infection |
| ARSH | : | Adolescent Reproductive and Sexual Health |
| ASHA | : | Accredited Social Health Activist |
| AWW | : | Anganwadi Worker |
| AYUSH | : | Ayurveda, Yoga, Unani, Siddha and Homeopathy |
| | | BPMU : Block Programme Management Unit |
| BMO | : | Block Medical Officer |
| BPL | : | Below Poverty Line |
| CDHO | : | Chief District Health Officer |
| CMOH | : | Chief Medical Officer, Health |
| CHC | : | Community Health Centre |
| CDHO | : | Chief District Health Officer |
| DC | : | District Collector |
| DC Division | : | Donor Coordination Division |
| | | DRCHO : District Reproductive Child Health Officer |
| DHAP | : | District Health Action Plan |
| DHFW | : | Department of Health and Family Welfare |
| DH | : | District Hospital |
| DHO | : | District Health Officer |
| DHRC | : | District Health Resource Centre |
| DHS | : | District Health Society |

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|---|---|---|
| DLHS | : | District Level Household Survey |
| DFID | : | Department For International Development |
| DPMU | : | District Program Management Unit |
| DWCD | : | Department of Women and Child Development |
| UNICEF<br>GTZ | : | United Nations International Children Fund |
| EC | : | Emergency Contraception |
| EmOC | : | Emergency Obstetric Care |
| FMG | : | Finance Management Group (MOHFW) |
| FMR | : | Financial Management Report |
| FNGO | : | Field NGO |
| FOGSI | : | Federation of Obstetric and Gynaecological Societies of India |
| FP | : | Family Planning |
| FY | : | Fiscal Year |
| GOI | : | Government of India |
| JSY | :<br>Janani Suraksha Yojana | |
| USAID | | United States Agency for International Development |
| NPCC | :<br>National Programme Coordination Committee | |
| | German Agency forTechnical Co-operation | |

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UT : Union Territory

NGO : Non Government Agency

HIMACHAL PRADESH : Himachal Pradesh

HR : Human Resources

: National Rural Health Mission

NRHM

PIP : Programme Implementation Plan
PHE : Public Health Engineering

RKS: Rogi Kalyan Samiti

RCH: Reproductive Child Health

NE: North East

SHSRC : State Health Systems Resource Centre

SOE : Statement of Expenditure

DPMU District Programme Management Unit
SPMU State Programme Management Unit
TAST: Technical Assistance Support Team
WB: West Bengal

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## REPORT ON

## ANALYSIS OF PLANNING PROCESS UNDER NRHM

The following key points emerged from the analysis of the planning process in the states under NRHM. The source of the data for analysis are the State PIPs of 2009-10, information provided by State health officials ,SPMU, DPMU and SHSRC staff during state and district visits undertaken by respective Consultants of the Public Health Planning team. Detailed information on the planning process is available for 20 states of which 13 are from high focus states.

### Village Plans

- Status of village plans: Madhya Pradesh, Orissa, Rajasthan are some of the large EAG states which have prepared sample village plans. Out of the eight North East states, at least six have prepared some form of village plans. Among other high focus states, MADHYA PRADESH chose 5 villages in 2007-08 and 45 villages in 2008-09 for preparing plans; Orissa has prepared plans for 5 villages in each block and Rajasthan's PIP states that 41367 village plans would be in place by Dec, 2008.Among the North Eastern states, Arunachal had prepared 42 village plans between October to January 2008-09; Assam for 2 districts; Meghalaya prepared plans for villages in three districts including 300 plans for West Khasi Hills district. Mizoram prepared 234 village plans between Oct-Dec 2008-09 and Sikkim prepared plans for 147 villages.

