भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

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D.O. No. A. 11033/61/2007-Trg
Dated the 10th September, 2008

Subject: Performance based payment to ASHAs

Dear

The National Rural Health Mission (NRHM) created the institution of Accredited Social Health Activists (ASHAs) as a community volunteer who could seek health care services for rural households. The ASHA was seen as one among the community who facilitates access to health care for the households that she is responsible for. Very Consciously, the institution of ASHA was seen as a community institution rather than a paid employee of the government. She was never intended to be the last member of a government health bureaucracy. It was on this account that a conscious decision was taken to provide only performance based payments to ASHAs. All health care programmes were requested to work out performance based payments arrangements which could accrue to ASHAs. Many National Health Programmes have created such performance based arrangements over the last few years.

2. An assessment of the role of ASHAs across the States brings out issues like delays in performance based payments and the primacy of JSY and Immunization session payments in the compensation actually received by the ASHAs. It has been felt that a large number of important public health challenges have not received adequate attention as they have not been incentivised. It is in this context that I am writing to you to enlarge the scope for performance based payments to ASHAs in a manner that the key priorities in public health of a particular region receive the attention of ASHAs and at the same time ensure a reasonable performance based payment to them every month. Perusal of the State Programme Implementation Plans indicates that this broadening of the scope for performance based payments has already started happening in the States. An illustrative list of some such performance based payment being made by States is enclosed at Annexe-A.

3. It has been felt that a wider range of public health functions be brought under the performance based payment arrangements for ASHAs. An illustrative list of such public health functions is as follows:

I. Organising Village Health & Nutrition Day

II. Making a series of five family visits in the first month of life of which one visit is in the first two hours-for home based oriential newborn care and early detection of sickness in the neonate.

III. Maintaining and updating a village health register that could be used in village health planning and promotion of complete registration of births and deaths.

4. As regards the delayed performance based payments, the current arrangement is to provide this payment under the approved programmes of government. While efforts been made to ensure timeliness of such payments, the States may consider, if feasible (if account could be maintained and expenditure reported periodically), creating a permanent advance of Rs.5000/- at the level of the Sub Health Centre in the joint account of ANM and Sarpanch to facilitate performance based payments for activities which are not covered under existing approved programmes. The Gram Panchayat shall make the decision for payment based on the priorities and the approved norms for the specific region. The provision for a permanent advance at the Sub centre level has been provided in the Framework for Implementation of NRHM. State Governments, may like to operationalize this to facilitate both the timeliness of payments as also the wider range of performance based arrangement that will meet region specific health channels.

5. While submitting their PIPs, the States will have to provide complete details of activities for which performance based payments will be admissible to the ASHAs. The payment arrangements from programme funds must be taken into account before determining the activities for which the Gram Panchayat shall provide payments to ensure that there is no duplication or delay.

6. We would like States to decide in the context of their needs to ensure that the Accredited Social Health Activists remains a community worker accountable to local community institutions like the Village Health and Sanitation Committee, This is being emphasized to retain the character of the ASHA worker as a member of the community rather than the last rung in the health bureaucracy.

With regards,

Yours sincerely,

(G.C. Chaturvedi

To all mission Dirtrs/Secretaries(Health & FW)
- All states & UTs.

Shri K. I. Sayed Mohd. Koya,
Secretary,
Health & FW,
UT of Lakshadweep,
Kavaratti - 682555.

Enclosure: Annex-A

MEMORANDUM

Subject: - Incentive packages for Accredited Social Health Activist (ASHA)

ASHA for every Anganwadi Centre (AWC) is being engaged to serve as a link between the community and the Rural Health System Anganwadi Worker (AWW) under the ICDS is engaged in organizing supplementary nutrition programme and other supportive activities. The vary nature of her job responsibilities with emphasis on supplementary feeding and pre- school education does not allow her to take up the responsibility of a change agent on health in a village. The new band of community based functionaries is proposed to fill this Govt. of India has approved engagement of ASHAs in all the blocks the state.

ROLE AND FUNCTIONS OF ASHA:

- Preparing a list of beneficiaries for all relevant programmes by doing a house to house survey. This data needs to be updated every year.
- Counsel women on birth preparedness, importance of sale delivery, breast feeding & complementary feeding, Immunization, contraception.
- Mobilize community and facilitate accessing health & health related services such as Immunization, ANC, PNC etc.
- Escort / Accompany pregnant women and children requiring treatment / admission to the nearest pre- identified health facility.
- Provide primary medical care for minor ailments such as diarrhea, fever and first aid for minor injuries; provide directly Observed Treatment short course (DOTs) under RNTCP as and when decided.
- Depot holder for essential provision like ORS, Iron Folic Acid (IFA) tablet Chloroquine, Disposable Delivery Kits (DDK), Oral pills and Condom etc. a Drugs kit will be provided to each ASHA.
- Inform about births and death in her village and any unusual health problems / disease outbreaks. Other role envisaged for ASHA in promoting nutrition, sanitation and safe drinking water.
- Be a link between the Govt. Health System and the community for all health related services.
- Keep close liaison with the Gram Panchayat.

COMPENSATION TO ASHA:

- ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood.
- ASHA will get a compensation package as per the rate and hand linkage provided below.

Sl.No	Heads of Compensation	Expected Compensation	Source of Fund / Fund Linkages.
1. RCH-II			
1.1	JSY		
1.1.1	JSY -- Institutional delivery including 2 (two) PNC	@ Rs. 600/-	Fund from JSY
2. Sterilization			
2.1	Tubectomy	@ Rs. 150/-	Sterilization Compensation funds.
2.1.1	Vesectomy /NSV	@ Rs. 200/-	Sterilization Compensation funds.
2.1.2	Immunization	@ Rs. 150/-	Routine Immunization.
2.1.3	Pilse Polio Day	@ Rs. 25 /-	IPPI
2.1.4	Organizing Village Health & Nutrition Day	@ Rs. 150 /-	VHND
3. RNTCP			
3.1	DOTs	@ Rs. 250/-	RNTCP Fund

3.1.1	Household toilet promo fee	@ Rs. 100/-	
4.NLEP			
4.1	Detection, referral, confirmation and registration of leprosy case	@ Rs. 100/-	NLEP Fund
4.1.1	After complete treatment for PB leprosy case	@ Rs. 200/-	
4.1.2	After complete treatment for MB leprosy case.	@ Rs. 400/-	
5. NVBDCP			
5.1	Blood smear collection & transportation to nearby PHC	@ Rs. 50 /-	NVBDCP fund
5.1.1	RKD Test	@ Rs. 50 /-	
6. NPCB			
6.1	Detection and escorting of cataract cases	@ Rs. 175/-	NPCB fund

NOTE: -

1. This is only indicative estimate regarding incentive which ASHAs are entitled and may also be treated as the minimum incentives which as ASHA might obtain per month based on this compensation packaged.
2. An Untied fund of Rs. 10.000/- would be available at Sub- Centre level, the state mission / District Health Mission / Village health Communities could propose additional performance based incentives to ASHAs from this fund upto Rs. 1000/- per annum.

This memorandum will come into force w.e.f 1st December 2007.