



Ministry of Health & Family Welfare
Government of India

PIP Guidance Note 2026-27

National Health Mission (NHM)
Ministry of Health and Family Welfare,
Government of India

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A. Introduction

The Programme Implementation Plans (PIPs) are one of the most crucial documents in the National Health Mission (NHM) through which States plan, prioritize, and propose budgets required to implement mutually agreed strategies and activities to the Ministry of Health and Family Welfare (MoHFW). This guidance note introduces significant reforms to PIP preparation, submission, and approval processes for 2026-27, emphasizing outcome-focused planning, state flexibility, and alignment with Sustainable Development Goal (SDG) targets.

NHM's Contribution to Sustainable Development Goals: The National Health Mission has been central to India's progress toward the Sustainable Development Goals, especially SDG 3 on health and well-being. Through targeted interventions, NHM has significantly reduced maternal, neonatal, infant, and under-five mortality rates, positioning India to meet several SDG health targets ahead of 2030. In disease control, major programs such as the National TB Elimination Programme and the National Sickle Cell Anaemia Elimination Mission have accelerated reductions in disease incidence and mortality. Expanded cancer screening and affordable treatment have further strengthened early detection and improved outcomes.

Social Benefits and State Budget Complementarity: NHM's comprehensive strategy focusing on prevention, early diagnosis, treatment, and health-system strengthening has generated broader social benefits including higher productivity, reduced healthcare expenses, and improved quality of life, particularly for marginalized populations. While the exponential growth of NHM has increased States/UTs dependence on the mission, it is emphasized that NHM was introduced as an interim arrangement, and States are encouraged to maintain adequate allocations from their own budgets to complement NHM funding.

Simplified Budget Formats and Consolidated Resource Pools: The guidance note introduces simplified budget formats, consolidated resource pools, and enhanced focus on measurable deliverables rather than detailed input-based budgeting. This merging of pools allows better resource allocation based on local priorities and needs.

Shift to One-Year PIP Cycle: A significant reform shift from multi-year to a one-year PIP cycle is brought about to strengthen responsiveness and efficiency. This annual cycle enables rapid course correction based on implementation experience and evolving health priorities, ensures better alignment with annual budget cycles and improved fiscal discipline, enhances accountability through yearly performance reviews, reduces complexity in budget tracking and financial management, and allows States greater flexibility to respond to emerging health challenges such as disease outbreaks or natural disasters.

Bottom-Up Planning Approach: The PIP 2026-27 process mandates a participatory, bottom-up planning approach beginning at the facility level and progressively aggregating to district, state, and national levels. This approach ensures that:

- Local health needs and priorities are accurately identified and addressed.
- Facility-level personnel such as ANMs, ASHAs, and Medical Officers actively participate in planning.

- District Health Action Plans (DHAPs) reflect ground realities and community needs.
- The Local public representatives (MPs, MLAs, Panchayati Raj Institutions, etc.) should also be consulted before finalizing the DHAP. (please refer to Hon'ble Minister (Health & Family Welfare and Chemicals & Fertilizers, Government of India) letter - D.O. No. M.11016/ I/12025-NHM-II, Dated the 27th May,2025).
- Evidence-based and context-specific resource allocation is promoted.
- Ownership and accountability are strengthened across all levels of the health system.

To effectively implement this approach, states must ensure adequate capacity building and provide continuous handholding support to facility-level, block-level and district-level planning teams.

State Flexibility in Resource Allocation: The PIP 2026-27 offers States significant flexibility in planning and resource allocation within defined limits. States may allocate funds across programme heads within the approved envelope, propose innovations aligned with NHM priorities, and make justified inter-component reallocations based on emerging needs. However, key non-negotiables must be followed. States cannot exceed the approved budget ceiling without GoI approval and must adhere to the NHM Framework, revised PIP format, and financial norms/unit costs in the RoP. Compliance with MoHFW quality assurance and monitoring requirements is essential to ensure standardization, fiscal discipline, and effective tracking of outcomes.

Strategic Planning Guidelines for States: The strategic planning guidelines encourage States and Union Territories to align their PIP proposals with relevant Sustainable Development Goal (SDG) targets while ensuring that adequate state budget allocations are maintained. They should prioritize directing resources toward lagging areas of implementation and underperforming programs, and actively study and adopt best practices from high-performing States. States are also advised to review the findings of the Common Review Mission (CRM) before preparing their proposals so that identified gaps can be appropriately addressed. Throughout the planning process, States should make prudent use of the flexibility available within the NHM framework to maximize health outcomes while upholding accountability.

