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Working as an ASHA to Improve Maternal and Child Health in Uttar Pradesh, India

At less than 1.5 meters tall, Savita was petite but could fill a room with her hearty laugh and big smile. She seemed permanently at ease. She had a round face with freckles on her nose and a *bindi* between her eyebrows. When she talked, her bangles jingled as she motioned energetically with her hands.

Savita sat down in her bedroom on a January night after putting her children to bed and turned on her battery-powered lamp. She removed a large journal from its plastic wrap, opened to a page of meticulously kept records, and began filling in columns with various symbols. As a community health worker for nearly a decade, Savita had supported, educated, and kept records on the health and life events of those in her village and two nearby villages. While she was achieving her goals of increasing institutional delivery and immunizations, she struggled with others, such as uptake of contraception and family planning. She wondered why it was harder to help beneficiaries make certain changes: *What would it take to convince them?*

December 2016

Life at Home

Savita's days began at 5 a.m. Each morning, she prepared breakfast for her husband, Lalit, while he collected water from the village well and before he left for the farm he and his brother cultivated to feed their family and earn extra income. Savita and Lalit lived with their 15- and 17-year-old sons and Lalit's brother's family: his wife, Jamini, and their two children. Savita woke her sons at 6 a.m. six days a week to serve them breakfast before they biked to their private secondary school and university.

Julie Rosenberg, Claire Donovan, Amy Madore, and Rebecca Weintraub prepared this case for the purposes of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.

Editor's Note: This profile is part of a case series intended to shed light on reproductive, maternal, newborn, and child health in Uttar Pradesh, India. In this case, we aim to explore the factors influencing an individual's health-related decision making. Savita, the frontline health worker featured, generously agreed to share her story with our case writers. While this document cannot possibly represent Savita's story in full, we have tried to provide a lens into her life and the many factors impacting her work and decisions. All names have been changed to protect informants' privacy.

For the past 10 years, Savita had been dressing almost daily in the white and brown sari of an accredited social health activist (ASHA; see **Appendix** for list of acronyms and program names). She felt proud when she wore it.

Savita was responsible for her village of around 400 and two neighboring villages, an area comprising 1,237 people. She left home between 9 a.m. and 10 a.m. most days to visit the highest-priority households on her monthly "due list"—a register of women, children, newly married couples, and adolescent girls due for specific services. With her years of experience as an ASHA, Savita knew the list was not necessarily a step-by-step plan for the month; she had to consider who lived closest to her, her relationships in the village, and what she believed was important. Financial incentives were a factor too, although payment often was delayed and came as a lump sum, making it difficult to know which activities payments covered.

Savita visited around five households and worked about four hours each day. She also visited lower-priority homes when a woman or her mother-in-law called to request her services or if the household was conveniently located on her route home.

Like Savita, most families in her village were Hindu and Brahmin, the highest caste of Hindu society, and most earned their livelihood farming. Her ASHA wages helped supplement income from the farm.

Becoming an ASHA

Savita first began searching for a job in 2004. She applied unsuccessfully for two that favored college-educated applicants; Savita had only a 12th-grade education. Three years later, a recruiter from the national health ministry approached Lalit about an ASHA position opening in their village. Lalit was unaware of the specifics of ASHA compensation but thought this could be an opportunity to supplement the family income and encouraged Savita to apply. At age 28, with two young sons, Savita was selected to be an ASHA. She quickly learned that while ASHAs were technically considered volunteers, they received financial incentives for completing specific services.

Gaining Respect in the Community

Savita was initially apprehensive about her new role. She was the first woman in her family to work outside the home, part of one of the earliest cohorts of ASHAs, and the first ASHA in her community, where there were no other door-to-door service providers. "I didn't know how people in my village would react," she reflected.

