National Health Mission

Memorandum of Understanding (MOU)

Between

Ministry of Health & Family Welfare,

Government of India

and

Government of Bihar

[NOTE: Explanatory Footnotes and Sample Annexes are for purposes of clarification and illustration only.]

1. Preamble

1.1 WHEREAS the National Rural Health Mission, (hereinafter to be referred as NRHM), which was launched in April, 2005 and was extended for a period of five Years from April, 2012 to March , 2017 AND WHEREAS the National Urban Health Mission (hereinafter to be referred as NUHM), which was launched in May 2013, was subsumed as a Sub Mission along with NRHM as the other Sub-Mission of overarching National Health Mission, (hereinafter to be referred as NHM) which has been extended from 1st April, 2017 to 31st March, 2020.

1.2 AND WHEREAS the NHM aims at supporting the States and UTs in attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs[1], with effective inter-sectoral convergent action to address the wider social determinants of health consistent with the outcomes envisioned in the Sustainable Development Goals (SDG)-3 indicators falling within the health domain and general principles laid down in the National and State policies, including the National Health Policy, 2017 and National Population Policy, 2000.

1.3 AND WHEREAS the key objective of this phase of NHM will be towards enabling and achieving the stated vision, making the health system resilient and responsive to people's needs, building a broad based inclusive partnership for realizing national health goals, expanding access to comprehensive primary health care, completing the unfinished agenda in respect of the survival and well being of women and children, reducing existing disease burden, particularly on account of non-communicable diseases, and ensuring financial protection for households. Working towards these goals would enable the country to progress towards meeting the targets under the Sustainable Development Goal 3, i.e. ***"Ensure healthy lives and promote wellbeing for all at all ages"***, including Universal Health Coverage, and build broader public health competencies to develop resilient and responsive quality health systems.

1.4 NOW THEREFORE, the signatories to this Memorandum of Understanding (hereinafter to be referred as MoU) have agreed as set out herein below.

2. Duration of the MoU

2.1 This MoU[1] will be operative with effect from 1st April, 2017 or the date of its signing by the parties concerned whichever is earlier and will remain in force till 31st March 2020 or till its renewal through mutual agreement or till extension of NHM by the Government of India, whichever is later.

---

[1]Framework for Implementation, National Health Mission, 2012-2017, Ministry of Health and Family Welfare.

3. Scope of MoU

3.1 The Central Government will provide a resource envelope to support implementation of an agreed State NHM Programme Implementation Plan (hereinafter to be referred as PIP), reflecting:

a) all sources of funding for the health sector, including State contribution;

b) a plan for action leading to achievements of specific outputs and outcomes and;[2]

c) proposals and time frame for policy and institutional reforms[3] related to health goals mentioned in para 1.3 above.

3.2 The agreed outlay for the PIP for each financial year and the sources for the funding of the same reflected in the Performa prescribed for the purpose [Appendix-I].

3.3 Each State shall prepare a Progamme Implementation Plan in line with broad guidelines provided by MoHFW. The PIP will be consistent with the general principles laid down in the National and State policies relevant to the sector and other agreed action plans.

3.4 Based upon the PIP, each State will set its own annual level of achievement for the programme's core indicators aligned to SDG/National Health Policy 2017 targets in consultation with Central Government. States shall also have similar arrangements with the Districts. The set of targets to be achieved by the State is laid down in Appendix II to this MOU.

3.5 NHM provides supplementary financial support to State for strengthening primary care systems. It shall not be utilized to substitute state's own spending. Hence it shall be mandatory for the State to increase spending on primary healthcare by at least 10% annually (compounded over the budget spend by states in primary care in 2016-17).

3.6 A certain portion of NHM budget will be linked to performance in key outcomes, process/output indicators and health sector reforms. Currently this is 20% of NHM budget under flexible pools and set of indicators with their weightage for 2018-19 as provided at Appendix-III of this MOU.

---

[2] The Plan of Action should include convergence plan covering water, sanitation and nutrition etc. and should list out specific action points and the time schedule for their implementation.

[3] Institutional reforms would relate to the 'architectural correction' referred to in the NHM documents such as restructuring and decentralization of cadres, delegation of financial and administrative authority to the PRIs, streamlining and strengthening of support systems (logistics, MIS, IEC etc.) etc

3.7 An annual review of both progress on the plan and on the institutional reform would be carried out by a multi-disciplinary /multi -stakeholder team comprising of Central Government officials, public health experts, civil society representatives, other partners and stakeholders in the form of a Common Review Mission.

