IMMUNIZATION INCENTIVE SYSTEM for ASHA Workers

Standard operating procedures to streamline process of incentivising ASHA for immunization services

SUGGESTED FRAMEWORK

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

Contents

List of Abbreviations

AHS	:	Annual Health Survey
ANM	:	Auxiliary Nurse and Midwife
ASHA	:	Accredited Social Health Activist
BAC	;	Block ASHA Coordinator
BAM	:	Block Accounts Manager
BCM	:	Block Community Manager
BPHC	:	Block (level) Primary Health Centre
BPM	:	Block Programme Manager
CHC	:	Community Health Centre
CRM	:	Common Review Mission
DAM	:	District Accounts Manager
DCM	:	District Community Manager
DDO	:	Drawing and Disbursing Officer
DPM	:	District Programme Manager
DLHS	:	District Level Household Survey
FIC	:	Full Immunization Coverage
GIS	:	Geographic Information System
HMIS	:	Health Management Information System
ICDS	:	Integrated Child Development Services
INR	:	Indian Rupees
JSI	:	John Snow Inc.
JSY	:	Janani Suraksha Yojana
LHV	:	Lady Health Visitor
MCH	:	Maternal and Child Health
MCTS	:	Mother and Child Tracking System
MPW (M)	:	Multi Purpose Worker (Male)
NFHS	:	National Family Health Survey
NHM	:	National Health Mission
PFMS	:	Public Financial Management Software
PIP	:	Programme Implementation Plan
PPA	:	Print Payment Advice
RCH	:	Reproductive and Child Health
RCH	:	Reproductive and Child Health Officer
SFM	:	State Finance Manager
SMS	:	Short Message Service
SOE	:	Statement of Expenditure
SOP	:	Standard Operating Procedures
UC	:	Utilization Certificate
UIP	:	Universal Immunization Programme

Background

ASHA workers support India's Universal Immunization Programme through mobilizing beneficiaries and generating awareness among the community. In return they get fixed performance based incentives for the services they offer. After more than 10 years of inception of the ASHA programme since 2006, this cadre of voluntary front line functionary has become an inherent part of the Indian government health system.

For Universal Immunization Programme (UIP), ASHA workers work for getting all pregnant women and children under five years of age immunized with vaccine doses as per the national immunization schedule, in a timely manner. The services which ASHA workers do for immunization programme, for which they receive fixed incentives are – mobilization of due beneficiaries to immunization sessions, getting all infants fully immunized before one year of age, and ensuring booster doses to all children in their area by the age of two years.

Evaluation surveys have shown a gradual improvement in the proportion of fully immunized children. The gain in full immunization coverage between 1998 and 2005 was a mere 1.5 percent from 42 percent (NFHS-2, 1998-99) to 43.5 percent (NFHS-3, 2005-06). On the other hand, the achievement gained between 2005 and 2015 in terms of fully immunized children was 62 percent (from NHFS-3, 2005-06 to NHFS-4, 2015-16). This duration of nearly 10 years matches with the period when ASHA workers got operational. However, still despite having a community based and dedicated cadre of ASHA workers who are paid incentives specifically based on number of children whom they get fully immunized, the evaluated increase in the proportion of fully immunized seems to be less.

To ensure continuation of activities undertaken by ASHA workers in their respective communities, especially for immunization programme, without any hindrance, regular payment of incentives is critical. The timely payments will not only ensure continuation of activities but also help in building motivation of ASHA workers to fulfil their responsibilities. But, Government of India's Common Review Missions (CRM), and some independent reviews conducted during last few years, have raised concern related to payment of ASHA incentives with specific mention of huge back log in ASHA payments, and partial release or untimely payments in some states of India.

Gavi, the Vaccine Alliance, funded JSI Research & Training Institute to carry out a field level review to understand and review the processes and practices that underlie the payments of incentives to ASHA workers for their support to immunization services. The field level review also aimed at identifying operational challenges and gaps that may feed into the development of standard operating procedures for ASHA immunization incentive payment in order to reap full benefits of these immunization incentives.

Detailed report on the findings of field level review has been submitted separately. This document outlines the suggestive operating procedures with an operational framework, and specific steps that need to be followed for streamlining the ASHA incentivization process for immunization programme.

Activities undertaken

To facilitate development of suggestive standard operating procedures with an objective to streamline processes for incentivising ASHA workers for immunization services, following activities were undertaken:

1. Field level review

An in-depth field level review was conducted in 12 districts of 6 states by an external independent research agency between January 2017 to March 2017. The objective of review was to understand different processes related to disbursement of immunization incentives to ASHA workers, and identify related operational challenges, gaps and opportunities.

States and districts were selected by composite scoring method based on immunization related indicators from reported HMIS data for years 2014-15 and 2015-16. In addition, some indicators were also taken from the most recent evaluation surveys (DLHS, AHS, NFHS) as applicable for different states. The 6 states included in this review were Bihar, Haryana, Madhya Pradesh, Tripura, Rajasthan, and Maharashtra.