Savita attended the eight-day ASHA training with the other new ASHAs in her block of 180 villages, in a district 7 km away from her village. Like all ASHAs, her first project was to conduct a needs assessment of her assigned population. "From that survey, I knew how many women were pregnant and how many children still needed immunization. I knew where I needed to work and who needed help," she said. The district provided multiple data-tracking logs: one for pregnant women, one for infant and child immunizations, one for family planning, and one for deliveries. Savita carried these cumbersome logs to each home, recording the name, age, and caste of the head of the family, as well as information about others in the home. She enjoyed filling in the logs at night, taking pride in her day's work. She knew this was not the case for many of her colleagues who were illiterate and needed their husbands' or children's help.

Villagers were skeptical at first. "My neighbors and my family—especially my parents and brother-in-law—were saying a lot of things," she recalled. "They used to ask, 'What kind of a job is this where you have to visit houses for work?'" It was not typical for women to leave their homes alone. Savita asked Lalit

to accompany her on her first few home visits in the neighboring villages because she did not know anyone there and felt unsure what to expect.

Savita shared her logs with the supervising auxiliary nurse midwife (ANM), who reviewed them and gave her advice (see **Exhibit 1** for a table of frontline health worker roles and ratios). In 2013, the central government added an additional supervisor, the ASHA Sangini, a former ASHA responsible for observing and reviewing the logs of about 20 ASHAs in her home geographic area. ASHA Sanginis' financial incentives were based on household and ASHA visits and provided a more stable, predictable income.

The following year, the state sent a community resource person (CRP) to help advise Savita and other field staff on data collection and household interactions. "I was glad to have the extra support," she said. Her CRP, responsible for more than 60 ASHAs, spent a majority of her time in the field, shadowing home visits and hospital deliveries and supporting coordination between ASHAs and other frontline health workers. Savita was 10 years older than her CRP and thought she was helpful and smart. They quickly grew to like each other and enjoyed spending time together.

Priorities as an ASHA

In 2014, the district health office issued a condensed version of the data-tracking logs, called the Village Health Index Register (VHIR; see **Exhibit 2** for a photo). Savita was relieved—the new version was much easier to keep track of and carry and took an hour less to complete each day. She conducted a census every six months and used the information to update her VHIR. She also updated it monthly as people married, became pregnant, and gave birth. In 2016, she earned USD 14.70 per month for maintaining her VHIR (see **Exhibit 3** for a list of ASHA incentives). She also reported maternal and child deaths directly to the ANM.

Savita created her monthly due list from her VHIR logs and the initial village survey. The VHIR provided a tracking component that made it easier for her to prioritize households: pregnant women, followed by recent mothers and newborns, then women and infant immunizations. Savita offered other services, including family planning and nutrition counseling, to most women occasionally, during different stages of life. Often, she observed additional needs that she was not able to address.

Most households spanned three generations. Mothers-in-law typically controlled access to their daughters-in-law and made decisions about health—including pregnancies—and well-being for their families. Savita had learned that mothers-in-law cared about some health decisions more than others; for example, they often dictated whether their daughters-in-law attended postnatal checkups but allowed them to decide if they wanted to take supplements.

On her first visit to a household, Savita would ask the mother-in-law for permission to speak with the woman in the home. After gaining a sense of the woman's needs and beliefs, Savita partially directed her educational counseling at the mother-in-law. Once she had established her reputation as the ASHA and learned how to tailor her message to household dynamics, Savita found many mothers-in-law to be generally open to her messages.

Savita typically prioritized higher-caste families because they tended to be more receptive to her advice. When she visited lower-caste homes, she sat on the floor alongside the women she counseled to earn trust and promote her objectives. "My duty is to take care of my area," she said. "If I am concerned about caste, how can I do my work?"

Savita walked to women's homes in her village and went with Lalit by bicycle to the two other villages she covered and to the Khairabad community health center (CHC) or district hospital. Lalit also

accompanied Savita at night. "There is no need to fear because I am coming with you," he would tell her. Jamini was happy to care for their sons as needed.