3.8 The PIP shall be jointly appraised and reviewed by Central Government and State to arrive at an agreed PIP for the subsequent year.

3.9 The NHM contribution to support the Sector PIP shall cover, among others, implementation of plans for Reproductive and Child Health including Immunization and Population Stabilization, Disease Control Progammes including National Programmes for control of Vector Borne Diseases, Leprosy, Tuberculosis, Blindness, disease surveillance, Iodine deficiency, Non Communicable Diseases and some aspects of mainstreaming AYUSH services.

3.10 The NHM would operate as an omnibus broadband programme by integrating all vertical programmes of the Departments of Health and Family Welfare.

4. Funds Flow arrangements

4.1 The first tranche of funds would be released to States/UTs upon fulfillment of Department of Expenditure conditionalities. The release of subsequent tranches of funds (beyond 75%) would be regulated on the basis of a written report to be submitted by the State indicating the progress of the agreed State PIP including the following, namely:-:

- Documentary evidence indicating achievement of targets / milestones for the agreed performance indicators referred to in para 5 herein below;
- Statement of Expenditure confirming utilization of at least 50% of the previous release(s);
- Utilization Certificate(s) and Audit reports wherever they have become due as per agreed procedures under General Financial Rules (GFR) Rules 2017;
- Increase in State budget on primary healthcare by at least 10% annually.

4.2 Release of grants-in-aid shall be further subject to satisfactory progress of agreed mandatory conditionalities and Performance Indicators relating to implementation of agreed State PIP including institutional reforms. The agreed performance indicators and institutional reforms would be made part of the PIP approvals.

5. Performance Incentive Fund

5.1 The 20% of the total outlay for NHM (excluding Infrastructure Maintenance) will be allocated to States.

5.2 Each year, the set of indicators with their weightage for following year would be shared as part of PIP approval. Performance on key reforms, performance indicators (State health reform) may translate into a increases or reduction in outlay.

6. Institutional Arrangements: National Level

6.1 At the National level, Mission implementation will be steered by a Mission Steering Group (MSG) headed by the Union Minister for Health & Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health & Family Welfare.

6.2 The State PIPs will be appraised for approval by the National Programme Coordination Committee (NPCC) chaired by the Additional Secretary and Mission Director (AS & MD), NHM and approved by Secretary (HFW) as chairperson of the Empowered Programme Committee.

6.3 Principal Secretary / Secretary of the State Government as well as Mission Director (NHM) will be invited to the meeting of the Committee whenever their proposals are listed for consideration.

7. Institutional Arrangements: State, District and Hospital Levels

7.1 At the State level, the State Health Mission headed by the Chief Minister will provide guidance to State Health Mission activities and the State Health Society which integrates all existing vertical programme societies in the health sector will provide programme management support for the State Directorate and District Health Administration in the State. The State Health mission will meet at least once in a year.

7.2 The State Health Society shall have a governing body Chief Secretary/Development Commissioner as the Chair and the Mission Director, NHM as its Member Secretary. The Executive Committee shall be chaired by the Principal Secretary Health and the Mission Director would be its Member Secretary. The Governing Body of the State Health Society will meet at least once in a six months.

7.3 At the district level, District Health Mission chaired by Chairperson, Zila Parishad/Mayor and co-chaired by District Collector will guide the District Health Society, chaired by District Collector, in policy and operations. The District Health Society shall meet at least once every quarter. The Member Secretary of the District Health Society is the Chief Medical Officer of the district. The (model) Rules / bye-laws of the District Health Society as notified through Resolution / Notification will continue to be applicable for this phase of NHM. However, any new district will be required to constitute, register and notify the District Health Society in order to get funds from SHS and NHM.

7.4 The Hospital Management Society called Rogi Kalyan Samiti (RKS) are required to be set up in public health facilities and will meet at least once in a Quarter. The existing model Rules / bye-laws of the Hospital Management Society regarding registration will continue to be applicable. Guidelines on Rogi Kalyan Samiti would continue to guide the working of the RKS.

8. Performance Review

8.1 The Ministry of Health & Family Welfare will convene national level meetings to review progress of implementation of the agreed State PIP from time to time.

8.2 The review meetings may sometimes lead to proposals for adding to or modifying one or more Appendices of this MoU. Such modifications will have to be recorded in writing and will form supplements to this MOU.

9. Government of India Commitments

9.1 Release of funds in accordance with the approved funding pattern and budget, compliance to conditionalities and agreed performance indicators, within an agreed time. However the funds committed through this MoU may be enhanced or reduced, depending on the pace of implementation of the agreed State PIP and achievement of the milestones relating to the agreed performance Indicators including the conditionalities.

