JSI INDIA

# Review the mechanism of documentation, distribution, claim and verification of ASHA incentives

***Submitted to:***
Immunization Division,
Ministry of Health & Family Welfare,
Government of India, New Delhi

Review the Mechanism of Documentation, Distribution, Claim and Verification of

# Asha Incentives

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# List of Abbreviations

| | | |
|---|---|---|
| AAA | : | Accounts cum Administrative assistant |
| AEFI | : | Adverse Event Following Immunization |
| AF | : | ASHA Facilitator |
| AHS | : | Annual Health Survey |
| AMG | : | ASHA Mentoring Group |
| ANC | : | Ante Natal Care |
| ANM | : | Auxiliary Nurse Midwife |
| ANO | : | ASHA Nodal Officer |
| ARC | : | ASHA Resource Centre |
| ASHA | : | Accredited Social Health Activist |
| AWW | : | Anganwadi Worker |
| BAA | : | Block Account Assistant |
| BAC | : | Block ASHA Coordinator |
| BAM | : | Block Accounts Manager |
| BAO | : | Block Accounts Officer |
| BAF | : | Block ASHA Facilitator |
| BCM | : | Block Community Mobilizer |
| BCMO | : | Block Chief Medical Officer |
| BEE | : | Block Extension Educator |
| BF | : | Block Facilitator |
| BHA | : | Block Health Accountant |
| BHS | : | Block Health Supervisor |
| BHM | : | Block Health Manager |
| BMO | : | Block Medical Officer |
| BNO | : | Block Nodal Officer |
| BPM | : | Block Program Manager |
| CCH | : | Cold Chain Handler |
| CUG | : | Closed User Group |
| CHC | : | Community Health Centre |

| | | |
|---|---|---|
| CHW | : | Community Health Worker |
| CMO | : | Chief Medical officer |
| CMHO | : | Chief Medical Health Officer |
| CRM | : | Common Review Mission |
| CS | : | Civil Surgeon |
| DAC | : | District ASHA Coordinator |
| DAM | : | District Accounts Manager |
| DAPM | : | District ASHA Program Manager |
| DCM | : | District Community Mobilizer |
| DDO | : | District Development Officer |
| DEO | : | District Education Officer |
| DHS | : | District Health Society |
| DIO | : | District Immunization Officer |
| DLHS | : | District Level Household Survey |
| DM | : | District Magistrate |
| DNO | : | District Nodal Officer |
| DPM | : | District Program Manager |
| DPT | : | Diphtheria, Pertussis, Tetanus |
| FGD | : | Focus Group Discussion |
| FI | : | Field Investigators |
| GOI | : | Government of India |
| HBNC | : | Home Based Newborn Care |
| HMIS | : | Health Management Information System |
| HRH | : | Human Resource in Health |
| HW | : | Health Worker |
| ICDS | : | Integrated Child Development Services |
| IDI | : | In Depth Interview |
| IPV | : | Inactivated Polio Vaccine |
| LHV | : | Lady Health Visitor |
| MCP | : | Mother and Child Protection (Card) |
| MCTS | : | Maternal Child Tracking System |
| MD | : | Mission Director |
| MGCA | : | Mentoring Group for Community Action |
| MO | : | Medical Officer |
| MOIC | : | Medical Officer In-Charge |
| MPW | : | Multi-Purpose Worker |
| MR | : | Measles, Rubella |
| MSG | : | Mission Steering Group |
| NFHS | : | National Family Health Survey |
| NHM | : | National Health Mission |
| NO | : | Nodal Officer |
| NRHM | : | National Rural Health Mission |
| PFMS | : | Public Finance Management System |
| PHC | : | Primary Health Centre |
| PHN | : | Public Health Nurse |
| PIB | : | Performance Based Incentives |
| RI | : | Routine Immunization |
| RCHO | : | Reproductive & Child Health Officer |
| SAL | : | State ASHA Lead |
| SDAPM | : | Sub Divisional ASHA Program Manager |
| SCM | : | State Community Mobilizer |
| SNCU | : | Sick Newborn Care Unit |
| SDR | : | Service Delivery Register |
| SIHFW | : | State Institute of Health and Family Welfare |
| SIO | : | State Immunization Officer |
| SMO | : | Senior Medical Officer |
| SOPs | : | Standard Operating Procedures |
| SPM | : | State Program Manager |
| SPMU | : | State Program Management Unit |
| SPO | : | State Program Officer |
| SC | : | Sub Centre |
| THO | : | Taluka Health Officer |
| TMO | : | Taluka Medical Officer |
| UIP | : | Universal Immunization Program |
| VHSNC | : | Village Health Sanitation & Nutrition Committee |
| VPD | : | Vaccine Preventable Disease |
| WCD | : | Women and Child Development |

# Acknowledgment

JSI would like to express sincere thanks to the officers at the Ministry of Health & Family Welfare, Govt. of India for their constant support and guidance, with special thanks to Ms. Vandana Gurnani (Joint Secretary - RCH), Dr. Pradeep Haldar (Deputy Commissioner, Immunization), and Dr. M. K. Agarwal (Deputy Commissioner, UIP), for their continuous contribution in stimulating suggestions and mentorship in conducting the assessment.

JSI would also like to express thanks to Dr. Rajani R. Ved (Executive Director, National Health System Resource Centre) and her team for providing invaluable inputs that helped to design the study tools in accordance to the study objectives.

We extend our gratitude to Gavi, the Vaccine Alliance for awarding financial grant to JSI Research & Training Institute, Inc. for this technical assistance opportunity to India's Ministry of Health and Family Welfare (MoHFW), to further strengthen and build on the current technical support system in routine immunization.

JSI would also like to acknowledge the contribution of State, District and Block Immunization officers and other staff, who devoted their time and shared perspectives about processes and practices underlying payment of incentives to ASHA workers for their support to immunization services.

We also acknowledge the contribution of health workers in expressing honest views and discussing concerns/ queries related to immunization incentives with us. Their support is deeply appreciated and has a significant contribution in the report.

We would like to acknowledge with much appreciation the crucial role of Dr. Manish Jain, who has been instrumental in providing inputs at every step of the study. JSI acknowledges the efforts by IMS Health and Consulting Services, in designing the data collection tools, conducting the field-level assessment, in doing the preliminary analysis of the data collected, and drafting the initial report.

JSI is grateful to the experts, Dr. Vikas K Desai, Dr. Khirod Kumar Rout, and Mr. Anil Garg for their critical inputs for finalizing this report and developing standard operative procedures for optimization of ASHA incentives for maximizing gains in terms of increase in proportion of fully immunized children.



# Executive Summary

ASHA Programme under National Health Mission has marked a new chapter in India's experience with community level workers. ASHA workers support India's Universal Immunization Programme through mobilizing beneficiaries and generating awareness among the community about immunization services, and in return of these services get fixed performance based incentives. Evaluation surveys have shown improvement in the proportion of fully immunized children, with variations between states, but still the progress is slow with only two percent point improvement per year. Though, ASHA workers, a cadre of frontline functionaries belonging to the same communities get incentives based on the number of children who got fully immunized due to their efforts, but still the evaluated increase in proportion of fully immunized children does not match with amount of incentives paid.

Gavi, the Vaccine Alliance, funded JSI Research & Training Institute to carry out a review to understand the gaps in existing ASHA incentivization system, especially those for immunization services, and to provide technical support in developing standard operating procedures for reaping full benefit of immunization incentives.

To understand different processes related to disbursement of immunization incentive, field level review was conducted in 12 districts from 6 states of the country through in-depth interviews and focus group discussions with various stakeholders at state, district, and sub-district levels, including female health workers (ANM) and ASHA workers. The review also aimed to identify and document the operational challenges, gaps, and opportunities to guide development of standard operating procedures that can be recommended to Ministry of Health and Family Welfare, Government of India, for streamlining the ASHA incentivization process.

For this review, states and districts were identified based on scoring of immunization related indicators from reported HMIS data (2014-15 and 2015-16); as well as the most recent evaluation surveys (DLHS, AHS, NFHS) as applicable for different states. The field work was done by IMS Health & Consulting Services, an independent research agency with considerable experience in conducting similar health system related reviews in Indian states. Total 140 in-depth interviews were conducted with different

stakeholders, like, State Immunization Officers, District Immunization Officers, Medical Officers, and district and block program managers from National Health Mission. In addition, 80 Focus Group Discussions were conducted with groups of ANMs', ASHA Facilitators, and ASHA workers to meet the objectives of this review.

**Major findings, in terms of ongoing practices and processes, operational challenges and gaps as revealed from the review are as follows:**

- **Immunization status and reasons for variation between different areas:** respondents believed that in last few years immunization coverage has improved, and that ASHA workers have played a key role in achieving this. ASHA workers have been able to build confidence in the community regarding immunization services, and mobilize parents for immunization. The reasons for variation in coverage included inadequate reach in hard to reach areas, fear of side effects such as fever, vacancies of staff members at various levels, work overload on health care staff, and mismatch between target number and actual beneficiaries further compounded by unavailability of real head count data. Inefficiencies of some ASHA workers in fulfilling their responsibilities due to faulty selection process was also highlighted for variation in the immunization coverage.

- **Guidelines for ASHA incentivization, and current incentive structure:** The national ASHA incentive guidelines provide a roadmap for states to plan activities for support by ASHA workers along with the budget estimate to incentivize them. These guidelines are similar for all programmes supported by ASHA workers, including immunization. These national guidelines provide flexibility to states for inclusion of additional state-specific services that can be borne by the state budget. It was revealed that compliance with guidelines is uniform across the states with minor variations at some places. Immunization service related incentives were same across the review states as specified in the guidelines.

  Guidelines issued from the national level, or any revision, are adapted in different states in terms of language, and state specific policies and directives. In charge of health facilities and NHM contractual staff at various levels are responsible for sharing and compliance of guidelines and any revisions. The responsible staff positions vary widely within the states and districts, depending on the staff availability, staff structure, and position hierarchy.

  Dissemination of guidelines and instructions is usually done during the block level meetings, organized on a monthly or bi monthly basis. Awareness regarding the incentives and guidelines was mostly found uniform among various cadres of concerned staff members. Minor state and district level variations in understanding of guidelines were mainly due to variability in administrative and ASHA support structure in these states

- **ASHA support structure at various levels:** At national level, there is a "National ASHA Mentoring Group", which serve as a technical and advisory body for ASHA programme; and "NHM Steering Group", which is the highest policy making and steering institution constituted under National Health Mission. It was found that ASHA support structure exists in all states with institutional variations in different states. Support structures were also found functional at the district and block levels, Female Health Worker (ANM) and ASHA facilitators being the first line of support for ASHA workers.

  Coordination at the community level between ASHA worker, ANM and Anganwadi worker was revealed as a critical factor for achieving maximum efficiency in service delivery. During the review, specifically during discussion with frontline workers, it was revealed that there are some challenges with

respect to this inter-sectoral coordination; interpersonal issues being a major reason for this. It was further revealed that this coordination challenge is mainly due to respective line departments; MOHFW being that for ANM and ASHA, while DWCD for ICDS and Anganwadi workers.

- **Incentivization related processes:** The formats used by ASHA workers for preparing consolidated reports of activities done and claiming incentives were different in different states. Some states use a consolidated format for all programme areas, while others have separate claim formats for different programmes. For claiming incentives, step for verification and validation of claims submitted by ASHA workers was found to exist in all review states. In some states the claims are re-verified at the block level facility.

  Other underlying processes include consolidation of ASHA claims in computer worksheets, generation of ASHA wise payment advice, approval by facility in charge (or Drawing Disbursing Office), and finally release of incentives electronically to bank accounts of ASHA workers. Final approval of payment advice is generally done jointly by facility in charge and some other staff member nominated as joint signatory for financial approvals. Minor variations were observed in processes, mainly due to state wise difference in administrative structure, government policies, and the staff structure.

- **Grievance redressal mechanisms for ASHA:** national guidelines require every state to establish a grievance redressal mechanism for ASHA workers at all levels. It was found that some form of grievance redressal mechanism exists in all states, varying from helpline numbers to problem solving at the inter-personal level by the ANM and/or ASHA Facilitator. In some states grievance redressal committees have been constituted with representation from other related departments, like WCD and Panchayat. Monthly staff meetings were found to be a common platform for grievance redressal in all states.

**Major operational challenges revealed from the review included:**

- Year-round availability of funds for incentive payments to ASHA workers
- Complicated processes for claiming incentives with requirement of multiple documents and supporting vouchers
- Vacancies at staff positions responsible for incentive processing and release; or concerned staff given additional responsibilities
- Lack of standard operating procedures for ASHA claim and disbursement
- Lack of feedback sharing regarding delayed or partial payment with ASHA workers.

Based on the findings of the field review it was observed that there is need to strengthen ASHA incentive disbursement process at various levels. These include:

- Standardization of different steps involved in entire incentivization process
- Undertaking efforts required for ensuring year-round availability of funds for ASHA incentives
- Simplification of claim submission process by ASHA workers
- Establishing a mechanism to check and initiate corrective action for regular and timely payment of ASHA incentives.


# Background

The ASHA programme has marked a new chapter in India's experience with community health workers. Accredited Social Health Activist or ASHA workers, the cornerstone of the National Health Mission (NHM), act as an interface between the community and the government health system. An ASHA worker is a woman who is resident of the same community, selected by the community, trained and deployed by the health department, and who provide services in her own village to improve the health status of the community through generating awareness and facilitating people's access to health care services. In return she gets incentives for each service she delivers as per the fixed norms specified by national and state government.

After more than 10 years of inception of the ASHA programme since 2006, this cadre of voluntary frontline functionary has become an inherent part of the health system. They have repeatedly demonstrated their efficiency in bringing out visible improvement in awareness, and for mobilizing the community for seeking benefits of various government health schemes and services.

The immunization programme in India is one of the largest public health programmes in the world, targeting nearly 30 million pregnant women and 26 million infants, every year. For ASHA workers also, this is an important programme and they work towards achieving the target of getting all pregnant women and children under five years of age immunized, in a timely manner, with vaccine doses as per the national immunization schedule. Immunization services performed by ASHA workers include mobilization of due beneficiaries to immunization sessions, getting all infants fully immunized before one year of age, and ensuring administration of booster doses by the age of two years, for which they receive fixed incentives.

Table 1: Status of immunization coverage as per National Family Health Surveys (in percent)

| Proportion of children 12-23 months who | NFHS 1 (1992-93) | NFHS 2 (1998-99) | NFHS 3 (2005-06) | NFHS 4 (2015-16) |
|---|---|---|---|---|
| Fully immunized | 35.5 | 42.0 | 43.5 | 62.0 |
| Received BCG | 62.2 | 71.6 | 78.2 | 91.9 |
| Received three doses of polio vaccine | 53.6 | 62.8 | 78.2 | 72.8 |
| Received three doses of DPT vaccine | 51.7 | 55.1 | 55.3 | 78.4 |
| Received measles vaccine | 42.2 | 50.7 | 58.8 | 81.1 |

Proportion of full immunization coverage increased from 42 percent in 1998-99 (NFHS 2) to 43.5 percent by 2005-06 (NFHS3), merely a 1.5 percent increase in 7 years. This proportion increased to 62 percent by 2015-16 (NFHS 4). The period between 2006 to 2016 matches with the period when ASHA programme was implemented and established across the country. Still, an increase in proportion of fully immunized by 18.5 percent points during a period of 10 years, i.e. just less than 2 percent per year, is much less than what was expected after introduction of incentives to ASHA workers for promoting immunization services.

Due to the presence of ASHA workers at the grass root level it is expected that they can ensure reach of services to hard-to-reach areas, as well as the under-reached and unreached beneficiaries, thereby resulting in a significant increase in immunization coverage. But progress as revealed from evaluation surveys indicate that there have been some gaps and lacunae at the level of ASHA workers or ASHA programme management, which has limited their impact in achieving the expected coverage. These underlying gaps must be identified and addressed to maximize the gains achieved so far, and enhance the impact of ASHA workers for improving immunization coverage and maternal and child health outcomes.

Incentivizing ASHA workers for the services they deliver is a principal factor motivating them to work hard and ensure reach of services to each beneficiary in their catchment area. Published literature show that incentives are considered as a source of income by ASHA workers, bringing out a sense of financial independence, and play an empowering role for ASHAs'. (1) Some studies to understand performance and motivating factors behind ASHA workers have shown that incentives for ASHAs are inadequate, irregular, delayed, and partly paid, affecting their motivation and performance adversely. (2) Government of India's Common Review Missions (CRM) have also raised concern related to ASHA incentives with specific mention of huge backlog in ASHA payments, and partial or untimely payments in many states in India.

Empowering ASHA workers to effectively play multiple roles of community mobilizer, activist, and as the first point of contact for care at the community level is now the growing challenge of this programme. Much more is required to institutionalize and enable ASHA workers as a key resource. This requires enhanced focus on improving the quality and processes like selection, training, timely incentivization, and supportive supervision. Therefore, before considering steps required to further enhance performance of ASHAs it is important to explore relationship between performance and the incentives paid.