Annexures and Supporting Documents: This PIP Guidance Note references several annexures that provide detailed budget formats, programmatic priorities etc. States and Union Territories must ensure all annexures are accurately completed and submitted as part of the overall PIP package. Key annexures include:

- Budget Sheet Format for FY 2026-27.
- Revalidation Format
- SDG and Disease Elimination Action Plan
- CRM Action Taken Report
- Key Deliverables
- Expenditure incurred to meet Key Deliverables
- Training Calendar

All annexures must be submitted in prescribed formats, ensuring alignment with national health priorities and compliance with established standards.

B. Purpose of the Guidance Note

Following are the main purposes of this PIP guidance note:-

- To lay down the key principles for PIP 2026-27
- To outline the process and format of the PIP
- To enumerate the expectations of MoHFW with respect to the PIP including the outputs that States are expected to achieve
- To provide programmatic priorities for FY2026-27

C. Resource Envelope

The SNA SPARSH initiative has been implemented, and any unspent balance will not be carried forward, as the Mother Sanction will lapse at the end of the financial year. Proposals that were not implemented or were only partially implemented in previous Programme Implementation Plans (PIPs), and are now planned for implementation in FY 2026-27 with associated financial implications, must be clearly highlighted along with the year of approval and the related financial requirements.

These items will be issued and provisioned from the Resource Envelope for FY 2026-27, to be submitted as an annexure in the standard format. Both NPCC and Pre-NPCC deliberations will ensure that recommendations do not exceed the maximum limit of the Resource Envelope. Maximum financial provisions should be retained for the programmatic priorities of the National Health Mission (NHM). Proposals related to human resource needs and infrastructure projects should be minimized, and alternative resource options may be explored as appropriate. Budgets for IEC, training, HR, and IT components should not be distributed across various programme heads but should instead be consolidated under the designated FMR codes for optimal resource utilization.

The States/UTs should confine the overall proposal to the limit of 25-30% more than the Resource Envelope (RE) so that the recommendations of the NPCC can be finalised during the meeting itself. The mutually agreed recommended amount and the deliverables for each of the programmes/interventions/activities will be populated during discussion in the NPCC. Suitable observations and reasons shall also be recorded, especially for the proposals identified for discussion. The proposal so finalised would be deemed to have been revised by the State/UT.

Revalidation of Previous Years' Approvals in PIP 2026-27: When submitting proposals for revalidation of previous years' approvals in the PIP for FY 2026-27, states should use the prescribed format to provide comprehensive details of approvals granted in earlier years' Records of Proceedings (RoP). This process allows states to request that unutilised amounts from approved activities, which were not executed in their respective years, be revalidated for implementation in FY 2026-27.

The amount proposed for revalidation will be counted within the current year's resource envelope and will correspondingly reduce the funds available for new activity approvals. For

example, if a state's resource envelope for FY 2026-27 is ₹1500 crore and ₹50 crore of the previous years is sought for revalidation, the remaining ₹1450 crore will be available for current year's proposals, ensuring fiscal discipline and clear tracking of revalidated activities within the overall budget. (The details to be received is in the format at annexure-5)

D. Key Features and Reforms in PIP 2026-27

To enhance usability and reduce administrative burden, the PIP 2026-27 budget format has been simplified with the following key reforms.

1. Revised PIP FY2026-27 Budget Format

The PIP budget format for FY 2026-27 has been revised to enhance clarity and provide more flexibility to states for planning as per the program requirements. To enable this, the format has been further streamlined by consolidating selected components and reorganising them from the functional areas (columns) into Themes (rows). The major changes in the Budget sheet are as follows:

Introduction of new budget heads/ serial numbers: New serial numbers for Capacity building, ASHA Incentives, IT interventions, IEC and Printing, PSA Plants funded under PM-CARES and State specific Initiatives and Innovations (Sl. Nos. 201 to 206) have been added.

- **201 Capacity building including training** – to streamline planning and budgeting for all capacity-building initiatives and integrate training activities across programmes.
- **202 ASHA Incentives** – to reduce duplication and enable better monitoring, and analysis of incentive-related activities.
- **203 IT interventions** – to support better planning for digital interventions, including hardware, software, IT systems, and related maintenance for service delivery across programmes. This will also help reduce duplication and multiplicity.
- **204 IEC & Printing** – a consolidated budget head may enable comprehensive planning for IEC and Printing activities under various programs.
- **205 PSA Plants funded under PM-CARES** – States/UTs may submit proposals related to Annual Maintenance Contract (AMC) and Comprehensive Annual Maintenance Contract (CAMC) for PM-CARES supported PSA plants under this head.
- **206 State specific Initiatives and Innovations** – All proposals pertaining to innovations/ state-specific strategies, pilot initiatives, and scalable models under various programmes within the States/UTs to be included under this head.

