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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली-110011

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI - 110011

Important

Dear colleague,

D.O. No. Z-15015/11/2017- NHM-I
16th June, 2017

You are all aware of the key role that the frontline workers namely, the triple AAA, that is the ANM, ASHA and the Anganwadi Workers play in delivery of primary healthcare in the community. To optimize health care delivery at the community level and accelerate improvements in health and nutritional indicators the Ministry has designed team based incentives for the frontline workers. Providing team based incentives have the following distinct advantages:

(i) It fosters cooperative team spirit, enhances coordination, complementarity and more pertinently, provides a mechanism to influence the collective motivation of team members
(ii) It enables recognition of good performance on high impact interventions and also measure outcomes independently.
(iii) It further enables identification of areas for performance improvement and the need for skill upgradation.
(iv) It ensures simultaneous action by key health and nutrition incentives.

685/CP/2017
27/6/17

2. The Guidelines on Team Based Incentives is enclosed. It includes list of indicators along with scoring and calculation sheet with amount for each category and sampling methodology & field plan for external verification. The draft has already been shared with the States/UTs earlier. While there are obvious difficulties in validating individual based incentives of ASHAs, these guidelines provide for an independent validation.

3. Many States have already budgeted for Team Based Incentives. For those that have not so far proposed Team Based Incentives in their PIP, may do so in revised/supplementary PIP.

With regards,

Yours sincerely,

(Manoj Jhalani)

Encl: As above

Additional Chief Secretary-Health/Principal Secretary-Health/Secretary (H&FW)-All States/UTs

Copy to:
Mission Director. NHM - All States/ UTs
JS (ICDS), Ministry of Women and Child Development, Shastri Bhawan, A - Wing, Dr. Rajendra Prasad Road,New Delhi,110001.
JS(RCH), Ministry of Health and Family Welfare
Dr Rajani Ved, Advisor (Community Process) NHSRC, Munirka, New Delhi

Performance Based Team Incentives

1. **Level of incentive distribution**: Sub-Centre

2. **Periodicity**: Annual

3. **Personnel**: ANM/ASHA/AWW

4. **Baseline**: The baseline for each indicator *(Table 1)* could be fixed based on the previous performance over the years of the district/ state or the difficulty criteria (of district/block) etc. The HMIS or where available, latest survey data (DLHS/NFHS) could serve as the district baseline.

5. **Targets**: Table 1 has a set of indicators categorized in four groups. The targets in Table 1 are to be achieved over a period of time depending on the baseline. An annual target for the sub centre/block should be set based on current status, context, availability of HR, and geographic difficulty. Except for the use of modern contraceptive methods, a sub centres should aim for at least an annual increase of at least 10%. In Box 1, the example shows the incremental increase over a five-year period, given a baseline of 60% and a target of 10% for the first two years.

Yearly Target (%)					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
60	66	72	78	84	90

Annual targets could vary within districts- for instance in one block, achievement of institutional delivery could be 60% in year 1 and increase by ten to fifteen percent, till the standard is reached. For those districts where there are larger dispersed areas, or with low HR, the levels of achievement could be reduced by the state, but the aim should be to reach the standard defined in the indicators within a fixed time frame.

6. **List of indicators**: The indicators (Table 1) and team incentives are designed in such a way as to include behavioural and service delivery indicators, so that good health is viewed as holistic rather than piecemeal service delivery interventions. Achievement of a set of indicators should connote seamless integration between health and ICDS. A clear, predictable, and formula-based incentive is expected to be more effective than subjective assessment methods. Group 1 relates to Maternal and New-born Health, Group 2 to Communicable Diseases, Group 3 to Child Health, and Group 4 to Family Planning. The last category is applicable to states where

the TFR is greater than 2.0. The indicators for Non Communicable Diseases (NCDs) are currently part of the population based NCD screening programme which is applicable only to selected districts where it is being rolled out currently.

7. **Means of Verification**: The data for calculation of these indicators (in Table 2) would be derived from review of Sub Centre records. The data would then need to be validated. While ideally annual validation should be done, for the first two-three years the incentive fund would be divided into two. At the end of first six months, achievements will be assessed through records. At the end of the year, the second instalment will be released based on an external verification process. There are two options to undertake the process of validation:
   (i) The district could commission an external agency (research organization, NGOs, medical colleges) – to undertake a sample survey (10% of the population under consideration) in each sub centre area, to validate the reported data. The state could facilitate the process by creating a list of empanelled agencies for districts to draw on, as required. These empanelled agencies will be medical colleges, academic and research organizations including schools of public health.
   (ii) The state could also constitute a two-member team (Block PHN/Block Programme Manager/Block Community Mobilizer/NGO representative) who could be sent to other blocks within the district to undertake a sample survey, and validate reported data.