Pregnant Women

Savita educated pregnant women at their home about proper health and nutrition practices, discussed the importance of institutional delivery, and developed a birth preparedness plan with them. She advised them to start saving money to pay "gifts" to public hospital staff and, in the case of delivery complications requiring transportation to a different facility, ambulance drivers. In addition, Savita looked for signs of a high-risk pregnancy, such as swelling in the face or hands, low or high blood pressure, or convulsions. If she recognized any symptoms, Savita would flag the pregnancy in her VHIR and accompany the woman to the hospital for treatment or monitoring.

Savita learned that pregnant women in the area she monitored were not attending antenatal care (ANC) visits at the hospital because of the distance from their homes and their reluctance to neglect their housework. She worked to change this by educating women on the importance of ANC services; informing them that hospital antenatal visits were necessary only for high-risk pregnancies and women in their third trimester; and accompanying them to Village Health Nutrition Days (VHNDs) much closer to their homes. At VHNDs, the ANM provided ANC for pregnant women (including tetanus vaccines and iron and folic acid supplements), child immunizations, and family planning advice and contraceptives.

In addition to ANC visits, Savita focused on promoting institutional delivery. As the ASHA Sangini counseled her to do, Savita explained the potential risk of unexpected complications in home deliveries. She also informed women that all women in Uttar Pradesh who had institutional deliveries were entitled to a payment from the Indian Government's Janani Suraksha Yojana (JSY) program, which aimed to increase institutional delivery numbers in the low-performing state. The incentive was around USD 22 and helped offset travel and other delivery-related costs. Savita also received USD 4.42 for each institutional delivery she facilitated at a public hospital.

Savita, however, was keenly aware of the reality that women often faced in local hospitals. In December 2016, for example, the Khairabad CHC only had two female physicians (or "lady doctors") who, like most lady doctors, were not trained or expected to perform deliveries. Staff nurses conducted most deliveries and were bound by protocol to refer patients with complications that required a C-section or other special services to the district hospital 9 km away. Savita felt conflicted about sending women to this CHC, knowing they might be referred elsewhere and experience a potentially life-threatening delay in receiving care.

Savita had seen firsthand how the long chain of referrals had negative consequences. In 2009, she accompanied Jamini to the Khairabad CHC with her first labor pains. The hospital staff was not equipped to deliver at night and turned her away. They found transportation to the district hospital, where staff judged Jamini's case to be too critical and high-risk to handle and also turned her away. Finally, Savita and Jamini went to a private hospital, where Jamini gave birth to a stillborn baby.

Savita was shaken by this experience and reminded of her own limitations. From then on, she encouraged women and their families to have backup plans. "Now I tell people, 'Don't depend entirely on me or the government hospital. If I am not available or if the government hospital does not have the facilities, go to the private hospital,'" she said, even though she knew she could only get her institutional delivery incentive if they went to a public facility. Per her training, she also advised pregnant women to go to the hospital for ultrasounds during their third trimester and to avoid strenuous activities such as climbing stairs and carrying heavy loads.

Recently, Savita had visited several pregnant women in their homes. One woman in particular concerned Savita. She was 20 years old and six months pregnant with her first child. The woman was reserved and soft-spoken. Her husband did not want her to leave the house to attend VHNDs. Like many men, he believed respectable women, especially those of higher castes, should not venture outside their homes. As a result, this young woman had not yet received a tetanus shot or iron and folic acid supplements. Savita visited frequently, trying to gradually convince the woman's husband and sister-in-law to allow Savita to accompany her to a VHND. Savita knew this was just the first hurdle to ensuring the woman would give birth at the hospital. After trying a few times without success, Savita decided to move on and focus on families who were less challenging to persuade. Some of her extended family members lived in her village and were easiest to work with because they already knew and trusted her.

Accompanying Women in Hospital Deliveries

After often spending months convincing women of the importance of institutional delivery, Savita accompanied them to the local Khairabad CHC or district hospital at the first sign of labor. On average, Savita accompanied two or three women each month. Once there, she informed hospital staff of any preexisting conditions or risk factors the ANM had identified, such as anemia or preeclampsia. She also worked to ensure staff nurses and lady doctors respected and properly cared for the patient and new baby.

