

OPERATIONAL GUIDELINES FOR PIP 2016-17

PIP for 2016-17 is to be submitted by the States/UTs in the software application developed by NIC. The user manual/guide for the software has already been shared with the States vide letter No.10 (36)/2014-NRHM I part dated 20th October, 2015 addressed to the Principal Secretaries (H&FW)/Mission Directors (NHM).

As discussed during orientation of the SPMs on the PIP software, the underlying principles and processes of planning remain the same. The Framework for Implementation of the National Health Mission remains the mainstay.

This document lays down the operational guidelines, processes to be followed and the form and budget format in which the PIP 2016-17 is to be sent to GoI. It also reiterates the priorities to be addressed by PIP 2016-17.

Background work required for PIP 2016-17

The starting point of PIP 2016-17 would be the RoP/approvals for 2015-16 PIP [Main and supplementary (if any) and progress both physical and financial against the approvals (State as well as district wise).

State level Programme Divisions as well as districts should be asked to reassess the approvals for 2015-16 and list down the changes required in 2016-17.

States along with their districts should assess the progress, both physical and financial, made till November 2015 against the approvals given in 2015-16 and fill up the required annexures in the excel sheets and upload as part of the PIP in the relevant sections.

PIP 2016-17 would be a consolidated PIP of districts and the State. The District Health Action Plans (DHAPs) would have to be prepared and uploaded by the districts. The approved DHAPs would be consolidated at the state level and sent to MoHFW. The process of forwarding PIPs to the next level has been explained in the User manual for the PIP software.

PIP 2016-17:

As in any PIP, the PIP for 2016-17 too would consist of two types of activities:

A. Continued /Existing Activities

Based on the feedback of the Programme Divisions and the districts, State may propose the same budget and activities as approved in 2015-16, or propose changes which would fall in three categories:

1. Discontinuation of an activity: no budget required
2. Increase in budget: change would be either be in number of units or cost per unit
3. Decrease in budget: changes are likely to be in number of units and in some cases cost per unit

The changes required are to be clearly mentioned in the budget sheet and its explanation is to be provided in the remarks column.

B. New Activities

For all new activities the norms laid down in manual of PIP 2015-16 would apply. The State should clearly mention 'new activity' in the comments column and upload the justification sheet in the software. The State should provide a brief description, rationale, data/background information required to appraise the proposal and budget break-up for each new activity (as shown in exhibit). New activities should also address the priorities set for 2016-17 (see below).

Priorities 2016-17

It is expected that PIP 2016-17 would apply health systems approach to all activities proposed and ensure both effectiveness and efficiency. The PIP should address the following key priorities such as:

1. Strengthening of District Hospital by addition of specialities including dialysis as per IPHS and training facilities etc for nursing and allied health professionals, particularly neo natal nursing diploma, midwifery training diploma etc
2. Roll out of NHM Free Drugs Service Initiative including strengthening of basic lab, drug warehouses, IT systems for drug logistics and supply chain
3. Roll out of NHM Free Diagnostics Service Initiative including PPPs for tele radiology, hub and spoke model model, CT Scan etc
4. Operationalization of FRUs including Blood banks (Blood storage units)
5. Quality Assurance Systems
6. Kayakalp
7. Group/Team based incentives at Sub-Centre/PHC (for primary care)
8. Comprehensive primary care including UHC pilots
9. Grievance Redressal mechanism
10. Haemoglobinopathies
11. Operationalization of DEICs
12. State level Innovation

JUSTIFICATION SHEET: NEW ACTIVITY

- a. FMR code :
- b. Activity Proposed:
- c. Name of the Activity:
- d. Justification:
- e. Deliverables:
- f. Funding Proposed:

No of Units*	Cost per unit	Total Cost

Note* - Attach separate sheet for the detail components and tentative cost of each component e.g. if Labour Rooms are to be created - unit cost of the LR should be indicated, however if different components of LR are to be strengthened, then their tentative cost should be annexed.

Innovation

Upto a maximum of 10% of the health systems strengthening budget (Mission Flexipool and NUHM) may be proposed for innovations. Please note that this is part of the overall budget envelope.

The budget for innovation is to be proposed under B.14 for Mission Flexipool and budget head 7 for NUHM. Any activity already budgeted/approved under innovation would continue to be budgeted under these FMR codes and would be included in calculation of 10% innovation funds.

It is expected that the States would use the flexibility and budget to come up with innovative and sustainable solutions for state specific /local needs. The innovations/projects should ideally have a baseline and must be independently evaluated after 1 ½ - 2 years' of implementation.

The innovations budget **cannot** be utilised for:

1. Purchase of vehicles
2. Support/4th grade staff. Any HR required (service delivery/ Programme management) is to be budgeted under A.8 and A.10 respectively of NRHM & RMNCH+A Flexipool, and under appropriate budget heads of NUHM.
3. Any cost already budgeted /covered under some other budget head in NHM (No double budgeting)
4. Any activity already disapproved
5. Infrastructure exceeding 33% of budget under NHM

State must ensure that the activities are budgeted under correct budget heads and F.M.R codes. In case there is more than one F.M.R code with similar activity, a logical decision must be taken to budget the activity under the broad budget head which is closest to it and reflects the actual nature of the activity. Guidance may also be sought from the Director/Deputy or PIP process.

PIP Summary

States must provide a write up (not exceeding 5 pages) summing up the major problems in health (based on evidence with source) and the ways in which the PIP intends to tackle them in 2016-17. A part of the write-up should also explain how the State is planning to leverage the existing structures, systems and programs to establish new programmes and additional services. The State PIPs are expected to be contextual and tailor made for the particular state.

Budget Format:

There is no major change in the activities listed or the FMR in the budget sheet. However in line with the requirement of the department of Finance/Tribal Affairs, a few columns have been added and budgets for activities have to be further allocated/classified under Scheduled Caste sub plan, Scheduled Tribe Sub Plan and General sub plan.

Budget Envelope

As communicated vide letter no. 7 (139)/2015-NRHM I dated 16th November 2015, the NHM funding between the Centre and States would be in the ratio of 60:40 (for all states except NE and 3 Himalayan States), 60 from Central government and 40 from State.

It can be reasonably expected that there may be a 10% increase in the central budget over and above the budget given in 2015-16; Hence States are requested to estimate the resource envelope accordingly. FMG would communicate the resource envelope separately.

Queries on PIP /PIP Software

States may address any query on PIP to helpdeskpip2016@gmail.com

Timelines for PIP process 2016-17

PIP Guidelines to be issued by 9 December, 2015

PIP orientation for MoHFW officials and consultants: 1st December 2015

PIP orientation workshops in states 15st-25th Dec 2015

Last date of submission of PIP- 31st December 2015

Letter from Secretary Health for continued activities by 31st Jan 2016

PIP appraisal and iterations (if any) by MoHFW divisions- 1st Jan-15th February 2016

NPCC meetings -15th Feb-31st March

Issuing of RoP- 1st March-30th April 2015