Introduction of Annexures: The PIP format for FY 2026-27 introduces 6 new Annexures. Proposals related to Capacity building, ASHA Incentives, IT interventions, IEC and Printing, State specific Initiatives and Innovations, and Planning and Program Management are to be proposed exclusively in their respective annexures. It must be ensured that:

- Each annexure should comprehensively list specific interventions, activities, and financial requirements corresponding to its budget line. For example, the budget related to ASHA incentives under various heads/ schemes are to be budgeted under Sl. No 202.
- The sub-totals from these annexures are linked to the corresponding serial numbers in the main PIP proposal sheet. The states do not need to enter the budget separately in the main sheet; only the proposal details are to be provided in the relevant annexures.

Merging of old budget heads/serial numbers: To enable comprehensive and streamlined planning, a few old serial numbers have been discontinued (marked in black). No activities are to be proposed under these discontinued heads. E.g. the proposals related to Planning and M&E are to be shifted from column to the Planning and Programme Management row (Sl. Nos. 146 and 194). Details of the new serial number to which these components have been shifted are provided in Annexure 1(i).

Separate Sl. No. for TeleMANAS: To consolidate TeleMANAS related proposals, Sl. No. 98 has been redesignated from State-specific Initiatives and Innovations to Implementation of TeleMANAS.

Renaming of Schemes/Activities: Certain schemes and activities have been renamed. The updated nomenclature is reflected in the revised budget sheet. This includes:

- Village Health & Nutrition Day (VHND) as Village Health Sanitation & Nutrition Days (VHSNDs)
- Adolescent Friendly Health Clinics as Adolescent Friendly Health Centers (AFHCs)
- Weekly Iron Folic Supplement (WIFS) as Weekly Iron Folic Acid Supplementation (WIFS)
- Peer Educator Programme as Peer Education Programme
- Screening and Testing through NGOs as Screening and Testing through Outreach Activities

Indicative/ suggestive list of activities for FMR

An indicative list of activities corresponding to each Financial Monitoring Report (FMR) code in the PIP is prepared based on prior experience from past PIP discussions and NPCC meetings. This helps ensure that states do not face difficulties or confusion while proposing activities in particular budget head.

- FMR codes clearly define the budget heads under which specific activities should be categorized, promoting uniformity and reducing ambiguity in budgeting.
- Past experience with these codes provides guidance on expected activities under each FMR, reducing the risk of misclassification or unnecessary duplication.
- States can adapt and contextualize activities based on their needs but within the framework of predefined FMR codes, which simplifies alignment and approval processes.

[Revised Budget sheet is provided in the Annexure 1]

2. SDG & Disease Elimination Targets Plan

The evaluation of progress on the Sustainable Development Goals (SDGs) and national disease elimination targets has been included as a part of the Programme Implementation Plan (PIP). By integrating these reviews into the planning cycle, states and UTs will be motivated to align their strategies with national and global commitments. Their performance on priority indicators will be regularly assessed, enabling timely identification of gaps in outputs, services, and outcomes.

This structured review will encourage states and UTs to adopt evidence - based approaches and strengthen implementation. Over time, this will promote a culture of accountability, improve overall programme performance, and support India's progress toward sustainable and equitable public health goals. The states are encouraged to prepare a short term and long term holistic strategy to improve state indicators to help achieve the NHM targets. *(The details to be received are specified in Annexure-2)*

3. CRM Action Taken Report

The 16th Common Review Mission (CRM) assessed the implementation of NHM strategies and identified both strengths and gaps across states. States and UTs are required to submit an Action Taken Report (ATR) that summarizes steps taken to address CRM recommendations, including improvements and innovations adopted at various levels. Submission of CRM ATRs along with the NHM PIP process are essential for targeted planning, effective resource allocation, and ongoing health systems strengthening. *(The details to be received in the annexure-3)*

4. Key Deliverables (Budget Expenditure)

Key deliverables under the NHM include strengthening primary healthcare systems, improving maternal and child health services, expanding immunization coverage, reducing the burden of communicable and non-communicable diseases, and enhancing health infrastructure and human resources. These deliverables are essential as they convert policy priorities into clear, measurable targets for implementation at State and District levels. They also serve as the basis for monitoring progress, identifying service gaps, and ensuring accountability. Tracking these deliverables enables assessment of outcomes such as reduced mortality, improved service access, and greater health equity, thereby supporting evidence-based planning and continuous system improvement.

