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PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN
(2010-2011)

(FIFTEENTH LOK SABHA)

ELEVENTH REPORT

'WORKING CONDITIONS OF ASHAs'

[Action Taken by the Government on the recommendations contained in the Fourth Report (Fifteenth Lok Sabha) of the Committee on Empowerment of Women (2009-2010) on 'Working Conditions of ASHAs']

LOK SABHA SECRETARIAT

NEW DELHI
SEPTEMBER, 2011/BHADRA, 1933 (Saka)

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[Action Taken by the Government on the recommendations contained in the Fourth Report (Fifteenth Lok Sabha) of the Committee on Empowerment of Women (2009-10) on 'Working Conditions of ASHAs']

Presented to Lok Sabha on 7th September, 2011

Laid in Rajya Sabha on 7th September, 2011

LOK SABHA SECRETARIAT

NEW DELHI
SEPTEMBER, 2011/BHADRA, 1933 (Saka)

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CONTENTS

APPENDICES

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN
(2010-2011)
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Shrimati Chandresh Kumari - Hon'ble Chairperson

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3.	Smt. Mamta Kemwal	Deputy Secretary
4.	Shri Girdhari Lal	Committee Officer

*ceased to be a Member of the Committee consequent upon her retirement from Rajya Sabha w.e.f 18th August, 2011.

INTRODUCTION

I, the Chairperson, Committee on Empowerment of Women having been authorized by the Committee to submit the Report on their behalf, present this Eleventh Report (Fifteenth Lok Sabha) on the action taken by the Government on the recommendations contained in their Fourth Report (Fifteenth Lok Sabha) on 'Working Conditions of ASHAs'.

2. The Fourth Report (Fifteenth Lok Sabha) of the Committee on Empowerment of Women was presented to Lok Sabha on 26th August, 2010 and laid in Rajya Sabha on 26th August, 2010. The Ministry of Health and Family Welfare has furnished the action taken replies to all the Observations/Recommendations contained in the Report.

3. The Committee on Empowerment of Women (2010-2011) considered and adopted the Draft Report at their sitting held on 6th September, 2011. Minutes of the sitting are given at Appendix I.

4. An Analysis of the action taken by the Government on the recommendations contained in the Fourth Report (Fifteenth Lok Sabha) of the Committee is given in Appendix II.

5. For facility of reference and convenience, the Observations/Recommendations of the Committee have been printed in bold letters in the body of the Report.

NEW DELHI **SMT. CHANDRESH KUMARI**
6th September, 2011 **CHAIRPERSON**
16 Bhadra, 1933 (Saka) **COMMITTEE ON EMPOWERMENT OF WOMEN**

CHAPTER I

REPORT

This Report of the Committee deals with the action taken by the Government on the recommendations contained in the Fourth Report (Fifteenth Lok Sabha) of the Committee on Empowerment of Women on the subject 'Working Conditions of ASHAs'. The Fourth Report of the Committee was presented to Lok Sabha on 26th August, 2010. The report was simultaneously laid in Rajya Sabha.

2. The Ministry of Health and Family Welfare were, thereafter, requested to furnish action taken replies on the recommendations contained in the Report. Replies of the Government in respect of all the 21 recommendations/observations have since been received and are categorized as under:-

i) Observations/Recommendations which have been accepted by the Government.
Recommendation Para Nos:-78, 80, 81, 85, 86, 87, 88, 89, 90, 92, 93, 96, 97 and 98. (Total-14)

ii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government.
Recommendation Para No:- 83 (Total-1).

iii) Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee and which require reiteration.
Recommendation Para Nos:-79, 82, 91, 94 and 95 (Total-5).

iv) Observations/Recommendations in respect of which the Government have furnished interim replies.
Recommendation Para Nos:- 84 (Total-1)

3. The Committee trust that utmost importance would be given by the Government to the implementation of their recommendations. In case where it is not possible for the Government to implement the recommendations in letter and spirit for any reason, the matter should be reported to the Committee with reasons for non-implementation. The Committee further desire that the Action Taken Notes on the recommendations/observations contained in Chapter- I of this Report should be furnished by the Government expeditiously.

4. The Committee will now deal with those action taken replies of the Government which need reiteration or merit comments.