9.2 Facilitating multilateral and bilateral development partners to co-ordinate their assistance, monitoring and evaluation arrangements, data requirements and procurement rules etc. within the framework of an integrated State Health Plan.

9.3 Assisting in development of District Action Plans and state PIPs through such means as may be mutually agreed.

9.4 Assisting the States in mobilizing technical assistance inputs.

9.5 Developing and disseminating protocols, standards, training modules and other such materials for improving implementation of the programme.

9.6 Consultation with States, on a regular basis, at least once a year, on the reform agenda and review of progress.

9.7 Prompt consideration and response to requests from states for policy, procedural and programmatic changes.

9.8 Holding joint annual reviews with the State, other linked Central Government Departments and participating Development Partners;

9.9 Dissemination of and discussion on any evaluations, reports etc., that have a bearing on policy and have the potential to cause a change of policy.

10. State Government Commitments:

10.1 The State Government shall ensure that the funds made available to support the agreed State PIP under this MoU are used for financing the agreed State PIP approval in accordance with agreed financing schedule and not used to substitute routine expenditures that are the responsibility of the State Government.

10.2 The State share shall be 40% in all States and UTs with legislature except for Jammu & Kashmir, Himachal Pradesh, Uttarakhand, North Eastern States where the State/UT contribution will be 10%. State share contribution is not applicable in respect of other Union Territories (UTs) without legislature.

10.3 The State shall ensure that the implementation of the programme/activities envisaged under the Mission is as per the Framework of Implementation of NHM and other guidelines provided by Ministry of Health and Family Welfare from time to time.

10.4 The share of public spending on Health from state's own budgetary sources will be enhanced at least at the rate of 10% every year. Overall there should be at least 10% annual compounded increase in primary healthcare over the baseline of 2016-17.

10.5 State shall ensure that its own resources and the resources provided through this MoU flow to the districts on an even basis so as to ensure regular availability of budget at the district and lower levels. Further, high priority districts shall be allocated at least 30% more per capita as compared to rest of the districts in the State

10.6 Structures for the programme management are fully functional with sufficient manpower and the key personnel engaged in the design and implementation of the agreed State PIP. The key positions including Mission Director and heads of programs from Directorate should ideally be retained for at least three years to provide stability to the program.

10.7 Representative of the MoHFW and/or development partners providing financial assistance under the MoU mechanism as may be duly authorized by the MoHFW from time to time, may undertake field visits to any part of the State and will have access to such information as may be necessary to make an assessment of the progress of the health sector in general and the activities related to the activities included under this MoU.

10.8 The accounts are maintained and audit is conducted as per the rules and utilization certificates are submitted within the period stipulated under General Financial Rules (GFR), 2017. Further the State shall undertake to ensure that District Health Society accounts are also duly audited and audit reports acted upon.

10.9 The State shall take steps for decentralization and promotion of District level planning and implementation of various activities, with the coordination of Panchayati Raj Institutions/Urban Local Bodies. State shall open account of all agencies in PFMS and ensure that expenditure is duly captured.

10.10 The State Government shall adhere to all the existing manuals, guidelines, instructions and circulars issued in connection with implementation of the NHM, which are not contrary to the provisions of this MOU.

10.11 The State shall take prompt corrective action in the event of any discrepancies or deficiencies being pointed out in the audit. Every audit report and the report of action taken thereon shall be tabled in the next ensuing meeting of the State Health Mission and Governing Body of the State Society. The State Government should also table the audit report in the house of State Legislative Assembly.

10.12 State shall endeavor to implement all the activities as indicated in the plan and take such other action as is needed to achieve the plan objectives.

10.13 State will plan completion of all activities related to construction of buildings including new constructions and renovations/up-gradations sanctioned under NHM within agreed time-lines.

10.14 State shall make effort in filling up vacant posts as per the agreed institutional reforms.

11. Bank Accounts of the Societies and their Audit:

11.1 State and District Society funds shall be kept in interest bearing accounts in any Scheduled Commercial Bank as may be specified by the State Health Society. However, State agrees to follow the directions of MoHFW, if any, issued in this regard during the currency of the period of MoU.

11.2 The State will organize the audit of the State and district societies after close of every financial year. The State Government will prepare and provide to the MoHFW, a consolidated statement of expenditure, including the interest that may have accrued. Hospital Management Society/RKS audit shall be conducted as directed by the Ministry of Health and Family Welfare (Hereinafter to be referred as MOHFW) State shall share consolidated audit report covering all programs under NHM and submit to the MoHFW.