With this background, a field level review was planned and conducted in selected states and districts, though limited only to immunization services and related incentives, with the following specific objectives:

- Understand and review processes and practices underlying payment of incentives to ASHA for her support to immunization services (including documentation, claim, verification, consolidation, and disbursement).
- Identify operational challenges (gaps, opportunities, and systemic issues) in incentivizing ASHAs' for immunization services.
- Identify good practices and suggest ways to strengthen and streamline this incentive system for achieving maximum benefit in terms of increasing immunization coverage.

[1]*The mixed nature of incentives for community health workers: lessons from a qualitative study in two districts in India. Enisha Sarin, Sarah Smith Lunsford, Ankur Sooden, Sanjay Rai and Nigel Livesley. 38, s.l.: Frontiers in Public Health, March 2016, Vol. 4*

[2]*Improving the performance of Accredited Social Health Activists in India. Dholakia, Nirupam Bajpai and Ravindra H. s.l.: WORKING PAPERS SERIES, May 2011*



# Methodology

## Overview

The field level review was done using qualitative methodology through in-depth interviews with program managers and related stakeholders, and focus group discussions with the frontline functionaries (ANM and ASHA). The data was collected at various levels like, states, districts, blocks, and subcenters.

Progress of immunization programme is measured in terms of coverage achieved for individual vaccines, as well as by the proportion of fully immunized beneficiaries. There are defined performance indicators to measure these in the reported government health department data (Health Management Information System or HMIS portal). Different evaluation surveys (like District Level Household Survey, National Family Health Survey, and Annual Health Survey) also use specifically defined indicators to evaluate the performance of immunization programme.

The scoring criteria and final selection of states, districts and blocks was done in consultation with Immunization Division of Ministry of Health and Family Welfare, Government of India. Details of the steps followed for sampling of states, district, and blocks are given in this section.

## 1. Selection of states, districts and blocks

States (six), districts (two per state), and blocks (two per district) were selected using composite scoring method based on the reported and evaluated outcome indicators.

### 1.1 Composite scoring method for sampling

Reported and evaluated performance indicators vary widely between the states and districts. To address this appropriately and arrive at a representative sample, states, districts, and blocks were selected using composite scoring method. A mixed set of standard performance indicators were identified from reported and evaluated data sources for sampling.

## 1.2. Data sources used for sampling

Performance indicators from three sets of data were used to arrive at composite scores for selecting study areas. Two sets comprised of reported data from government health system, i.e. HMIS data for reporting years 2014-15 and 2015-16; and one set of most recent evaluated data.

There are three sources for evaluation survey data, viz. DLHS, AHS, and NFHS. DLHS and AHS surveys were not conducted in all states of the country. Most recent data from NHFS 4th round survey (2015-16) was also not available for all states at the time of planning for current review. Therefore, while compiling the evaluated data for scoring, the most recent and applicable survey was selected out of the three types of surveys specified above.

The categorization of states (and union territories) according to the most recent and available survey data at time of sampling is as follows:

- **NFHS 4 (2015-16):** Andaman & Nicobar Islands, Andhra Pradesh, Assam, Bihar, Goa, Haryana, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Puducherry, Sikkim, Tamil Nadu, Telangana, Tripura, Uttarakhand, and West Bengal
- **DLHS 4 (2012-13):** Arunachal Pradesh, Chandigarh, Delhi, Himachal Pradesh, Kerala, Mizoram, Nagaland, and Punjab
- **AHS 3 (2012-13):** Chattisgarh, Jharkhand, Odisha, Rajasthan, and Uttar Pradesh

Evaluation survey data was not available for 2 states (Gujarat, and Jammu & Kashmir) and 3 Union Territories (Dadar & Nagar Haveli, Daman & Diu, and Lakshadweep). These were therefore not included in the list of states (and union territories) for selection.

## 1.3. Indicators and scoring

Four immunization performance related indicators were identified from each of the reported and evaluated data sets for sampling. These indicators are also indirectly related to performance of ASHAs' in their respective areas (i.e. generating awareness and demand, and mobilization).

A. Health Management Information System (HMIS) - Reported
   a. Percent newborns given BCG to reported live births
   b. Percent infants (0-11 months) old who received measles
   c. Percent immunization sessions held to immunization sessions planned
   d. Percent immunization Sessions where ASHAs were present to sessions planned

B. District Level Household Survey (DLHS) - Based on card and recall
   a. Children aged 12-23 months who have received three doses of DPT vaccine
   b. Children aged 12-23 months who have received measles vaccine
   c. Children aged 12-23 months who are fully immunized
   d. Children who did not received any vaccination

C. Annual Health Survey (AHS) – Based on card and recall
   a. Children aged 12-23 months having Immunization Card (%)
   b. Children aged 12-23 months who have received 3 doses of DPT vaccine
   c. Children aged 12-23 months who are fully immunized
   d. Children who did not received any vaccination

D. National Family Health Survey (NFHS) – Based on card and recall
   a. Children aged 12-23 months fully immunized
   b. Children aged 12-23 months who have received three doses of DPT vaccine

c. Children aged 12-23 months who have received measles vaccine

d. Children aged 12-23 months who have received three doses of Hep B vaccine

For all these indicators (except one), specific range was fixed for calculation of scores (Refer table 2). One remaining indicator from DLHS data being an inverse or negative) indicator (i.e. children who did not received vaccination) was given different range for scoring (Refer table 3).

**Steps followed for selection of states are as follows:**

1. State wise data for the selected performance indicators, from applicable datasets, was populated in a worksheet.
2. Score calculated from the data ranges was populated in another column adjacent to each indicator.
3. Composite score for each state (and UT) was calculated as sum of four scores representing the selected indicators. This composite score was populated in the last column of the worksheet.
4. It was found that the range of composite score for all states (and UT) was in the range of 17 to 36. Therefore, as next step, based on the composite scores all states (and union territories) were categorized into 4 groups, each with difference of 5 points (refer table 4). These categories comprised of states with good, average, moderate, and poor performance.
5. Categorization of states in 4 categories showed that maximum numbers of states were in average and moderate performing categories. Therefore, three states from each of these two categories were selected for the field level review.

Table 2: Scoring for selection of states and districts

| Indicator Range (in %) | Performance | Score |
|---|---|---|
| <30 | Very Poor | 0 |
| >100 | Over reporting/very poor | 0 |
| 30 to 50 | Poor | 1 |
| >50 to 70 | Moderate | 2 |
| >70 to 90 | 42.2 | 50.7 |
| >90 to 100 | Good | 4 |

Table 3: Scoring for negative indicator in DLHS survey used for selection of states and districts

| Indicator Range (in %) | Performance | Score |
|---|---|---|
| 0-5 | Good | 4 |
| >5-10 | Moderate | 3 |
| >10-15 | Average | 2 |
| >15-20 | Poor | 1 |
| >20 | Very poor | 0 |

Table 4: Composite scores based on scoring for selection of states and districts

| Group No. | Score range | Performance | States falling in this range |
|---|---|---|---|
| 1 | 17-21 | Poor | 2 |
| 2 | 22-26 | Average | 14 |
| 3 | 27-31 | Moderate | 10 |
| 4 | 32-36 | Good | 5 |

While selecting the states consideration was given to the geographical variation within states and the operational feasibility for conducting the field-level review. The states selected and geographical location within the country is given in table 5.

## 1.4. Selection of districts

Similar approach as used for selection of states was also adopted for selection of districts within the selected states. For selecting districts, HMIS reported data (2015-16) was utilized. Reported data was used for selection of districts because evaluation survey data is not available for all districts. Performance indicators from reported data selected for scoring were as follows:

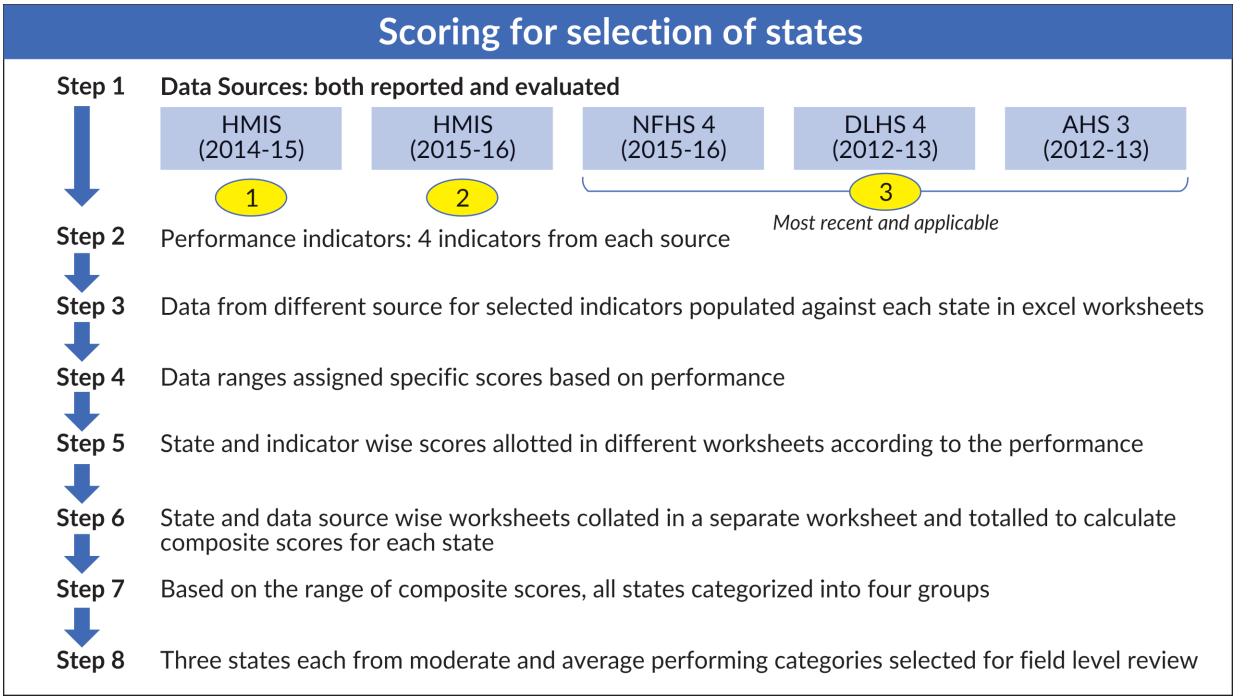
1. Percent infants 0 to 11 months who received Measles vaccine to reported live births
2. Percent children fully immunized
3. Percent immunization sessions held to immunization sessions planned
4. Percent immunization sessions where ASHAs were present to total sessions planned

State wise list of districts was prepared on separate worksheets. HMIS (2015-16) data for each performance indicator was populated in respective worksheets. Based on the range of each indicator, as used for selection of states, they were assigned specific scores (i.e. <30 & >100: "0"; 30-50: "1"; >50-70: "2"; >70-90: "3"; >90-100: "4"). District wise composite scores were calculated by totaling scores for all four indicators.

Table 5: **States selected for field level review**

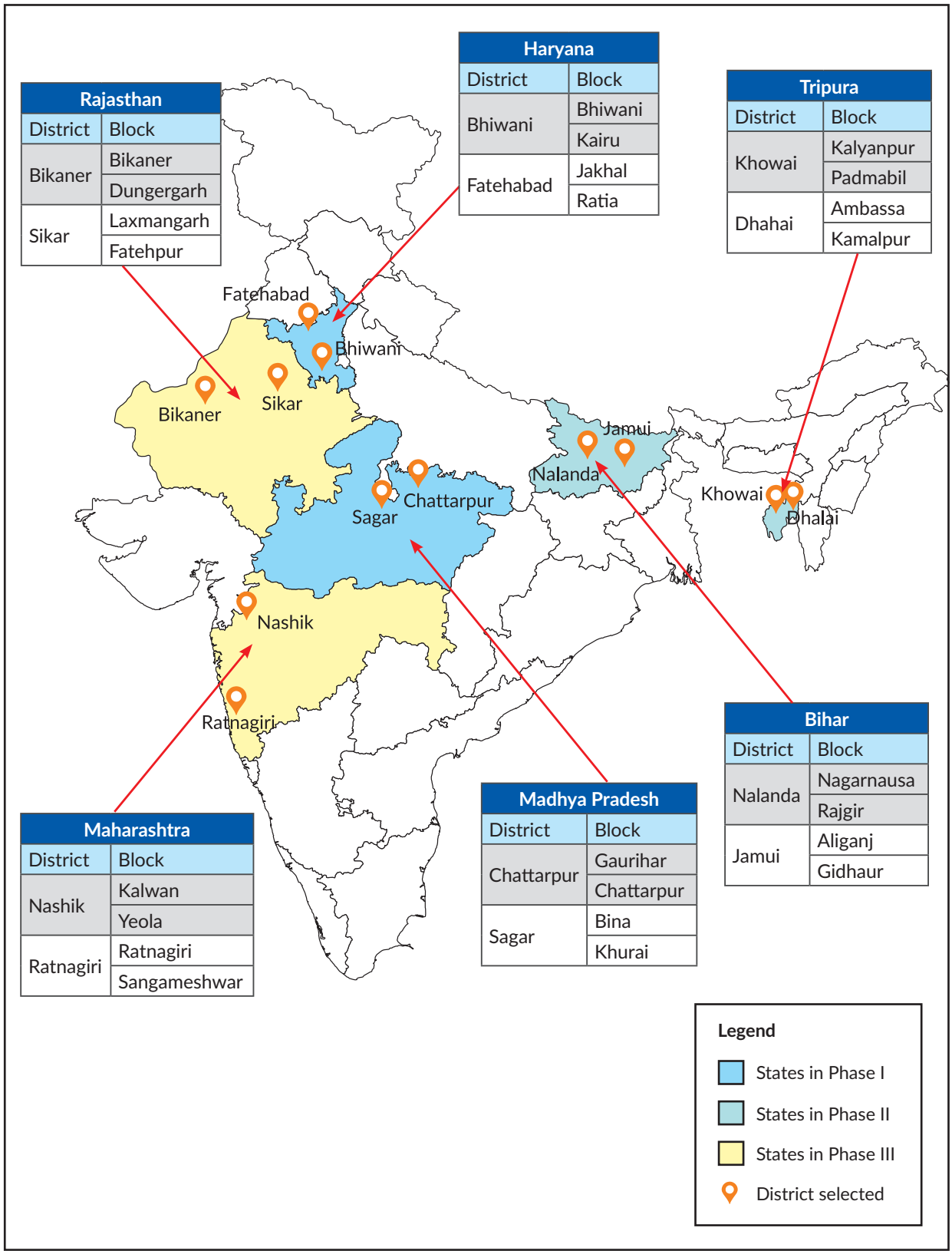
| S. No. | State | Category | Geographical location |
|---|---|---|---|
| 1 | Maharashtra | Average | West coastal |
| 2 | Bihar | Average | East coastal |
| 3 | Tripura | Average | North east |
| 4 | Madhya Pradesh | Moderate | Central |
| 5 | Haryana | Moderate | North |
| 6 | Rajasthan | Moderate | North west |

Figure 1: **Steps followed in scoring for selection of states**



Two districts with lowest composite score were selected for review in each of the 6 selected states. For districts in any state with same composite score, consideration was given to geographical variation and operational feasibility for conducting the field-level review.

Figure 2: States, districts and blocks selected for the field level review



### 1.5. Selection of blocks

Two blocks in each of the 12 selected districts were further sampled based on two performance indicators from HMIS reported data for year 2015-16. These indicators were taken as they indicate of immunization coverage status, and availability of ASHAs to mobilize children to the immunization sessions. These were:

a. Percent infants (0-11 months old) who received measles vaccine to reported live births

b. Percent dropout between BCG and measles vaccines

A mix of blocks was selected for review – few with very high dropout rate (due to poor follow up or compliance) and few with very high negative dropout rate (owing to reporting issues). Opinion of district level health officers was also sought before selecting blocks, to check availability of health staff for interviews and discussions, operational feasibility, and accessibility.

## 2. Development of interview schedules and discussion guides

Before developing study tools, a detailed review of existing government guidelines, orders, circulars, IEC/BCC material, published reports, and "Update on ASHA programme" (issued by MOHFW) was done to identify factors that must be included in the tools to make them comprehensive.

Four sets of data collection tools were developed for this review:

a. In-depth interview schedule for state/ district immunization officers, and block level medical officers

b. In-depth interview schedule for NHM staff (like state/district/block program managers, district/block account manager, and other staff involved in ASHA incentives)

c. Discussion guide for FGD with ANM groups

d. Discussion guide for FGD with ASHA groups

An Informed Consent format was also developed to facilitate introduction of organizers and investigators, explain objectives of the interview/discussion, and seek verbal consent of respondents before conducting interview/FGD.

The tools were finalized after review by Institutional Review Board (IRB) of JSI. To pre-test the tools, a pilot was done in one block health facility - CHC Mashobra (Shimla, Himachal Pradesh) through organizing interviews and group discussions to ensure:

- Completeness of tools for collecting requisite information
- Applicability in terms of uniform understanding about the queries by respondents.
- Effectiveness in eliciting the responses based on clear understanding about the question

After finalization of the tools, a one day orientation was organized for field investigators of the investigating agency to orient them on review design, sampling procedure, objectives of the review, and details about using the data collection tools.