Further, all Key Deliverables (KDs) have been mapped to FMR Codes. Mapping KDs with financial progress provides a clearer picture of how effectively NHM resources are being used to achieve intended outcomes. Expenditure patterns are directly mapped to KD achievements to identify gaps between spending and performance, such as areas where funds are utilized but expected service improvements are not visible. This will enable timely corrective actions, better prioritization, and improved targeting of interventions. All States/UTs are requested to provide expenditure against same during the PIP meetings.

The Key Deliverables (KDs) for the National Health Mission in 2026-27 have undergone significant rationalization, reducing from 186 to 65 in total, reflecting a more focused and streamlined planning approach. Program-wise changes are as follows:

- Reproductive and Child Health (RCH) saw a reduction from 64 to 17 KDs, with major cuts in Maternal Health (from 11 to 3), Child Health (16 to 3), and Immunization (8 to 2). Some new inclusions such as Child Health RBSK have 2 KDs added.
- Communicable Disease programs decreased from 36 to 16 KDs, with notable changes including TB Mukh Bharat Abhiyan (7 to 3), National Viral Hepatitis Control Programme (4 to 2), and new programs like Program for Prevention and Control of Leptospirosis and National Program for Prevention and Control of Snakebite Envenoming introduced with 1 KD each.
- Non-Communicable Diseases KDs were reduced from 29 to 15, maintaining focus on National Programme for Non-Communicable Diseases and other related areas.
- Health System Strengthening KDs have been streamlined from 57 to 17, ensuring focus on essential systemic improvements.

The details of KDs are provided in Annexure - 4A and the details of KDs Mapped with FMR is code is provided at Annexure - 4B. States/UTs are requested to provide targets against each before the PIP process.

New program areas have emerged, reflecting evolving public health priorities and better resource targeting. This rationalization indicates a shift toward outcome-oriented planning, with clearer prioritization of activities and better alignment with program goals for enhanced implementation efficiency. Furthermore, this approach promotes data-driven decision-making, allowing officials to allocate budgets more efficiently in subsequent PIP cycles. Ultimately, it not only improves financial efficiency but also ensures that investments under NHM lead to tangible, measurable, and sustained health outcomes for communities.

5. Conditionality framework:

The Conditionality Framework under NHM for FY 2026–27 is designed to drive improvement in health outcomes and enable health systems strengthening across states and union territories through monitoring and accountability mechanism.

The key screening criterion for the assessment of conditionalities is the full immunization coverage at least 85% coverage for Northeastern, Hilly, and EAG states and 90% for other States/UTs. There are 12 conditionality indicators with incentive and penalty scoring ranging from +120 to -120 points. Each of these indicators is monitored using various data sources such as state health portals, official report submitted to programme divisions etc.

Assessment of the States/UTs will be conducted across four categories –Non- High Focus States and UTs, High Focus States, North Eastern States, and Hilly States with each category evaluated through a separate scoring system to ensure context-sensitive measurement of performance. The 12 conditionality indicators for FY 2026-27 are listed below. (The details of conditionality framework will be shared separately.)

Conditionalities for 2026-27

1. AAMs State/UT Score
2. Implementation of DVDMS
3. ANC Check-up Coverage in 1st Trimester
4. Availability of HRH as per IPHS Norms
5. Uploading district wise RoP on NHM Websites
6. Implementation of Tele-MANAS
7. Implementation of TB Mukh Bharat Abhiyan (NTEP)
8. NQAS Certification
9. IPHS Compliance for Infrastructure
10. Increase in State Health Budget
11. Implementation of NP-NCD
12. Implementation of Anaemia Mukh Bharat

E. Programmatic PIP Priorities for 2026-27:

- **Reproductive and Child Health:** Roll out a special antenatal care (ANC) package in 11 High Focus States (Assam, Bihar, Chhattisgarh, Haryana, Madhya Pradesh, Rajasthan, Odisha, Punjab, Uttar Pradesh, Uttarakhand, and West Bengal), ensuring four or more ANC visits including at least one during the first trimester. Incentivize ASHAs for biweekly home visits during the critical 8th and 9th months of pregnancy. Provide financial support and wage compensation for companions of pregnant and lactating women, especially during institutional deliveries, postnatal check-ups, and stays at Birth Waiting Homes. Establish Birth Waiting Homes, Maternal Child Health wings, Obstetrics HDUs, and ICUs in high priority districts. Promote pre-pregnancy care through ASHA-led mobilization for risk assessment and folic acid supplementation.