Labor could take hours or days. Savita waited in the hospital, taking quick breaks to get something to eat nearby. Jamini helped care for her family while she was away.

Once the baby was born, Savita ensured that the mother initiated breastfeeding within 30 minutes in the case of a vaginal delivery, or within one hour in the case of a C-section. Savita cleaned the nipple with warm water, guided the baby to the mother's breast, and showed how the baby would properly latch onto the nipple. She discouraged the mother-in-law from feeding *ghutti*, a honey mixture, to the newborn, a tradition that was becoming less common. She explained to new mothers the importance of early and exclusive breastfeeding for the first six months of life.

She reminded new mothers to remain at the hospital for 24 hours post-delivery for monitoring and the baby's immunizations, and she stayed with them to make sure they received those services. Sometimes women refused to stay the full 24 hours, which frustrated Savita.

Savita worried that the tools staff nurses used cut the umbilical cord might not be sterilized, as some of the mothers she cared for had gotten infections in the hospital. She instructed mothers on cord care: Women should not apply anything to their baby's umbilical cord. "When I had my boys, the midwife taught me to massage them with oil, which got on the cord. Everyone did it, so I did, too. I didn't know it could lead to an infection," she remembered.

Over time, Savita built positive relationships with the staff at both the local and district hospitals. Through these partnerships, she protected her patients and their babies from maltreatment—a relatively common occurrence in the public health system, where staff were overworked, faced with constant supply shortages, and compensated with a low fixed salary. The private hospital system was known to treat patients better, but the comparatively high cost was prohibitive for many of the women with whom Savita worked.

In 2015, the delivery ward at Khairabad hospital was updated and new delivery beds, IV poles, and a baby weight scale were added. ANMs received blood pressure machines and training on how to use them so they could inform both the ASHA and pregnant woman of any hypertension or hypotension, potentially preventing complications during labor, delivery, and recovery.

Home-Based Newborn Care

After pregnant women and institutional delivery, Savita's second priority was Home-Based Newborn Care (HBNC). She was responsible for recording the infants' date of birth and making home visits on days 3, 7, 14, 21, 28, and 42. In a follow-up ASHA training, Savita had learned the five steps of an HBNC visit: washing her hands, swaddling the baby correctly, weighing the baby, taking the baby's temperature, and checking its pulse. Because many homes, like her own, lacked indoor plumbing, Savita often skipped the hand-washing step. She had a government-issued thermometer and infant scale to take the baby's weight and temperature. Savita verified with the mother that the baby was only breastfeeding. She also asked the mother-in-law what the baby ate, knowing she might be feeding *ghutti* without the mother's knowledge. If her observations of the baby revealed signs of complications such as jaundice, pneumonia, or an infection of the cord stump, she accompanied the mother to the hospital. When she wanted to persuade a family to change something, Savita spoke to both the mother and the mother-in-law.

Savita asked the recent mothers about their recovery and accompanied them to the hospital if they had any complications such as continued bleeding 20 days post-delivery. She promoted good nutrition and explained how the mother's eating habits had a direct impact on the nutrients her baby received.

Many new mothers viewed Savita as they would a trusted aunt. They respected her position in the community as well as her knowledge. Savita's repeated interactions throughout pregnancy, presence at the birth, and post-delivery visits often cultivated closeness and trust between Savita and the new mother. Family members of the new mothers often felt a similar sense of gratitude toward Savita for the support and reassurance she provided.

Savita earned USD 3.67 for completing all required HBNC visits. Occasionally, she had difficulty correctly recording the date of birth and determining the days for HBNC visits. Her CRP noticed these errors and pointed them out, and Savita worked to correct them.

Child Immunization

Savita tracked children following their birth and recorded their immunizations. She informed mothers of opportunities for immunizations, including VHNDs, and accompanied mothers and children to these services. She received USD 2.20 each time she encouraged women to bring their children to immunization days, USD 0.73 for each child completing his or her first-year-of-life vaccinations, and USD 1.47 for second-year vaccinations.