- These templates have been used by ANMs and Block Facilitators in collecting information from the villages Exceptions could be Madhya Pradesh which states in its PIP that the village plans are an aggregate of physical activities. Most of the NE states have also reported the use of a pre designed template for the village plans. Meghalaya had used village level survey data and situational analysis in their plans; the village plans of Sikkim consist of an introduction to the area under the PHSC followed by a demographic profile and actual health scenario at the PHSC level. In states like Punjab, Jammu and Kashmir where the planning process was carried out by an external agency, a Gram Panchayat level template was used for collecting information on villages under the blocks. In village plans, standard set of activities were proposed in Madhya Pradesh and Orissa across many plans.

- Efforts have been made by states in ensuring community participation in the planning process at the village level. In Madhya Pradesh, there was participation of ASHAs and ANMs in the committees which prepared the village plans; in Orissa, plans were prepared by the Gaon Kalyan Samitis; in Punjab by Village volunteers ;in Sikkim by community mobilisers.In NE states e.g. Arunachal, Manipur and Meghalaya, the plans were prepared through the DPMs and facilitated by the DRCHO and BPMU staff.

- Use of village plans**:** Although sample village plans have been prepared in some states, their use has been limited across the states; Jammu and Kashmir, Punjab and Himachal Pradesh (in one district) has used the information collected from the villages (in the standard templates) to identify issues at the village level (including hot spots from Gram Panchayat level plans) which have been incorporated in the block plans. Budgetary allocation at the village level are not carried out in most of the states based on the village plans as re-appropriation exercise of plan documents have not been conducted.

- In West Bengal till 08-09 FY the village plans were in place in template form which was assisted by WB, TAST but since the planning process during 09-10 FY in West Bengal was independently carried out by SPSRC the village plans are not formulated

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due to time constraint. West Bengal has started to develop Plan Plus soft ware for perspective plan in coming years.

**Block Plans**

- As per data provided by states, at least 11 states (Madhya Pradesh, Orissa, Himachal Pradesh and the 8 NE states) have managed to prepared block plans. In Orissa 314 Block plans were formulated whereas in Madhya Pradesh almost all the blocks have their own block plans. In Orissa Block PIP Development Team has been constituted to assist them. Orissa, Madhya Pradesh has used predesigned template for block planning. In most of these states, block plans have been made for few sample districts except in Sikkim and Himachal Pradesh. In Sikkim, block plans were prepared for Madhya Pradesh blocks in the all four districts.Himachal Pradesh has prepared block plans for its 22 districts. Plans were prepared for all the blocks in Shimla district. In Solan district, a comprehensive block plans was prepared as a sample for one block (Nalagarh). The block plan exercises in most of the southern states have not been carried out.

- Structure: An analysis of the block plans prepared for the respective districts plans of Himachal Pradesh shows that the plans are largely an outline of the issues and constraints in the blocks along with a set of recommendations. However, actionable strategies or activities have not been included. The block plans prepared by Madhya Pradesh have a set of strategies and activities which are uniform across all the blocks and have not been customised according to the requirements of the blocks. Further, there is a gap between the situational analysis and the proposed strategies. In Madhya Pradesh, Orissa planning exercise has been carried out by a designated team involving the BPMU staff and BMOs. Consultation with working partners, workshop, brainstorming exercise was carried out while doing the planning activities.

- Integration of village plans into block plans: Orissa has reported that five of its village plans under each block have been consolidated by GKS (Gaon Kalyan Samitis) plans. Himachal Pradesh has used the information collected from the village level group discussions and hot spots from the villages in the block plans.

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- Use of blocks plans: Assam has reported that salient points from the block health plans have been incorporated into the district plans. Orissa have used sample block plans in preparing the district PIPs. In Madhya Pradesh district has allotted the funds based on the approved activities and priority of activities as decided by states and districts.

- Budgets in block plans : Some states e.g. Madhya Pradesh , Assam, Arunachal Pradesh, Meghalaya ,Sikkim have included budgets in the block plans ; block plans of HIMACHAL PRADESH and Tripura do not have budgets whereas the sample plans of Uttarakhand consists of budgets only. Orissa has formulated activity wise budgeting for the block plans.