11.3 The funds routed through the MoU mechanism shall also be liable to statutory audit by the Comptroller and Auditor General of India.

11.4 The State Governments shall comply to the financial guidelines issued to the states by the Financial Management Group established under National Health Mission by the Ministry of Health and Family Welfare. In addition, states shall have to follow State Finance Rules related to procurement and General Finance Rules in relation to furnishing of Utilization Certificate and other related Matters.

12. Recruitment/Appointment of HR

12.1 The National Health Mission is not a permanent programme and requires periodic approval of the Cabinet for continuation. Hence, only contractual/outsourced Human Resource is permissible to be engaged under the Mission. However, if the State Government appoints permanent human resources either on its own or by virtue of orders of Hon'ble Court, then the State Government shall be liable to maintain the same at its own cost, and the liability of the Central Government will strictly be only to the extent of agreed and approved PIP.

12.2 The State Health Society is responsible for appointment (contractual/conditional) employees, their transfers/termination of services, payment of wages, salary, remuneration, etc. There would be no privity of contract between the Central Government and the employees appointed by the State Health Society.

12.3 NHM does not substitute the expenditure to be borne by States/UTs on health care but only supplements efforts of the State Governments who have the primary responsibility of providing healthcare to all its population. The role of Central Government is to only provide financial & technical assistance to each State as recommended by the National Program Coordination Committee, and the implementation is under the exclusive domain of the States/UTs.

13. Suspension

Non compliance of the commitments and obligations set in the MOU and/or upon failure to make satisfactory progress may require Ministry of Health & Family Welfare to review the assistance committed through this MOU leading to suspension, reduction or cancellation thereof. The MoHFW commits to issue sufficient alert to the State Government before contemplating any such action.

Signed this day of 2019

For and on behalf of the Government of Bihar Department of Health	For and on behalf of the Government of India, Ministry of Health & Family Welfare
23/4/2019 **Principal Secretary** **Department of Health,** **Government of Bihar** ..... **(Shri. Sanjay Kumar)** **Date :**	14/5/2019 **Joint Secretary (Policy)** **Ministry of Health and Family Welfare** **Government of India** (डा. मनोहर अगनानी) .....(Dr. MANOHAR AGNANI) संयुक्त सचिव Joint Secretary स्वास्थ्य एवं परिवार कल्याण मंत्रालय Ministry of Health & F.W. भारत सरकार/Govt. of India नई दिल्ली/New Delhi **Date :**

APPENDIX I

Central Allocation under National Health Mission for the FY 2018-19 and 2019-20

Sl. No.	Name of the State/UT	2018-19	2019-20
1	Bihar	1622.65	-

Note:

1. The above allocation of funds to States does not include kind Grants under Immunization.
2. The State-wise financial allocation for the F.Y. 2019-20 is estimated to increase by 5% by assuming normative increase over the previous year except Infrastructure Maintenance (where the allocation in 2019-20 is estimated with 5% increase)

Appendix –II (a)

Performance Indicators

MOU MILESTONES AND TARGETS			
Sl No	Major Milestones	Yr 2018-19	Yr 2019-20
1.	Reduction of MMR	142	133
2.	Reduce I. U5MR II. IMR III. NMR	I. 37 II. 32 III. 24	I. 35 II. 29 III. 23
3.	Reduce and sustain TFR	0.1	
4.	Increase Modern Contraceptive Prevalence Rate	0.5	0.5
5.	Increase I. ANC (% Pregnant Women aged 15-49 years who had at least one ANC visit. II. SBA (% of delivery attended by skilled health professionals)	I. 60.8 II. 77.9	I. 62.6 II. 80.5
6.	Full immunization of all newborns by one year of age	90	
7.	Achieve and maintain elimination status, in respect of: (i) Leprosy (ii) Kala- Azar & (iii) Lymphatic Filariasis (iv) Malaria Annual Blood Examination Rate (ABER) i.e. persons screened annually for Malaria	Targets as recommended by WHO, Global Leprosy Strategy, 2016-2020, (to be achieved and maintained in all districts) i.e.,: Grade II disability/ million population <1 / million population (ii) Achieve target in remaining 47 blocks (iii) Achieve Mf rate <1% in 36 districts Observe 2nd TAS in 2 districts i.e. Madhepura & Katihar (iv) At least 10% with increased surveillance during transmission season to ensure	Targets as recommended by WHO, Global Leprosy Strategy, 2016-2020, (to be achieved and maintained in all districts) i.e.,: Grade II disability/ million population <1 / million population (ii) Sustenance of elimination target achieved (iii) Observe 1st TAS in at least 20 districts (iv) At least 10% with increased surveillance during transmission season to ensure diagnosis and treatment of 100% malaria cases.

