CONDITIONALITIES AND INCENTIVES: IMPLEMENTATION FRAMEWORK

Conditionalities and incentives	Progress by the State	% incentive / disincentive	Method of verification	Compliance	Timeline	Responsible Officer
1. Rational deployment of HR with the highest priority accorded to high focus districts and delivery points/priority facilities (Non compliance would lead to reduction of up to 7 ½%).						
1.1 Policy criteria		**us**				
1.1.1 Rational deployment policy which would inter alia include: Posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections),rational deployment of specialists especially gynaecologists, anaesthetists, EmOC and LSAS trained doctors in teams, posting of trained HR as per the level of the facility e.g. LSAS and EmOC to be posted in the FRUs, and filling up of vacancies in high focus/remote areas on priority basis	In place by November, 2012	Otherwise, deduction of up to 2% of MFP	Policy notification (copy) and Website posting ; state report on compliance by November, 2012	**a)** For rational deployment of regular staff and posting of trained doctors proposal will be send to GOM. Once the policy is decided regarding posting of staff on the basis of case load, rational deployment of specialist and EMOC and LSAS trained doctors posting at FRU's copy of same policy will be posted on website. **b)** Regarding Contractual Staff -- 2nd ANM is posted at **6617** Sub-Centres. Circular is already issued on **31/03/12 and 31/08/12** date regarding shifting of 2nd ANM from non-delivery to delivery point.	Oct-12	a) Directorate of Health Services b) Asst Director (T)
1.2 Implementation criteria						
1.2.1 Preparation of baseline data for HR including the current place of posting and their productivity/caseload; system in place for updation.	As a minimum for all delivery points/ priority facilities and SCs in high focus districts; by Nov 2012	Otherwise, deduction of up to 2% of MFP.	Website posting and state report on compliance by November , 2012	List with base line data for HR of delivery points/priority facilities like IPHS facilities and SCs in High Focus Districts will be prepared and posted on website.	Oct-12	Joint Director (Technical)
1.2.2 Evidence of corrective action in line with the policy	90% of all delivery points/ priority facilities staffed in line with norms by Dec 2012; 90% of all SCs in high focus districts should have atleast one ANM	Otherwise, deduction of up to 2% and up to 1.5% of MFP respectively.	State report; website posting by December 2012.	**1)** As on today 90% of Sub-centers in High Focus Districts are having atleast one ANM in place. DATA is as follows. **Nandurbar**-290/272(regular)&183(contractual) **93.79%** **Gondia-** 238/236(regular)& 236(contractual) **99.15%** **Gadchiroli**-376/356(regular)& 319(contractual) **94.68 %** **2)**For other delivery points data will be uploaded by November 12	Dec-12	a) Joint Director (Technical) b) Asst. Director (Technical)