8. **Derivation of denominators for each indicator**: This would be done, using population based estimates- and compare with MCTS registration, as a measure of validation and the higher number would be used. For example, if in a population of 5000, about 150 pregnancies are estimated but the number registered in the MCTS is 160, then the latter would be used.

9. The overall responsibility for monitoring and supervision of field activities is with the Primary Health Centre Medical officer. Review of the programme should be an integral a part of monthly review meetings, field supervision, and data monitoring. Recording and reporting at all levels would be aligned with existing guidelines. The indicators in Table 1 would be used to monitor the programme.

10. **Scoring Criteria:** For each percentage point increase in the indicator a score of one point would be allocated to the team. Even if the team performance surpasses the target the one-point score criterion would be followed.

Table 1: List of Indicators

Indicator (s)
Group 1: Maternal and Newborn Health 1. Pregnant Women registered in the first trimester of the total registered >95% 2. Registered pregnant women who received complete ANC - >80 % 3. Institutional Delivery against expected delivery > 80% 4. Tracking, referral and follow up of women with high risk of pregnancy/delivery complications: >90% 5. Newborns receiving six home visits home visits: >80% 6. Proportion of sick newborns with assured (family readiness, transport organized, higher level facility contacted and alerted to newborn arrival) referral: >90% 7. Awareness amongst mothers about danger signs during pregnancy >95% 8. Proportion of pregnant and lactating mothers given 1 tablet of IFA daily for 180 days starting after the first trimester, i.e at 14-16 weeks of the gestation >75%
Group 2: Communicable Diseases 1. Proportion of fever cases seen for whom RDK test undertaken and ACT given: >90% 2. Proportion of people with fever/cough and weight loss for more than 2 weeks referred for sputum examination> 90% 3. Proportion of people with hypo-pigmented lesions who are referred>90%
Group 3: Infant and Child Health and Nutrition 1. Exclusive breastfeeding >80% for infants (<6months) 2. Complementary feeding initiated > 80% for infants over six months of age 3. Children in the age group of 12-23 months who have received all due vaccines (BCG to Measles 1st dose) before the first year of life >90% 4. Children in the age group of 24 months to 35 months who have received all due vaccines (upto Measles 2nd dose and DPT 1st booster) within 2 years of life >90% 5. Growth monitoring of all eligible children as per MCP cards >90% 6. Children six months to 59 months receiving bi-weekly doses of IFA syrup:>90% 7. Awareness level about use of ORS/Zinc in Diarrhoea, >80% 8. Awareness about Danger signs of pneumonia >80% 9. % of SAM children referred to Nutritional Rehabilitation Centers >90%
Group 4: Family Planning (in states where TFR is greater than 2) 1. Eligible couples registered in the sub center: >95% 2. Proportion of eligible couples using modern contraceptive methods: >60%[1] 3. Proportion of newly married couples using a method to delay first child birth by two years >75% 4. Proportion of couples with one child delaying second childbirth by at least three years: >75%

[1] For this indicator the expected annual increase, based on average annual trends is 0.5%.

Sampling Methodology for survey for performance based team incentives

The sample households to be surveyed under each ASHA (assuming she caters to 250-300 households) **are 20 (rounded off)**[1]. Thus if a sub centre is served by 5 ASHAs, a total of 100 households are to be surveyed under a sub centre. The 20 households to be surveyed per ASHA are selected using a **stratified random sampling method** given below:

Step 1: ASHA to categorize all households covered by her into four groups from the household register

- Group 1: Households with fever or a known case of TB/history of TB.
- Group 2: Households with a child aged less than 1 yr (targeted at capturing information on family planning services; antenatal, delivery and postnatal services, new born care, breast feeding, weaning foods, immunization etc.)
- Group 3: Households with a child aged 1 to 5 yr Child (targeted at capturing indicators for family planning services, infant nutrition, IYCF, immunization, etc.)
- Group 4: Households with men/women aged >30 yr suffering from Diabetes/ Hypertension (targeted at capturing information on screening and management of non-communicable diseases)

It is to be ensured that households featuring in one group not to feature in the next group. For example, while selecting households for group 2, households selected in group 1 should be removed from the list of households.