The ANM had scolded Savita at a recent VHND for incorrectly recording the age of a few children on her register, which misaligned them with their proper immunization schedule. Savita was discouraged but began to double-check children's ages before adding them to her VHIR.

Few educated women like Savita were willing to take on the non-salaried ASHA role. At last month's cluster meetings (a gathering of the area's Anganwadi workers [AWWs], ANMs, and ASHAs), Savita saw other ASHAs—some of whom were illiterate—struggle with their registers. She knew those ASHAs required much more of the CRP's, ASHA Sangini's, and ANM's attention. Savita heard of one ASHA in her cluster who talked down to the families she visited. Both the ASHA Sangini and CRP corrected that ASHA and observed her more frequently on household visits until she improved.

Family Planning Counseling

Savita counseled recently married couples to wait at least two years before becoming pregnant and advised they use condoms or an intrauterine device (IUD) between pregnancies. "I didn't want them to

have the same difficulty that I did having two babies close together," she said, remembering the hardship she experienced raising her sons, "and it's better for the mother's and baby's health to wait at least two years." She had also seen many families who were not using contraception have more children than they could afford. "I wanted to help them," she added.

Savita asked mothers how many children they wanted and how they planned to space pregnancies. She asked about their previous use of family planning—abstinence, the rhythm method, or contraceptive devices such as condoms, IUDs, and oral contraception. The Indian public health system offered contraceptives free of charge. However, Savita rarely recommended oral contraceptives, since they were available only at hospital pharmacies, which were frequently out of them and inconvenient for families to travel to. Many families preferred the rhythm method—known locally as the "safe method"—because they saw it as the most natural choice. Savita had seen many families learn the hard way that it was not the most reliable method.

Family planning was not always the easiest topic for Savita or families to discuss. Religious and cultural practices, as well as strict gender roles, made it a taboo subject for many women, and Savita rarely broached the topic with men, who often made the final decision in this matter. "I feel shy to talk so openly about these topics with males," said Savita, "I am a daughter and daughter-in-law to somebody, so I worry how it reflects on me to talk about these things." Other ASHAs shared her discomfort. The topic of family planning was especially sensitive with families who had not yet had a male child.

For couples who did not want to have more children, Savita recommended female sterilization. Savita herself had undergone sterilization two years after the birth of her second child, and she was pleased with her decision. She knew sterilization carried the risk of serious infection and did not like subjecting women to unnecessary risk; however, as a permanent method of contraception, it came with a more significant financial incentive for Savita: USD 2.94 per woman, or USD 14.73 if it was after the birth of a second child.

Savita often brought women to the Khairabad CHC sterilization camps—fixed days where the surgical procedure was performed. Savita found that women tended to be receptive to the idea after two or three pregnancies, but often their husbands would not let them undergo the procedure. "Men say that children are God's gift and ask why they should try to change that," Savita explained. "And some Muslim women say that it is not permitted by their religion. I tell them not to look at religion but to look at their condition—having more children than they can afford. And now even some Muslims have started to get sterilized." Most men would not consider male sterilization, so she usually steered away from the topic.

Savita was encouraged when couples started to ask about family planning, a practice that had become more common over the past five years. She also began to sense that gender preference was less prevalent but knew of some families who had found doctors willing to tell them, despite the law against sex disclosure at ultrasounds, and had aborted female fetuses.

Despite her counseling, some women did not use contraception or still became pregnant. Savita generally discouraged women from seeking an abortion because of the risk of infection and the potential long-term negative impact on their bodies. "We [ASHAs] advise women not to get into that position knowingly because it might cause trouble for themselves or their children," she said.

Abortions did happen, however. Savita supported a woman who had lost a child with heart problems and decided to abort a fetus her doctor said appeared weak. After helping her recover, Savita was proud that the woman became pregnant again, this time with what appeared to be a healthy baby, according to ANC checkups.