The review was done through in-depth interviews and focus group discussions with different stakeholders involved in incentivization process. A total of 140 in-depth interviews were conducted with stakeholders at various levels (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 done with ANMs', ASHA Supervisors, and ASHA workers to meet the objectives of the review.

Major operational challenges identified were – unavailability of all year-round funds for paying ASHA incentives; complex processes for claiming incentives requiring multiple documents and supporting vouchers; vacancy or multiple responsibilities on critical staff members; lack of standard guidelines to be followed for ASHA claim and disbursement at various levels; and inefficiency of grievance redressal system for ASHA workers in case of partial or delayed payment.

Findings of this review indicated that to maximize the gain and increase the proportion of fully immunized children there is a need to standardize processes to streamline release of ASHA incentives, especially immunization incentives.

2. Expert group consultation for developing SOP

To brainstorm on the findings of field level review, highlight and document systemic issues, and propose a revised and uniform mechanism to ensure timely payment of incentives to ASHA workers an expert group consultation was convened.

The group comprised of experienced and renowned members from public health, immunization programme, and finance departments. The group also included team leader from the external research agency that conducted the review, and JSI team members. The list of members of expert group is given in Annexure 4.

The group consulted for five days during April 2017 to synthesize and consolidate the findings from the review, specifically in terms of the ongoing practices, opportunities, gaps and challenges within the health system; and innovative approaches developed and adopted in some districts/states for improving the processes.

The group discussed in detail to answer the question– why despite payment of immunization incentives to ASHA workers, there is no significant improvement in proportion of fully immunized? The group developed a set of suggestive standard operating procedures to address the operational challenges identified during the review, within the context of current health system, practices, and guidelines.

Although, the group primarily aimed at developing SOPs for streamlining disbursement of ASHA incentives for immunizations services, but the suggested procedures and steps outlined in this document are applicable for all kinds of incentives paid to ASHA workers for their services to the community.

Support structure for incentivizing ASHA workers

1. National guidelines envisage procedures and steps required for timely release of incentives to ASHA workers. The national ASHA incentive guidelines provide a roadmap to states to plan activities for ASHA workers, and prepare budget estimates required to incentivize them.

   National guidelines provide flexibility to states for setting incentive for different services, and include additional services that can be paid from the state budget. These guidelines are uniform for all programme areas, including those for immunization.

2. Revised guidelines in case of any revision or addition of incentives are shared with the states, which are further adapted in line with the state policy directives, translated (in regional languages), and shared further till the grassroot level.

   District and sub-district level stakeholders, mostly facility-in-charge and/or NHM contractual staff is responsible at the respective levels for dissemination and compliance of revised guidelines.

3. To support and strengthen ASHA programme, MOHFW (GOI) has constituted National ASHA Mentoring Group, which provides technical guidance and policy inputs, undertakes supportive supervision visits to states to identify constraints, and give feedback and strategic recommendations to the health ministry. Based on the recommendations of this group NHM Mission Steering Group takes policy decisions, which includes need-based revision or addition of incentives, and other programmatic decisions. ASHA support structure also exists at the state and district levels, with variations due to variable organizational structures.

   The first line of support for ASHA comprise of newly introduced cadre of ASHA facilitators, and Female Health Workers (ANM).

4. Release of incentives to ASHA workers follow various steps including claim submission, claim validation, consolidation, verification, approval, and finally release. All states follow these procedures with difference in the sub-procedures, guidelines, templates, tools, and timelines. Some states use a consolidated claim format for all programmes, which eases the entire process; while some states use separate formats for different programmes making this step tedious and complex.

   Some states have adopted online consolidation of claims and monitor the activities done by ASHA workers, while others rely on traditional supervision and monitoring methods.

5. National guidelines require every state to establish a grievance redressal mechanism or committee for ASHA workers in all districts. Some form of grievance redressal mechanism exists in all states, but have variable structure, composition, and representation from related departments.

   Monthly meetings (mostly review meetings) at the sub-district and district levels is a common platform for grievance redressal in all states.

Proportion of fully immunized vis-à-vis ASHA incentives

The objective of field review was to assess why the proportion of fully immunized children has not increased significantly despite incentivising ASHA workers for providing immunization services. Expert group discussed the findings in detail. Earlier ASHA workers received receive incentives for their services to immunization programme under three heads. These are mobilization of beneficiaries (INR 150 per session), full immunization till 1 year (INR 100 per child), and complete immunization by two years of age (INR 50 per child). Recently, there has been a revision, and activities like mobilization of beneficiaries and preparation of duelist have been included under a common head named as "Routine Activities".[1]

It was revealed during review that amount paid as immunization incentive is very less as compared to that for other activities like family planning and JSY. Therefore, ensuring full immunization is not a motivational factor for ASHA workers, and they prefer to provide services that are more beneficial.