To achieve the accelerated reduction in neonatal & under 5 mortality (as per SDG goals for 2030), States/UTs may propose for establishment of Mother Newborn Care Units (MNCUs), strengthening of Newborn Stabilization Units (NBSUs) and upgradation of Special Newborn Care Units (SNCUs) in 11 High Focus States. Under **RBSK**, States/UTs may also propose for saturation of District Early Intervention Centres (DEICs) (including infrastructure, equipment & HR) with re-appropriation of Mobile Health Teams (MHTs) (including mobility support, equipment and laptops) with existing HR in other vertical programs like counsellors for strengthening screening in schools (Government/Government aided).

Anemia Mukh Bharat (AMB) Programme focus on reduction of anaemia across beneficiaries to promote improved health outcomes especially among mother and infants through new strategies of-

- Testing beneficiaries – procurement of DIH, Hb strips for ANM and RBSK teams
- Procurement of IFA for Prophylactic and therapeutic dosage, prioritizing vulnerable populations (option of other iron salts)- PW, LM, Severe anaemic WRA and Adolescent girls

- Procurement of intravenous iron for severe anaemic pregnant women

States/UTs to propose the budget for above mentioned interventions in a phase wise manner.

- **Introduction of the HPV vaccine:** States/UTs to undertake micro-planning, ASHA training, and incentivize activities like head-count surveys, due-listing, and vaccination team honoraria. Strengthen vaccine transport and cold chain logistics from district to health facility points. Implement planned monitoring and review meetings at district and health facility levels.
- Reduce **TB** incidence and mortality through early detection and prompt treatment including drug-resistant TB. Implement differentiated TB care for high risk and co-morbid TB patients. Nutrition interventions such as Ni-kshay Poshan Yojana, Ni-kshay Mitra Initiative, and energy-dense nutrition supplements for TB patients and families. Comprehensive case tracking, follow-up monitoring, and TB death audits. Target vulnerable populations including congregate settings and identified vulnerable wards and villages. Use chest X-ray as a screening tool for all vulnerable groups to detect asymptomatic and symptomatic TB cases early. Deploy hand-held X-rays, radiographers, and NHM lab technicians in multi-shift operations. Transport samples efficiently from health facilities and Ni-kshay Shivirs to laboratories. Ensure private sector engagement through PPSA / alternate models. Community Health Officers to visit every TB patient every 15 days and ASHAs weekly. Promote TB prevention with TPT for contacts and other risk groups.
- **Blood Disorders:** Identify priority areas for antenatal and infant screening for Sickle Cell Disease and Thalassemia. Promote prenatal diagnosis to prevent affected births. Address supply chain issues for diagnostic kits and reagents promptly. Link counselling services closely with screening and treatment, and train counsellors to manage stigma. Ensure availability of safe blood for transfusion-dependent patients, along with essential medicines like hydroxyurea and iron chelation drugs. Train healthcare providers in prescription and administration of relevant therapies. Register patients and data entry into the SCD portal for better management and tracking.
- **Goal aligned with SDG 3.3 to combat viral hepatitis** by reducing infected population, morbidity, and mortality. Scale up decentralized hepatitis services through integrated approaches. Universal screening of pregnant women for Hepatitis B with interventions to prevent mother-to-child transmission. Administer HBIG and Hepatitis B vaccine to newborns of screened positive mothers. Screen and treat eligible hepatitis B and C patients. Operationalize national helpline 1800-11-6666 and provide digital access through the NVHCP website.
- **Expansion of Non-Communicable Disease:** Implement the hub-and-spoke model for management of acute conditions like STEMI with 24/7 diagnostic and treatment capabilities. Early detection and management of conditions like COPD, asthma, CKD/Stroke and NAFLD at primary and secondary care levels via screening, spirometry, and risk assessments. Promote lifestyle modifications for NAFLD and obesity

management. Enhance dialysis coverage and quality of care, including infection prevention and promotion of peritoneal dialysis in difficult terrains.