Adolescent Counseling

Savita worked with the Anganwadi worker to counsel girls about proper nutrition, and she advised them to wait until age 18 to marry. Their bodies needed to be strong before pregnancy and childbirth, she said, and she knew there was a lot of pressure on girls to "prove their fertility" after getting married.

It was hard to convince adolescent girls to receive the tetanus vaccine; many were scared of the pain, while others mistakenly believed the injection could make them pregnant. "Someone needs to come in from the outside to talk about tetanus," said Savita. "They will listen to someone like that. They won't listen to me." She wondered: *Why is it that they listen to me on some issues but not on others?*

Savita's impact on adolescent girls was difficult to measure because most moved to their husbands' village upon marriage.

Tracking Life as an ASHA

Collaborating

On the first Monday of each month, Savita received a USD 2.20 transportation stipend to travel to the Khairabad Hospital for a "cluster meeting." The meeting gave Savita an additional opportunity to meet with her supervisors and her only official opportunity to meet and talk with nearby ASHAs: "I have learned from ASHAs how to better maintain the VHIR and how to have harmonious relationships with the other people in the village by talking to them," she said, "I take the advice of other ASHAs and leave motivated."

Monthly AAA ("triple A") meetings began in 2015, bringing together the ASHA, AWW, and ANM of each block. The meetings were overseen by the CRP and ASHA Sangini. Hoping for praise, Savita excitedly turned in her VHIR to the CRP monthly, who reviewed it for completion and accuracy. The group members used their logs to identify beneficiaries who needed to be visited or attend a VHND or Anganwadi Center that month and confirmed high-risk pregnancies they needed to prioritize. Speaking about a woman who recently delivered at home, Savita explained, "The ANM said we should try to convince her in an even better way next time."

Compensation

In total, Savita earned between USD 29.40 and USD 36.75 per month, the majority of the family's income (see **Exhibit 3** for ASHA incentives). To get paid, she recorded her work within one week of completing the service on a voucher that the ANM verified and submitted to the hospital director or medical officer in charge (MOIC). Once approved, money was deposited electronically in Savita's bank account, which she had created upon becoming an ASHA. Savita felt the system worked in general, although it was hard to keep track of all the compensation she was owed, and which of her many activities paid the most. She would have to go to the ATM in a nearby town to confirm each deposit, and the transport to town could cost more than the incentive itself, so she did not check often.

Some of the incentives available to ASHAs in the 2015–2016 period were for other types of health services, such as malaria screenings, tuberculosis patient recruitment and treatment, and surveying households for lymphatic filariasis. Savita found these incentives impractical because of how much time they took and the relatively low incidence rates compared with maternal and child health events.

Looking Forward

After nearly 10 years as an ASHA, Savita felt like an integral part of her community's well-being. "I have seen what she does, including helping my wife with her pregnancy and delivery, so I know she is a good ASHA," said one man in the village. Savita reflected on how much things had changed: "At first, some mothers-in-law wouldn't let me see their daughters-in-law. Now, sometimes they come to me to request that I visit. Before I became an ASHA, people in the village were scared to go to the government hospital, fearing they'd be turned away or there would not be services available. By going with women to the hospital and advocating for them there, I helped people get over this fear."

Savita believed that because of her efforts, combined with those of other ASHAs, the AWW, the ANM, and hospital staff, all women in her village were breastfeeding. "Because of my work," she added, "children are born a healthy weight, and more women are delivering in the hospital." The CRP told Savita that vaccination rates in the district also had increased, due in part to the work of ASHAs. "Polio rates have reduced," Savita said. "We're not seeing this or other common childhood diseases as much."

Savita received consistent praise from the women she worked with, many of whom came to view her as a trusted family member. She viewed her job as "social work" and enjoyed watching women around her take up correct practices and even pass those on to other women. "Now the neighbors give us more respect because my wife takes pregnant women to the hospital," said Lalit.