Discussion was done regarding other possible issues which has not resulted in significant increase in the proportion of fully immunized. Three reasons, along with the underlying issue, and required action were identified and are mentioned in the following table:

Table 1: Reasons for missing beneficiaries in the ASHA catchment areas

Reason	Underlying issue	Action required
ASHAs do not update beneficiary records by home visits on regular basis	ASHA workers are supposed to conduct monthly visit to all households in their areas to identify immunization beneficiaries, track vaccination status and prepare due list of beneficiaries. Due list of beneficiaries currently prepared by ASHA workers for use during immunization session is mostly made based on her records. They do not visit every household and may miss a few with new beneficiaries (like migrants or relatives). This may result in missing out some beneficiaries.	Monthly household visit by ASHA workers need to be ensured through rigorous monitoring and supervision. The status must be a reviewed as an agenda item during the district and sub-district level meetings. Annual headcount survey in ASHA areas and six monthly update must be tracked and ASHA wise documentation regarding progress must be reviewed periodically. Inclusion of any new child in the immunization due list (like, new born, migrant, left out etc.) should be considered for additional incentives.
Catchment areas of ASHA workers not defined	ASHA area wise maps, depicting geographic limits and number of households in her area are seldom found. Her services are dependent mainly on the families registered. No specific steps have been undertaken to identify any missed areas or habitations which do not fall in the catchment area of any ASHA worker.	Proper mapping needs to be done to appropriately define ASHA catchment areas, along with exact number of households. This will ensure that there is no overlapping or missed areas in any village. GIS enabled mapping using smart phones can be a technology intervention to define the area (geographical expanse) and locations of households. This can be tracked to ensure if ASHA has visited all households on monthly basis
Supportive supervision at the field level is ineffective	Guidelines exist for supervision from all levels; tools and monetary support also exist under NHM plans. Despite this support structure, the supervision in the field has not been effective. Issues identified during field visits and interaction with frontline functionaries are not reviewed and tracked at any level.	Supportive supervision visits, observations, and actions taken need to be tracked at the immediately higher level. There must be documented mechanism of feedback and feed forward for issues identified during the supervisory visits

[1]*Update of ASHA programme, MOHFW, Government of India, July 2016*

Cross-cutting Recommendations

1. Matching immunization incentive with expected improvement in coverage

- Immunization programme is a priority national health programme, and to meet the urgent need for improving coverage and reducing associated mortality and morbidity among children under five years of age there is a need for strategic investment in the ongoing processes at the community level.
- To further build upon the gains there is a need to review the incentive structure paid under immunization programme and make it similar like for Janani Suraksha Yojana (JSY).

2. Prioritization of ASHA incentive payment

- Regular and timely payment of incentives to ASHA is indirectly an appreciation of her services towards community and helps to enhance and sustain her motivation.
- For uninterrupted release of incentives to ASHA workers, concerned department of national government need to issue a circular to state governments and further to district health departments to consider payment of ASHA incentives as important as payment of salary to the government staff.
- Clear directive should be released making payment of incentives to ASHA workers as a priority "routine activity". Instructions must specify not to delay or stop incentive payments once approved by the concerned authority, for any reason like late submission or approval of PIP, late submission of claims by a few ASHAs, ongoing physical verification of incentives claimed, etc.
- At all levels availability of adequate funds must be monitored to ensure timely payment of incentives. Wherever possible a buffer fund for 2-3 months should be ensured to meet demand from districts or blocks.
- Unspent balance at the end of year should be earmarked as committed unspent balance for ASHA incentive payment during the initial months of next fiscal year.

3. Establish handholding institutions

- Various operations under ASHA programme are extensive and need day to day implementation. To manage this large scale programme, interested institutions can be identified who can provide handholding support to the health department to ensure timeliness and quality of operations like recruitment, trainings, performance reviews, supportive supervision of ASHA workers and ASHA Facilitators.
- Such model can be implemented in public private partnership mode, like that adopted for ICDS programme.

4. Utilization of information technology for streamlining ASHA incentive disbursement and monitoring

- Delays generally occur due to paper work involved, and manual errors related to accounting. Therefore, information technology based model should be piloted and institutionalized for saving time and ensuring quality in processes related to claim, consolidation and release of ASHA incentives. Information technology based support can facilitate quality and timeliness in submission of reports related to ASHA incentive payment.
- Use of smart phone based apps should be implemented for ASHA workers to concurrently enter details of activities done and beneficiaries benefitted. This information can be accessed through cloud based server and on authentication by ANM can generate online claims, collated at block levels, and linked with ongoing financial management software to release payment.
- ASHA workers should have mobile app based record of all children beneficiaries, list of fully and completely immunized children generated from RCH portal; and text messages reminding dropout beneficiaries.
- In states like Rajasthan and Maharashtra, use of ASHA SOFT demonstrates utility of IT models in effective operationalization and monitoring of different incentive related processes. Scale up of portals like ASHA soft should be considered for other states.

5. Implementing need based strategies in specific areas

- Strategies for providing services to easily accessible population, in contrary to strategies for reaching out to areas like urban slums, tribal and hard to reach areas are much different. Therefore, specific strategies need to be designed and implemented in difficult and hard to reach areas.
- The needs, geographical spread, terrain, and availability of infrastructure and healthcare service delivery platforms need to be considered while deciding operating procedures for incentivising ASHA workers who work in such hard to reach areas. Additional incentives for immunizing children belonging to difficult to access communities can also be considered to motivate ASHA workers.