Step 2: After the households are categorized into four groups, the number of households to be surveyed in each group is the proportion of households in each group multiplied with **total sample size of 20**.

For example, of the total 300 households served by one ASHA, assuming 80 households fall under the four categories combined (10 HH in Group1, 38 in Group 2 and 30 in Group 3, 2 in Group 4), the proportion of households in each group and the sample is calculated thus:

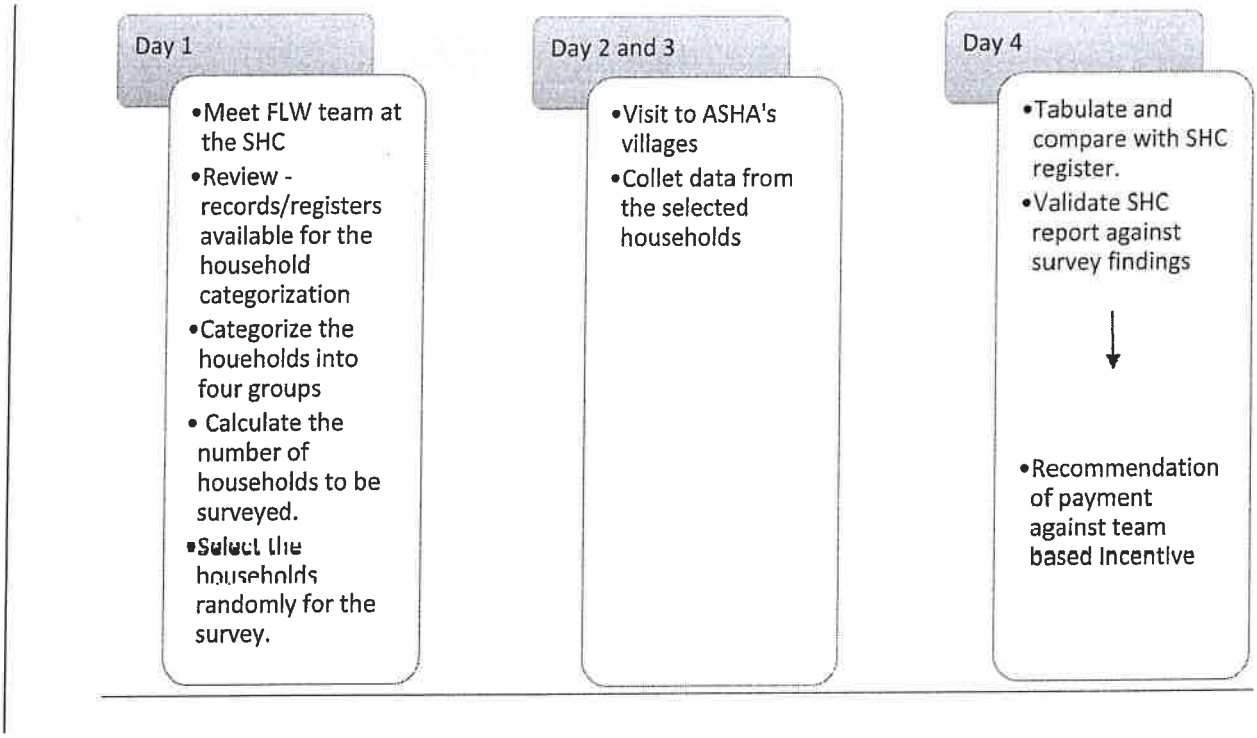
	Assuming that estimated no of Households in total households (300) according to ASHA register	Proportion of households in all the three groups (80)	Sample Households to be selected for the survey (n=20) in each group
Group 1	10	(10/80)=0.1	0.1*20=2
Group 2	38	(40/80)=0.47	0.47*20=9
Group 3	30	(30/80)=0.4	0.4*20=8
Group 4	2	(2/80) =0.02	0.02*20 =1
Total	80		20

Step 3: The households to be surveyed in each group are to be selected randomly according to the sample size calculated above in step 2 for that particular group.

[1] Survey intends to capture information on several indicators related to maternal, child health and communicable diseases, considering the variability of the same across India, a p value of 0.5 and d value of 0.20 is proposed at 95% confidence interval.