- **Operationalization of Day Care Cancer Centres:** The operationalization of Day Care Cancer Centres (DCCCs) under the NHM is a new initiative. The plan is to establish DCCCs in district hospitals, prioritized in high-burden districts using ICMR cancer registry data. Each centre is designed to provide accessible chemotherapy, counseling, essential medicines, and pain management services locally, staffed by oncologists or trained medical officers, nurses, pharmacists, and counselors. DCCCs will function within district hospitals or other government facilities as per logistics and feasibility, enabling patients to receive subsequent chemotherapy sessions without needing to travel to tertiary centers.
- **National Mental Health Programme (NMHP):** Build capacity of PHC/CHC medical officers and nurses in mental health management. Recruit dedicated human resources including clinical psychologists, psychiatric social workers, and trained medical officers across districts. Expand tele-mental health services (Tele-MANAS) with multilingual counselling support. Implement community outreach through ASHA/ANM based mental health screenings. Conduct regular awareness drives to reduce stigma and enhance service utilization.
- **Urban implementation framework:** Expand urban primary health care infrastructure including UPHCs, USHCs, Polyclinics, and UCHCs in urban, peri-urban, and outgrowth areas. Extend coverage beyond slums to include vulnerable populations in non-slum areas. Enhance specialist services through Polyclinics and teleconsultations. Operationalize facilities with flexible timings such as evening and Sunday OPDs to increase accessibility and uptake. Strengthen convergence with national health programmes including NCDs, TB, NVBDCP, NLEP, IDSP, and NMHP. Ensure availability of a comprehensive 12-service package at all Urban AAMs.

Promote home-based care for geriatrics, palliative care, and NCD management with home delivery of drugs and diagnostics. Map slum and non-slum populations along with their specific health needs. Implement differentiated operational models based on city governance categories and facility availability, ensuring clear reporting structures. Expand ASHA coverage in both slum and non-slum areas, including recruitment of ASHA facilitators as required. Initiate engagement with Resident Welfare Associations (RWAs), cooperative societies, and ward committees in non-slum areas. Conduct IPHS assessments using digital ODK toolkits to ensure compliance across urban facilities. Address urban health workforce shortages through policy-level measures and incentives. Strengthen convergence with Urban Local Bodies (ULBs) for integrated health planning, monitoring, and capacity building. Collaborate closely with departments like Women and Child Development, Social Justice, Water and Sanitation, and with schemes such as NULM, SBM, AMRUT, and Smart Cities Mission for synergistic outcomes. Encourage innovative solutions and pilot projects aimed at enhancing service delivery to urban populations adapted to local needs and contexts. The new NUHM Framework may be referred for the implementation of the National Programs in the urban areas.

- **Ensuring availability of Drugs and Diagnostics:** Ensure 100% availability of essential quality generic medicines across all public healthcare facilities following IPHS Essential Medicines List. Strengthen procurement systems, quality control mechanisms, drug warehouses, and supply chain management via IT-enabled DVDMS. Promote rational prescription audits and on-boarding of facilities on the DVDMS supply chain management system. Expand dialysis coverage on saturation mode at DH and below levels, aiming for near 100% district coverage. Promote adoption of peritoneal dialysis particularly for hilly, difficult terrain areas.

Achieve **availability of over 80 diagnostic tests at all healthcare facilities**, progressively increasing across all facility levels. Operationalise IPHL and BPHL with quality equipment; establish sample transportation systems. Leverage drone technology for sample transport in hilly and difficult terrains. Strengthen block public health units as diagnostic hubs including lab services, X-ray, ECG, USG, and tele-radiology. Upgrade conventional X-ray systems to digital radiology compliant with tele-radiology standards. Low-cost, high-volume drugs and diagnostics need to be prioritized.

- **Strengthening for Expanded Package of Services:**

- Ensure 100% implementation of 12 expanded packages of services (EPS) at AAM.
- Focus on achieving National Quality Assurance Standards (NQAS) certification for all public health facilities by December 2026.
- Expand and improve Kayakalp certification and patient feedback mechanisms. States should ensure integration and synergy between quality assurance programmes including NQAS, NQAP (National Quality Assurance Programme), LaQshya (Labour Room Quality Improvement Initiative), Kayakalp, and Muskan (smile initiative for pediatric care). PIPs must allocate resources for quality assurance cells at state and district levels, regular facility assessments, corrective action plans, and capacity building of QA teams. Refer to quality assurance guidelines and standards available on NHM portal (www.nhm.gov.in) for detailed technical specifications and assessment protocols.
- Target high equipment uptime (95% DH, 90% CHC, 80% PHC) with annual equipment audits. Ensure life-saving biomedical equipment covered under maintenance contracts. Maintain availability of trained biomedical engineers per IPHS recommendations. Keep oxygen assets functional including PSA plants, LMO plants, and oxygen concentrators. Implement scheduled equipment preventive maintenance and calibration.