Opportunities for streamlining ASHA incentivization

A) Monthly Review Meetings at the subcentre level

According to NHM guidelines, monthly meetings for ASHA workers are conducted at the BPHC/CHC the blocks (in some blocks also at the PHC level). These are convened by BPHC or PHC Medical Officers, and facilitated by Block Programme Managers/Block Community Mobilizers or LHV/ANM.

These meetings are mostly scheduled in the last week of every month, after end of reporting period. The reporting period varies in different states, example, 21st to 20th or 26th to 25th etc.

The objectives of these monthly meetings are:

a. Capacity building

b. Review of performance monitoring reports

c. Drug kit replenishment

d. Submission of payment vouchers and support documents

e. Problem solving

f. Dissemination of new orders and guidelines

It was revealed from the field review that due to considerable number of participating ASHA workers these meetings merely act as a forum for submission and verification of payment vouchers. They mostly do not address other objectives, unless there is instruction from the higher level to focus on any specific activity.

Each PHC generally has 6-8 subcentres in its catchment area, each subcentre serving 5-6 villages. Taking one ASHA per village, total ASHA workers in a PHC catchment area will be 30 to 36. In a BPHC/CHC area there are 4 PHCs and so number of ASHA workers under any BPHC. CHC is between 120-150. Though there is variation in different blocks, districts and states, but this is a general estimate applicable to majority of blocks. These many number of ASHA workers participating in monthly meetings will not serve the purpose and meet the objectives of these meetings.

In some blocks subcentre level meetings are also organized, covering approximately 30-36 ASHA workers, and led by the ANM. These subcentre level meetings is an opportunity and these should be formalized and strengthened. The calendar for these meetings should be prepared by ANMs in discussion with ASHA workers, ASHA facilitators, and also Anganwadi workers. These meetings can serve the purpose of capacity building, orientation, review of reports, etc. along with collection and verification of ASHA incentive claims. Verified claims can then be submitted at BPHC (CHC) for further action.

B) Supportive supervision visits with focus on ASHA incentives:

Supportive supervision is an inbuilt provision of ASHA programme and is to be done by the concerned staff at all levels. To further strengthen the ongoing supportive supervision and to expand the ambit of this process, review of ASHA incentive payment should be included as a part of checklist being used.

Following suggestive steps can be considered to strengthen ongoing supportive supervision:

- New or revised guidelines on activities and incentives should be disseminated to ASHA workers during the field visits by ASHA Facilitators, ANMs, and other staff members.
- At block level, physical verification and matching of ASHA performance and incentives claimed must be done. This has been initiated in some status using ASHA SOFT portal, like Rajasthan and Maharashtra, and must be replicated to other states.
- A sample of 10% of ASHA workers in a block catchment area must to be visited by ASHA supervisory staff for providing supportive supervision, and to cross check incentives claimed with ASHA records.
- Sample of ASHA workers claiming incentives in the lowest and highest range, those working in high-risk or hard to reach areas, and those with repeated grievance must be purposively selected for the visit.
- Number of supportive supervision visits per month by each of the concerned staff member from district and blocks (DPM, DCM, DAM, BPM, BCM, BAM, or equivalent staff) must be fixed (example, 10 visits per month). State government may issue directive specifying release of month's salary to be contingent upon completing the number of scheduled visits for that month and submission of filled checklists.

Note: Field level supportive supervision for assessing performance and incentives claimed by ASHA workers is an ongoing process. Release of ASHA incentives should not be contingent upon the approval after such assessment/verification.

- Feedback from supportive supervision visits should to be shared with ANM, ASHA Facilitators, ASHA workers, and the other coordinating staff at the appropriate forums (example, monthly district, block, and subcentre meetings).
- Supportive supervision visit report should include the findings and also the feedback regarding performance, strengths, and challenges faced by ASHA workers for ensuring corrective actions.
- ASHA programme should also be monitored at the district and state levels using reports generated by PFMS and RCH portals. This will enable matching of total incentives paid and achievement made in terms of beneficiaries benefitted. This will further ensure monitoring of regular and timely payment of incentives, and undertake taking corrective actions where required.

Suggestive Standard Operating Procedures (SOPs) for ASHA incentive payment

The standard operating procedures outlined here have been documented under different headings relating to different steps in the incentivization process, viz. claim preparation and submission; verification and validation; and consolidation and disbursement.

1. Claim preparation and submission by ASHA workers

- **Use standard template for claim voucher.** It should have uniform fields in all states, districts, blocks and sub-centres, with minor state level variations as per policies and guidelines (suggested template given as annexure 2).
- **Adapt claim voucher template in the regional languages** for ensuring acceptance and uniform understanding among the workers.
- ASHA workers should **prepare and submit complete, correct, and duly signed claim voucher, on monthly basis.** It should have clear mention of activities performed by them during the reporting period (timelines for each activity are specified in the next section of this document).
- ASHA workers should use Village Health Register and ASHA Diary as records for preparing monthly claims. These records should be updated on regular basis and should be checked by ASHA Facilitators during their supervisory visits.
- **Claim voucher should be prepared by ASHA in three copies** (Xerox can be used, if feasible). After verification all three copies should be signed by ANM and ASHA Facilitator.
    - First and original copy should be submitted at the block health facility, second copy should be filed by ANM at her subcentre for record, and the third copy should remain with ASHA worker.