## 3. Selection of stakeholders for interviews/discussions

During the review, information on processes

Table 6: **Stakeholders and number of interviews/discussions conducted**

| Level | Approach | Stakeholders | Number per state |
|---|---|---|---|
| State | IDI | SIO, SPM | 2 |
| District | IDI | DIO, DPM, DAM, DCM (or DAC) | 8 (4 per district) |
| Block | IDI | BMO, BPM, BAM, BCM (or BAC) | 16 (4 per block or 8 per district) |
| Block | FGD | ANM and ASHA Supervisor groups | 8 (2 per block or 4 per district) |
| Subcenter | FGD | ASHA groups | 4 (1 per block or 2 per district) |

underlying incentivization of ASHA workers, especially for immunization, was collected at various levels and from different cadres of the health department. Effort was made to interview all stakeholders who are involved in any ASHA incentivization related process.

Levels, cadres of stakeholders, and interviews/ discussions conducted are given in table 6.

The field review was conducted in 3 phases. During first phase Haryana and Madhya Pradesh, in second phase Bihar and Tripura, and in third and last stage Maharashtra and Rajasthan were covered (Refer table 7 and Figure 3 for periods of review and details of interviews/discussions)

Before interviews, all respondents were informed about the purpose of the review, and a verbal consent was taken before proceeding. Recording of the conversation and taking photographs was also done only after the consent from respondents. For selection of FGD participants, pre-decided inclusion and exclusion criteria was followed to ensure quality of information revealed (Refer table 8).

Table 7: **Period of field level review and districts/blocks covered**

| Phase | States covered | Period of review | Districts covered | Blocks covered | Interviews conducted | FGD conducted |
|---|---|---|---|---|---|---|
| I | Madhya Pradesh, Haryana | Jan 2017 | 4 | 8 | 40 | 32 |
| II | Tripura, Bihar | Feb 2017 | 4 | 8 | 52 | 24 |
| III | Rajasthan, Maharashtra | Feb-Mar '17 | 4 | 8 | 48 | 24 |
| | | **Total** | **12** | **24** | **140** | **80** |

Table 8: **Inclusion and exclusion criteria for selection of ASHA and ANM for FGD**

| Stakeholder group | Inclusion criteria | Exclusion criteria |
|---|---|---|
| ANM | Posted at subcenters | Those in supervisory role (e.g. LHV, matron etc.) |
| | Involved in implementation of immunization programme | Not in charge of sub center (posted at the CHC/PHC) |
| Discussion in a group of 7-8 ANMs at the block level facility. | At least 5 years of working experience in immunization (excluding any training period) | Newly recruited (<5 years) |
| | Agreement or recommendation of facility in-charge. | |
| ASHA | Married and daughter in law of the village where posted | Those working as ASHA supervisor |
| Discussion in a group of 7-8 ASHAs preferably in the subcenter village. | Involved in immunization programme (receive incentives) for at least last 2 years | Newly recruited or those who have not received immunization incentives |
| | Agreement or recommendation of facility in-charge. | Those who do not reside in the villages they are posted |
| ASHA Facilitator | Involved in immunization programme for at least 5 years (excluding any training period) | Newly recruited, having less than five years of experience of immunization programme. |
| Discussion in a group of 7-8 ASHA Facilitators at the block level facility. | They are from different sectors of the block facility catchment area | |
| | Agreement or recommendation of facility in-charge. | |

Variation was observed in terms of staff cadres responsible for ASHA incentivization related processes. Cadres had different designations in different states, and sometimes this was also variable in different districts within the states. To address such situations, open communication was maintained between the national office and the investigating team, and appropriate flexibility was provided to ensure that any important stakeholder does not get missed.

## 4. Data collection

Interviews and discussions were conducted by trained teams of investigators, each team comprising of two investigators - one interviewer and one note taker. The state level interviews were conducted by senior team members from the investigating agency. In regional language speaking states (i.e. Tripura and Maharashtra), it was ensured that one of the investigating team members could speak and understand local language.

The teams deployed to selected districts coordinated with district and block level officers from health department to plan and conduct interviews/discussions with relevant stakeholders. Respective teams also prepared interview/discussion transcripts for analysis.

During the review a total of 140 in-depth interviews were conducted, comprising of 12 state level, 44 district level, and 84 block level interviews. Total 80 focus group discussions were done at the block/sub-center levels with 32 ANM groups, 32 ASHA groups and 16 ASHA Facilitator/Supervisor groups in the selected districts.

Quality Assurance: To ensure completeness and quality of the field review, as well as of the information collected through interviews and discussions, following steps were taken:

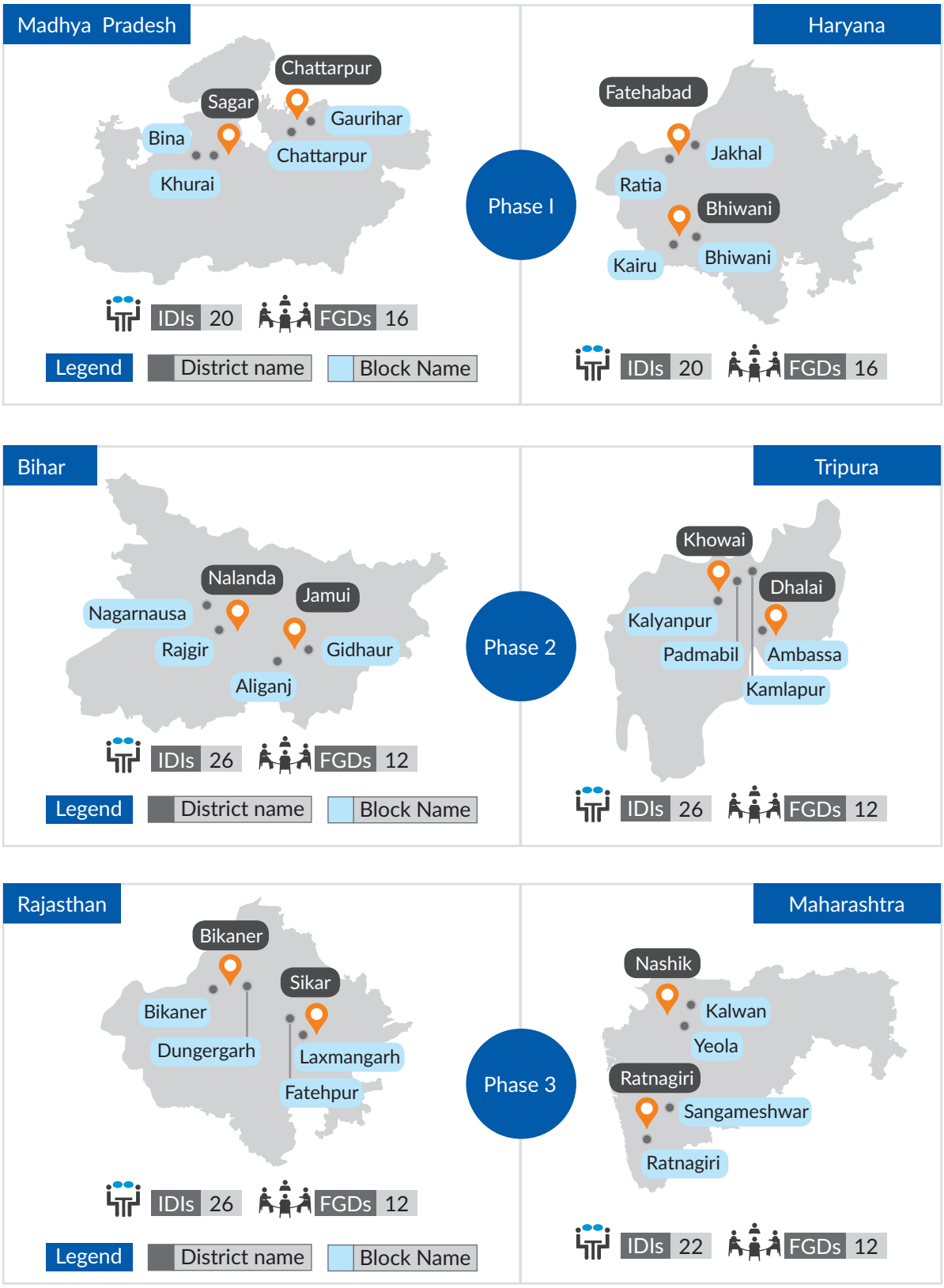
- The senior team members visited selected districts, blocks and facilities, to participate in the interviews/discussions.
- Regular updates were shared with national team, and field investigators, through mobile based social media group. Accordingly, computer based tracker was updated on regular basis.
- Field investigators were contacted via telephone periodically to understand major observations, progress made, and challenges faced.
- National team reviewed transcripts as well as the audio recordings (of FGDs) to ensure completeness of the information.

## 5. Data analysis

Analysis of the observations was based on review and coding of the interview/discussion transcripts. Before coding, the analysis team at the national level scrutinized all transcripts (and audio recordings) for completeness, correctness and content relevance; and were revised where they lack clarity.

For analysis, transcripts were reviewed to identify the emerging themes. The findings were organized as narrative of common processes, along with details of any deviants observed in any state, district or block. To facilitate analysis and thematic grouping, a qualitative data analysis and research software, Atlas-ti (version 7) was used. This software enables cross comparisons between different themes and sub-themes.

Figure 3: Phase wise state, districts, and blocks covered





# Salient Findings

Under India's Universal Immunization Programme, incentives are given to ASHA workers for immunization services. These services include identification and mobilization of due beneficiaries to session sites, and to ensure that all beneficiaries are fully and completely immunized by one year and 2 years of age respectively. These incentives are given to ASHA workers across all states and districts of the country for nearly last ten years.

Despite this large investment in a cadre of voluntary workers belonging to the same community, the proportion of fully immunized children has only marginally increased. This indicates that in order to meet the expectations in terms of fully immunized children, the mechanism and procedures related to incentivization of ASHA workers should be reviewed and strengthened.

The present section of the report narrates the findings emerged from discussion with different stakeholders who are part of ASHA support structure, and who are involved in incentivizing ASHA. This also include findings revealed from ASHA workers regarding the support they provide to the immunization programme, processes they follow to get incentives, and challenges they face in claiming and receiving the incentives.

## 1. Current immunization status and reasons for variation in coverage

Respondents were asked about their opinion regarding status of immunization coverage in their areas, and reasons for variation in coverages, if any.

Stakeholders at all levels, including the frontline workers believed that immunization coverage has improved in last few years, though there are variations in coverage of different antigens and proportion of fully immunized infants in different areas.

> "There are many factors which have contributed to better performance of UIP programme"
> SIO, Bihar

The reasons for improvement in immunization coverage were attributed to several factors ranging from improved coordination and supervision to improved planning and management at various levels.

Support of ASHA workers was revealed as an important factor for improvement in coverage in last few years. It was told that earlier there was a lack of awareness regarding importance of vaccination in the community, but now home visits by ASHA workers has helped in sensitizing parents about immunization programme. ASHAs being from the same community, have developed trust among people and this has contributed to increase in demand for immunization services.

The most common reasons cited for variations in coverages were - hard to reach areas, distance and locations of immunization sessions, migration, fear of fever, and vaccine hesitancy among a limited group of parents. Program managers cited reasons like lack of staff, vacancy for extended periods, and work overburden on health workers. District level program managers mentioned about mismatch between target beneficiaries allocated to district/blocks from the state level and actual number of beneficiaries in the community as a likely reason for variation in coverage. Besides this, the limited capacity and efficiency of certain ASHA workers, due to gaps in selection process, was also stated as reason for inferior performance in certain areas.

> "Lack of availability of ASHA and ANM's in health system has also affected immunization coverage limiting the reach especially to the scattered population..."
>
> NHM Staff, Rajasthan

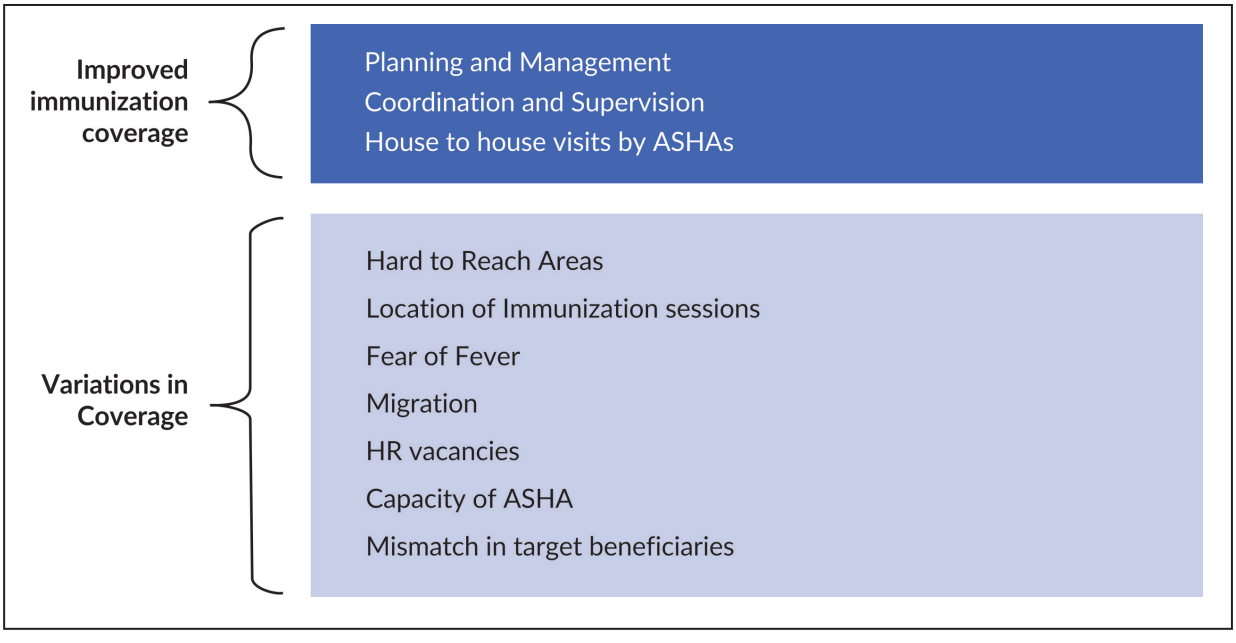
## 2. Guidelines for ASHA incentivization, and current incentive structure

ASHA is an honorary volunteer who is compensated for her time dedicated to delivery of services under national health programmes. ASHA workers are compensated for their time in the following situations:

i. For the duration of their training (both travel and dearness allowance)

ii. For participating in the monthly/bi-monthly meetings, other than for travel and refreshments at the meeting site.

iii. For undertaking specific measurable tasks related to health and other social sector programmes.



**Examples of state specific non-monetary incentives to ASHA workers**

- Benefit scheme in which ASHA workers are paid a matching amount of incentive that she earns during a year (Meghalaya)
- 'ASHA Kiran' scheme to provide medical benefits up to Rs. 25,000/- per calendar year, and insurance of Rs. 1 lakh in case of normal or accidental deaths (Assam)
- Fixed amount of Rs. 1300 INR to ASHA every month (West Bengal)
- Fixed amount of Rs. 3000 to ASHA every month (Sikkim)
- Radio program dedicated to ASHA (Nagaland)
- Posting success stories of ASHAs on state's health portal, accessible to public (Tripura)
- Innovative scheme to build knowledge of ASHA workers ('Mobile Kunji') and supporting enhancement of education level through National Open School (Bihar)
- Career opportunity to Mitanin by reservation in ANM schools, insurance benefits, and scholarships for ASHA children (Chattisgarh)

In addition to incentives offered under various national health programmes, ASHA workers are also eligible to have income from social marketing of certain health care products. States may also consider other non-monetary form of incentives like, group recognition/awards, cycles, ID cards, social security, exposure visits, annual conventions, etc.

The updated guidelines for ASHA incentives released by MOHFW, GOI in 2016 (3), have been built on the original guidelines (2006) and various supplementary orders issued between 2006 and 2012. These guidelines provide a roadmap to the states to plan additional activities to be supported by ASHA workers, and allocate budget for ASHA incentives for these activities from the state budget.

## 2.1 Incentives under immunization programme

Under Universal Immunization Programme, ASHA workers are eligible to claim incentives for 3 services, viz. mobilization of children, full immunization of children by one year of age, and complete immunization of children by two years of age. In addition, they also get incentives for mobilizing children for OPV under pulse polio programme (refer table 9).