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**District Plans**

- Inception of district planning process : Gujarat, Uttarakhand are two states who started preparing district plans for sample districts in 2005-06.Analysis of one of the earliest district plans of Gujarat , Vadodara shows that it a well articulated plan prepared by the state with the technical support of an external consultant. In most states, process for preparing district plans began around 2007-08. By 2008-09 basic district plans were in place for these states. In many states like West Bengal, Madhya Pradesh, Orissa presence of Development agencies are noted during initial years of district and State PIP planning process. Development of template, framework, guidelines, and software are noticed in these three states by development partners.

- Status of district plans: Out of the 29 states ( excluding the 6 UTs), 23 states have districts plans in place which shows at least 79% states have made progress in preparing district plans . Of these states, 20 have prepared 100% plans for its districts (12 EAG and non EAG states and 8 NE states). In most states the plans have been prepared by the district health officials. Some states e.g. Madhya Pradesh, Orissa, Rajasthan, Himachal Pradesh and Gujarat have formed District Core Team, District Core Groups which includes DRCHOs,CDHOs, CMOHs , DPMU staff and in some cases PRI members RKS members and NGO representatives . Review of DHAPs in some states reveal that officials from other departments of Rural Development, Women and Child Development , PHE, Irrigation and Public Health and Education departments have participated in the district planning process. This is a positive trend which needs to be and continued and strengthened further.

- At the onset of NRHM, in the early years, some states such as Gujarat, West Bengal, Bihar, Uttarakhand and Himachal Pradesh sought the technical assistance of external agencies including Development Partners such as World Bank, DFID, UNICEF, GTZ, and USAID for preparing the DHAPs. Gradually, the states adopted the planning skills while working with these agencies and started preparing the plans themselves. At present, states with strong DP presence in their region work in tandem with these DPs seeking limited help in the technical areas. In the NE states, the NE-RRC has been providing the technical support in preparing the district plans through its respective State Facilitators, SPMU and DPMU staffs. Of late, with several states preparing to set up SHSRCs, which include positions for Public Health Planning, it is envisaged that the need for technical support for planning would be managed in –house.

- Some states such as Jammu and Kashmir, Himachal Pradesh, Haryana, Punjab, Andhra Pradesh and the NE states had outsourced the planning function to external agencies/consultants with technical skills for undertaking planning (in JK and Punjab, these have been prepared as perspective plans with a set of activities and budgets for a time frame of 5 years ). This had its pros and cons. Prepared by professionals, these plans are comprehensive, well structured, in sync with the NRHM framework for district plans prescribed by GOI, includes a range of

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information on the district level indicators and identifies local issues within the limited time frame for planning. However, the plans could have been more participative and decentralised. The perspective plans should have been more rooted in reality in terms of the planned activities and costing. Due to the minimal involvement of the district health authorities in the planning process, ownership of these outsourced plans also appears to be an issue with the district and state health authorities.

- Review of District plans from various states indicates that certain standard templates were used to collect data from the districts which were further structured in a uniform pattern into district plans. This is the norm in the case of plans prepared by external agencies that have developed standard templates for the purpose. These templates have been used with need based modifications across all the states for which the respective agencies have undertaken planning.

- Integration of block plans into DHAPs: Few states have managed to integrate the block plans into the district plans. The probable reasons are that preparation of the block plans were delayed and were not in place for assimilation into the district plans; block plans were not complete documents e.g. either qualitative aspects or budgets are available ; only sample block plans could be prepared for the districts which indicates that block plans are not available for all districts. It appears that block planning is more of a mechanical exercise per se for the blocks and districts. Districts are yet to comprehend the value and utility of the block plans as crucial inputs into the district plans.