Note: *In case there is a vacancy or unavailability of any signatory, alternative arrangements should be made to verify, submit and approve the ASHA claim vouchers without delaying the process.*

- The claim voucher should be the ONLY document to be submitted by ASHA workers for claiming incentives.
    - No additional supporting document or any other format, like, list of names of children fully immunized / completely immunized etc. should be required for incentive disbursement. This will ensure that workload of ASHA is not increased due to excessive paperwork.
    - In case there is need to crosscheck number of activities mentioned in claim voucher, the records maintained by ASHA, respective ANMs, and the online portals (RCH portal, HMIS portal), can be referred to.
- ASHA Facilitators/Supervisors during their visits to ASHA workers:
    - Should review and support them in maintaining and updating their records
    - Guide and support ASHA workers in preparing the claim vouchers. They should ensure that ASHA workers prepare and submit claims in timely manner.

- Missing claims of ASHA worker/s should be processed in the subsequent month. In such cases ASHA should be required to submit two separate claims for the missed month and the regular month.

For example, an ASHA worker could not submit her claim for September. Then at the end of October reporting period, she should submit two separate claim vouchers, one each for September and October.

2. Verification and validation

- Verification of ASHA claim vouchers should be done by ANM of the subcentre and ASHA Facilitators during the monthly subcentre level meetings.
- These subcentre monthly meetings should be organized in all subcentres (within 2-3 days of end of reporting period). Terms of reference for these meetings are given in Annexure 3.
- Claim vouchers should be checked for correctness, completeness and must be cross verified with the following records:
  - ASHA village register and ASHA diary
  - ANM records – MCTS register, immunization register, MCH register, eligible couple register, due cum tally sheets
  - Counterfoils of MCP cards
  - Discharge tickets from health facilities (for JSY cases)
  - Relevant records for other programmes (as applicable)

Note: *ANM should be made accountable for correctness of the claims submitted by ASHA workers. They should be notified that in case of any in discrepancy or mismatch between performance and incentives claimed, these can be re-checked during the monitoring visits by supervisors.*

State directives should clearly fix accountability of ANM for the correctness of incentives claimed by ASHA workers of the respective areas.

Verified and signed claim vouchers are adequate to validate the authenticity and correctness of this claim. Any supporting document from ASHA records should not be required along with the claim.

- ASHA Facilitators/Supervisors should play an active role in supporting ASHA workers during the verification process.
- Subcentre ANM should be responsible for collecting, verifying, ad submitting the claim vouchers of ASHA workers from her subcentre area at the block level facility, in timely manner. At block level facility, vouchers should be submitted during the monthly review meeting.
- In case if delay is anticipated in submission of claims at block health facility by ANM, any of the following two processes can be adopted:
  - ASHA worker can directly visit the health facility for submitting verified claim within 2-3 days after subcentre meeting
  - ASHA facilitator can collect verified claims and submit them during the monthly block level meeting

- For field verification of incentive claims, records of ASHA workers as well as ANM should be checked.

3. Consolidation and disbursement

- Block level staff responsible for claim settlement (BCM, BAC, etc.) should,
  - Compile and computerize all claim vouchers in ASHA and programme wise matrix
  - Forward the consolidated sheet to account section
  - File the original claim vouchers for record
  - Prepare list of ASHA workers who have not submitted the claim for the reporting period. ASHA facilitators should follow up with these ASHAs and provide required support in preparing the claim.
- Account section staff (BAM, BAC, etc.) should,
  - Consolidate the claimed incentives in budget head wise worksheet
  - Submit the sheet along with file note to facility in charge/DDO for approval
- Facility in charge/DDO and joint signatory will approve the consolidated worksheet.
- After approval, account section should enter ASHA wise details in PFMS portal and prepare Print- Payment-Advice (PPA), and get it signed for onward submission to bank for release of payment.

Note: In case of non-availability of funds under any budget head (example, ASHA incentive), there should be provision for re-appropriation of funds from other underutilized budget heads. This will ensure that payment of ASHA incentives is done on monthly basis, without any delay or backlog.

- Responsible accounting staff should prepare and submit the consolidated financial and physical report (including the incentives paid to ASHA workers), also known as Statement of Expenditure (SOE) or Utilization Certificate (UC) to the district on monthly basis (example, by 10th of each month).

District health department and district administration should establish a mechanism to send SMS/ text messages to ASHA workers on their registered numbers, informing them about the amount paid into their accounts.

Information regarding incentives disapproved or deducted from the claim should also be shared with ASHA workers both by SMS as well as by the concerned staff members.