National guidelines provide guidance and flexibility to states to add more incentives that can be borne by the state budget, but four activities as mentioned in table 9 have been marked as critical components of immunization incentive package that will have to be followed

Table 9: **Immunization incentives for ASHA workers**

| S. No | Immunization Activities | Incentives (INR) |
|---|---|---|
| 1 | Social mobilization of children for immunization during VHND[4] | 150 per session |
| 2 | Full immunization for a child under one year | 100 per child |
| 3 | Complete immunization per child up to two years of age | 50 per child |
| 4 | Mobilizing children for OPV under pulse polio Programme | 100 per day |

[3]*Update on ASHA programme, MOHFW, Govt. of India, 2016*

[4]*This has been revised as per the recent guidelines and included in section of routine activities*

by the states. This implies that though states may increase incentives for these activities, but in no condition, they can reduce this amount or divert it to other activity.

According to revised guidelines (2016) ASHA workers will now receive a fixed amount of Rs. 1000 per month for undertaking five routine activities, which overlap some activities related to immunization programme. These activities are:

- Line listing of households at the beginning of year, updated every 6 months
- Maintaining village health registers and supporting universal birth and death registers
- Preparing due list of children to be immunized, updated every month
- Preparing list of ANC beneficiaries, updated every month
- Preparing list of eligible couples, updated every month

Here, line listing of households and preparation of due list of children to be immunized are crucial in the context of immunization.

Figure 4: **Thematic area wise activities for which ASHA receive incentives**

**Meternal Health**

- JSY Financial package
- Reporting Death of woman (15-49) years age group) by ASHA to Block PHC Medical Officer

**Child Health**

- Undertaking six (in case of institutional deliveries) and seven (for home deliveries) home- visits for the care of the new born and postpartum mother

**Immunization**

- Social mobilisations of children for immunization during VHND
- Full immunization for a child under one year
- Complete immunization per child up to two years age (all vaccination received between 1st and second year age after completing full immunization after one year
- Mobilizing children for OPV immunization under Pulse polio Programme

**Family Planning**

- Ensuring spacing of 2 years after marriage
- Ensuring spacing of 3 years after birth of 1st child
- Ensuring a Couple to opt for permanent limiting method after 2 Children
- Counseling, motivating and follow up of the cases for Tubectomy
- Counseling, motivating and follow up of the cases for Vasectomy/NSV
- Social marketing of contraceptives- as home delivery through ASHAs

**Adolescent Health**

- Distributing sanitary napkins to adolescent girls
- Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene

**Nirmal Gram Panchayat Program**

- Motivating households to construct and use a toilet

**Village Health Sanitation and Nutrition Committee**

- Facilitating monthly meetings of VHSNC followed by meeting with woman and adolescent girls

**Revised National Tuberculosis Program**

- Being DOTS provider (only after completion of treatment or cure)

**National Leprosy Eradication Program**

- Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy
- Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy

**National Vector Borne Disease Control Program**

- Preparing bloods slides
- Providing complete treatment for RDT positive pf cases
- Providing complete radical treatment to positive Pf and Pv case detected by blood slides, as per drug regimen

## 2.2 Findings from the review

### 2.2.1 Incentive structure in states

In all states reviewed, payment of immunization incentives was found to be in line with the national guidelines, and is being implemented uniformly across the districts and blocks. All states are paying incentives to ASHA workers for the four immunization specific support activities.

When enquiries were made about any changes to the guidelines in recent years, it was told that though the guidelines are revised every year, there has been no change in immunization incentive package. The revised guidelines are mainly for programs like Home Based Newborn Care (HBNC) and Sick Newborn Care Unit (SNCU).

Apart from the above mentioned national guidelines, the review revealed certain state level variations in immunization incentive schemes for the ASHA as follows:

#### Haryana

- Additional 50% of incentives are earned as bonus, paid from the state budget, when total incentives earned for a month are more than INR 500.
- In cases, when total incentive earned by any ASHA is less than INR 500 for three consecutive months, then fixed amount (INR 500) is also not paid to them.
- Incentive for social mobilization is equally distributed among all ASHA workers present at the immunization site.

#### Tripura

- ASHA workers get additional 33.3% bonus of total incentives earned by them in a month.
- Incentive for social mobilization for any session the amount is distributed equally between the ASHA and the Anganwadi Workers.

#### Bihar

- If at any immunization session, the day's coverage is below 70% against the expected number of beneficiaries (i.e. against the due list), then ASHA worker of that respective area will not be paid for social mobilization.
- If coverage is between 70 and 80 percent then they are paid INR 100 (instead of INR 150). If coverage is between 80 and 90 percent they are paid full amount of INR 150; and if coverage is more than 90% the ASHA worker will get an incentive of INR 200, i.e. additional INR 50 as bonus.
- ASHA worker is also not paid social mobilization incentive if total turn out at any session for immunization is less than 10.

#### Rajasthan

- Although the state guidelines specify that ASHA workers will be paid an incentive of INR 200 for social mobilization, it was found during the review that they are only paid INR 150 as per the national guidelines.

#### Maharashtra

- Incentive for social mobilization for any session the amount is distributed equally between the ASHA and the Anganwadi Workers.

### 2.2.2 Awareness regarding the immunization incentives

All stakeholders interviewed were aware about the immunization relative incentives paid to ASHAs, with few minor deviations in knowledge about amount of incentives that are paid. These variations were mainly due to variations in administrative and ASHA support structure in those states.

For example, in Tripura, the State ASHA Program Manager is responsible for ASHA incentivization, therefore, State Program Manager (SPM) was not fully aware of incentives and if there has been any revision in guidelines recently. Similarly, District Account Manager (DAM) of Bikaner district in Rajasthan was not clear if ASHA workers are paid any incentive for conducting head count survey. One Block Account Manager (BAM) of same district and one ASHA Facilitator of Jamui district

in Bihar were not aware of incentive being paid for preparing due lists.

An important finding was the understanding of the definition of fully immunized child (an activity for incentivizing ASHA) among some block level stakeholders. In this regard, it was revealed that some of them have not been informed about criteria for a fully immunized child. While in some other cases it was found that respondents were not aware of any change in definition after introduction of new vaccines in the recent years.

Except for above few cases, understanding regarding the ASHA incentives for immunization services among all stakeholders was found to be correct. This indicates proper dissemination and compliance of national guidelines up to the grass root level.

### 2.2.3 Dissemination and orientation on guidelines

During the review, discussion was done on the process being followed in different states for dissemination of incentive related guidelines, and for orientation of ASHA workers on maintaining their documentation, and preparing claims according to the revised guidelines.

It was revealed that whenever there is any change in the national (or state) guidelines regarding ASHA incentives (also applies to non-incentive related guidelines) instructions are sent electronically as well as in hard copies to the state level program managers (for example, Mission Director (NHM) in majority of states). At state level, the guidelines are adapted in regional languages, according to state policies and directives, and appended with revised templates or reporting formats, and shared further with the districts (and blocks).

State and district level stakeholders told that specific staff positions are responsible at each level for ensuring that revised guidelines are shared and complied. These cadres/positions vary widely within the states, based on the staff availability, staff structure, position hierarchy, and accountability of the concerned. Different cadres involved in six review states are specified in table 10.

Variations were observed at the district and block levels when asked about the persons responsible for sharing guidelines. These variations were mainly due to vacant positions, when next position in hierarchy takes the responsibility. For example, in Khowai district of Tripura, ANO or BNO are primarily responsible for sharing guidelines. In case both are not available then AAA takes over the responsibility. However, in Dhalai district of Tripura, Sub-Divisional ASHA Program Managers are responsible for the same activity. At the subcentre level, ANM is responsible for informing ASHAs' regarding any change in guidelines. In states where cadre of ASHA Facilitators has been placed, they inform ASHAs about the guidelines in their respective areas, and also provide support in preparing and maintaining records/reports accordingly.

Table 10: **Health staff (cadres) responsible for sharing updated guidelines at various levels**

| State | State Level | District Level | Block Level | PHC | Sub Centre |
|---|---|---|---|---|---|
| Bihar | SIO, SPM | DPM, DAM, DDA | BMO | | ANM, ASHA Facilitator |
| Madhya Pradesh | SIO, SPM | DPM, DAM, DIO | BMO | | ANM, ASHA Facilitator |
| Maharashtra | SPM | DIO | BAO, THO, TMO | BAF | ANM |
| Rajasthan | SPM | DAM, DPM, DAC | BCMO, BPM, BHS | ASHA Facilitator | ANM, ASHA Facilitator |
| Tripura | SAPM | DIO, DAPM | ANO, BNO, AAA, SDAPM | MOIC, AAA | ANM, ASHA Facilitator |
| Haryana | SPM, SIO | DAC | | BAC, MO | ANM, ASHA Facilitator |

Platform or means by which the guidelines are shared or disseminated vary between states, ranging from using monthly/bi-monthly meetings, electronically through e-mails, and recently by use of mobile and social media (like WhatsApp) through which scanned copies of instructions or simple messages are sent to a group of stakeholders (like ANM or ASHA). Mix of methods are also used in some states as described below.

### Bihar

- Guidelines are shared through email, social media (WhatsApp), as well as during the monthly meetings
- Guidelines and other issues are published in their monthly periodical "Priya Behan ASHA".

> "No training is required, it is a simple format that is already being followed. We have just compiled it and put it in a diary. Above all ASHA get continuous support from block facilitators and ANM"
>
> SPM, Maharashtra

### Madhya Pradesh

- Guidelines are disseminated both through e-mails and hard copies in monthly meetings.

### Tripura

- Guidelines with the covering letter from state authority are shared both in hard copies and soft copies (e mail).
- Flex banners in Bengali and tribal languages are displayed to share guidelines with ASHAs.

Some respondents said that sharing electronically and by social media are fast means and have wide dissemination as compared to sharing of hard copies during the meetings, which are conducted only once (or twice) in a month.

### 2.2.4 Orientation of ASHA workers on guidelines

The staff members mentioned above who are responsible for sharing the guidelines, along with other staff, like, ANMs, supervisors, etc. are involved in the orientation of ASHA workers on - updated guidelines, use of reporting formats/ templates, and supporting documents that need to be submitted for claiming the incentive. ANMs, supervisors, and other concerned staff members are oriented separately during their weekly meetings, which are usually conducted before organizing orientation of ASHA workers.

Newly recruited ASHAs are oriented on incentive structure, reporting formats etc. during their induction training. Besides this, ANMs and ASHA Facilitators/Supervisors provide handholding as and when required. Orientation of recruited ASHA workers was generally found to be done during a session in the monthly ASHA meetings organized at the block level facility or PHC (sector level facility, in some states). It was told that besides these meetings, there is no other alternative for organizing dedicated trainings for all ASHAs (or in batches) on revised guidelines. As an exception, in Tripura, ASHA workers are oriented on guidelines during the district level meetings.

Many respondents believed that since there has been no change in guidelines recently (last change in incentive related guidelines was done in 2014), these monthly meetings for ASHA workers are mainly done for reviewing their activities, addressing their concerns related to the incentive payment, and their grievances.

## 3. ASHA support structures at national and state levels

### 3.1 Institutional mechanisms at various levels

To ensure success of the ASHA programme and provide ongoing support to ASHA workers, MOHFW, GOI has constituted National ASHA Mentoring Group (NAMG) in July 2015. This group consist of representatives from leading Non-Government Organizations (NGO), and experts from the community health. The group provides technical guidance and policy inputs, undertakes

Table 11: Suggested support structure for ASHA programme

| Level | Support structure |
|---|---|
| National | National ASHA Mentoring Group |
| State | State Mentoring Group in line with NAMG comprising of experts from community health, NGOs, training and research institutions, academia and medical colleges |
| | State Management Team, within SPMU, with one Nodal Officer and ASHA Programme Manager |
| | State ASHA and Community Processes Resource Center, either outsourced or placed within State Health System Resource Center (SHSRC), and comprising of a team of Team Leader, Programme Managers and consultants |
| | State Training Team |
| District | District Coordination Committee for ASHA and Community Processes, to function under strategic guidance and leadership of District Health Society, and convened by District Nodal Officer/Chief Medical Health Officer, with one District Community Mobilizer |
| | District ASHA and Community Processes Team, having a team of District Community Mobilizer, District Data Assistant, and all Block Community Mobilizers |
| | District Training Team |
| Block | Block ASHA and Community Processes Team, comprising of Block Medical Officer/Block Nodal Officer, Block Community Mobilizer, and all ASHA Facilitators |
| Subcentre | One ASHA Facilitator for a cluster of 20 ASHA (10 in specific situations) |

supportive supervision visits to states to identify constraints, and give feedback and strategic recommendations to the health ministry. It also facilitates scale up of ASHA trainings, conduct evaluations, identify emerging priorities and plan future goals. On the recommendation of this National ASHA Mentoring Group, the NHM Mission Steering Group takes policy decisions, which includes need-based revision or addition of incentives, and other programmatic decisions.

The national guidelines on community processes (2013) have elaborately documented requirement to establish similar ASHA support structures at state level and below. The suggestive guidelines for this support structure can be adapted by states in accordance to their context and requirement. The suggested structures for supporting ASHA programme are given in Table 11.

Cadre of ASHA Facilitators is a supervisory cadre selected from among experienced ASHA workers, and they provide need based support to ASHA workers, along with day to day support to ANMs' and AWW.

Main roles and responsibilities of ASHA Facilitators include supporting the trainings of ASHA workers at the block level; provide supportive supervision and hand-holding to ASHA workers for improving their performance; conduct home visits to provide child specific support; co-facilitate VHSNC and other community level meetings; monitor performance of ASHA workers in respective catchments areas; participate and co-facilitate monthly meetings with ANM, ASHA, BMO and LHV; and address grievances of ASHA workers.

## 3.2 Grievance Redressal Mechanism

According to the national guidelines, a grievance redressal mechanism for ASHA workers is essential in every district as recourse for issues related to payments, lack of support and coordination, supplies and drug kits, record keeping, referral support, hospital services, and even gender related issues.

These committees are to be constituted under notification of District Health Society, chaired by District Collector and Chief Medical & Health Officer (CMHO), and comprising of five members - two NGO representatives, two government representatives from WCD, ICDS, Education, Rural Development, and/or PRI, and one nominee of the CMHO. It is also required that at least three members of the committee are women. The committee must meet once a month to review the grievances and take actions.

**Guidelines also specify that:**

- All ASHA workers in respective districts should be aware of the existence of the Grievance Redressal Committee, along with its landline number of PO box number.
- Complaints can be initiated telephonically, but they must also be submitted in writing for which a signed receipt should be issued.
- The committee should write to the concerned department/officer, who is then required to take appropriate action and reply within 21 days to the complainant.
- Written documentation of the name, date of receipt of grievance, specific complaint and the action taken report should be maintained.

ASHA facilitators have also been made responsible to hear grievances and act immediately, if possible, or else consult higher authorities. In case an ASHA is not satisfied on action taken against her complaint, she can appeal to the Chairperson of the District Health Society or the Mission Director of State Health Society.

## 3.3 Findings from the review

The national guidelines have provided flexibility to the states to evolve their own ASHA support structure, ensuring that there are support mechanisms and accountable positions at all the levels. During review, stakeholders were asked about the existence and functionality of ASHA support structures and mechanisms. It was revealed that ASHA support structure existed in all the six states, with some variations where the states have adapted it to their own needs.

Assessment of the exact structure, in terms of various positions, the team structure, and its terms of reference was not an objective of the current review, rather it was only to understand if some functional mechanism exist that can be approached by ASHA workers in case of any incentive related issues.

State level variations revealed are as follows:

### Bihar

- In line with the national guidelines, state has established a state level ASHA mentoring group (AMG) and an ASHA Resource Center (ARC). DCM, DDA and Regional ASHA coordinator are posted at the district level, Block Community Mobilizer at the block level, and ASHA facilitators at sub-block level.

### Haryana

- State has functional support structure at all the levels with ARC at state level, District and Block ASHA Coordinators (DAC and BAC) at district and block level respectively, and ASHA facilitators at the PHC level.

### Madhya Pradesh

- State level AMG and ARC are merged to form one “State Mentoring Group for Community Action” (MGCA). Similar MGCA also exist at the district and block levels. Blocks also have Block Community Mobilizers (BCM) to support ASHA workers.

### Rajasthan

- The state has an AMG and one ASHA consultant at the state level to support ASHA programme. State Institute of Health and Family Welfare (SIHFW) also support SPMU in ASHA related activities.
- Besides this, state has District ASHA Coordinator (DAC) and District Program Manager (DPM) at the district level, Block ASHA Coordinator (BAC) at the block level, and PHC ASHA supervisor at the PHC level.

### Tripura

- AMG and ARC are present at the state level, and a cadre of ASHA Program Manager at the district and sub-divisional level.
- The state does not have any support structure at block level and Sub-Divisional ASHA Program Manager (SDAPM) coordinate activities that are to be undertaken at the block level. At PHC level the state has ASHA Facilitators.

### Maharashtra

- ASHA support structure is present at all levels, comprising of AMG and ARC at state level; DCM and District AMG at the district level; Block AMG at block level; and ASHA facilitators to coordinate activities at sub-block level.