A. Need to revise qualification and method of appointment of ASHAs.

(Recommendation Para No. 79)

5. The Committee in their original report, *inter-alia,* emphasized the need to revise qualification and method of appointment of ASHAs and recommended as under;

> The Committee note that ASHA primarily is a woman resident of the village (married, widowed, divorced) and preferably in the age group of 25 to 45 years and she is required to have formal education upto 8th Standard. The Committee also note that the final selection of ASHA is made by Gram Sabha out of three names shortlisted by Block Nodal officer and facilitators. The Committee feel that the educational qualification for the appointment of ASHAs i.e. 8th standard is not enough to render primary medical help for minor ailments. The Committee, therefore, recommend that the educational qualification for ASHAs may be increased to 10th Standard for future appointments and no relaxation should be made in the educational qualification by the State Government without the consent of the Central Government. The Committee also feel that to rule out favourtism and nepotism in the selection of ASHAs by gram sabhas, the process of selection may be monitored by block level and district level officers.

6. The Ministry of Health and Family Welfare in its action taken reply on the aforementioned recommendation had, *inter-alia*, stated as under:-

> "States need flexibility in ASHA selection to ensure meeting the criteria of local selection, and representation of marginalized communities.

Making 10th Standard as mandatory minimum educational qualification of ASHA without giving any flexibility to the State Government may result in poor coverage of ASHA in areas where they are needed the most i.e. amongst the marginalized communities. As per the recent evaluation conducted by the National Health Systems Resource Centre (NHSRC) the mandatory requirement of Class X in West Bengal has meant that in tribal blocks of West Bengal, no ASHA have been selected. In Kerala, in selected tribal blocks, because of the paucity of candidates that meet the educational qualification, ASHAs are not selected from the local community. So the minimum qualification should remain Class VIII pass. In many places, women with much higher educational qualification also are working as ASHAs. State Governments have been advised to enforce the Class VIII pass criteria in selection of ASHAs and not to relax any condition without prior approval of the Government of India.

As per the guidelines for selection of ASHA issued by the Ministry, District Health Society is required to oversee the process of selection of ASHAs. The Society has to designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved."

Comments of the Committee

7. Observing that the educational qualification for the appointment of ASHAs i.e. 8th standard is not enough to render primary medical help for minor ailments, the Committee, in their original report, had recommended that the educational qualification for ASHAs may be increased to 10th Standard for future appointments and no relaxation be made in the educational qualification by the State Governments without the consent of the Central Government. To rule out the possibility of favourtism and nepotism in the process of selection of ASHAs by Gram Sabhas, the Committee also recommended that the process of selection might be monitored by block level and district level officers.

The Ministry of Health and Family Welfare in their action taken reply have, *inter-alia*, stated that States need flexibility in ASHA selection to ensure meeting the criteria of local selection, and representation of marginalized communities. Making 10th Standard as mandatory minimum educational qualification of ASHA without giving any flexibility to the State Government may result in poor coverage of

ASHA in areas where they are needed the most i.e. amongst the marginalized communities. In view of the fact that NRHM is a central scheme but implemented through the state Governments, the Committee find some justification in the reply of the Ministry that the States need some flexibility in the selection of ASHAs and making 10th standard mandatory qualification for ASHAs may result in poor coverage of the programme in the marginalized communities. However, the Committee feel that the 10th standard should be made a desirable qualification for selection of ASHAs in these areas and wherever sufficient number of candidates with qualification of 10th standard are available such candidates may be given preference for selection of ASHAs so that along with quantitative, qualitative results are achieved. The Ministry should issue necessary directions to the States in this regard.

As regards the monitoring of the selection process by the block level and district level officers, the Ministry have stated that as per the guidelines for selection of ASHA issued by the Ministry, District Health Society is required to oversee the process of selection of ASHAs and the Society has to designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved. While giving due credence to the guidelines issued for District Health Society to oversee the process of selection of ASHAs and to designate a District Nodal Officer, the Committee, however, emphasise the necessity for strict monitoring by the government functionary in regard to qualification so as to ensure that the selection of ASHAs is conducted in a fair and impartial manner.

