ASSESSMENT OF PERFORMANCE BASED INCENTIVE OF ASHAS IN JAIPUR URBAN BLOCK OF JAIPUR I DISTRICT, RAJASTHAN

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

Sheetal Sharma

Under the Supervision and Guidance of

Dr. Nutan P. Jain

2024

Declaration by Student

I hereby declare that this dissertation titled "Assessment of Performance Based Incentive of ASHAs in Jaipur Urban block of Jaipur I district, Rajasthan," is the Bonafede record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Sheetal Sharma

Date: 04/07/24.

IIHMR UNIVERSITY

Certificate

This certifies that **Sheetal Sharma** completed the research for the dissertation **" Assessment of Performance-Based Incentive of ASHAs in Jaipur Urban block of Jaipur I district, Rajasthan"** as part of the requirements for the MBA (Hospital and Health Management) degree from IIHMR University, Jaipur, under my direction and supervision. The approach taken by her throughout the research study was sincere, scientific, and analytical.

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Date: 04/07/2024

Abstract

Title: Assessment of Performance-Based Incentives for ASHAs in Jaipur Urban Block, Rajasthan

Author: Sheetal Sharma

Advisor: Dr. Nutan P. Jain

Keywords :ASHAs, Performance-Based Incentives, ASHA, claim form,motivation,Rajasthan

Background

Accredited Social Health Activists (ASHAs) are vital healthcare workers in rural India, connecting communities to essential programs. Despite performance-based incentives, challenges hinder their effectiveness.

Objective: This study assesses the performance-based incentive system for ASHAs in Jaipur Urban block, aiming to identify factors influencing its effectiveness and suggest improvements.

Methodology: A cross-sectional design employing mixed methods was used. A sample of 50 ASHAs was selected through stratified random sampling. Data collection involved semi-structured phone interviews and document review.

Results/Findings: The study revealed issues like unclear incentive structures, payment delays, and data entry challenges. The need for enhanced training, particularly in digital literacy and new health programs, was highlighted. ASHAs expressed a desire for recognition of their efforts, especially for unforeseen tasks.

Conclusions: Streamlining the incentive structure, digital transformation, effective workload management, and improved recognition/support are recommended. While limitations like sample size and geographic focus exist, these findings can inform policies to improve the ASHA program and enhance community health outcomes.

Acknowledgement

I wish to express my heartfelt appreciation to all those who contributed to the completion of this paper. Firstly, I extend my thanks to Dr. Nutan P. Jain, Professor at IIHMR University, Jaipur, for his unwavering guidance, expertise, and support throughout the research process. Her valuable insights and constructive feedback have significantly influenced the direction and improvement of this study.

I want to acknowledge Community Health Workers whose feedback and day-to-day experiences enriched this study with accurate and essential information. Their contributions have made this research more interesting and valuable.

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ABBREVIATIONS

ANC & PNC	Antenatal care and post-natal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activists
CBAC	Community based assessment checklist.
CHIP	Community Health Integrated Platform
HBNC & HBYC	Home based newborn care and home-based young care
FP	Family planning
MCH	Maternal and Child Health
NCDs	Non-communicable diseases
PBI	performance-based incentives
PCTS	Pregnancy and Child tracking system
TB	Tuberculosis