Like ASHA support structure, ASHA grievance redressal mechanism also has variations in structure and functioning in different states. These state wise variations are as follows:

### Bihar

- Structure of grievance redressal mechanism varies from district to district. In Jamui, there is no formal mechanism in place, but still written complaints from ASHA workers are accepted at district and block levels and are addressed by Civil Surgeon and District Magistrate.
- On the other hand, In Nalanda, there is a formal mechanism but understanding about its working varies among the staff members. Different stakeholders have different perceptions about the process by which complaints are lodged, and about the officers who resolve them. The monthly meeting of the grievance redressal committee, as specified in the national guide-lines are not conducted regularly.

> "There is no any formal grievances redressal mechanism in my district. But civil surgeon and DPM monitor and solves complaint from ASHAs"
>
> DAM, Jamui

### Haryana

- The state has a centralized complaint number (telephone helpline), by which ASHA workers can lodge their complaints. But it was revealed that some of the block level stakeholders were not aware about this facility, while there were some who could not recall the phone number. During discussion with the ASHA group too, it was revealed that they are not aware about such facility.
- According to respondents, ASHA workers register their complaint through the District Community Mobilizer (DCM) and Block ASHA Coordinators (BAC) at the district and block levels respectively.
- In some areas ANMs also play role in addressing the complaints of ASHA workers. In cases, when the complaint requires higher level intervention, the respective ANMs facilitate submission of these complaints to district or block level coordinators.

### Madhya Pradesh

- There is no formal grievance redressal mechanism in place.
- The complaints of ASHA workers are addressed by District and Block Community Mobilizers (DCM and BCM).

### Rajasthan

- State has toll-free numbers (8290266668/82902666690) through which ASHA workers can register their complaints. These numbers are also printed on ASHA incentive claim form, and all stakeholders involved in ASHA related processes were found to be aware of this facility. This facility is being directly monitored by the state ASHA consultant based at SPMU.
- During the district level interviews, it was revealed that district officers prefer that ASHA workers first contact them before lodging complaint on this toll-free number.

> The ASHAs are given CUG sim cards. They can call for free and discuss their issues with ANMs, LHVs, and supervisor, BAF, BCMO and MOIC. They call and inform these people before dialling the helpline number
>
> BCMO, Dungargarh

- The state has provided Closed User Group (CUG) mobile numbers to all ASHA workers, and they have contact numbers of all the block level medical officers and supervisors (LHV, BAM, Block ASHA Coordinators, and even ANM) whom they can directly approach in case of any grievance.

### Tripura

- The state has formal grievance redressal committees in its districts, but designation and cadres of its members vary between districts. For example, in Khowai district, committee members are from health department (CMO, DPM, DAPM, DAM, and DNO); In West Tripura district, it has representatives from education department, ICDS, NGO and Tripura Commission of Women, with a nominee from CMO office; In Dhalai district, committee has District Collector, CMO, NGO representatives, along with other members.
- In Dhalai district, *"Varusha Diwas"*, and in Khowai district *"Bharosa Diwas"* are celebrated on monthly basis, where complaints of ASHA workers are resolved by medical officers and other concerned staff.

### Maharashtra

- The State has a helpline number (104) on which ASHA workers can register their complaints. ASHA also have an option to write complaint directly to Block Facilitator, Medical Officer or Taluka Health Officer.
- According to a district level officer, ASHA workers generally prefer to get their complaint resolved using the direct route through medical officers instead of using the helpline number.

**Coordination between ANM, ASHA and Anganwadi worker:**

A review conducted by MOHFW in Rajasthan (2011) revealed existence of some management issues due to dual ownership where ANM (from Department of Health) and Anganwadi worker (from Integrated Child Health Development Services) ask ASHA workers to complete their priority activities, resulting into ASHA workers performing multiple tasks, many of them not even being their work areas.

Stakeholders during current review mentioned that there are five activities with overlapping roles between three cadres of frontline functionaries viz. ANM, ASHA and AWW where they coordinate and support each other. These activities include home visits, Village Health Nutrition Days/Immunization sessions, meetings of Village Health Sanitation and Nutrition Committees, maintenance of beneficiary records, and referring/accompanying beneficiaries to health facilities for seeking curative services.

It was told that the overall coordination between ASHA, ANM and AWW is good, with some exceptional situations where there are personal conflicts hampering their performances. Some respondents mentioned about cases of poor coordination, like few ANMs showing inappropriate behaviour towards ASHA workers; and sometimes when ANM and AWW delegate their responsibilities on ASHA workers.

Table 12: **Variation in ASHA support structures and grievance redressal mechanisms**

| | | State Level | District Level | Block Level | Sector/PHC Level |
|---|---|---|---|---|---|
| Bihar | Institutions | AMG and ARC | DCM, DDA and Regional ASHA Coordinators | Block Community Mobilizers | ASHA Facilitators |
| | Grievance redressal | | Civil Surgeon and District Magistrate | Block Health Manager and Block Community Mobilizer | |
| Haryana | Institutions | ARC | District ASHA Coordinator | Block ASHA Coordinators | ASHA Facilitators |
| | Grievance redressal | Centralized complaint number | District Community Mobilizer | Block ASHA Coordinators | ANM |
| Madhya Pradesh | Institutions | AMG merged with State MGCA | District MGCA | Block Community Mobilizers and Block MGCA | ASHA Facilitators |
| | Grievance redressal | | District Community Mobilizer | Block Community Mobilizer | |
| Rajasthan | Institutions | AMG, State ASHA Consultant and SIHFW | District ASHA Coordinator and DPM | Block ASHA Coordinator | PHC ASHA Supervisors |
| | Grievance redressal | Toll free number and state ASHA consultant | District ASHA Coordinator | Block ASHA Facilitator | ANM |
| Tripura | Institutions | AMG and ARC | DAPM and SDAPM | | ASHA Facilitators |
| | Grievance redressal | | Grievance redressal committee | MOIC, AAA, MPW, ANO/BNO | |
| Maharashtra | Institutions | State AMG and ARC team based within SPMU | DCM and District AMG | Block AMG | ASHA facilitators |
| | Grievance redressal | Helpline number (104) | | BF, MO and THO | |

*AAA: Accounts cum Administrative Assistant, AMG: ASHA Mentoring Group, ANO: ASHA Nodal Officer, ARC: ASHA Resource Centre, BF: Block Facilitator, BNO: Block Nodal Officer, DAPM: District ASHA Program Manager, DCM: District Community Mobilizer, DDA: District Data Assistant, MGCA: Mentoring Group for Community Action, MO: Medical Officer, MOIC: Medical Officer In Charge, MPW: Multi-Purpose Worker, SDAPM: Sub Divisional ASHA Program Manager, THO: Taluka Health Officer*

## 4. ASHA incentive claim and disbursement process

Payment of incentive to ASHA workers maintaining accuracy, timeliness and transparency is one of the key factors to keep these voluntary community level workers motivated and committed to perform their activities. Indirectly, this is also a means to monitor the activities performed by ASHA workers programmatically as well as geographically. It is the responsibility of health department to ensure that ASHA get her full incentive on monthly basis as per her entitlements.

The sustenance of the NHM programme depends on the long-term motivational factors for the ASHAs to keep them going with spirit and enthusiasm. Previous studies done to assess the effect of incentives paid to ASHA workers have shown that ASHA frequently cite the financial incentives as a major motivating factor for the position. It has also been found in studies that payments to ASHA are frequently delayed, often due to procedural issues (e.g. funds not transferred to districts or sub-districts, unfamiliarity with e-banking, and confusion over what incentives are available).

Though there are no standard operating procedures highlighting the steps to be followed from claim request by ASHA to disbursement of approved amount, a general flow of steps as reported by stakeholders in the current review are shown in figure 5.

The current review specifically focused on understanding the ongoing processes, identify gaps, and document good practices and innovative approaches that have been implemented in different states. It was observed that knowledge and perceptions among the stakeholders from state level till grass root level were different in terms of processes that exist for paying incentives to the ASHA workers. However, variation was noted in the steps and processes that are being followed for claim and disbursement of incentives.

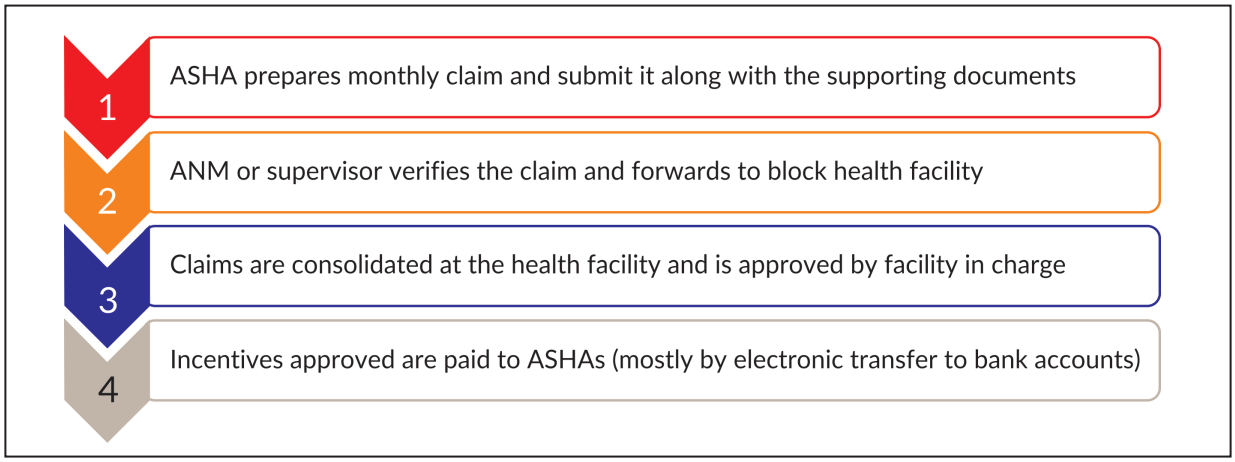
### 4.1 Incentive claim submission

Different states have differences in the processes followed for claiming the incentives. Steps followed by ASHA workers in different states to submit their claims as revealed from review are as follows:

#### Bihar

- There are separate claim formats for different national health programme which are to be filled by ASHA workers to receive incentives.
- Services provided for immunization programme are to be filled in Maternal and Child Health (MCH) claim format. In this format, ASHA has to enter the details of all children vaccinated in her area at the session site, including names of mothers and the names of vaccines and doses provided.

Figure 5: **Processes involved from claim till disbursement of ASHA incentives**



- All these different claim formats are filled on monthly basis by ASHA workers and submitted to ANM of her area.
- ANM checks the details and submit all claim forms of ASHA workers from her subcenter area at the PHC for approval and payment.

### Haryana

- There is a separate claim voucher booklet, which has exhaustive description of all incentives that are to be paid to ASHA workers, along with the conditions involved for verification and/or non-payment of incentives.
- The claim voucher to be filled by ASHA workers is complex with four pages and includes information about beneficiaries, like their names, and also names of father/mother; as well as numbers. In addition, it also mentions FMR codes for each incentive head.

### Madhya Pradesh

- There is separate claim format for every national health programme, but ASHA has to fill the activities performed only in terms of numbers (details like names etc. are not required). For example, number of children fully immunized, or number of children vaccinated on the session day/at VHND.
- The format does not have space for filling the details of beneficiaries. The details are however checked by female health worker (ANM) from records and verified for further submission.

### Maharashtra

- There is separate claim format for every national health programme, but ASHA fills only the numbers in the format and not the details of the beneficiaries.
- The numbers filled in the format are checked and verified by respective ANMs
- No other administrative information or supporting documents are required to be submitted with the claim.

### Rajasthan

- There is only a single format for preparing claim and same format has space for filling details of approximately 27 activities, including immunization services that ASHA is supposed to undertake in her respective area.

### Tripura

- Process of preparing claim is more complex. For preparation of claim for immunization services, she has to fill 3 separate forms every month, one each for children fully immunized within one year, children completely immunized by 2 years of age, and for preparation of due list and social mobilization at the session site.
- All above formats include details of beneficiaries, which demands lot of paper work by ASHA workers. Along with this, there is a separate format for consolidation of incentives from three previous formats.
- There are different supporting documents, like Xerox copies of due lists, immunization cards, counterfoils, etc. that are required to be submitted along with the claim.

> “The ANMs/MPWs check and validate the reports submitted by ASHAs by cross checking the reports with the register that they maintain. They also keep Xerox copies of the reports”
>
> SAPM, Tripura

**Periodicity of filling and filing the claim formats:**

It was revealed that the claim formats are generally filled by ASHA workers during the last week of every month. Some ASHA workers seek help from respective ASHA facilitators (or supervisor), ANMs, or other concerned staff member for filling the claim formats correctly and completely. A common observation across all six states was regarding the verification of claim by ANM of the respective subcenter area. It was revealed that in majority of cases these claim

forms are verified on the VHND or immunization session day when ANM comes to that area or village.

In some states and districts, with separate cadre of ASHA facilitators, the claim formats are first checked by them for correctness and completeness, and then they are verified and signed by ANM for further processing. It was also found that in most cases ASHA workers do not require going to the health facility for submitting the claim (and support documents), rather they hand all documents to their supervisors for submitting at the facility (ASHA Facilitator in Maharashtra and Tripura, ASHA Supervisor in Rajasthan, and ANM in Bihar, Haryana and Madhya Pradesh).

**Capacity of ASHA workers for filling the claim formats:**

When enquired about capacity of ASHA workers to fill the claim formats, especially at places where these are complex, it was told that most of the ASHA workers are able to fill these formats. Sometimes, family members help them in filling, while there are some ASHA who take help from ANM and/or ASHA Facilitator in filling the formats.

There were few respondents, especially in Rajasthan and Tripura, who believed that there is need to further build the capacity of ASHA workers in filling the formats correctly, as many a time they face queries resulting from wrong entries.

**Capacity building on use of claim formats:**

Respondents told that whenever there is introduction of any new format there are a series of trainings organized from state till grass root level, in a cascade manner. For example, in Rajasthan, State ASHA Consultant facilitate training of district NHM staff on filling the formats correctly, who further orient block level staff (BCMO, BPM, BHA, and ASHA Supervisors). This block staff are then responsible for orienting ANMs as well as ASHA Facilitators. Finally, ASHA workers are oriented during their monthly meetings by block level staff, and hand-holding is done as and when required by the ANMs and ASHA facilitators in their respective areas.

**Verification of claim formats:**

Two levels of verification were revealed that take place before actual processing for disbursement of incentives.

The first level of verification is at the village level by respective ANM (or in some cases ASHA Facilitator). ASHA Facilitators support ASHA workers in filling the formats but at the same time also check to ensure that correct information is filled. ANMs' cross-check the information filled in the claim format with her records, like, immunization tally sheets, service delivery register, or RCH register. After checking they verify claims for further submission at the health facility. In some states, both ASHA Facilitator/ Supervisor and ANM approve the claim before they are accepted at the health facility.

The second level of verification takes place at the block level health facility from where the incentives are released. There is however variation within states and districts in terms of staff member/s that are responsible for verification at the block level.

- In Madhya Pradesh, Block Community Mobilizer (BCM) verify the claims and for this they use a portal interfaced with the RCH data. In other words, they cross match beneficiary details and services availed from claim formats with their service delivery records.
- In Rajasthan, Block Health Supervisor (BHS, also known as ASHA supervisor), with support of data entry operator enters the data from claim formats in PCTS and ASHA soft, and verify the data using RCH registers and ASHA diary. Medical Officer in charge with support of Lady Health Visitor (LHV) randomly check a sample of data entered by BHS. Here, there is yet another level of verification at the district level, where random checks are also done by District

ASHA Coordinator (DAC) and District Nodal Officer (DNO) using ASHA soft.

- In Haryana, Block Account Assistant (BAA) and block ASHA coordinator (BAC) do verification checks of ASHA claims using ANM records (service delivery registers, like, immunization register, ANC register, FP register, etc.).
- In Maharashtra, Block Community Mobilizers (BCM) is responsible for verification of ASHA claims at the facility level, and they do it using ASHA soft portal.
- In Tripura, Block Nodal Officer (BNO), HMIS Assistant, and Accounts cum Administrative Assistant (AAA), jointly verify the submitted claims by cross-checking it with data from MCTS portal (now RCH portal).
- In Bihar, Block Health Manager (BHM) has been made responsible for verification of ASHA claims.

> "I do the verification. I verify the records at the subcentre level every two months. Also, we randomly go to houses and check their cards to verify the dates"
>
> BAC, Bhiwani

> "ASHA Soft has made the tracking really simple and now notices are issued to non-performing ASHAs within a month. The state has given us timelines to follow for the entire claim processing, approval, authorization and disbursement. Everyone has clear roles for each these different activities in the incentivization and it is followed strictly, as the actions are taken promptly by the state for any delayed or missed out payments. All the officials are answerable for any negligence, if any, in this process"
>
> DAM, Bikaner

## 4.2 Incentive disbursement

The field review also focused on the process of actual disbursement of incentives to ASHA workers after submission of claims and their verification. Difference was revealed in terms of point of release of funds, and authority that finally authorize for release of incentives. State wise steps followed for disbursement of incentives after verification of claims are as follows:

### Bihar

- ANMs' collects the claim forms from ASHA workers working in their respective areas and give them to the cold chain handler at the block level health facility, who forwards them to Block Accounts Manager (BAM).
- BAM consolidates the claim formats into one ASHA and incentive wise payment sheet and gives it to Block Health Manager (BHM) for verification and approval.
- BHM is responsible for verification of claims with available records, approves it and gets it approved from Block Medical Officer (BMO).
- After final approval from BMO the incentives are released directly into the bank accounts of ASHA.