Savita planned to continue her work as an ASHA but hoped to be promoted to the role of ASHA Sangini. Her job had gotten easier over the years, as she had begun to establish new practices and norms for maternal and child health that were spreading within her community. She thought about what she would tell a woman interested in being an ASHA: *This is very good work. ASHAs carry themselves with pride because mortality rates of mothers and children are falling. We give people hope.*

Exhibit 1 *Frontline Actors in the UP Health System, 2016*

Frontline Actor	Role	Number in Uttar Pradesh	Catchment Area in Uttar Pradesh	National Standards for Catchment Area
ASHA (Accredited Social Health Activist)	Facilitates health services; links community members and health facilities; provides community-level health services; activist building understanding of health and right to health	150,000	1 ASHA per 1,500 population	1 ASHA per 1,000 population
ANM (Auxiliary Nurse Midwife)	Provides antenatal care, family planning, and immunizations in villages; provides follow-up for infectious disease care (TB, leprosy, and malaria)	23,000	1 ANM per 8,000–10,000 population	1 ANM per 3,000–5,000 population
AWW (Anganwadi Worker)	Weighs children each month; surveys facilities; supervises preschool activities; carries out child nutrition programming	180,000	1 AWW per 1,000–2,000 population	1 AWW per 500–800 population
ASHA Sangini	Supervises ASHAs	6,080	1 ASHA Sangini per 20 ASHAs	1 ASHA Sangini per 20 ASHAs

Source: GHD case writers.

Exhibit 2 *ASHA Village Health Index Register (VHIR)*

Source: Photo taken by GHD case writers.

Exhibit 3 *ASHA Incentives, 2016–2018*

Category	Incentive/Activity	2016–2017 Incentive Amount	2017–2018 Incentive Amount	Frequency
Maternal Health	Antenatal care	INR 300 (USD 4.42)	INR 300 (USD 4.42)	Case basis; every pregnant woman
	Promoting institutional delivery	INR 300 (USD 4.42)	INR 300 (USD 4.42)	Case basis; every pregnant woman
	Referring high-risk pregnant women to higher care for treatment, institutional delivery; entering the detail in the MCTS/RCH portal		INR 300 (USD 4.42)	Case basis
Death Reporting	Maternal death reporting	INR 200 (USD 2.95)	INR 200 (USD 2.95)	Case basis
Home-Based Newborn Care (HBNC)	6–7 newborn care home visits under HBNC program module	INR 250 (USD 3.68)	INR 250 (USD 3.68)	Case basis; 6–7 home visits in the first two months post-delivery
Nutrition Rehabilitation Center (NRC)	Referring severely acute malnourished child to NRC		INR 50 (USD 0.74)	Case basis
	Home visit on return of malnourished children from NRC or after Community-Based Malnutrition Management (until girth of midportion of upper arm becomes 125 mm)	INR 150 (USD 2.21)	INR 100 (USD 1.47)	Case basis
Special Care Newborn Units (SCNU)	Monthly home visits following return of underweight children from SNCU (for two years)	INR 50 (USD 0.74)		Case basis
	For monthly home visits on return of normal weight children from SNCU (For two years)	INR 50 (USD 0.74)		Case basis
Village Health and Nutrition Day (VHND)	For encouraging beneficiaries to go to VHND and attend it	INR 200 (USD 2.95)	INR 200 (USD 2.95)	Monthly
Regular Vaccination Program	For encouraging people to bring children on Vaccination Day	INR 150 (USD 2.21)	INR 150 (USD 2.21)	Monthly
	For complete immunization of children in the first year	INR 100 (USD 1.47)	INR 100 (USD 1.47)	Case basis; for every 1 year old