Chapter: 1

Introduction

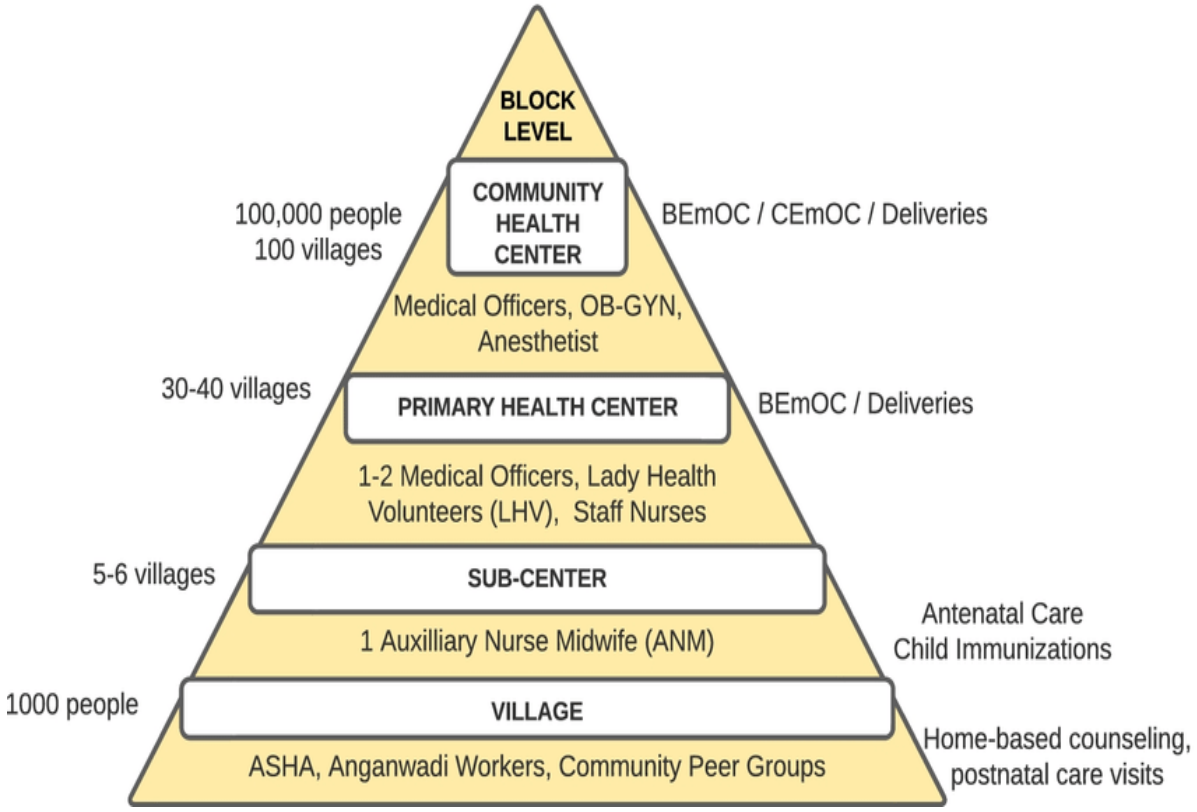
The foundation of India's healthcare system is made up of Accredited Social Health Activists (ASHAs), particularly among rural areas. However, because different states have different demographic and geographic contexts, the type of work they do and the particular activities they engage in differ greatly. Maternal and Child Health (MCH) services are the key priorities for ASHAs as she belongs to the same village and understand the cultural context, in most of the cases.

1.1 Nature of ASHAs Work

Primary health care system in India starts in the village, where the ASHA (accredited social health activist) identifies and counsels eligible couples for family planning, identifies postnatal infant warning signs, and distributes health awareness for various health programmes. The assistant nurse midwife, or ANM, provides immunisations, nutritional supplements, and conducts prenatal and paediatric checkups at the sub-centre. Here, women and children who are deemed to be at high risk are referred to the primary health centre for higher level care, where they receive treatment and delivery from the Medical Officer (MO).

In Rajasthan, ASHAs are essential link to Maternal and Child Health services. These frontline workers perform 74 different tasks related to eight main functions. Their incentive system varies in rural and urban environments.

ASHAs in Rajasthan's rural areas, which are frequently marked by dispersed populations and a lower level of literacy, encounter considerable obstacles in providing education to their communities and are compensated more heavily for these difficulties. On the other hand, urban settings have less barriers, which means that ASHA incentives are reduced there.



focused *Fig 1 : The primary health care system in India*

Research question

What is the facilitating and hindering factors in performance-based incentives for ASHAs during the incentivization process of claims?

Objectives: The study aims to identify challenges faced by ASHAs in receiving their rightful compensation, which can affect their motivation and performance.

The objectives of the study are:

- ❖ To review the guidelines, roles, and responsibilities of ASHAs.
- ❖ To study the incentivization processes.
- ❖ To study facilitating and hindering factors.

- To suggest possible ways to minimize hindering factors, if any.

Rationale for the study:

The study focuses on assessing the performance-based incentive system for Accredited Social Health Activists (ASHAs) in the Jaipur Urban block of Jaipur I district, Rajasthan. The study examines the incentivization processes for ASHAs.

ASHAs play a crucial role in India's healthcare system, particularly in rural and urban underserved areas. Understanding the effectiveness of their incentive structure is vital for improving healthcare delivery.

Despite the importance of performance-based incentives in motivating ASHAs, there are concerns about accountability, transparency, and the impact on their overall effectiveness.

By examining both facilitating and hindering factors, the research seeks to provide insights that can lead to improvements in the incentive scheme.

The focus on urban ASHAs in Jaipur addresses a gap in existing research, as most studies have concentrated on rural settings.

The findings from this study can inform policy decisions and interventions to enhance the effectiveness of the ASHA program, ultimately leading to better health outcomes for the communities they serve.