- **National Programme for Health Care of the Elderly (NPHCE):** Equip Sub-Health Centres, PHCs, and CHCs with essential screening tools, machinery, and CGA (Comprehensive Geriatric Assessment) forms. Strengthen rehabilitation facilities in high burden districts and enhance training programs at district levels. Ensure continuous supply of machinery and training support across health facility levels.

- **Revised Ayushman Arogya Shivirs:** Scale up health camps with increased access to medical officers and specialists in various specialties like gynecology, pediatrics, surgery,

psychiatry, AYUSH, etc. Engage community and local representatives (MPs, MLAs, PRI, ULB) in these health initiatives. Revise budgets and targets for expanded service delivery.

- **Human Resources for Health (HRH):** Human Resources for Health (HRH): The states should ensure that availability of HRH in the health facilities is as per IPHS 2022 norms and caseload. The states are advised to not allocate more than half of the Resource Envelope to Human Resources (HR) for Health to better enable use of the resources for programme interventions.
- Rationalisation of service delivery and programme management HR may be facilitated through integration—i.e., optimal utilisation of posts with similar functions across vertical programmes. It is advised to adopt a health-systems approach rather than programme-wise deployment to avoiding duplication and enable more efficient utilisation of staff. States are kindly requested to propose Funds specifically for contractual employees. Salaries for regular staff must be covered under the State Budget.
- For service delivery HR, IPHS 2022 and workload norms should guide rational deployment. States/UTs are expected to establish the required number of posts under the regular cadre in accordance with IPHS 2022 norms across the core cadres, namely Multi-Purpose Worker (Male + Female), Staff Nurses, Lab Technicians, Medical Officers, and Specialists, and use NHM support solely for filling gaps in the short to medium term.
- For programme management HR, a suggestive PMU structure which States/UTs may adapt based on local needs has been shared (please refer to AS&MD, NHM's letter - D.O. No. Z-18015/93/2025, dated 9th December 2025). The PMU structure may be reorganized by redistributing the work and reassigning the roles based on competency and educational qualification, ensuring optimal utilisation of resources. Instead of maintaining programme-wise or scheme-wise posts, States should establish integrated, function-wise cells within PMUs. For example, rather than having separate Accountants under each programme, a unified Finance and Accounts cell may be created to serve all programmes as required.
- Uniformity should be ensured in appraisals, increments, and remuneration across contractual NHM HR.
- The MSG-mandated 9%/14% ceiling on Programme Management Costs must be strictly adhered to and the PMU structure may be reorganised by dropping vacant posts and revising Terms of Reference (ToRs) where needed. NHM support is to be extended to only contractual HR. Salaries and emoluments for regular staff deputed under NHM PMU should be booked from the State Budget.
- **Integrated Training Approach :** From FY 2026-27, for ASHAs and 4 key service delivery cadres of MPW, CHO, Staff Nurses and Medical Officers, an integrated comprehensive training approach would be adopted so that the same person is not required to attend multiple training programmes. Modules for the integrated trainings will be provided by NHSRC, MoHFW. Further, to decentralise trainings, Medical and Nursing colleges would be engaged as Regional Training Institutes (RTIs) to function as technical hubs for mentoring and training. The operational workflow follows a cascade model:

- **Strategic Oversight:** MoHFW and NHSRC provide the national strategy, standardized curriculum, and funding, while managing the SASHAKT platform for tracking progress.
- **Regional Execution:** The identified RTIs (110 Medical and 112 Nursing colleges possible Regional Institutes mapped) are responsible for conducting region-wise State Training of Trainers (SToTs), maintaining academic standards, and managing logistics. States are requested to evaluate the institutes for feasibility to be designated as Regional Training Institutes for NHM cadres.
- **State Action:** States facilitate the process by nominating trainers, coordinating district-level deployment, and integrating budget requirements into their Program Implementation Plans (PIPs).

This structure ensures resource efficiency and standardized quality across the primary healthcare workforce.

Training Plan and Training Calendar: In the PIP formats for FY 2026-27, a template for training plan has been incorporated. States and UTs are expected to plan and propose the trainings as per the specified format. Once the RoP has been issued, States and UTs are also expected to go through the approved training programmes and prepare a training calendar (Annexure 6) and send it MoHFW /NHSRC within 15 days of RoP issuance.