(Recommendation Para No. 82)

C. The incentive for taking pregnant woman to the hospital to be enhanced and paid at different stages.

8. Highlighting the fact that the incentive for taking pregnant woman to the hospital be enhanced and paid at different stages, the Committee recommended as under:

"ASHA being the primary health functionary at the grass root level is engaged in bridging the gap between the health facilities and the masses. However, the Committee note that due to the excess workload on ASHA, they are unable to discharge all the duties assigned to them. The Committee also note that aspects concerning delivery of child are often looked after and handled by midwives in the villages which is an age old practice. The Committee, therefore, recommend that alongwith ASHAs, the midwives in the village should also be given training to facilitate safe child birth. This will ease ASHAs of the excessive workload and also lead to safe child birth. The Committee further recommend that the incentive to ASHAs for taking pregnant woman should be structured in a way that she is taken at four stages to the hospital i.e in the 4th and 7th month of pregnancy, at the time of delivery and finally one month after delivery for post natal checkup. The incentive for taking the mother to the hospital should be paid at each stage i.e. Rs 250 at the 1st, 2nd and 4th stage and Rs 600 at the time of delivery i.e. the 3rd stage. The pregnant woman should be tested for sugar, hypertension etc. Such an arrangement will help in identifying complicated cases of delivery and in turn reduce the Maternal Mortality Rate."

9. Replying to the above recommendation, the Ministry of Health and Family Welfare has submitted as follows:

"ASHA is not trained to conduct any delivery. The policy of Ministry is to ensure safe deliveries by skilled Birth Attendants (SBAs). National Population Policy, 2000 envisaged that by the year 2010, 80% institutional delivery and 100% deliveries by SBA should take place. But in the remote tribal and remote hilly villages, wherever it is not possible to reach the pregnant woman quickly to health facility or ANM quickly to the village, the traditional birth attendants can be provided with training and also clean delivery units.

The restructuring of incentives in four stages to cover pregnancy, delivery, and the postpartum period will be difficult to administer and will also multiply the existing workload on the system. ASHA get only Rs. 200 as incentive and it will not be possible to increase the incentive to such an extent as recommended.

These tests are already part of ANC."

Comments of the Committee

10. With a view to reducing ASHAs of the excessive workload and also facilitating and ensuring safe child birth, the Committee had

recommended that alongwith ASHAs, the midwives in the village should be given training to facilitate safe child birth. The Committee further had recommended that the incentive to ASHAs for taking pregnant woman should be structured in a way that she is taken at four stages to the hospital i.e in the 4th and 7th month of pregnancy, at the time of delivery and finally one month after delivery for post natal checkup. The incentive for taking the mother to the hospital should be paid at each stage i.e. Rs 250 at the 1st, 2nd and 4th stage and Rs 600 at the time of delivery i.e. the 3rd stage.

Replying to the recommendation, the Ministry of Health and Family Welfare have submitted that ASHA is not trained to conduct any delivery. The policy of the Ministry is to ensure safe deliveries by skilled Birth Attendants (SBAs). National Population Policy, 2000 envisaged that by the year 2010, 80% institutional delivery and 100% deliveries by SBA should take place. However, in the remote tribal and remote hilly villages, wherever it is not possible to reach the pregnant woman quickly to health facility or ANM quickly to the village, the traditional birth attendants can be provided with training and also clean delivery units. In this context, the Committee feel that the Government should examine the feasibility of extending similar training to traditional birth attendants in other areas also. As regards the training to ASHAs, the Committee opine that though ASHAs are not involved directly in conducting the delivery, they may play an educative role for the pregnant and expectant mothers.

As regards the restructuring of incentives in four stages to cover pregnancy, delivery, and the postpartum period, the Ministry have stated that it will be difficult to administer and will also multiply the existing workload on the system. ASHA get only Rs. 200 as incentive and it will not be possible to increase the incentive to such an extent as recommended. The Committee note with concern that the Ministry have expressed helplessness in implementing the recommendation of the Committee while no due justification in this regard has been advanced.

The Committee feel that ASHAs play an important role to make the NRHM programme of the country a real success by their referral services. They, therefore, reiterate their earlier recommendation and desire that a detailed account of reasons for non-implementation of the recommendation may be furnished expeditiously.

D. Annual ASHA Awards.

(Recommendation Para No.91)

11. The Committee in their original report, *inter-alia*, emphasized the need for institution of the Annual ASHA Awards at the Central level and recommended as under:

> "ASHA being a community health worker is selflessly involved in serving the society. The Committee feel that mere performance based incentive is not sufficient to compensate her for the services rendered by them. The Committee have been informed that few States like Assam, Orissa, Uttarakhand have recognized the contributions of ASHAs by conferring ASHA awards. The Committee feel that it is a positive step taken by these State Governments which should be replicated in other States and the Central Government should also institute ASHA Awards. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue directives to concerned State Governments to institute such ASHA awards and the Union Ministry should also institute annual ASHA Awards to recognize the contributions made by ASHAs."