Annexure 2: Field plan for survey for Performance Based Team incentives

Field Plan:



Activities:

Day 1-

On day one, the investigators will meet the frontline worker team at the subcenter (SHC). From the household register, with help of ASHA the households can be categorized into four groups.

e.g:

Household listing	*Group 1*	*Group 2*	*Group 3*	*Group 4*
1	√			
2				√
3	√			

Day 2 and 3-

On day two, a team of two investigators can start the survey with random selection of the households from their list.

The two investigators will divide HH among themselves in accordance with the sample, distance and time.

A questionnaire will be given to the investigators, which has to be filled for every household they visit. All the questions are to be covered for each household visited.

Day 4-

The data collected will be tabulated and compared with the information collected from the SHC register. It will be validated with the ANM's register and thus the recommendation will be made against the team based incentive.

INDICATOR SCORING AND INCENTIVE CALCULATION

1. Scoring for Group -1 (Maternal & New Born Health) & Group-2 Indicators (Communicable Disease)

· **Total Indicators -**	11
· Total annual team incentive (Rs)	30,000
· Maximum score team can avail	110

1 Sub centre = 5 ASHA + 2 ANM + 5 AWW

Incentive Calculation							
Score	**110-85**			**80-65**			**Below 65**
Incentive amount	30,000			15,000			0
	ASHA (5)	ANM (2)	AWW (5)	ASHA (5)	ANM (2)	AWW (5)	
	22,500	4,500	3,000	11,250	2,250	1,500	
Per Person	4,500	2,250	600	2,250	1,125	300	

- The total proposed incentive is Rs 30,000 which would be allocated in the ratio of **75:15:10** to ASHA ANM and Anganwadi Worker.
- For a score range between 110-81: 100% incentives (Rs 30,000) would be divided in the ratio of **75:15:10** to ASHA (Rs 4,500 per ASHA) ANM (Rs 2,250 per ANM) and Anganwadi Worker (Rs 600 per AWW).
- For a score range between 80-65: 50 % incentive (Rs 15,000) would be divided in the ratio of **75:15:10** to ASHA (Rs 2,250 per ASHA) ANM (Rs 1,125 per ANM) and Anganwadi Worker (Rs 300 per AWW).
- No incentive would be given for a score below 65.

2. Scoring for Group-3 Indicators (Infant and child health and nutrition)

· Total Indicators -	9
· Total annual team incentive: (INR)	20,000
· Maximum score team can avail is -	90

1 Sub centre = 5 ASHA + 2 ANM + 5 AWW

Incentive Calculation							
Score	**90-71**			**70-55**			**Below 55**
Incentive amount	20,000			10,000			0
	ASHA (5)	ANM (2)	AWW (5)	ASHA (5)	ANM (2)	AWW (5)	
	15,000	3,000	2,000	7,500	1,500	1,000	
Per Person	3,000	1,500	400	1,500	750	200	

- For a score range between 90-71: 100% incentives (Rs 20,000) would be divided in the ratio of **75:15:10** between ASHA (Rs 3,000 per ASHA), ANM (Rs 1,500 per ANM) and Anganwadi Worker (Rs 400 per AWW).
- For a score range between 70-55: 50% (Rs 10,000) of total incentive would be divided in the ratio of **75:15:10** between ASHA (Rs 1,500 per ASHA), ANM (Rs 750 per ANM) and Anganwadi Worker (Rs 200 per AWW).
- No incentive would be given for a score below 55.

3. Scoring for Group-4 Indicators (Family Planning) - in states where TFR is greater than 2

· Total Indicators -	4
· Total annual team incentive: (INR)	10,000
· Maximum score team can avail is -	40

1 Sub centre = 5 ASHA + 2 ANM + 5 AWW

Incentive Calculation							
Score	**40-31**			**30-20**			**Below 20**
Incentive amount	10,000			5,000			0
	ASHA (5)	ANM (2)	AWW (5)	ASHA (5)	ANM (2)	AWW (5)	
	7,500	1,500	1,000	3,750	750	500	
Per Person	1,500	750	200	750	375	100	

- For a score range between 40-31: 100% incentives (Rs 10,000) would be divided in the ratio of **75:15:10** between ASHA (Rs 1,500 per ASHA), ANM (Rs 750 per ANM) and Anganwadi Worker (Rs 200 per AWW).
- For a score range between 30-20: 50% (Rs 5,000) of total incentive would be divided in the ratio of **75:15:10** between ASHA (Rs 750 per ASHA), ANM (Rs 375 per ANM) and Anganwadi Worker (Rs 100 per AWW).
- No incentive would be given for a score below 20.