***Note:** In case few ASHA claim vouchers are not submitted in timely manner then this should not be a cause of delaying entire process of incentive release.*

Step wise timelines for ASHA incentive payment

This section outlines the days involved and timelines for each of the activity specified in the previous section on suggestive standard operating procedures.

Table 2: Suggestive timelines for different processes related to incentive disbursement

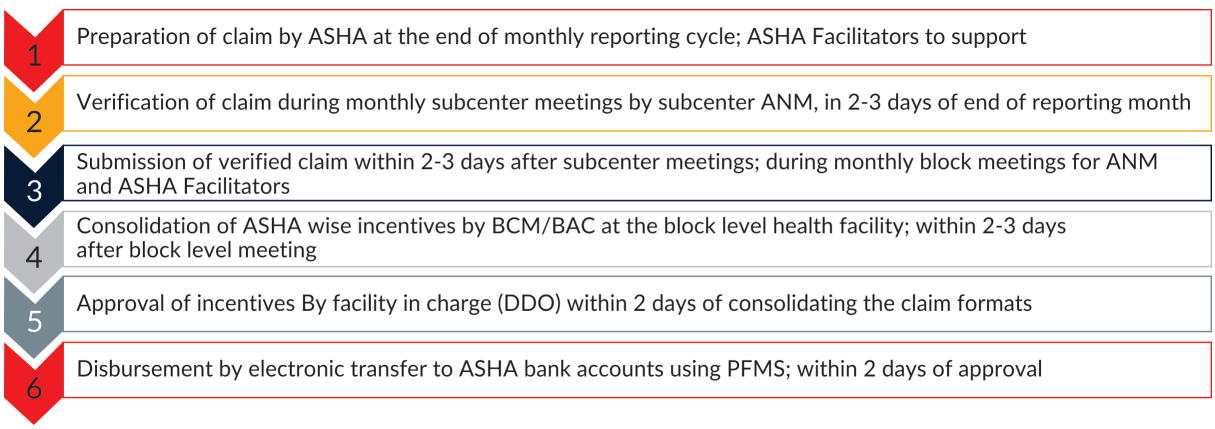
Step	Activity	Responsible person	Days involved
1	Preparation of claims (filling incentive claim vouchers)	ASHA workers	at end of reporting period
2	Claim verification during subcentre level meetings	ANM (and ASHA facilitators)	within 2-3 days of end of reporting period
3	Submission of claim vouchers during BPHC (CHC) or PHC meetings	Subcentre ANM	within 2-3 days after subcentre level meetings
4	Consolidation of claim vouchers at BPHC (CHC) or PHC	BCM, BAC	within 2 days of BPHC/ PHC monthly meeting
5	Approval of consolidated ASHA wise claim	Facility in charge or DDO	within 2 days of preparation of consolidated format
6	Upload in PFMS for disbursement (for electronic transfer to accounts)	Accounting section	within 2 days after approval

Incentives must be transferred in ASHA accounts every month within 10-12 days of end of monthly reporting period.

Table 3: Example showing activities and dates by which they are to be completed

Activity	Days	Suggested Timelines	Example (for reporting period of 21st to 20th)
Preparation of claims by ASHA workers	0	End of reporting period	20th to 21st of same month
Subcentre level meetings for claim verification by respective ANM	2-3	2-3 days after reporting period	21st to 23rd of same month
BPHC (CHC) or PHC level meeting for submission of claim vouchers	4-6	2-3 days after subcentre meetings	24th to 26th of same month
Consolidation of claim vouchers at BPHC (CHC) or PHC	6-8	2 days after BPHC/PHC monthly meeting	27th to 28th of same month
Approval of consolidated ASHA wise claim by facility in charge	8-10	2 days after preparation of consolidated format	29th to 30th of same month
Upload in PFMS for disbursement	10-12	Within 2 days after approval	1st to 2nd of next month

Figure 1: Suggestive steps in ASHA incentive claim and disbursement



Annexure 1

Suggestive ASHA support structure for streamlining incentive payment

Level	Designation	Responsibilities related to incentives claim and release
Village (or urban ward/ slum)	ASHA Facilitator or Supervisor	▪ Share updates, guidelines, and recording-reporting formats with ASHA workers ▪ Guide ASHA workers in filling their claim vouchers forms correctly and completely ▪ Ensure timely submission of claim vouchers ▪ Support ANM during monthly subcentre meetings to verify ASHA claim vouchers ▪ Collect verified vouchers from ASHA workers and submit at block facility during monthly block level meetings (if required) ▪ Follow up with ASHA who could not submit their claims and ensure support for timely submission of claims
Subcentre (or urban health post)	ANM and MPW (M)	▪ Organize and facilitate monthly subcentre meetings ▪ Share guidelines, provide updates and resolve problems ▪ Update ASHA about release of incentives of the previous month (and inform reasons to those who received less incentive) ▪ Verify claim vouchers of ASHA workers in their areas with available records at subcentre ▪ Submit ASHA claims during block level monthly meeting
Block /sector	BCM/ BAC	▪ Co-facilitate monthly meetings at the block level to share guidelines and updates related to ASHA programme ▪ Collect ASHA claim forms from ANM or ASHA Facilitators during monthly block meeting ▪ Identify and enlist ASHA workers who have not submitted their claims and share with concerned ASHA Facilitator/ANM ▪ Consolidate activity wise ASHA claims in computerized template and share with account section ▪ Prepare and share list of ASHA workers receiving incentives in lowest and highest range, those working in high-risk or hard to reach areas, and those with repeated grievance for supervisory visits ▪ Conduct field visits to support ASHA and ASHA Facilitators for capacity building to fulfil their responsibilities
Block /sector	BAM	▪ Keep records of all funds received and expenditure incurred with vouchers ▪ Consolidate activity wise ASHA claims in budget heads required for disbursement (as per FMR codes) ▪ Take approval from facility in charge/DDO and after approval upload on PFMS/issue cheque to bank for payment ▪ Timely prepare and submit the statement of expenditure and utilization certificate to district level ▪ Conduct field visits to support ASHA and ASHA facilitators and, cross check and address any incentive related issues.