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2. Facility wise performance audit and corrective action based thereon. (Non compliance would lead to reduction of up to 7 ½% of MFP)						
2.1 Policy criteria						
2.1.1 Range of services (as in MNH guidelines for RCH services, OPD, IPD and other services to be determined by the State) specified at least for delivery points	By September, 2012	Up to 2½% of MFP	State report and Website posting by September, 2012	List of Delivery points and services provided as per norms will be uploaded on website	Sep-12	Joint Director (Technical)
2.2 Implementation criteria						
2.2.1 Facility wise reporting on HMIS portal by all priority facilities/delivery points for October(SC data if needed be uploaded from PHC)	By November, 2012	Up to 2½% of MFP	State report ; State HMIS : October data to be uploaded by November as a minimum		Octomber 12	Dr Pawar (ADHS MIS Cell)
2.2.2 Corrective action (priority to be given to high focus districts) based on facility wise reporting.	By December, 2012	Up to 2½% of MFP	State reports on corrective action by December, 2012. State visits			Dr Pawar (ADHS MIS Cell)
3. Gaps in implementation of JSSK (May lead to a reduction in outlay upto 10% of RCH base flexi-pool.)						
3.1 Policy criteria						
3.1.1 Government order for coverage of entire State regarding: • Free delivery (including C-section if required) • Free diet • Free treatment to sick new born upto 30 days • Grievance redressal system with specified timelines for redressal	By September, 2012	Upto 2½% of RCH base flexi-pool	Copy of GO ; Website posting	As per PHD-GR 26th Sept 2011, UDD letter dt: 7th January 2012 & DMER letter dt: 30th May 2011, all concerned are informed to provide free entitlements under JSSK A.O. of Health at district level is incharge of grievance cell.Specified Timeline for grievance redressal will be prepared and posted on website.		Program Officer (RCH) Dr Kokne
3.2 *Implementation criteria*						
3.2.1 State wide dissemination of GO/policy ; visible IEC in facilities and community awareness.	By October 2012	Up to 2½% of RCH base flexi-pool	Sample community visits show high awareness.	JSSK Display boards are put up at 8729 sub-centres, 1609 PHCs, 419 RH-SDH, 36 DH-WH which comes under PHD as per report received from IEC Bureau,Pune. Information about JSSK regarding Toll Free No. free entitlements is included in MCH cards under printing.		state program officer for (RCH) - Dr Kokne
3.2.2 No user charges for pregnant women and newborns. Drugs, diagnostics, diet should be available free. Grievance redressal system operational.	By October 2012	Upto 2½% of RCH base flexi-pool	Field visits; exit interviews or community level sample interviews ; grievance redressal records, MCTH feedback	As in 3.1.1		Program Officer (RCH) Dr Kokne
3.2.3 At least 50% of pregnant women and sick newborns coming in should be using assured and cashless means of transport- and getting a similar drop back home.	By November, 2012, assured referral transport system in place- both local tie-ups and dial 108/102 systems- as per approval in ROP	Upto 2½% of RCH base flexi-pool	-do-	By end of August 22% mothers are provided Home to Institution transport facility & 61 % provided drop back facilities who were admitted in institutions under PHD.		Program Officer (RCH) Dr Kokne

Conditionalities and incentives	Progress by the State	% incentive / disincentive	Method of verification	Compliance	Timeline	Responsible Officer
4. Continued support under NRHM for 2nd ANM would be contingent on improvement on ANC coverage and immunization as reflected in MCTS. Vaccines, logistics and other operational costs would also be calculable on the basis of MCTS data						
4.1 Increase in ANC coverage (first ANC and full ANC) as per MCTS data in (1) State (2) High Focus districts	Increase in April-December 2012 over the same period last year		MCTS website ; state report by January, 2013	1) State - ANC registration is 26.4%till August 2012 end for year 2012-13. This year performance is monitored against total target including urban area (corporation & council) as in the last year it was for rural area only. 2) High Focus Districts - ANC registration is 27.6%till August 2012 end for year 2012-13. 1)Training of District level Officers in rural as well as urban area. 2) Estabilshment of MCTS call centre 3) Provision of Computers in urban area as soon as possible 4) Real time data entry. 5) backlog of all services of mother should be entered first. 6) Data entry should be done after each ANC registration, after each ANC Clinic do will be entered each ANC registration. 7) After delivery status of mother should be entered in MCTS.		Program Officer (RCH) Dr Kamlapurkar
4.2 Increase in full immunization as per MCTS data in (1) State (2)High Focus districts	Increase in April-December 2012 over the same period last year		MCTS website ; state report by January, 2013	1) State - Children registration is 16.5%till August 2012 end for year 2012-13, This year performance is monitored against total target including urban area (corporation & council) as in the last year it was for rural area only. 2) High Focus Districts - Children registration is 18.8%till August 2012 end for year 2012-13. 1)Training of District level Officers in rural as well as urban area. 2) Estabilshment of MCTS call centre 3) Provision of Computers in urban area as soon as possible 4) Real time data entry. 5) backlog of all services of Children should be entered first. 6) Data entry should be done after each Immunization, 7) Entryf of each immunization given to child will be entered on second day after delivery birth of child should be registerd and further services should be given.		Program Officer (RCH) Dr Kamlapurkar
5. Responsiveness, transparency and accountability (incentive upto 8% of MFP).						