12. In this regard, the Ministry of Health and Family Welfare has, inter-alia, submitted the following reply:

> "Ministry has requested the State Governments vide letter dated 4th February 2011 to take action in the matter immediately. At the Central level, it may not be possible to institute ASHA awards."

Comments of the Committee

13. Lauding the efforts of Assam, Orissa and Uttarakhand for conferring ASHA awards in recognition of the contributions of ASHAs in health services area, the Committee desired that this positive step should be replicated in other States and Central Government also. The Committee, therefore, recommended that the Ministry of Health and

Family Welfare should issue directives to concerned State Governments to institute such ASHA awards besides exploring the possibility of instituting Annual ASHA award at the Central level to recognize the contributions made by ASHAs.

In this regard, the Ministry of Health and Family Welfare has submitted that they have requested the State Governments to take action in the matter immediately. However, at the Central level, it may not be possible to institute ASHA awards. The Committee are disappointed that the recommendation has been turned down without furnishing reasons therefor. The Committee take a serious note of the casual approach of the Ministry in dealing with a Parliamentary Committee. The Committee, therefore, strongly desire that in future whenever it may not be possible to implement the recommendation of the Committee, the reasons for that should be furnished.

E. Steps to be taken to avoid under utilization of funds.

(Recommendation Para No. 94)

14. On underutilization of the funds for ASHA programme, the Committee recommended as under:

> "The funding of ASHA programme flows from Centre to State and then to the District Health Societies (DHS). The DHS further disburses the funds to block health officials, who make payment to ASHA directly or through joint account of ANM and Gram Pradhan. The compensation to ASHA based on measurable outputs is given under the overall supervision and control by Panchayat. The Committee observe that there is a wide gap in the funds allocated and utilized. For instance, in the year 2007-08, in high focus States, the amount allocated was Rs. 158.42 crore, whereas only Rs. 90.88 crore was utilized. Similarly, in 2008-09 only Rs. 135.17 crore was utilized out of Rs. 243.62 crore allocated. The Committee also note that though there is no receipt of reports about utilisation of funds, gaps and delays from Bihar and Jharkhand. The Committee feel that the Ministry of Health and Family Welfare should ascertain the reasons for under-utilization of funds. The Committee, therefore, recommend that a study should be conducted to establish the reasons for under-utilization of funds specially in the case of high focus States. The Committee also desire that steps should be taken to ensue that there

is no shortage, delay or gaps in allocation of funds especially in the case of Bihar and Jharkhand."

15. The Ministry of Health and Family Welfare in its action taken reply on the aforementioned recommendation has, inter-alia, stated as under:-

"Low fund utilization for ASHA has been due to delays in training and establishing support structures. With states accelerating the trainings and setting up support structures, the expenditure pattern is likely to show an upward trend. National Health Systems Resource Centre (NHSRC) has been asked to conduct the study on the issue.

ASHA is one of the non-negotiable core activities under NRHM and allocation is made under the same as per norms. Funds are allocated to all States including Bihar and Jharkhand based on fixed norms. Allocation is done based on the Annual Program Implementation Plan submitted by the State and discussions on the same in the meeting of National Program Coordination Committee (NPCC)."

Comments of the Committee

16. Taking note of the fact that there is a wide gap in the funds allocated and utilized for ASHAs, the Committee observed that the Ministry of Health and Family Welfare should ascertain the reasons for under-utilization of funds and accordingly recommended that a study should be conducted to establish the reasons for under-utilization of funds specially in the case of high focus States. The Committee also recommended that steps should be taken to ensure that there is no shortage, delay or gaps in allocation of funds, especially in the case of Bihar and Jharkhand.

The Ministry of Health and Family Welfare in their action taken reply on the aforementioned recommendation have, inter-alia, stated that low fund utilization for ASHA has been due to delays in training and establishing support structures and with States accelerating the trainings and setting up support structures, the expenditure pattern is likely to show an upward trend. Further, National Health Systems Resource Centre (NHSRC) has been asked to conduct the study on the issue. The Committee are however, concerned as the reply of the

government has been furnished while the findings of the National Health Systems Resource Centre (NHSRC) entrusted with the task of conducting the study to ascertain the reasons for low fund utilization for ASHA is still awaited. As pointed by the Committee in their recommendation that steps should also be taken to ensure that there is no shortage, delay or gaps in allocation of funds, the Committee however, note with dismay that the action taken reply of the Government is conspicuously silent about this. While deprecating the lack of responsibility being displayed by the Ministry in the matter, the Committee strongly reiterate their earlier recommendation and desire that the Ministry should expeditiously initiate all necessary steps.