### Haryana

- There is inter-district variation in the processes often being guided by the decisions taken by District Health Society, taking into consideration available staff positions and other district specific issues.
- In district Fatehabad, after verification of claims Block Account Assistant (BAA) prepares a consolidated list of ASHA wise incentives to be released. This list is approved by Block Medical Officer, following which incentives are released into ASHA accounts.
- However, in district Bhiwani, Block ASHA Coordinator (BAC) prepares the list of ASHA wise incentives, which is first approved by BAA after re-verification from ANM register, and after this Block Medical officer finally approves for release of incentives.

### Madhya Pradesh

- After verification of claims by Block Community Mobilizer (BCM), they are approved by Block Program Manager (BPM)
- Block Accounts Manager (BAM) generates payment advice. This payment advice is finally approved by Block Medical Officer (BMO) to initiate incentive release to ASHA accounts.
- After this, incentives for a month are received in ASHA accounts by 10th of next month.

### Maharashtra

- ASHA Facilitators collect the claim forms and submit to Block Community Mobilizer (BCM), who verifies the claim and also feed (manually enter) activity and ASHA wise incentives claimed in the ASHA-soft software.
- From this software, Block Accounts Manager (BAM) prepares a consolidated sheet and takes approval from Taluka Health Officer (THO) for transfer of incentives electronically to the ASHA accounts.
- In district Nashik, funds (incentives) after approval are first transferred to bank account of the Medical Officer, who then initiates transfer into ASHAs' accounts.
- In two districts covered during the review, the incentives claimed for a month were found to be transferred into the ASHA account by the end of first week of the next month.

### Rajasthan

- The incentive amount is not released into the bank accounts of ASHA workers from the block level health facility, rather they are released from district level, using ASHA soft portal. Variation was also observed within districts in the state.
- For example, in Bikaner, after verification of ASHA claims by DAC and DNO at the district level, Chief Medical & Health Officer (CMHO, head of district's health department) gives approval for release of funds directly into the ASHA accounts. In case of CMO's absence, RCH Officer (RCHO) has the responsibility for approving the release of funds.
- On the other hand, in Sikar, second district covered during the review, there is an additional step followed for the release of funds. Here, after approval from CMHO level, there is an additional zonal level where the Zonal Officer (ZO) gives final approval for release of the payments into ASHAs' accounts. However, despite these processes, and delay due to administrative reasons, it was revealed that all ASHA workers receive payment of their incentives for a month by 7th of the next month.

### Tripura

- There is inter-district variation in the steps and processes as observed during the review.
- In district Dhalai, incentives are released from the PHC level, i.e. below the block level facility. The claim formats are first verified by Accounts cum Administrative Assistant (AAA) and HMIS Assistant. After this AAA prepares incentive release sheet by 25th of every month and gets final approval from Medical Officer in charge, which generally happens by 30$^{th}$ of every month. After final approval incentives are transferred electronically into ASHAs' bank accounts.
- In district Khowai, the Block Nodal Officer (BNO) is also involved in the verification process along with AAA and HMIS Assistant.

## 5. Issues and challenges

The ASHA workers play a critical and effective role in bridging the gap between NHM and the communities, therefore it is important to keep this cadre of community level workers motivated to perform their duties efficiently. Another review ( ) done in year 2011 revealed that there are several key issues regarding incentives and

compensation for ASHAs, which, if mitigated, could greatly contribute to an improvement in ASHA's motivation and performance.

In studies ASHA workers frequently cite the financial incentives as a major motivating factor for the position. Current review revealed that nearly 25% of ASHA workers feel that the monetary compensation they receive is not sufficient for the effort that they put in. Secondly, payments to ASHA are frequently delayed, often due to procedural issues (e.g. funds not transferred to sub-district, unfamiliarity with e-banking, confusion over what incentives are available).

The issues and challenges related to incentives (claim or disbursement) and other processes are given in the following section.

**Low incentives for the services provided**

Some stakeholders stated that the incentives that are paid to the ASHA workers are low as compared to the services they provide, and this has a negative effect on their motivation.

> "The ASHA worker gets only Rs. 150 to organize the VHND where she has to work for two full days"
>
> SCM, Madhya Pradesh

> "For ensuring full immunization of a child she visit that child again and again, but incentives given to her for all these efforts are less"
>
> SAPM, Tripura

In Madhya Pradesh, it emerged that many a times ASHA workers prioritize the services according to the amount of incentive they receive. For example, incentive for facilitating institutional delivery is more than that for immunization mobilization, so ASHA workers prefer institutional delivery over immunization.

Stakeholders in Tripura also responded in an analogous manner and believed that incentives currently being paid (for all services and not specific to immunization) are less. SAPM of the state also reported the same. One respondent told that the funds allocated to provide incentives are sometimes utilized by state for other purposes, depending on the state's priority.

**Multiple formats in use for documentation and submitting claim**

Stakeholders in some states said during interviews, that there are different claim formats for different health interventions. This makes it difficult for ASHA to track the claims as well as incentives paid against them for all services she has offered during a period. This further gets challenging when ASHAs raise claims for more than a month.

> "ASHA has to do a lot of paper work to claim incentives"
>
> SCM, Madhya Pradesh

Specific issues were revealed in Tripura, a regional language speaking state where many ASHA workers are from a tribal community. These ASHA workers are unable to understand the language used in claim formats, which is generally English. In these cases, ANM or block level staff has to translate the claim forms in regional language and photocopied formats are then provided to ASHA workers.

**Many supporting documents are required with claim voucher**

Respondents in some states told that ASHA workers are supposed to annex many supporting documents, like, Xerox copies of MCP card, duty slips, ASHA register etc. with the claim voucher. This increases the paper work for ASHA and review work (verification) at facility level, sometimes leading to delay in release of incentives. Some ASHA workers told that they do not get any money for these entire Xerox that are required every month, and so this is actually loss for them.

In Tripura, ASHA workers have to submit Xerox copies of immunization cards (mother and child

protection cards), and problem arises when parents have lost their cards or cannot provide to ASHA for getting it Xeroxed. In these cases, the claim is considered incomplete and results in delay in payment of incentives, which is only done after physical verification done by health worker or supervisor.

Some other respondents also stated that ASHA workers submit supporting vouchers and require Xerox copies. This is an additional cost that ASHA workers bear that is not reimbursed. Sometimes this process of getting Xerox copies and compiling all support vouchers delays submission of claims and release of incentives.

**Staff vacancies**

Vacant positions were revealed as an important reason for delay in disbursement of incentives in all states. In these situations, alternate staff member is given the additional responsibility of the vacant post overloading his/her work. In some states, it was observed that there are staff members who have to fulfil responsibilities at the vacant positions in more than one block.

Vacancy also limit supervisory visits to support ASHA workers and field level verification of claims made.

**Selection of ASHA workers**

> "For ensuring full immunization of a child she visit that child again and again, but incentives given to her for all these efforts are less"
>
> SAPM, Tripura

> "The health system is working fine, but only if the people who are crucial are all available and functional. Many blocks have vacant posts leading to avoidable delays in payment of incentives. Due to staff vacancies, we are unable to track field level activities. Only when we recruit people for these vacant positions we will be able to ensure timely and complete disbursement of ASHA incentives on time"
>
> BPM, District Sagar, Madhya Pradesh

Some respondents raised concerns about the quality of selection of ASHA workers, leading to appointment of workers who are either not educated or are from rich or respected or politically influenced families who never work in their communities. According to one district level respondent, initially when ASHAs were introduced they only had few activities to fulfill, but with time many more activities have been added in their portfolio and due to limited capacity of these workers they fail to accomplish them. Some ANMs' believed there are few uneducated or far less educated ASHA workers in their areas and they are totally dependent on ANMs or ASHA Facilitators for documentation and filling claim vouchers.

State level respondents in Rajasthan shared that they have tried to address the issue of qualification of ASHA workers for improving the quality of services they deliver. In Rajasthan, minimum qualification for selection as ASHA has now been increased to 8$^{th}$ standard as compared to 5$^{th}$ standard that was followed initially.

On the other hand, Group of ASHA facilitators in a district of Tripura believed that quality of services provided by ASHA workers is not dependent on their qualification, rather their acceptance in the community. In some cases, it was found that documentation for ASHA is done by their family members, including their children.

**Delay in receiving funds at districts and blocks**

Numerous studies conducted in the past to assess gaps in the ASHA programme have identified issues with the flow of funds from state to districts and to block levels as a significant problem adversely affecting timely payment of ASHA incentives. A similar issue was stated by respondents in the current review as well. It was mentioned that sometimes there is delay in receiving funds by the district and blocks, and besides there are times when funds received is less than requested. It was a general opinion that delays in receipt of funds lead to delay in processing and release of incentives to ASHA workers.

When discussing the issues behind delays in receiving funds it was revealed that this is related to non-compliance of timelines for submitting Programme Implementation Plans (PIP), which delays review and approval process at the national level. This implies that sometimes there is also a delay in placing a request for funds, which leads to a delay in receiving the same. A state level respondent stated that this can be addressed when program managers at levels starting from block to district and state monitor the timelines, and comply with the guidelines related to submission of fund utilization certificates and PIPs.

Regarding the reason for issue of receiving fewer funds as compared to the request sent it was revealed that it is mainly an administrative issue, and can be addressed through timely utilization of already available funds, submitting utilization certifications, and doing planning on basis of realistic targets.

> "Funds are released only after 80% of utilization of previous funds, hence even though only 25% of funds are left, state cannot request more funds resulting not enough money left to pay to ASHA"
>
> State ASHA Lead

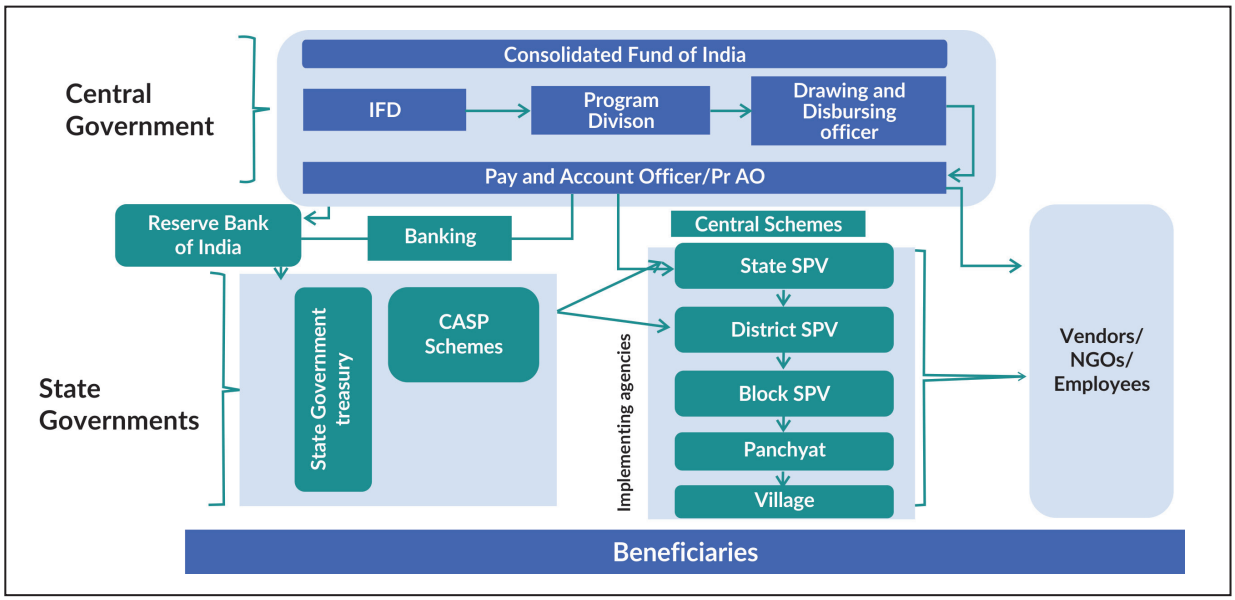
With respect to the immunization programme, it was stated that funds for social mobilization of children to session sites is released to blocks based on the number of revenue villages. During the last several years, because of increase in population and development of new habitations around villages the actual number of villages (and hamlets) has become much more than the number of administrative villages. So, now number of VHND conducted is also more as compared to those for which blocks get funds, and due to this reason funds are often not adequate to meet the requirement.

> "Sometimes we have to use funds from other heads, like 'Muskaan' programme to make payments to ASHA"
>
> State ASHA Lead

### Use of PFMS portal for release of ASHA incentives

Public Financial Management System (PMS), earlier known as Central Plan Scheme Monitoring System (CPSMS) are Government of India's online portals to track the fund disbursement from central government to various levels down below under all plan schemes till the last level of utilization.

Figure 6: Public Financial Management System



Introduction of PFMS has raised concerns among some officials involved in ASHA programme. Respondents at state and district level states raised issues like: code generation for ASHA workers in PFMS is going to be a big challenge; introduction of PFMS will further delay the process of disbursement; staff members using PFMS will take time in understanding the approval processes, etc.

> "RTGS based payment is a better way to pay ASHA compared to PFMA"
>
> State ASHA Lead

**Difficulties in using ASHA Soft**

ASHA-soft is an online monitoring and payment system which facilitates health department to capture beneficiary wise details of services provided by ASHA workers; generate various reports to monitor the progress of ASHA programme; and initiates online payment of ASHA incentives to their bank accounts (through PFMS). ASHA soft is used in state of Rajasthan for monitoring and making payments, while in Madhya Pradesh it is currently being used for verification of work done by ASHA workers. The software is also being used in some districts of Maharashtra (like, Ratnagiri) for filling details of work done by ASHA workers at the block level.

Stakeholders interviewed in Rajasthan said that sometimes duplicate entries of beneficiaries are created in the software whenever those beneficiaries take services from a higher level of health care facility. There is no way of validating an existing beneficiary in the system. This creation of duplicate entries for a beneficiary immediately freezes the payment to respective ASHA worker. Some respondents also stated that Rajasthan also has urban ASHA workers, and since ASHA-soft is primarily for ASHA workers in the rural areas, they are facing issues with manual off line payment to urban ASHA. Sometimes, ASHA workers having same names when entered in the software also creates issues with identification taking a lot of time to be resolved.

**Delay in incentive payment due to beneficiary related issues:**

**a) Beneficiaries do not have bank accounts:**

In programs like Janani Suraksha Yojana (JSY) ASHA workers are paid incentives only when financial support being provided to mothers (i.e. incentive to mothers) is transferred into their bank accounts. There are instances when beneficiaries either don't have bank accounts, or they are not interested in opening an account due to prevalent social reasons. In such cases, incentive payment to concerned ASHA workers gets delayed or they do not get any payment.

> "For many reasons family members do not want open a bank account, and in such cases ASHA gets penalized as she does not get her incentive"
>
> SCM, Madhya Pradesh

**b) Beneficiaries approach different facilities**

During discussion with ASHA groups it was revealed that beneficiaries availing services in one health facility are registered at that facility, and a specific ID is allotted to them. If any of these beneficiaries approach other facility for any service they will be given a new ID. In this case ASHA worker will not get incentive, and these cases are difficult to reconcile, and resolution may take at least a year.

**ASHA recommending beneficiaries to private hospitals for delivery:**

Some respondents told that since introduction of JSY scheme institutional deliveries have increased which has affected the business of private providers. Now, ASHA workers have started referring such cases to private hospitals for which they get money. Children delivered in private hospitals get vaccinated there and do not get registered in government records. Respondents stated that children receive vaccination in the private sector and get fully immunized but they are not reported in government system.

> "Now ASHA's mindset has been changed, now they have become the agent of private hospital for delivery and they get money from them"
>
> DAM, Nalanda, Bihar

> "ANM's have attitude problems while interacting with ASHA. They do not speak respectfully during the verification process"
>
> SCM, Madhya Pradesh

**Coordination issues between ANM and ASHA:**

ANM was revealed as the first check point where the claims prepared by ASHA workers are verified. Different issues, mostly individual rather than systemic, were revealed by different respondents. Some respondents stated that ANM consider them to be at a senior position, and some ANMs behave inappropriately with ASHA workers. This leads to coordination issues and is resolved by making visits to those areas or during the monthly meetings.

A district level respondent told that at vacant subcentres there is no ANM to verify the claims, and this result in delay in payment to ASHA workers of that area. In such cases, other staff member is given responsibility to verify the claims.

Some respondents also mentioned that there are cases when some ASHA workers belonging to influential families' force ANM to verify their claim vouchers even for the services that have not been delivered.

Mismatch in ASHA and ANM records: some respondents mentioned that in few cases the record that ASHA maintains do not match with RCH register, using which ANM verifies the claims. In these cases, verification of claims is delayed and is only done after physical verification with the beneficiary. This also creates conflicting situations between ASHA and ANMs involved.