MOU MILESTONES AND TARGETS			
Sl No	Major Milestones	Yr 2018-19	Yr 2019-20
		diagnosis and treatment of 100% malaria cases.	
8.	Reduce/sustain case fatality rate for Dengue at <1% (by 2018 & 2019) and set up one sentinel site hospital (SSH) in each district. Accordingly, number of new SSH in 2018 and 2019 is 15 and10, respectively	To bring and maintain CFR due to dengue <1%	
9.	I. Tuberculosis - Achieve and maintain a treatment success rate of 90% amongst notified drug sensitive TB cases by 2020 II. Total number of patient notification III. TB notification rate (per lakh population) IV. TB mortality rate (per lakh population)	I. 90% II. 210200 III. 175 IV. 54	I. 90% II. 241404 III. 197 IV. 46
10.	Blindness - Reduce the prevalence of blindness and the disease burden	I. Cataract Operation: 421309 II. Free Spectacles distribution to school children: 50000 III. Collection of Donated Eyes:400	I. Cataract Operation: 421000 II. Free Spectacles distribution to school children: 50000 III. Collection of Donated Eyes:500
11.	To halt premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2020. Baseline ICMR India State Level Disease	25.5 %	

MOU MILESTONES AND TARGETS			
Sl No	Major Milestones	Yr 2018-19	Yr 2019-20
	Burden Study		
12.	Reduce prevalence of current tobacco use	16%	
13.	Increase utilization of public health facilities	OPD: 12.8 IPD: 0.5	OPD:3.2 IPD: 2.2
14.	Reduce OOPE (OOPE as a percentage of Total Health Expenditure)	72.4	69.9

Appendix - A 2

Share of State Budget for health sector [Benchmark: minimum 10% (nominal) increase every year]

As per the National Health Policy, 2017, the state government should increase share of health budget to at least 5% of its overall budget.

Item /category	Last Financial	Current Financial	%age Increase over previous year
State Budget-Total			
Outlay for health sector			

Framework – 2018-19

SNo	Conditionality / Indicator1	Incentive/penalty	Source of verification	% Incentive / Penalty 2
		EAG to be penalized up to 10 points		
3.	Operationalization of Health and Wellness Centers (HWC)	At least 5% of the total budget to be proposed for HWC and CPHC. State to operationalize 15% of SCs and PHCs as HWCs	State report NHSRC report	+10 to -10
4.	% districts covered under Mental health program and providing services as per framework	If 75% of the districts covered:10 points If 50% districts in Non-EAG and 40% districts in EAG states: incentive 6 points Less than 40% EAG and less than 50% Non EAG to be penalized 6 points Less than 30% in EAG and 40% in Non EAG to be penalized 10 points	Report from Mental Health Division MoHFW	+10 to -10
5.	% of 30 plus population screened for NCDs	15% of 30 plus population screened for NCDs: 10 points incentive 7% of 30 plus population screened for NCDs: 6 points incentive Less than 3% of 30 plus population screened for NCDs: 6 points penalty Less than 2% of 30 plus population screened for NCDs : 10 points penalty (Out of total State population)	Report from NCD division MoHFW and State reports Any Survey data available	+10 to -10
6.	HRIS implementation	Ensure implementation of HRIS for all HRH (both regular and contractual) in the state. Salary invoice and transfer orders	HRIS (State) and HMIS	+15 to -15

Framework – 2018-19

SNo	Conditionality / Indicator1	Incentive/penalty	Source of verification	% Incentive / Penalty 2
		to be generated by HRIS. Line listing of all staff for all facilities to be available. HRIS data should match with HMIS reporting. Cases where it doesn't, state should provide reason and numbers. +10 to -10 for HRIS operationalization and +5 to -5 for synchronization with HMIS State where data matches: 5 points incentive States where data doesn't match: 5 points penalty	report	
7.	Star rating of PHCs (both Urban and rural) based on inputs and provision of the service package agreed	75% (in Non EAG) and (60% in EAG and NE) of the PHCs having 3 or more star rating: 5 points incentive 50% (in Non EAG) and 40% (in EAG and NE) PHCs having 3 or more star rating: 2 points incentive Less than 40% (in Non EAG) and 30% (in EAG and NE) of PHCs having 3 or more star rating to be penalized: 5 points	HMIS	+5 to -5