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5.1 Demonstrated initiatives including innovations for responsiveness in particular to local health needs e.g use of epidemiological data, active participation of public representatives in DHS / RKS meetings , etc.	Initiative / Innovation implemented and impact demonstrated; State to send brief report in line with format provided in Annex 1 by November, 2012. (3 best practices , preferably one in each of 3 areas)		State report (format in Annex 1) by November, 2012 ; state visits for rapid appraisal.			state program officer for RKS and DHS- Mr Bhalerao.
5.2 Demonstrated initiatives /innovations for transparency e.g. mandatory disclosures and other important information including HR posting to be displayed on State NRHM website, schedule of MMUs and RCH camps etc. to be disseminated among user groups in addition to these being displayed in the State NRHM websites etc.						state program officer for Website-Dr Tayade, state Program Officer (RCH) - DR S.J.Kulkarni , state program officer for MMU -MR Jadhav (Sr.Consultant)
5.3 Demonstrated initiatives /innovation for accountability: e.g. call centre for integrated grievance handling system, aggrieved party to receive sms with a grievance registered number; action taken within stipulated time; community monitoring; Jan sunwai etc.		Up to 8% of MFP				state program officer for grievance cell ,CBM - Mr Bhalerao.
6. Quality assurance (incentive upto 3% of MFP).						
6.1 Policy criteria						
6.1.1 States notify quality policy/strategy (align to national policy) as well as standards	In place by November 2012	Up to 3% of MFP	Notification and state report by November, 2012.			Dr Chitale IPHS WING
6.2 Implementation criteria						
6.2.1 Constitute dedicated teams. Training of state and district quality team and DH quality team completed.	State team trained by November 2012					
6.2.2 Current levels of quality measured for all “priority facilities” and scored and available on public domain. Deadlines for each facility to achieve quality standards declared.			Quality scores of all priority facilities available in public domain.			Dr Chitale IPHS WING
7. Inter-sectoral convergence (incentive upto 3% of MFP).						All Bureau Chiefs
7.1 Policy criteria						
7.1.1 Implementation frame work for intersectoral convergence with allied sectors/departments	By November 2012	Up to 1% of MFP	State report (copy of implementation framework)			
7.2 Implementation criteria						
7.2.1 Intersectoral convergence opportunities identified with WCD, PHED, education, etc. and action initiated.	By November 2012	Up to 2% of MFP	Government order , State report			
8. Recording of vital events including strengthening of civil registration of births and deaths (incentive upto 2% of MFP).						Dr Chavan (HIVS)
8.1 A strategy paper identifying reasons and the road map for increasing registration	By October 2012	Up to 1% of MFP	Strategy document and policy statement.			
8.2 Death reports with cause of death (especially any under 5 child or any woman in 15 to 49 age group) shared with district health team on monthly basis.	By November 2012	Up to 1% of MFP	Death reports received at district level- verified in sample of districts.			

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9. Creation of a public health cadre (by states which do not have it already) (incentive upto 10% of MFP)				Public Health Cadre is already established in Maharashtra		
9.1 Policy criteria						
9.1.1 Stated policy and road map (including career path on creation of a public health cadre)	Policy & road map in place by November , 2012	Up to 4% of MFP	State report (copy of policy); website posting by November , 2012			
9.2 Implementation criteria						
9.2.1 Notification for creation of public health cadre	Government order in place.	Up to 6% of MFP	Website posting / state report			
10. Policy and systems to provide free generic medicines to all in public health facilities(incentive upto 5% of MFP)						Jt Director (Procurement)
10.1 Policy criteria						
10.1.1 Clear policy articulation of free generic medicines to all in public health facilities	By October 2012	Upto 2% of MFP	Website posting / state report	GR dated 06 Sept 2011 and GR dated 30 April 2012 will be posted on website.	Sep-12	
10.2 Implementation criteria						
10.2.1 EDLs finalised and drug formulary published and made available in all public health facilities	By November 2012	Up to 3% of MFP	Notification/ Publication/ Web posting	ELD is prepared and will be posted on website.	Sep-12	
10.2.2. Overall procurement and logistics strategy in place. Detailed design and plan for rate contracting, regular stock up dates, indent management, warehousing, promotion of rational drug use, contingency funds with devolution of financial powers etc. in place.	By November 2012		State report/ strategy document			