- Use of DHAP in preparation of State PIP: Some states which have prepared at least some DHAPs prior to the preparation of the State PIPs have utilised the DHAPs in some form or the other to add value to the PIPs. Gujarat have used the data from the districts for situational analysis in the State PIP and incorporated district specific strategies in the State Plans. However, in other states, there are major inconsistencies between the district Plans and the State PIPs and these two documents appear to be disjointed.

- State like Bihar, Chhattisgarh, and West Bengal continued to prepare new DHAPs way after the preparation of the State PIPs. Few states have done re appropriation exercise after allocation of central budget during NPCC. Orissa, Madhya Pradesh has already done this re allocation process before finalising the process of district wise allocation.

- District budgets incorporated into state PIPs: Sikkim, Chhattisgarh, Madhya Pradesh, Orissa, and Rajasthan are some states which have reportedly incorporated the proposed budgets in the DHAPs in the State PIP. Himachal Pradesh has prepared budgets in its DHAPs but has not aggregated them to form the state budget.

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- Gujarat, Karnataka, West Bengal, Madhya Pradesh, Rajasthan, Uttar Pradesh, Jammu and Kashmir, Kerala, Mizoram, Meghalaya, have provided details of the component wise fund allocated to the districts in the PIPs for 2009-10 . This is primarily for the RCH section.

- Basis for fund allocation to the districts: In spite of preparing district plans with budgets, states like Rajasthan, Himachal Pradesh, Punjab Arunachal Pradesh, Meghalaya and Nagaland have not used the proposed budgets as the basis for allocating funds to the districts. This is due to several reasons: delay in preparation of DHAPs, unrealistic budget projections (Punjab) in the perspective plans, absence of budgets in the district plans and non structured budgets with inconsistencies in budget heads which makes it difficult to consolidate the district budgets. The states like Madhya Pradesh, Orissa, Bihar has shown good progress in allocating the NRHM budget to their respective districts based on each activities as per allocation made in ROP exercises. Haryana has also initiated district wise allocation particularly for RCH activities but post NPCC DHAP re appropriation has not been conducted. The criteria used by the states ( Punjab, Himachal Pradesh, Arunachal Pradesh, Meghalaya and Nagaland ) for allocating funds to the districts are :

    - Rajasthan : review of previous year’s financial records and resource mapping
    - Himachal Pradesh : financial allocation norms for facilities ( Untied funds, AMGs) and programme ( unit cost for JSY beneficiaries and acceptors of sterilization)
    - Karnataka: previous year’s SOEs.
    - Punjab :previous year’s expenditure and requirements of the districts
    - Arunachal Pradesh: Statistical weightage designed based on population and area in square meter for districts, data from previous year’s performance.
    - Meghalaya : No. of manpower and facilities and also seasonal changes
    - Nagaland : Data from Facility Surveys

- District plans used in implementation: Information on use of DHAPs in implementation is sketchy. Some states such as Sikkim, Madhya Pradesh, West Bengal and Assam have reportedly used the DHAPs for implementation.

- Budgeting process reviewed by states after NPCC: District wise budget allocation based on revised DHAP has been carried out in Orissa and Madhya Pradesh and is

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under process in Tamil Nadu. Orissa and Bihar has already carried out the exercise of district wise budget allocation for RCH, Immunization and NRHM Additionalities including disease control programme. Tamil Nadu has also done district wise budget allocation recently.

- Institutional mechanisms for planning: With increased participation in the planning process for block, district in the last three years, the capacity of the states for planning has evolved simultaneously. Another prominent feature during this period is shift from external agencies participation towards development of internal capacity apart from negligible involvement of donor organisation. Several states have formed State and District level Steering Committees, Planning Committees, District Core teams and Groups specifically to undertake planning. These teams and groups largely consist of State and District level Health officials. In the last three years, there has been gradually more community participation in these forums (through members of Village Health and Sanitation Committees, NGOs and Women's Health Committee) who have managed to bring in varied and rich grass root level experiences to the planning process. This is expected to increase accountability and ownership of the health issues by the community at the periphery levels.

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