Chapter: 2

Review of Literature

S. No	Title and Authors	Sample size and Technique	Study Location	Salient Feature
1.	Analysing the effect on performance and motivation of ASHA workers based on the incentive systems based on geospatial context Shridhar Kadam, Saumya Pani, Shyama Sundari Devaraj, Sarit Rout (2022)	-	Rural and Urban Areas in India	Differentiates between monetary and non-monetary incentives' impact on ASHA performance in various geographical locations.
2.	Factors affecting the performance of community health workers in India: A multi-stakeholder perspective Reetu Sharma, Premila Webster, Sanghita Bhattacharyya (2017)	-	16 villages, 2 districts of Udaipur, Rajasthan	Complexities in claim procedures can demotivate ASHAs. - Unpaid labour and travel expenses can be a burden.
3.	An assessment of performance based incentive system for ASHA Sahyogini in Udaipur, Rajasthan R Bhatnagar , K Singh, T Bir, U Datta, S Raj, Deoki Nandan 2009	180 ASHAs (60 from each - rural, urban, tribal)	Udaipur district, Rajasthan, India	Highlights the importance of timely incentive disbursement, clear communication, and collaboration for ASHA satisfaction with the incentive scheme.
4.	Challenges Faced by ASHA Workers in Effective Implementation of Janani Suraksha Yojana Programme- A Cross-Sectional Study	-	Rural area of Kangra district, Himachal Pradesh, India	This study explores the challenges faced by ASHAs in receiving incentives for implementing the Janani Suraksha Yojana program, a maternal health initiative.

Chapter: 3

Methodology

This study aims to investigate the challenges faced by Accredited Social Health Activists (ASHAs) in Jaipur Urban district, Rajasthan, India, regarding receiving incentives for their work. The study will focus on understanding the experiences of ASHAs with the current incentive scheme and identify any roadblocks hindering them from receiving their rightful compensation.

Study Design

This research employed a cross-sectional design utilizing quantitative and qualitative data collection methods. This approach facilitates a deep understanding of their experiences and perspectives, capturing their suggestions and hurdles which they have been facing.

Study Setting

The study was carried out in Jaipur district of Rajasthan, India. Jaipur I boasted highest number of ASHA registrations (515) on the Digital ASHA platform within Jaipur district, making it an ideal location to explore incentive scheme challenges faced by ASHAs.Additionally, the necessary data was readily available in Jaipur, making it a favourable location for the study.

Sample Size and Justification

A total of 50 ASHA workers were selected for the study. All ASHAs registered on the Community Health Integrated Platform (CHIP) and the Digital ASHA Platform within Jaipur Urban district were 515 in number. Stratified random sampling was employed.

Sample Size

A 10% sample size of total number of ASHAs was targeted, aiming for 50 ASHAs. To achieve this following step were taken:

ASHAs were categorized into two cohorts based on the completion percentage of the Digital Household Survey: Highest and Lowest.

A list of 515 ASHAs was stratified based on these cohorts.

A random sample of 25 ASHAs was selected from each cohort using a random number generator.

Data Collection Methods

Review of Existing Documents, Guidelines, roles, and responsibilities of ASHAs regarding the incentive scheme.

CHIP data relevant to ASHAs and their incentive claims.

Process Mapping

A visual representation of the incentive scheme's workflow, identifying potential bottlenecks.

Semi-structured Interviews

Telephonic interviews were conducted with the selected ASHA sample using a pre-designed interview schedule. The schedule explored challenges faced in receiving incentives, clarity of the incentive structure, and any communication gaps.

Inclusion Criteria

- ASHA workers in the Jaipur district of Rajasthan
- Willingness to participate in a telephonic interview
- Availability to complete the entire interview

Exclusion Criteria

- ASHA workers who did not respond to phone calls (after two attempts at different times)
- Those who declined to participate
- Incomplete interviews for any reason

Data Collection Tools

Primary data was gathered through telephonic interviews using a structured questionnaire. The qualitative data from these interviews were then coded to streamline the analysis process. To secure the target sample of 50 completed interviews, approximately 100-120 calls were made.

Secondary data was also incorporated, involving a thorough review of the existing Incentive system, reports, and articles. This review focused on facilitating and hindering factors by ASHAs during the incentivization process of claims.

Data Analysis

The analysis of the data collected during the course of study was conducted using elementary statistical tools and techniques like distribution of raw data and percentage of responses on various aspects. With the help of Excel, graphical representation of responses was done. Bases on the responses, opinions were visualized. The challenges faced by ASHAs were identified with the help of visualizations.

Ethical Considerations

This study prioritised the ethical considerations ensuring that informed consent was obtained from all the respondents after briefing them on the study's nature, purpose, and the use of their information. Participants were assured of their confidentiality and their right to withdraw from the study at any time.

This methodology ensures a thorough and ethical exploration of the challenges faced by ASHA workers in the Incentivization process., offering valuable insights for enhancing Incentivization healthcare settings.

Duration of the Study

The study was conducted over a period of 3 months, from April 1, 2024, to June 15, 2024.

Chapter: 4

Results and Discussion

ASHAs are deeply concerned about transparency and accountability in the incentive system, despite their critical role.