Level	Designation	Responsibilities related to incentives claim and release
Block /sector	Facility in charge	▪ Monitor record-keeping of all funds received and expenditure incurred with vouchers ▪ Monitor timely dispersal of funds/ payments to ASHA ▪ Approves the claim disbursement ▪ Verify the statement of expenditure and utilization certificate ▪ Conduct supervisory field visits and facilitate capacity building activities for ASHA and ASHA facilitators
District	DCM/ DAC	▪ Oversee all community process related work including selection and training of ASHA workers ▪ Conduct field visits and provide supportive supervision and on job training to ASHA and ASHA Facilitators ▪ Co-facilitate district level review meetings to share updates and review activities ▪ Visit block facilities and subcentres to participate and provide inputs during community process related updates
District	DAM	▪ Oversee budget availability and utilization vis a vis allocation and plans ▪ Check consolidated data (financial and physical) submitted by blocks and provide feedback ▪ Keep records of all funds received and expenditure incurred ▪ Ensure availability of funds at the block level for priority activities including ASHA incentive payment ▪ Prepare the statement of expenditure and utilization certificate and submit to state level ▪ Visit block and sub-block facilities to verify incentive claims, and records
District	RCHO	▪ Oversee the ASHA programme, including vacancies, recruitment, training status, incentive status and grievance redressal ▪ Prepare and submit monthly community process report mentioning activities done and progress made vis a vis provisions under NHM PIP ▪ Ensure the timely release of funds to the blocks and availability of adequate funds at all levels to meet payment of incentive ▪ Monitor record-keeping of all funds received and expenditure incurred ▪ Conduct field visits for supportive supervision, and co-facilitate meetings and trainings at various levels
State	SFM	▪ Monitor availability, release, and utilization of funds at district level ▪ Ensure timely disbursement of incentives to ASHA workers and address any grievances related to incentives ▪ Conduct visits to districts and blocks to review record keeping, financial processes and share updates and feedback

Annexure 2

ASHA Monthly Claim Voucher Template

District: _____ Block: _____ Subcentre: _____

Name of ASHA: _____ Reporting month and year: _____ Incentive claimed: _____ Approved: _____

S. No	Heads of Compensation	Incentive at the Rate	No. of Cases/ Units	Incentive claimed (Rs.)	Incentive approved (Rs.)
	Maternal Health (JSY Financial Package)				
1.	Antenatal care	300 Rural, 200 Urban			
2.	Facilitating institutional delivery	300 Rural, 200 Urban			
3.	Reporting Death of women (15-49 years)	200			
	Child Health				
4.	Home-visits for the care of new born and post-partum mother	250			
5.	Follow up visits to a child discharged from SAM centre (facility/ community)	150			
6.	Monthly follow up of LBW babies and newborns discharged from NBCC	50			
7.	Child death review and reporting (children under 5 years of age)	50			
8.	Mobilizing & ensuring administration of Albendazole to children (1-19 years)	100			
9.	Prophylactic distribution of ORS	Rs 1 per ORS packet			
	Immunization				
10.	Full immunization of a child (under one year)	100/ per child			
11.	Complete immunization of a child (up to two years of age)	50/ per child			
12.	Mobilizing children for OPV immunization under Pulse Polio Programme	100/day			
	Family Planning				
13.	Registered mothers with spacing of 2 years or more after marriage	500/case			
14.	Registered mothers with spacing of 3 years or more after birth of 1st child	500/case			
15.	Registered couples opting for permanent limiting method after 2 children	1000			
16.	Follow up of the cases of Tubectomy (as per FP Programme)	150			
17.	Follow up of the cases of Vasectomy/ NSV (as per FP Programme)	200			
18.	Social marketing of condoms - as home delivery through ASHAs	Rs 1/pack of three			
19.	Social marketing of OCP - as home delivery through ASHAs	Rs 1/for a cycle			
20.	Social marketing of ECP - as home delivery through ASHAs	Rs 2/per pack			
21.	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	150/case			
	Adolescent Health				
22.	Distribute sanitary napkins to adolescent girls	Rs 1/pack of six			