				child
	For complete immunization of children in the second year	INR 50 (USD 0.74)	INR 50 (USD 0.74)	Case basis; for every 2 year old child
Family Welfare	Female sterilization	INR 200 (USD 2.94)		Case basis
	Male sterilization	INR 300 (USD 4.42)		Case basis
	Encouraging couples to go for permanent contraception method after two children	INR 1,000 (USD 14.73)	INR 1,000 (USD 14.73)	Case basis
	Encouraging couples to delay pregnancy for two years after marriage	INR 500 (USD 7.36)	INR 500 (USD 7.36)	Case basis
	Encouraging couples to keep a gap of three years between the first and the second child	INR 500 (USD 7.36)	INR 500 (USD 7.36)	Case basis
	For encouraging couples to get PPIUCD (postpartum intrauterine device) after childbirth and for taking them to hospital	INR 150 (USD 2.21)	INR 150 (USD 2.21)	Case basis
	Mobilizing women to go to the hospital to access safe abortion services through the surgical method		INR 150 (USD 2.21)	Case basis
	Mobilizing women to go to hospital for safe abortion services through medical method and three follow-up appointments		INR 225 (USD 3.31)	Case basis
Revised National Tuberculosis Control Programme (TB)	Completion of treatment of new patients of TB (Category-1)	INR 1,000 (USD 14.73)		Case basis
	Completion of treatment of new patients of TB (Category-2)	INR 1,500 (USD 22.09)		Case basis
	Completion of treatment of multi-drug resistant patients	INR 5,000 (USD 73.64)		Case basis
Leprosy	Identification of leprosy patients	INR 250 (USD 3.68)		Case basis
	Paucibacillary (complete treatment)	INR 400 (USD 5.89)		Case basis

	Multibacillary (complete treatment)	INR 600 (USD 8.84)		Case basis
Malaria	Blood platelets or rapid diagnostic test	INR 15 (USD 0.22)		Case basis
	On getting complete treatment for confirmed case of malaria	INR 75 (USD 1.10)		Case basis
Black Fever	For identification, referral and getting complete treatment of black fever patients	INR 300 (USD 4.42)		Case basis
Lymphatic Filariasis	Making list of all lymphatic and hydrocele cases	INR 200 (USD 2.95)		Case basis
	Surveying 50 houses or 250 people everyday (up to maximum three days)	INR 200 (USD 2.95)		Case basis
Encephalitis	For referral of acute encephalitis syndrome (AES) / Japanese encephalitis (JE) case to nearest community health care centre/district hospital/medical college	INR 300 (USD 4.42)		Case basis
Village Health Index Register (VHIR)	Making list of all houses at start of year and updating it every six months	INR 100 (USD 1.47)	INR 100 (USD 1.47) (part of 1,000 rupee monthly register incentive)	Monthly
	Registering all births and deaths in VHIR	INR 100 (USD 1.47)	INR 100 (USD 1.47)	Monthly
	Making a list of beneficiaries for vaccination and updating it every month	INR 100 (USD 1.47)	INR 100 (USD 1.47)	Monthly
	Making a list of beneficiaries of pregnant women due for ANC and updating it every month	INR 100 (USD 1.47)	INR 100 (USD 1.47)	Monthly
	Making a list of family planning–eligible couples and updating it every month	INR 100 (USD 1.47)	INR 100 (USD 1.47)	Monthly
Meeting of Committees on Village Health, Sanitation, and	Organizing meeting of Village Health, Sanitation, and Nutrition Committee	INR 150 (USD 2.21)	INR 150 (USD 2.21)	Monthly

Nutrition				
Cluster Meeting at CHC/PHC	Transportation to Block Primary/Community Healthcare Centre	INR 150 (USD 2.21)	INR 150 (USD 2.21)	Monthly

Source: Uttar Pradesh Technical Support Unit.

Note: Grey shading indicates there was no incentive attached to that activity. Currency conversions are based on the Indian rupee (INR) to US dollar (USD) exchange rate in December 2016.

MCTS: Mother and Child Tracking System; RCH: Reproductive and Child Health.

Appendix *Common Acronyms and Abbreviations*

ASHA	Accredited social health activist
ANC	Antenatal counseling
ANM	Auxiliary nurse midwife
AWW	Anganwadi worker
CHC	Community health center
CRP	Community resource person
HBNC	Home-based newborn care
IUD	Intrauterine device
JSY	Janani Suraksha Yojana, an incentive program promoting institutional delivery
MOIC	Medical officer in charge
VHIR	Village Health Index Register
VHND	Village Health Nutrition Day