Key Roles and Responsibilities

Reviewed-Govt.Rajasthan

Maternal Health

ASHAs play many roles for organisational delivery, promoting prenatal check ups (ANC), and providing medical care for both the mother and child after birth. This includes home visits, signing of registers, ANC exams, and referring the complicated cases to other health facilities.

Child Health

It also focuses on immunisation campaigns One of the central tasks that ASHAs are strategically involved in. They also oversee the growth and development of children and ensure the children get their due vaccinations to deadly diseases and provide parents with paramount health information.

Family Planning

ASHAs also advise women on various methods on family planning, provide contraceptives and encourage clients on proper reproductive health.

Beyond Vital Responsibilities

There are other various responsibilities that are performed by ASHAs based on the state-run or propagated programs and plans. These include:

Communicable Disease Control

ASHAs play an important role in Surveillance where they help in reporting such diseases, communicating suspected cases in the communities, raising health literacy about the precautions that should be taken, and mobilizing the community to participate in disease control activities. This ranges from facets concerning Dengue fever, malaria, Tuberculosis (TB) and the usual ailments. On the issue of this guarantee of adherence to treatment they do follow up.

Non-Communicable Disease Management

They also help in the prevention of NCDs including diabetes and hypertension through community mobilization on the risk factors and supporting patients to stick to their prescriptions and update the government.

Nutritional Support

ASHAs conduct IEC and counseling about the proper diet and daily requirement of food especially to the pregnant ladies, lactating mothers, and children- IFA and zinc tablet

Mental Health Awareness

Due to the increased awareness in mental health, ASHAs have been implicated in identifying those patients who may be having mental health problems and linking them to the appropriate service. Counselling suggestions are provided to them.

Social Welfare Programs

Besides, it is expected that ASHAs may help the beneficiaries in connecting to the government schemes to enrol them for disability pensions and widow pensions etc.

Health Education

ASHAs engage in community mobilisation on health promotion seeking to create awareness on various issues affecting people such as hygiene practices, sanitation, good health practices, awareness among others.

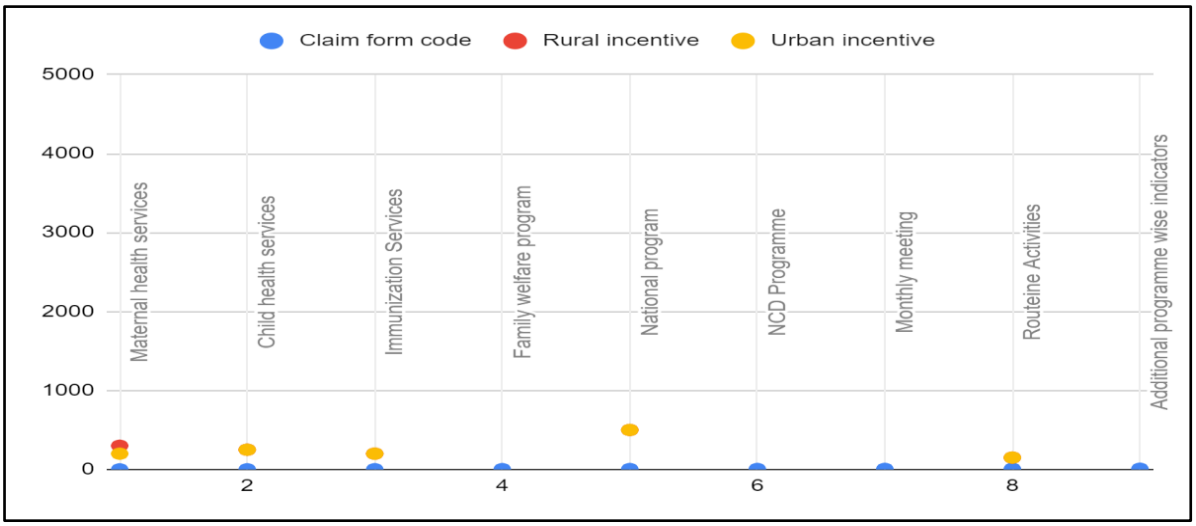
Data Collection and Reporting

ASHAs are responsible to record in ASHA diary, some vital records like, records of some health parameters and the other data collection and regular reporting to help in the planning and monitoring of the health program.

By acknowledging ASHAs roles and responsibility we can create a more supportive and enabling environment for these frontline health workers, ultimately leading to a more robust and responsive healthcare system across India.

ASHA Incentives

The Figure 1 reveals a performance-based incentive structure for ASHA workers, with most activities offering incentives below ₹1,000. National programs, however, appear to offer the highest rewards. The incentive structure for ASHAs also varies across states. While some states offer a fixed monthly honorarium, others provide performance-based incentives linked to specific activities they undertake like in Rajasthan. Additionally, some states offer benefits such as health insurance schemes or mobile phone recharge for work-related communication.