# Summary

The in-depth interviews and focus group discussions conducted during the review were informative and it was revealed that because of incentives that are paid to ASHA workers, they are motivated and more inclined to provide services to beneficiaries in their areas. At the same time, many issues and challenges related to claim, verification, and disbursement of incentives were also mentioned by stakeholders.

No specific mention was made regarding immunization incentives by the respondents. However, it was clear from the concerns stated that there is a need to strengthen the support structures and to initiate processes which are simpler and uniform, and ensure timely disbursement of incentives to ASHA workers.

**Major findings revealed from the interview are as follows:**

- ASHA workers play a significant role in mobilizing beneficiaries for immunization services and this has resulted in improved coverage with variation between different areas.

  ASHA workers receive three incentives for their services to immunization programme, including mobilization of beneficiaries, full immunization till 1 year, and complete immunization by two years of age. The incentives paid for immunization services were found to be uniform across all review states.

  There have been recent changes in incentive guidelines, and now ASHA workers don't get INR 150 for mobilization to immunization session. Rather this incentive has been merged with some other incentives to form a separate overarching head by name "Routine Activities" for which ASHAs' are paid INR 1000 per month.

- The ASHA programme has been operational for the last 10 years and during this period many activities have been added to the portfolio of ASHA workers. Besides activities for which these workers are incentivized there are few they do without being paid for. New activities and incentives have been added from time to time but those existing since the beginning have not been raised and are same as they were 10

years ago.

All stakeholders believed that incentives being paid to ASHA workers should be increased to match their work, their catchment area, and their experience.

- In the same context, some stakeholders pointed out that there have been changes in the services provided by ASHA workers over last few years. Now, they are providing more technical services, like, home based newborn care. Therefore, the initial education qualification criteria set for selecting ASHA is not applicable now and there is a need to recruit more qualified workers to deliver such services.

  It was revealed that ASHA selection process must be transparent to avoid any bias in selection.

- Some states have rolled out provision of non-monetary incentives to ASHA workers to enhance their motivation. Some states also contribute bonus amount to ASHA workers from state budgets in addition to the incentive earned as per national government guideline.

  Such approaches can be explored and implemented in line with the state policies to benefit ASHA workers and enhance their dedication and motivation.

- It was found that ASHA workers work in close coordination with ANM, and for some programs also with Anganwadi workers of their catchment areas to deliver their services. Stakeholders mentioned that proper communication between frontline functionaries is critical for quality delivery of services and any interpersonal differences affects the morale of ASHA workers as well as their ability to deliver services.

  In some cases, ASHA workers are asked by ANM and Anganwadi workers to perform activities for which they are not eligible for incentives, but still they have to do for maintaining coordination.

- Different cadres of stakeholders interviewed were aware and updated regarding the guidelines for ASHA incentives, and all states have some system to ensure that these guidelines are disseminated across various levels till ASHA workers.

  Some states have implemented innovative approaches for dissemination of information till the grass root level (like use of magazine and felicitation at district and state level), and these can be adapted for use in other states and districts.

- Similar processes were found to be followed in different states and districts for claim, verification, and disbursement, though with minor variations owing to state policies, human resource availability, staff hierarchy, and other system related reasons. As per the ongoing process ASHA workers fill their claim forms (different formats in different states), which are verified and validated at specified levels, mostly by the ANM of respective subcenters before they are submitted at block health facility for consolidation, approval and disbursement. In some states (or districts) ASHA workers also submit evidence for the services provided, and details of beneficiaries benefited. If in case few ASHA workers fail to submit supporting documents then they do not get their incentives.

- Stakeholders believed that process of release of incentives have improved in recent years, though it was a big issue for all concerned in the initial years. Still, there are case of untimely or delayed release of incentives across states and districts due to system related issues like non-availability of funds (delay in drafting and submitting district action plans and PIP also being a reason), and vacant positions at various levels and additional workload on available staff to meet the deadlines. In some districts, program managers do not consider release

of ASHA incentives as a priority activity and in such cases incentive release is always delayed.

- It was found that states like Rajasthan and Maharashtra have implemented software's for consolidating ASHA wise incentive claimed and to facilitate electronic transfer of incentives to ASHA bank accounts. This not only facilitates timely payment but also help in monitoring activities performed by different ASHA workers. Though some respondents believed that there are challenges, but feasibility of using such IT enabled applications need to be explored and implemented to address many system related issues.
- Grievance redressal mechanism was found to exist in all the states, districts and blocks, though with variations in the structure and mechanism of working. Respondents stated that the system is effective and prompt action is taken in case of a complaint. Stakeholders also mentioned that ASHA workers always have the option to approach any higher authority for redressal, but most effective platform for resolving complaints is that of block level meetings.

# Annex 1 : List of states, districts and blocks covered in field review

| S. No. | States | S. No. | Districts | S. No. | Blocks |
|---|---|---|---|---|---|
| 1 | Bihar | 1 | Jamui | 1 | Aliganj |
| | | | | 2 | Gidhaur |
| | | 2 | Nalanda | 3 | Nagar Nausa |
| | | | | 4 | Rajbir |
| 2 | Haryana | 3 | Bhiwani | 5 | Bhiwani |
| | | | | 6 | Kairu |
| | | 4 | Fatehabad | 7 | Jakhal |
| | | | | 8 | Ratia |
| 3 | Madhya Pradesh | 5 | Chatarpur | 9 | Chatarpur |
| | | | | 10 | Gaurihar |
| | | 6 | Sagar | 11 | Bina |
| | | | | 12 | Khurai |
| 4 | Maharashtra | 7 | Nashik | 13 | Kalwan |
| | | | | 14 | Yeola |
| | | 8 | Ratnagiri | 15 | Ratnagiri |
| | | | | 16 | Sangameshwar |
| 5 | Rajasthan | 9 | Bikaner | 17 | Bikaner |
| | | | | 18 | Dungergarh |
| | | 10 | Sikar | 19 | Fatehpur |
| | | | | 20 | Laxmangarh |
| 6 | Tripura | 11 | Dhalai | 21 | Ambassa |
| | | | | 22 | Kamalpur |
| | | 12 | Khowai | 23 | Kalyanpur |
| | | | | 24 | Padmobil |



# Annex 2 : List of stakeholders interviewed

| S. No. | States | Name | Designation | District & block |
|---|---|---|---|---|
| 1 | Bihar | Dr N.K. Sinha | SEPIO | |
| 2 | | Pranay Kumar | SPM | |
| 3 | | Dr Vinod Kumar | DIO | Jamui |
| 4 | | Sudhanshu Narayan | DPM | Jamui |
| 5 | | Pankaj Kumar | DCM | Jamui |
| 6 | | Shashi Bhusan Pandey | DAM | Jamui |
| 7 | | Dr Rajender Chaudhary | DIO | Nalanda |
| 8 | | Dr Gyanender Shekhar | DPM | Nalanda |
| 9 | | Nirbhay Kumar | DAM | Nalanda |
| 10 | | Ujjawal | DDA | Nalanda |
| 11 | | Dr B.K Rai | MOIC | Jamui (Block Aliganj) |
| 12 | | Dharamveer Mandal | BAM | Jamui (Block Aliganj) |
| 13 | | Santosh Kumar | BCM | Jamui (Block Aliganj) |
| 14 | | Mahinder Kumar | BHM | Jamui (Block Aliganj) |
| 15 | | Dr Ramswaroop Chaudhary | MOIC | Jamui (Block Gidhaur) |
| 16 | | Amit Kumar | BAM | Jamui (Block Gidhaur) |
| 17 | | Gautam Kumar | BCM | Jamui (Block Gidhaur) |
| 18 | | Pankaj Kumar | BHM | Jamui (Block Gidhaur) |
| 19 | | Dr Krishan Kanhaiya | MOIC | Nalanda (Block NagarNausa) |
| 20 | | Irshad Hussain | BAM | Nalanda (Block NagarNausa) |
| 21 | | Rahul Ranjan | BHM | Nalanda (Block NagarNausa) |
| 22 | | Sailendra Kumar | KTS | Nalanda (Block NagarNausa) |
| 23 | | Dr Umesh Chandra | MOIC | Nalanda (Block Rajbir) |
| 24 | | Stuti Kumar | BAM | Nalanda (Block Rajbir) |
| 25 | | Sanjay Kumar Singh | BCM | Nalanda (Block Rajbir) |
| 26 | | Bipin Kumar | BHM | Nalanda (Block Rajbir) |

| S. No. | States | Name | Designation | District & block |
|---|---|---|---|---|
| 27 | Haryana | Dr. Suresh Dalpath | SEPIO | |
| 28 | | Chand Asingh Madaan | SCM | |
| 29 | | Dr Jitender Kumar | DIO | Bhiwani |
| 30 | | Satpal Singh | DPM | Bhiwani |
| 31 | | Tina Singla | DAM | Bhiwani |
| 32 | | Dr Sunita Sokhi | DIO | Fatehabad |
| 33 | | Arun Sharma | DPM | Fatehabad |
| 34 | | Arun Bansal | DAM | Fatehabad |
| 35 | | Dr D.K. Ahuja | NO | Bhiwani (Block Bhiwani) |
| 36 | | Divya Gaba | BAA | Bhiwani (Block Bhiwani) |
| 37 | | Jagat Sheoran | BAC | Bhiwani (Block Bhiwani) |
| 38 | | Dr Jogiinder Singh | SMO | Bhiwani (Block Kairu) |
| 39 | | Neeraj Gupta | BAA | Bhiwani (Block Kairu) |
| 40 | | Sunil Sheoran | BAC | Bhiwani (Block Kairu) |
| 41 | | Dr Sushil | BMO | Fatehabad (Block Jakhal) |
| 42 | | Amit Sharma | BPM | Fatehabad (Block Jakhal) |
| 43 | | Rajinder | BAM | Fatehabad (Block Jakhal) |
| 44 | | Dr R K Jain | BMO | Fatehabad (Block Ratia) |
| 45 | | Ritu Rani | BPM | Fatehabad (Block Ratia) |
| 46 | | Kapil | BAM | Fatehabad (Block Ratia) |
| 47 | Madhya Pradesh | Dr Santosh Shukla | SEPIO | |
| 48 | | Dr Arti Pandey | SPM | |
| 49 | | Dr RK Verma | DIO | Chhatarpur |
| 50 | | Rajender Khare | DPM | Chhatarpur |
| 51 | | Shailender Shrivastava | DAM | Chhatarpur |
| 52 | | Dr Roshan | DIO | Sagar |
| 53 | | Mona | DPM | Sagar |
| 54 | | Rajesh Srivastava | DAM | Sagar |
| 55 | | Dr Sahu | Medical Officer | Chhatarpur (Block Chattarpur) |
| 56 | | Amit | BPM | Chhatarpur (Block Chattarpur) |
| 57 | | Presank Jain | BAM | Chhatarpur (Block Chattarpur) |
| 58 | | Dr S Prajapati | BMO | Chhatarpur (Block Gaurihar) |
| 59 | | BK Shukla | BAM | Chhatarpur (Block Gaurihar) |
| 60 | | Jitender | BCM | Chhatarpur (Block Gaurihar) |
| 61 | | Dr Sanjeev Agarwal | BMO | Sagar (Block Bina) |
| 62 | | Manish | BAM | Sagar (Block Bina) |
| 63 | | Prakash Vishwakarma | BCM | Sagar (Block Bina) |
| 64 | | Dr Sharma | BMO | Sagar (Block Khurai) |
| 65 | | Pramod Soni | BPM | Sagar (Block Khurai) |
| 66 | | Goswami | BAM | Sagar (Block Khurai) |

| S. No. | States | Name | Designation | District & block |
|---|---|---|---|---|
| 67 | | Dr. Shashikant Jadav | SEPIO | |
| 68 | | Anil Naxine | SPM | |
| 69 | | Dr Ravindera Choudhary | DCRHO | Nashik |
| 70 | | Abhijit | DPM | Nashik |
| 71 | | Sandeep Jadav | DAM | Nashik |
| 72 | | Sharad | DCM | Nashik |
| 73 | | Dr P.S. Thombre | DIO/ RCHO | Ratnagiri |
| 74 | | Anand Chougule | DPM | Ratnagiri |
| 75 | | Latha Gunjawale | DAM | Ratnagiri |
| 76 | | Abhijeet Kamble | DCM | Ratnagiri |
| 77 | **Maharashtra** | Dr Sudhi Patil | THO | Nashik (Block Kalwan) |
| 78 | | Aasma sheikh | BAO | Nashik (Block Kalwan) |
| 79 | | Bhawar | BCM | Nashik (Block Kalwan) |
| 80 | | Dr Naikiwadi | THO | Nashik (Block Yeola) |
| 81 | | Kamalakar chuge | BAO | Nashik (Block Yeola) |
| 82 | | Sharad | BCM | Nashik (Block Yeola) |
| 83 | | Dr Manoj M Suryavanshi | THO | Ratnagiri (Block Ratnagiri) |
| 84 | | Rohini Jagannath Kidaye | BAO | Ratnagiri (Block Ratnagiri) |
| 85 | | Amar Vichare | BCM | Ratnagiri (Block Ratnagiri) |
| 86 | | Dr Venkat R Rayabhole | THO | Ratnagiri (Block Sangameshwar) |
| 87 | | Pooja Prabhakar Raonak | BAO | Ratnagiri (Block Sangameshwar) |
| 88 | | Rajendra R Khurd | BCM | Ratnagiri (Block Sangameshwar) |
| 89 | | Dr S.K. Garg | SEPIO | |
| 90 | | R.C. Rawat | SNO | |
| 91 | | Dr. Ramesh Gupta | DIO/ RCHO | Bikaner |
| 92 | | Sushil | DPM | Bikaner |
| 93 | | Renu | DAC | Bikaner |
| 94 | | Rajeev Singhodia | DAM | Bikaner |
| 95 | | Nirmal Singh | DIO/ RCHO | Sikar |
| 96 | | Prakash | DPM | Sikar |
| 97 | | Keshardeo Pareek | DAC | Sikar |
| 98 | **Rajasthan** | Dheeraj Bhagaria | DAM | Sikar |
| 99 | | Dr Surender Chudhary | BCMO | Bikaner (Block Bikaner) |
| 100 | | Rishikalla | BPM | Bikaner (Block Bikaner) |
| 101 | | Suresh swami | BAF | Bikaner (Block Bikaner) |
| 102 | | Deepak | BAO/BAM | Bikaner (Block Bikaner) |
| 103 | | Dr Manish Varma | BCMO | Bikaner (Block Dungergarh) |
| 104 | | Rakesh Tallare | BPM | Bikaner (Block Dungergarh) |
| 105 | | Mahendar | BAF | Bikaner (Block Dungergarh) |
| 106 | | Rajender | BAO/BAM | Bikaner (Block Dungergarh) |
| 107 | | Dr Dilip Singh | BCMO | Sikar (Block Fatehpur) |

| S. No. | States | Name | Designation | District & block |
|---|---|---|---|---|
| 108 | | Subhash Pareek | BPM | Sikar (Block Fatehpur) |
| 109 | | Shiv Bhagwan | BAC | Sikar (Block Fatehpur) |
| 110 | | Ashok Joshi | BAM | Sikar (Block Fatehpur) |
| 111 | | Dr. Vinod Kumar | BCMO | Sikar (Block Laxmangrah) |
| 112 | | Vikas Kumar Tunwal | BPM | Sikar (Block Laxmangrah) |
| 113 | | Yogesh Saini | BAC | Sikar (Block Laxmangrah) |
| 114 | | Sushil Kumar Tachjara | BAM | Sikar (Block Laxmangrah) |
| 115 | | Rajib Ghosh | SAPM | |
| 116 | | Sujit Deb | SPM | |
| 117 | | Dr Himadri Daring | DIO | Dhalai |
| 118 | | Ranamoy Deb | DPM | Dhalai |
| 119 | | Umacharan Das | DAM | Dhalai |
| 120 | | Susham Rani Das | DAPM | Dhalai |
| 121 | | Dr. Monojit Burman | DIO | Khowai |
| 122 | | Pinaki Ranjan Bhattacharya | DPM | Khowai |
| S. No. | | Name | Designation | District & block |
| 123 | | Bipul Ray | DAM | Khowai |
| 124 | | Pinky Poddar | DAPM | Khowai |
| 125 | | Dr Sangita Reang | MOIC | Dhalai (Block Ambassa) |
| 126 | | Binoy Bhushan Bhattacharya | AAA | Dhalai (Block Ambassa) |
| 127 | | Dr Pranoy Adhikari | ANO | Dhalai (Block Ambassa) |
| 128 | **Tripura** | Birajit Debbarma | HMIS Assistant | Dhalai (Block Ambassa) |
| 129 | | Dr Amit Debbarma | MOIC | Dhalai (Block Kamalpur) |
| 130 | | Jayanta Biswas | AAA | Dhalai (Block Kamalpur) |
| 131 | | Prashanta Kumar Das | HMIS Assistant | Dhalai (Block Kamalpur) |
| 132 | | Manash Roy | SDPM | Dhalai (Block Kamalpur) |
| 133 | | Dr.Sutapa Das | MOIC | Khowai (Block Kalyanpur) |
| 134 | | Sanjoy Saha | AAA | Khowai (Block Kalyanpur) |
| 135 | | Dr. Supriyo Burman | BNO Officer | Khowai (Block Kalyanpur) |
| 136 | | Joydeep Roy | HMIS Assistant | Khowai (Block Kalyanpur) |
| 137 | | Padmaram Jamati | MOIC | Khowai (Block Padmobil) |
| 138 | | Sanjit Debbarma | AAA | Khowai (Block Padmobil) |
| 139 | | Dr. Pintu Kishore Debbarma | BNO | Khowai (Block Padmobil) |
| 140 | | Baijanti Debbarma | HMIS Assistant | Khowai (Block Padmobil) |



# ANNEX 3 : Tools used for data collection

## 1. In-depth Interview Schedule for SIO, DIO, and BMO

### Questions 1 to 4: Introduction

1. As you have told that you have been working at this position (of SIO/DIO/BMO) for last ____ years. What are your roles and responsibilities at this position?
2. What is your understanding about the performance of immunization program in your state/district/block about –
   a. The status of immunization coverage and fully immunized children?
   b. Has it improved in last few years or it has been the same?
3. Is there any variation in coverage between different districts of the state (for SIO); between different blocks of the district (for DIO); between different subcentre areas of the block (for BMO)?
4. If there is variation in immunization coverage, then what according to your experience are the underlying factors for this variation in coverage?