S. No	Heads of Compensation	Incentive at the Rate	No. of Cases/ Units	Incentive claimed (Rs.)	Incentive approved (Rs.)
23.	Organizing monthly meeting with adolescent girls pertaining to menstrual hygiene	50/meeting			
24.	Incentive for support to Peer Educator (for facilitating selection process of peer educators)	100 per PE			
25.	Incentive for mobilizing adolescents for Adolescent Health Day	150 per AHD			
	Revised National Tuberculosis Control Programme (Honorarium and counselling charges for being a DOTS provider)				
26.	For Category I of TB patients (New cases of Tuberculosis, over six or seven months of treatment)	1000 for 422 contacts			
27.	For Category II of TB patients (previously treated TB cases, over eight to nine months of treatment)	1500 for 57 contacts			
28.	Treatment and support to drug resistant TB patients (on completing treatment: 2000 intensive; 3000 consolidation)	5000			
29.	For notification if suspect referred is diagnosed to be TB patient by MO/ Lab	100			
	National Leprosy Eradication Programme				
30.	Referral and ensuring compliance for treatment in pauci-bacillary cases (facilitating diagnosis)	250			
31.	Referral and ensuring compliance for treatment in pauci-bacillary cases (follow up on completion of treatment)	400			
32.	Referral and ensuring compliance for treatment in multi-bacillary cases (facilitating diagnosis)	250			
33.	Referral and ensuring compliance for treatment in multi-bacillary cases (follow up on completion of treatment)	600			
	National Vector Borne Disease Control Programme				
34.	Malaria - Preparing blood slides	15/slide			
35.	Providing complete treatment for RDT positive Pf cases	75			
36.	Providing complete radical treatment to positive Pf and Pv case detected by blood slide				
37.	For referring a case and ensuring complete treatment	300			
38.	**Lymphatic Filariasis** - One time line listing of lymphedema and hydrocele cases in non-endemic and endemic districts	200			
39.	Annual Mass Drug Administration (for maximum three days in 50 houses and 250 persons)	200/day			
40.	**AES/ Japanese Encephalitis** - Referral of AES/ JE cases to the nearest CHC/ DH/ Medical College	300 per case			
41.	**Kala Azar Elimination** - Sensitizing the community during the indoor residual spray rounds (IRS) for acceptance	100 per round			
42.	**National IDD Control Programme** - Incentive for testing 50 salt samples in the month	25 per month			
	Incentive for Routine Recurrent Activities				
43.	Mobilizing and attending VHND/ UHND/ outreach session	200 per session			
44.	Convening and guiding monthly meeting of VHSNC/ MAS	150			
45.	Attending monthly meeting at Block PHC/U-PHC	150			
46.	a) Line listing of households done at beginning of the year and updated every six months b) Maintaining records as per the desired norms like – village health register c) Preparation of due list of children to be immunized updated on monthly basis d) Preparation of due list of ANC beneficiaries to be updated on monthly basis e) Preparation of list of eligible couples updated on monthly basis	500			

Signature of ASHA

Signature of ASHA Facilitator

Signature of ANM

Annexure 3

Terms of Reference of Monthly Subcentre Meetings

- Objectives of the meeting:
  - Review progress and performance of ASHA workers, and disseminate recent updated guidelines.
  - Review the progress of head count survey and number of new beneficiaries (newborns, missed out, and migrants) added
  - Verify claim vouchers prepared by ASHA workers
  - Facilitate coordination between ANM, ASHA and AWW through record sharing and preparing joint workplans
  - Address problems and grievances
- Frequency of meeting:
  - Subcentre meetings must be organized once every month, at least 2-3 days before the scheduled monthly meetings at BPHC (CHC) or PHC levels.
  - Additional meetings can be organized as required, and as per the state specific norms
- Meetings will be facilitated by subcentre ANM and/or MPW (M), and co-facilitated by ICDS sector supervisor. Block level staff (Medical Officer, NHM contractual staff, LHV) should also participate to monitor quality of meetings and provide supportive supervision.
- Participants will include – all ASHA workers, all ASHA Facilitators, all AWW of the subcentre catchment area.
- Agenda: meeting at subcentre should be organized at least for 4 hours with following proposed agenda

20 minutes	Welcome and sharing updates and guidelines
100 minutes	Verification and validation of ASHA claim vouchers
30 minutes	Review of progress made
60 minutes	Joint action planning for ASHA and AWW for next reporting month
30 minutes	Problem solving and grievance redressal

- All queries related to ASHA workers should be discussed among ANM, ASHA Facilitator, and ASHA; and any coordination related problem or grievance should be clarified through mutual discussion during the meeting.
- Minutes of meeting should be documented by ANM [or MPW (M)] in the meeting register available at the subcentres; with mention of names of participants, activities done, issues revealed, and follow up action points.

Annexure 4

Participants of the Expert Group Consultation

Experts

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2. Dr Khirod Kumar Rout, Former State Technical Officer, JSI Odisha, Former State Program Manager for MISP in Disaster, Former Deputy Director, Immunization, Odisha.
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