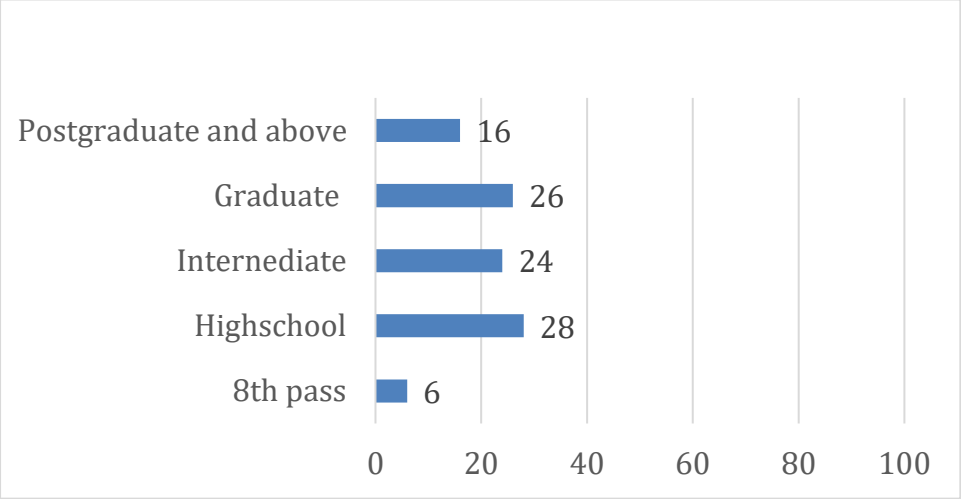
Based on the interview with 50 ASHAs, the results are presented. A majority of ASHAS fall in the age bracket of 31-45 years of age. Their age ranges between 26-56 years.

Table : Per cent distribution of ASHAs by their age

Age (in complete years)	%
26-30	6
31-35	28
36-40	28
41-45	22
46-50	10
50+	6

The essential qualification for ASHAs is 8th standard. However, of the 50 ASHAs a majority of were had more education than the prescribed.

Fig 3: Per cent distribution of ASHAs by their education



The ASHAs joined mainly for financial earning (48%) followed by contribution to health of people (30%), and learning new things (14%). A few ASHAs also expressed that this work gives an opportunity to build relation with community members.

Facilitating and Hindering Factors

On given a choice, the ASHAs were asked to express their preferences of the tasks they are supposed to perform. The result revealed that She get motivated with the recognition she gets from the community and family along with financial support helped them to perform their duties. The results revealed that the ASHAs preferred those tasks which has relatively more incentives like institutional delivery (83%); child immunization (78%); postnatal (58%), and antenatal care (42%). Surprisingly, many of the ASHAs did not respond in terms of the family planning. Only six ASHAs responded that they prefer Antara related services.

They were further asked for the reasons for not preferring some tasks over the others. Because they are supposed to all the prescribed activities. A number of problems that they dealt with regularly.

On being asked the reasons, they expressed lack of supplies (printed formats), multiple data entry (99% each); lack of understanding what has been reimbursed or not reimbursed against the vouchers (98%), registration of migrants pregnant women because in most of the cases they lack the required documents desired as per the rules (92%), and lack of support from ANMs (84%). There were others concerns as well but the mostly perceived reasons were as mentioned above.

Chapter: 5

Conclusion

ASHAs plays vital link between communities and medical facilities. Their responsibilities encompass a wide range, including:

Promoting health awareness: ASHAs educate communities on crucial health topics like sanitation, hygiene, and nutrition.

Delivering preventive care: They provide basic healthcare services like immunizations, prenatal care, and family planning counselling.

Facilitating referrals: ASHAs connect community members with appropriate medical facilities for advanced treatment.

Data collection and reporting: They play a vital role in data collection for various health programs, enabling informed decision-making.

Incentivization process outlines specific activities linked to various healthcare programs. Upon successful completion of these activities, ASHAs receive vouchers that can be redeemed. This system helped ASHAs by linking their efforts with financial rewards.

A significant concern, reported by 100% of respondents, is the burden of duplicative data entry across various platforms. Additionally, nearly all ASHAs (96%) expressed a need for enhanced monitoring and support systems to ensure their work is recognized and claims are processed fairly.

This study highlights significant challenges faced by ASHAs, including the burden of duplicative data entry across multiple platforms, a need for enhanced monitoring and support systems, and resource limitations such as lack of printing supplies and financial burdens related to phone repairs.