### Questions 5 to 7: Understanding immunization related incentives

5. Under National Health Mission (NHM), ASHA workers are given incentives (performance based) for the activities they do for the immunization program. Please mention what are the services they provide for immunization program and how much incentive do they get for each of them?
6. Has your state/district/block received any updated guidelines in last one year (or planning cycle) regarding norms of incentives for ASHA?
   a. If Yes,
      i. Have you shared these guidelines further with districts/blocks? HOW?
      ii. Do you also share these guidelines with ASHAs'?
   b. If No, what norms (of ASHA incentives) are you currently following?
7. Are these immunization related incentives (that you have mentioned before) given to ASHA workers in your state/district/block?
   a. If Yes, are all the different incentives are given to ASHA? And whether same norm of incentivization is being followed, as given in the guidelines?
   b. If No, what is the reason that your state/district/block does not pay incentives to ASHA for immunization services? Why this mechanism has not

started?

## Questions 8 to 15: Understanding mechanisms related to reporting, claiming and disbursement

8. In your experience, have these performance based incentives given to ASHAs' motivates them to deliver immunization services? OR Will ASHA's performance be affected if no incentives are paid to them for their services?
9. How do ASHA workers submit their reports for the immunization services they have provided and for claiming the incentives for those services?
10. If in response to question 9, it is revealed that there is a standard reporting format OR there is a standard process to be followed, then ask for
    a. Have ASHAs' been trained or oriented to fill the formats, and prepare reports? OR Do they have adequate understanding of the reporting process being followed in your state/district/block?
    b. Is this format standardized and used in entire state/district/block; OR are there variations in formats/ process being used in different districts/blocks? EXPLAIN
    c. Does anybody provide support to ASHA in filling this format? If yes, who?
11. Is there any mechanism for validation/checking of the reports filed by ASHAs' for the immunization services provided by them, and the incentive due for those services?
    a. If Yes,
        i. How the information is validated? Who all are responsible for validation?
        ii. Is field level verification done for validation of reports? If yes, by whom?
        iii. Are HMIS and MCTS reports cross matched for validating the work done? If yes, explain the process and persons involved.
    b. If No,
        i. Is there any reason for not having a validation mechanism? Have you never felt any need for having such system to ensure correctness in reporting?
        ii. What other accountability measure do you have and how does it works?
12. How does the reports submitted by ASHA workers flow to the authority who finally decide for payment of incentive? OR what is the channel followed for reporting by ASHAs'?
13. Once these reports are received at the facility that will be making the payment, then what process is being followed from receiving the reports to final disbursement of incentives to ASHA?
14. Who are the major stakeholders involved in finally deciding how much amount is to be paid to ASHAs' as incentives?
15. How are the incentives paid to ASHAs?

## Questions 16 to 23: Feasibility of current mechanism and its strengths and weaknesses

16. In your experience, does the current system (of claiming and disbursing incentives) in your state/district/ block efficient enough to ensure timely disbursal of incentives to ASHAs?
    a. If Yes, can you explain how this works to ensure timely payment?
    b. If No, what are the gaps that need to be plugged for more timely payment?
17. In this entire process that you have specified at levels of different stakeholders, what are the checks or monitoring mechanisms to ensure that ASHAs receive timely payment of their incentives?

18. What challenges have you experienced (or heard from other districts, block or department colleagues) in incentivizing ASHAs' for the services they provide for immunization program?
19. How do you address these challenges? OR how can these challenges be addressed
20. Whether status of incentivizing ASHAs' (e.g. pending payment etc.) discussed during the review meetings at state/ district/ block level?
    a. If Yes - What are the major issues discussed? How often and by whom (at what level – block, district, magistrate, divisional, state level)?
    b. If No - Why ASHA incentive disbursement issue is not on review agenda, at any level? What are the constraints?
21. Do you have any grievances redressal mechanism in the state/ district/ block related to ASHAs incentive disbursement? If yes, please describe something about it?
22. Are there any issues related to receiving ASHA incentive budget for immunization program from higher level (national/state/district)?

23. In your opinion, what other improvements could be made in the existing ASHA incentive payment process for ensuring complete and timely payment to ASHAs for the services they provide to immunization program?

## 2. In-depth Interview (IDI) schedule for SPM, DPM, and BPM

### Questions 1 to 3: Introduction

1. As you have told that you have been working at this position (of SPM/DPM/BPM) for last ____ years. What are your roles and responsibilities at this position?
2. What are your specific responsibilities with respect to immunization program?
3. In last few years many new initiatives have been taken to improve coverage. But it is found that still coverage is inadequate with wide variation between different areas (state, districts, and blocks). What in your opinion are the underlying factors for this variation?

### Questions 4 to 6: Understanding immunization related incentives

4. Under National Health Mission (NHM), ASHA workers are given incentives (performance based) for the activities they do for the immunization program. Please mention what are the services they provide for immunization program and how much incentive do they get for each of them?
5. Has your state/district/block received any updated guidelines in last one year (or planning cycle) regarding norms of incentives for ASHA?
    a. If Yes,
        i. Have you shared these guidelines further with districts/blocks? HOW?
        ii. Do you also share these guidelines with ASHAs'?
    b. If No,
        i. What norms (of ASHA incentives) are you currently following?
6. Are these immunization related incentives (that you have mentioned before) given to ASHA workers in your state/district/block?
    a. If Yes,
        i. Are all the different incentives are given to ASHA? And whether same norm of incentivization is being followed, as given in the guidelines?
    b. If No,
        i. What is the reason that your state/district/block does not pay incentives to ASHA for immunization services? Why this mechanism has not been started?

### Questions 7 to 16: Understanding mechanisms related to reporting, claiming and disbursement

7. In your experience, have these performance based incentives given to ASHAs' motivates them to deliver immunization services? OR Will ASHA's performance be affected if no incentives are paid to them for their services?
8. How do ASHA workers submit their reports for the immunization services they have provided and for claiming the incentives for those services?
9. If in response to question 8 it is revealed that there is a standard reporting format OR there is a standard process to be followed, then ask for
    a. Is this format standardized and used in entire state/district/block; OR are there variations in formats/process being used in different districts/blocks? EXPLAIN

b. Does anybody provide support to ASHA in filling this format? If yes, who?
c. Have ASHAs' been trained or oriented to fill the formats, and prepare reports? OR Do they have adequate understanding of the reporting process being followed in your state/district/block?
d. Do you conduct such trainings for ASHAs to fill the report and other documentation?
e. How often are these training conducted? [Collect copy of the standard format or any guidelines issued in this regard]

10. Is there any mechanism for validation/checking of the reports filed by ASHAs' for the immunization services provided by them, and the incentive due for those services?
    a. If Yes,
        i. How the information is validated? Who all are responsible for validation?
        ii. Is field level verification done for validation of reports? If yes, by whom?
        iii. Is HMIS and RCH/MCTS reports cross matched for validating the work done? If yes, explain the process and persons involved.
    b. If No,
        i. Is there any reason for not having a validation mechanism? Have you never felt any need for having such system to ensure correctness in reporting?
        ii. What other accountability measure do you have and how does it work?
11. How does the reports submitted by ASHA workers flow to the authority who finally decide for payment of incentive? OR what is the channel followed for reporting by ASHAs'?
12. Do ASHAs have challenges in coordinating with ANMs for incentive claim report submission and verification? If yes, please explain.
13. Once these reports are received at the facility that will be making the payment, then what process is being followed from receiving the reports to final disbursement of incentives to ASHA?
14. What is your SPECIFIC ROLE in this entire process of claiming, validation, approval, and disbursement of immunization incentives to ASHA?
15. What are the different documents taken from ASHA for validating and payment of their incentive?
16. Who are the major stakeholders involved in finally deciding how much amount is to be paid to ASHAs' as incentives?
17. How are the incentives paid to ASHAs?

## Questions 18 to 29: Feasibility of current mechanism and its strengths and weaknesses

18. In your experience, does the current system (of claiming and disbursing incentives) in your state/district/block efficient enough to ensure timely disbursal of incentives to ASHAs?
    a. If Yes, can you explain how this works to ensure timely payment?
    b. If No, what are the gaps that need to be plugged for more timely payment?
19. What is the approximate duration for payment to ASHAs after submission of incentive report? What are the factors leading to delay in some cases?
20. What are the different records and reports related to ASHA incentive that you have to maintain at the block (point of disbursement)?
21. In this entire process that you have specified at levels of different stakeholders, what are the checks or monitoring mechanisms to ensure that ASHAs receive timely payment of their incentives?
22. Are there any variations in ASHAs' incentive disbursal process across different blocks? If Yes, please explain

23. Do you conduct visits to the block offices/villages?
    a. If Yes, do you review and verify the records related to ASHA incentives? How do you verify and validate the information on incentives?
24. What challenges have you experienced (or heard from other districts, block or department colleagues) in incentivizing ASHAs' for the services they provide for immunization program?
25. How do you address these challenges? OR how can these challenges be addressed
26. Whether status of incentivizing ASHAs' (e.g. pending payment etc.) discussed during the review meetings at state/ district/ block level?
    a. If Yes - What are the major issues discussed? How often and by whom (at what level – block, district, magistrate, divisional, state level)?
    b. If No - Why ASHA incentive disbursement issue is not on review agenda, at any level? What are the constraints?
27. Do you have any grievances redressal mechanism in the state/ district/ block related to ASHAs incentive disbursement? If yes, please describe something about it?
28. Are there any issues related to receiving ASHA incentive budget for immunization program from higher level (national/state/district)?

29. In your opinion, what other improvements could be made in the existing ASHA incentive payment process for ensuring complete and timely payment to ASHAs for the services they provide to immunization program?

## 3. Discussion Guide for FGD with ASHA and ASHA Facilitator groups

1. You have been providing immunization services in your community for last many years.
   a. How has been the overall experience?
   b. Has your involvement helped in improving the immunization coverage in your areas?
   c. What is the attitude of parents and care takers when you tell them about benefits of immunization? Describe.
2. What are the specific areas in which you (ASHA) provide support to immunization program?
3. Under National Health Mission (NHM), ASHA workers receive specific incentives for services they provide for immunization program?
   a. Do you receive incentives for immunization services?
   b. What are the different services for which you get incentives (for immunization)?
   c. How much incentive is sanctioned OR what you get for these different services?
4. Have you ever faced any difficulty in convincing parents to mobilize their children to immunization sessions due to the incentives you receive for immunization services?
   a. Have you faced any problem from villagers or village leaders (Pradhan, panchayat members etc.)
5. How do you claim your incentives?
   a. What all reports you need to prepare for claiming incentives?
   b. What is the frequency for claiming incentives (weekly / monthly / 3 monthly / etc.)?
   c. How are the reports that you prepared are submitted, and where?
   d. What is the entire process from preparing claim to getting disbursed (receiving incentives)?
6. What support you get in this process of documenting (preparing report), claiming and disbursement from
   a. ASHA supervisor
   b. ANMs of your areas
   c. Any other person (enquire)
7. Do you (or peer ASHAs) face problem in preparing and submitting incentive reports? What are the common problems you face in this regard?
8. Are you trained or oriented for preparing reports and filling up the ASHA incentive report?
   a. If yes, when (how many years before), where, and by whom? Is there any plan to reorganize such training?
   b. If no, do you require such training; and what should be the topics of the training, who should be the trainer, duration, and frequency?
9. Who authorizes your claim and submit at the facility?
10. Once these claim reports are submitted then what is the process further followed for processing and disbursement of incentives for your services in immunization program?
11. Who are the other stakeholders involved in claiming, authorization, and payment of incentives to ASHAs?
12. How do you receive incentives (cash, online transfers, cheques etc.)? In your opinion is this method convenient for you?
13. Do you face any challenges in -

a. Preparation of report or claim
b. Authorization of the report by ANMs or other persons involved
c. Receiving claim [Probe for payment in kind, commissions, etc.]

14. Once you submit your claims, do you receive incentives in time?
    a. If yes, what is the normal time between claim and disbursement?
    b. If no, what are the reasons for delay, and how long it can be delayed?
15. In your opinion, does timely disbursement of incentives is a motivating factor for ASHAs' to perform better?

16. Is there any grievance redressal mechanism for ASHAs for timely payment of incentives? Describe in detail how do you raise your problems and issues, and where?
17. Can you suggest some ways by which the process of submission of ASHA incentive payment report, and timely payment of incentives to ASHAs can be improved?

## 4. Discussion Guide for FGD with ANM

1. In your experience, has involvement of the ASHAs helped in improving the immunization coverage in your areas?
   a. If yes, how has their involvement helped in improving coverage?
   b. If no, what has been your experience in this regard?
2. What are the specific areas in which ASHAs' provide support to immunization program?
3. Under National Health Mission (NHM), ASHA workers receive specific incentives for services they provide for immunization program?
   a. Do they receive incentives for immunization services?
   b. What are the different services for which they get incentives (for immunization)?
   c. How much incentive is sanctioned OR what do they get for these services?
4. Have you ever experienced that ASHAs' face difficulty in convincing parents to mobilize their children to immunization sessions (or else); or some hindrance from villagers or village leaders, due to the incentives they receive for immunization services?
5. How do ASHAs claim their incentives?
   a. What all reports they need to prepare for claiming incentives?
   b. What is the frequency for claiming incentives (weekly / monthly / 3 monthly / etc.)?
   c. How are the reports submitted, where, and who are involved?
   d. What is the entire process from preparing claim to getting disbursed?
6. Describe your roles and responsibilities in ASHA incentive process for their services in immunization program.
   a. What support do you provide to ASHAs in your areas to get incentives?
7. What is the role of ASHA supervisor in this process of documenting (preparing report), claiming and disbursement?
   a. Is there any other stakeholder at village or facility level who provides support to ASHA? If yes, who and how do they support?
8. Do ASHAs' (or few ASHA) face problem in preparing and submitting incentive reports? What are the common problems they face in this regard?
9. Are ASHAs trained or oriented for preparing reports and filling up the ASHA incentive report?
   a. If yes, when (how many years before), where, and by whom? Is there any plan to reorganize such training?
   b. If no, do they require such training; and what should be the topics of the training, who should be the trainer, duration, and frequency?
10. Once these claim reports are submitted then what is the current process for processing and disbursement of incentives to ASHA for their services in immunization program?
    a. Who authorizes the claim and submit at the facility?
    b. Who are the other stakeholders involved in claiming, authorization, and payment of incentives to ASHAs?

11. Once ASHA submit their claims, do they receive incentives in time?

a. If yes, what is the normal time between claim and disbursement? What is the normal frequency of incentive report submission by ASHAs?

b. If no, what are the reasons for delay, and how long it can be delayed?

12. How do they receive incentives (cash, online transfers, cheques etc.)?
    a. In your experience is this method of payment convenient to them?

13. Is there any process of verification of the claim submitted by ASHA?
    a. If Yes, what is the verification process and who are involved? Does any staff member visit ASHA area to verify the claim?
    b. If No, do you feel that there should some process of verification?

14. Are there any other challenges faced by them in this process of receiving incentives?

15. How do you support ASHAs in addressing the challenges faced by them in report preparation, submission and receiving payments?

16. In your opinion, is timely disbursement of incentives a motivating factor for ASHAs' to perform better?

17. Is there any grievance redressal mechanism for ASHAs for timely payment of incentives? Describe in detail how do they raise their problems and issues, and where?

18. Can you suggest some ways by which the process of submission of ASHA incentive payment report, and timely payment of incentives to ASHAs can be improved?

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