The proposed training schedule is planned as follows: Medical Officers – 3 days; Staff Nurses – 7 days; Community Health Officers – 7 days; ANMs – 7 days; and ASHAs – 10 days.

- **Integration of Portals:**

A National Aggregator Platform is developed to integrate program portals, such as NCD, Nikshay, Sickle, U-WIN, PMNDP, etc. This will allow seamless access to services, reduce duplication, and improve tracking of health outcomes. The platform will be a single window through which the healthcare worker can make entries. Further, cross-platform indicators and data points will be included which will help the healthcare workers to comprehensively evaluate the health parameters and track individual progress. A model of the same was also displayed during the conference on 27th and 28th November, 2025 at New Delhi. Such demands were made by States as there were multiple portals requiring multiple entries and consumption of time of health workers in data entries.

- **Integrated Information, Education, and Communication (IEC):**

Under the National Health Mission (NHM), **Integrated IEC** efforts at **all facilities** focused on delivering clear, consistent, and coordinated health messages to the community. This comprehensive approach utilizes a combination of methods including **interpersonal communication, community mobilization, visual aids, and digital platforms** to effectively improve public awareness and encourage positive healthy behaviours.

A standardized modal will be created for awareness and the practice of programmatic IEC to be discouraged in future. The messaging covers critical areas such as maternal and child health, infectious diseases, Non-Communicable Diseases (NCDs), nutrition, sanitation, etc. The IEC will also comprehensively cover 12 expanded packages of services at AAMs. Crucially, frontline workers like ASHAs, ANMs, and Community Health Officers (CHOs)

collaborate at the AAMs to ensure the information is culturally relevant and specifically tailored to meet local needs. By maintaining consistent and holistic communication, Integrated IEC aims to strengthen **preventive health practices**, boost the **uptake of health services**, and increase **community participation** for achieving better overall health results.

- **Mobile Medical Units:**

The Ministry of Health and Family Welfare (MoHFW) has provision of Mobile Medical Units (MMUs) under the National Health Mission (NHM) to provide healthcare services to remote/inaccessible areas and to vulnerable groups. Also, under PM-JANMAN (Pradhan Mantri Janjatiya Nyaya Maha Abhiyan), Ministry has been assigned to provide healthcare services to the 75 Particularly Vulnerable Tribal Groups (PVTG) through MMUs. The MMU Portal, available at staging.ayushmanshivir.mohfw.gov.in/mmu/, is an online monitoring and management system developed under NHM. Few salient features of portal are: Service Data Recording, Performance Assessment, Planning & Resource Allocation, Transparency & Accountability and Real-time Monitoring. In this regard, it is important to ensure that the MMU Portal is updated regularly and that all information reflected therein is current as financial releases will be made based on MMU Portal data.

F. Matters to be discussed in NPCC:

- It has been decided that one day before the NPCC, a pre-NPCC meeting will be conducted with the concerned Joint Secretaries to discuss the PIP proposals. The NPCC will finalize deliverables, review financial proposals outside cost norms, innovations and interventions not aligned with guidelines. States must provide justifications for any deviations. Senior officers from the State, MD NHM and ACS / PS (H) / Secretary (H) is expected to attend the Pre NPCC and NPCC discussions.
- For interventions provided in the technical/operational guidelines of any Programme, the State/UT shall prepare a list of such issues and provide the justification in the PIP proposal itself. The Programme Divisions in the Ministry would appraise such issues so that these can be discussed and decided in the NPCC.

G. Key Points to Remember

- PIP 2026-27 emphasizes outcome-based planning with measurable deliverables and simplified budget formats.
- States have flexibility in resource allocation within approved budget envelopes, subject to programmatic priorities.
- Integration with SNA payment systems is mandatory for all financial transactions.
- Unused balances will not be carried forward as Mother Sanction lapses at financial year-end.
- Quality benchmarks and SDG alignment are mandatory considerations for all program proposals.

H. Timeline for PIP 2026-27 Submission

States/UTs are requested to adhere to the following timeline for PIP 2026-27:

RE Communication to States/UTs	0 Week
Submission of PIP by States/UTs to MoHFW	2nd week
Scheduling of NPCC on desired date	As per NPCC Schedule
Post NPCC PIP by States/UTs	1 week after NPCC meeting
Preparation and submission of RoP FY 2026-27	1 weeks after Post NPCC comments by PDs

For queries and clarifications on PIP: For any technical queries or clarifications regarding PIP 2026-27, States/UTs may contact: pipprocess2025.26@gmail.com