The findings indicate a clear need for improved communication and collaboration within the healthcare system. Issues with data operator accountability and insufficient support from Auxiliary Nurse Midwives (ANMs) underscore the importance of fostering a more

collaborative work environment. Additionally, a significant portion of ASHAs reported difficulties receiving incentives through the Pregnancy and Child Tracking System (PCTS) platform.

Financial aspects of the incentive scheme were a major concern, with a majority of ASHAs calling for increased salaries and government benefits. The study also revealed a strong desire for professional development among ASHAs, with requests for training on various aspects of their work, including PCTS functionalities and incentive structures.

Concerning resource constraints there were also several reported difficulties. Challenges highlighted included no printing supplies (100%) and the costs of repairing phones (36%). Moreover, about half of the ASHAs (48%) stated that they did not receive proper training on important programs, such as HBYC.

These findings imply a need for better communication and integrated efforts. Lack of support from ANMs (42%) and problems with data operator accountability (46%) point to the need to improve cooperation at work. Also, 40% of ASHAs had challenges in accessing incentives through the PCTS platform in the last 2 months.

The feedback emphasizes a lack of opportunities for continuing education. A large proportion of ASHAs requested training on PCTS functionalities, incentive structures, and Ayushman Bharat cards: 34%, 30%, and 28%, respectively. Also, 32 % of the respondents mentioned the requirement for training that could be targeted at non-graduate ASHAs.

This study focused at identifying and evaluating the constraints and difficulties incurred by the ASHA workers in their redeeming their claim vouchers in their line of work.

Recommendations

- **Streamlined Incentive Structure:** It is imperative to set a definite policy regarding reward and recognition for migrants and their duties like the generation of Ayushman cards. Raise awareness by issuing status updates of the claims as well as the rationale for claim denial.
- **Digital Transformation:** Online CBAC forms must contain Aadhaar/Jan Dhan cards. Strengthen digital learning material which is used for training of every ASHA and make sure that the Ayushman works properly.
- **Workload Management:** Circumscribe focus on key assignments and reflect on activities that offer little or no rewards. Consider options for distribution of additional administrative work.
- **Recognition and Support**: Think of permanent contact or a promotion possibility, as well as increase in pay and any government grants. All levels of healthcare should consider incorporating strategies for appreciating OFS PHC implementing and the excellent performing ASHAs, for instance, attractive recognition awards.
- **Resource Allocation:** This should cover expenses related to photocopying necessary forms that will be used in the admission process. Consider possibilities for getting biometric printers with no ink or seek to acquire tablets for data capturing

Limitations of study

The above study provides insight about ASHAs in the district of Jaipur Urban regarding the incentive scheme. undefined

Sample Size and Generalizability: The study involved 50 ASHAs, which not necessarily is an adequate sample size to capture the realities of the ASHA workforce in Jaipur Urban. A larger sample might help generalize the results obtained in the study to the total population studied.

Cross-Sectional Design: The study design employed in the cause was cross-sectional whereby data was collected at one time. A design that follows the experiences of ASHAs for an extended period could help offer a better understanding of how the incentive scheme's dynamics fare.

Focus on Urban ASHAs: The study examined only the ASHAs in Jaipur Urban setting. Incorporating ASHAs from rural locations into the study could provide framed benchmark data that would be essential to a richer understanding of the issues connected with the incentive schemes in various settings.

Limited Data Sources: In the study, data collection involved the use of questionnaires administered on the ASHAs and secondary documents. Using other types of data sources, e.g., interviews with the policymakers or health care administrators, may offer a broader picture of the incentive scheme in operation.

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Annexure

Annexure 1: ASHA Claim form

S. no	Components	Claim form code	Activites	Rural incentive	Urban incentive	Remark
1	Maternal health services	1.1	4 ANC Checkup	300	200	
		Sub Activities under the Activity	Registration before 12 weeks	75	75	
			TD, IFA, 1st ANC	75	50	
			2nd ANC	50	25	
			3rd ANC	50	25	
			4th ANC	50	25	
		1.2	Institutional delivery	300	200	
		1.3	Female Death Notification (Maternal death 15-49 yrs)	200	200	
		1.4	Bank account and aadhaar update	5	5	
2	Child health services	2.1	HBNC	250	250	
		2.2	Child death notification	50	50	
		2.3	Refer and Admission of malnourished children	50	50	

			Follow up of severely malnourished children-MTC	100	100	
		2.4	**SNCU discharge follow up**	200	200	
		2.5	**MAA program meeting**	**100**	**100**	Max 3 meetings
		2.6	**IDCF Program**	**1**	**1**	
		2.7	**NIPI Program (IFA syrup)**	**100**	**100**	applicable only when coverage is more than 70 %
		2.8	**NIPI Program (School dropout girls)**	**50**	**50**	applicable only when coverage is more than 70 %
		2.9	**NDD Program**	**100**	**100**	applicable only when coverage is more than 70 %
		2.10.	**HBYC**	**250**	**250**	
		Sub Activities under the Activity	1 visit followup	50	50	
			2 visit followup	50	50	
			3 visit followup	50	50	
			4 visit followup	50	50	
			5 visit follow up	50	50	

3	**Immunization Services**	**3.1**	**Social mobilization for MCHN session**	**200**	**200**	
		3.2	**Social mobilization for immunization**	**150**	**150**	
		3.3	**1 year old who completed immunization**	**100**	**100**	
		3.4	**Children received DPT booster -1 & OPV boosters, measles and rubella-2**	**75**	**75**	
		3.5	**DPT booster 2**	**50**	**50**	
4	**Family welfare program**	**4.1**	**Postpartum vasectomy**			
		4.1.1	Female sterilization (Laparoscopic)	**300**	**200**	
		4.1.2	Female sterilization (Post partum sterilization)	**400**	**300**	
		4.2	**Male sterilization**	**400**	**300**	
		4.3	**Mobilization for Sterilization on 1 or 2 children**	**1000**	**1000**	
		4.4	**Mobilization for gap of two years in the**	**500**	**500**	

			birth of the first child			
		4.5	**Mobilization for gap of three years between two children**	**500**	**500**	
		4.6	**Mobilized for PPIUCD**	**150**	**150**	If PPIUCD is taken within 12 days of pregnance
		4.7	**Mobilized for PPIUCD**	**150**	**150**	If PAIUCD is taken within 12 days of pregnance
		4.8	**Mobilized for Antara Injectable Contraceptive (4 dose)**	**100**	**100**	
		4.9	**Mobilized for Saas Bahu Sammelan**	**100**	**100**	
		4.10.	**Distribution of Nayi Pehel Kit**	**100**	**100**	
5	**National program**	**5.1**	**New Identified(registered) TB Cases**	**500**	**500**	
		5.2	**Patients completed TB treatment (Drug sensitive)**	**1000**	**1000**	

		5.3	**Patients completed TB treatment (Drug resistant)**	**5000**	**5000**	
		5.3.1	For intensive Phase	2000	2000	
		5.3.2	For Continuous Phase	3000	3000	
		5.4	**ACF**	**5**	**5**	max 150 family per survey
		5.5	**Person underwent cataract surgery**	**350**	**350**	
		5.6	**Registration of leprosy**			
		5.6.1	Before deformation	250	250	
		5.6.2	After deformation	200	200	
		5.7	**Leprosy Treatment**			
		5.7.1	PB Case	400	400	
		5.7.2	MB Case	600	600	
		5.8	**Positive cases of malaria who got full treatment**	**75**	**75**	

		5.9	**Blood slides or R.T.D of fever patients**	**15**	**15**	
		5.10.	**Salt sample testing using salt testing kit**	**25**	**25**	50 tests/month after submission of report
6	**NCD Programme**	**6.1**	**NCD Programme**			per case after completion of 6 followup every month
		Sub Activities under the Activity	People in the age group of 30-65 whose CBAC form was filled	10	10	
			People mobilized for ncd screening among CBAC form filled	-	-	
			NCD patients who were followed up with for 6 months	50	50	
7	**Monthly meeting**	**7.1**	**Sector Level Monthly Meeting**			
		7.2	**Routine monthly activities**			
		7.3	**Women's Health Group Meetings**			

		7.4	**VHSNC Meetings**			
		8.1	**Information of VHSNC/ MAS Meeting**	**150**	**150**	
		8.2	**Information of Routine monthly activities**	**1500**	**1500**	
8	**Routine Activities**	**Sub-Activities under**	DHS survey done in starting of year	**300X5 = 1500**		
			ASHA Dairy completed and checked by supervisor			
			Due immunization list prepared			
			Due pregnancy list prepared			
			Due list of EC for family planning prepared			
			Is VNFSC record maintained properly			

Annexure 2: Informed consent and Data collection tool

Block:
Place :

Consent

नमस्ते। मेरा नाम _____ है। मैं IIHMR विश्वविद्यालय के साथ काम कर रहा/रही हूँ। राजस्थान के जयपुर जिले के जयपुर शहरी ब्लॉक में आशाओं के प्रदर्शन आधारित प्रोत्साहन का आकलन एक सर्वेक्षण का आयोजन कर रहे हैं। इस अध्ययन से प्राप्त जानकारी हमें मदद करेगी।आपके द्वारा दिए गए सभी उत्तर गोपनीय होंगे और सदस्यों के अलावा किसी अन्य के साथ साझा नहीं किए जाएंगे । आपका सर्वेक्षण में भागीदारी स्वेच्छानुसार है। अगर मैं आपसे कोई सवाल पूछती हूँ जिसका आप उत्तर नहीं देना चाहते हैं, तो बस मुझे बताएं और आप किसी भी समय साक्षात्कार रोक सकते हैं। यदि इस सर्वेक्षण के बारे में आपके कोई प्रश्न हैं, तो आप मुझसे पूछ सकते हैं।
क्या आपके पास कोई सवाल है?

क्या आप इस सर्वेक्षण में भाग लेने के लिए सहमत हैं?

Namaste. My name is _____. I am working with IIHMR University. We are conducting a survey about Assessment of Performance Based Incentive of ASHAs in Jaipur Urban block of Jaipur I district, Rajasthan. The information received from respondents will help us in our study. As you belong from Jaipur I block ,you were selected for the survey. The questions usually take about 20-30 minutes. All the answers you give will be confidential and will not be shared with anyone other than members of our survey team. Your participation in the survey is voluntary. If I ask you any question you don't want to answer, just let me know and you can stop the interview at any time. If you have any questions about this survey, you may ask me.
Do you have any questions?

Do you agree to participate in this survey?

SIGNATURE OF INTERVIEWER: _____ DATE: _____

Section A: Demographic Information
1. Age (in completed years)

2. Educational Qualification:

<8th……1
8th pass…… 2
Highschool……3
Intermediate……..4
Graduate……5
Post graduate and higher …6

3. Years of Experience as an ASHA:

Less than 5 years…….1
5 & more than 5 years……..2
10 & more than 10 years……3
15 or more than 15 years……4

4. How many households are you responsible for monthly?

Less than 50 ……1
Between 50-100…2
More than 100……3

5. How often do you visit each household in your area?

In a week ……1
Biweekly ……..2
Fortnight……3
Monthly ……4

6.Do you have android mobile phone

Yes….1
No……2

7.Do you get an incentive for using the ASHA Digital Health application ?

Yes….1
No……2

8.Are you doing Digital Household Survey (DHS) via ASHA Digital Health application ?
Yes….1
No……2

9. How many pregnant women till delivery are currently under your care?

Less than 5……..1
More than 5 but less than 10…….2
More than 10……3

10. How many children (0-5 years) are currently under your care?
Less than 5……..1
More than 5 but less than 10…….2
More than 10……3
More than 15 but less than 20……4

11. Are you aware of the performance-based incentive scheme?

Yes….1
No……2

13. How often do you receive your performance-based incentives?

Monthly…….1
Quarterly……2
Annually……..3
Other (Please specify)

14.Can you confirm if you've received timely incentive payment?Yes….1

No……2
No, then why ?.....

15. In which program do you feel the incentives you receive are the most / least in count?Immunization drives…….1
Antenatal and postnatal care visits……2
Institutional delivery…….3
Health awareness sessions…….4
Record keeping and reporting…….5
Referral services……6
Family planning services……..7
Other (please specify)

16. What motivated you to pursue a career as an ASHA worker?

Financial Earning……..…1

Learning ……2
Contribution toward community health…..3
Build relation in community…….……4

17. Do you enjoy performing your duties as an ASHA ?
Yes….1
No……2
No, then why

18. Does supportive supervision provided by Auxiliary Nurse Midwives (ANMs) contribute to the professional growth and development of Accredited Social Health Activists (ASHA) workers?

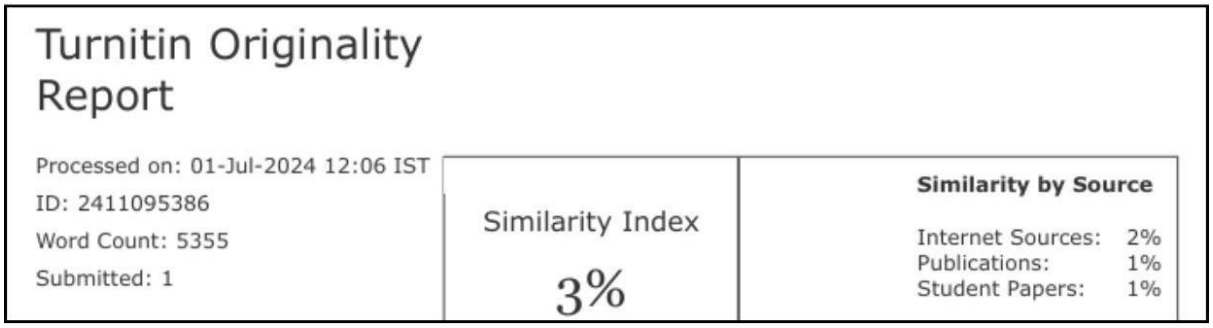
Yes….1
No……2
No, then why ?.....

19. Do you have any suggestions for improving the performance-based incentive scheme for ASHAs?

20. Any other important points which I might have missed.

Annexure

3: Plagiarism report



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