F. Proper delineation of functions assigned to ASHAs and ANMs.

(Recommendation Para No. 95)

17. Emphasizing the need for proper delineation of functions assigned to ASHAs and ANMs, the Committee inter-alia recommended as under:

> "ASHA being an honorary volunteer is placed at the lowest rung in the hierarchy of the medical service and she is supposed to report to ANM and Anganwadi Workers (AWWs). The role of ASHAs, ANMs and AWWs is defined and they are required to work in close coordination with each other. However, the Committee note that ASHAs, ANMs and AWWs often compete for the same activities which are incentivized such as motivating women to access institutional delivery or sterilization. The Committee feel that such conflict of interest between ASHAs, ANMs and AWWs not only de-motivates these functionaries but also affect the health services that are envisaged to be undertaken by them. The Committee, therefore, recommend that the guidelines defining the functions of ANMs and ASHAs should be revisited and their roles and responsibilities should be properly delineated within three months from the date of presentation of the Report. The Committee further note that ASHAs are often attached with other Government schemes. For instance, in Rajasthan, ASHAs have been involved in the Integrated Child Development Scheme (ICDS). Their involvement outside the ASHA programme such as ICDS leads to clash between ASHAs and Anganwadi Workers (AWWs) and often harassment by Child Development Project Officers (CDPOs). The Committee, therefore, recommend that the Government should ensure that ASHAs are not

attached to other schemes as it hinders the smooth functioning of ASHA programme."

18. In this regard, the Ministry of Health and Family Welfare has, inter-alia, submitted the following reply:

> "There are clear guidelines on the role of ASHA and ANM. Attachment of ASHAs to other schemes is not a general practice and has been reported only in Rajasthan. In Rajasthan, AWW helpers have been designated as ASHA Sahyoginis."

Comments of the Committee

19. Taking note of the fact that ASHAs, ANMs and AWWs often compete for the same activities which are incentivized such as motivating women to access institutional delivery or sterilization, the Committee observed that such conflict of interest between ASHAs, ANMs and AWWs not only demotivates these functionaries but also affect the health services that are envisaged to be undertaken by them. The Committee, therefore, recommended that the guidelines defining the functions of ANMs and ASHAs should be revisited and their roles and responsibilities properly delineated. Further, keeping in view the fact that ASHAs are often attached with other Government schemes, the Committee recommended that the Government should ensure that ASHAs are not attached to other schemes as it hinders the smooth functioning of ASHA programme.

In this regard, the Ministry has submitted that there are clear guidelines on the role of ASHA and ANM. The Committee are however, surprised as to how there is conflict of interest if clear guidelines on the role of the ASHA and ANM are defined. As regards attachment of ASHAs to other schemes, it has been stated that it is not a general practice and has been reported only in Rajasthan. In Rajasthan, AWW helpers have been designated as ASHA Sahyoginis. From the reply, impression is gathered that the Government is indifferent to the recommendation of the Committee as it has given a very vague and evasive reply. The

Committee, therefore, reiterate their earlier recommendation and desire that action for implementation of the recommendation is taken at the earliest.

CHAPTER II

OBSERVATIONS/RECOMMENDATIONS WHICH HAVE BEEN ACCEPTED BY THE GOVERNMENT

(Recommendation Para No. 78)

Survey to ascertain reasons for ASHA dropouts.

The institution of ASHA (Accredited Social Health Activist) has been envisaged as one of the core strategies under National Rural Health Mission (NRHM) to promote health care at the household level. Through this important component of the core strategy of NRHM, a female health activist (ASHA) is installed at the village level to ensure household level access to health care. The primary function of ASHA is to act as a bridge between the rural population and health service outlets with a central role in achieving National Health and Population Policy goals. Till February, 2010, the number of ASHAs appointed was 7,89,485 all over the country except in Dadra Nagar Haweli, Goa and Puducherry. Over a period of time ASHAs dropout of the programme and new ASHAs are selected from the panel of three names previously prepared on the recommendation of Gram Sabha. However, the Committee find that the data regarding ASHA dropouts has not been compiled by any State and no study on the status and reasons for dropouts has been conducted. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should impress upon the State Governments to get a survey conducted to ascertain the total number of dropouts per year and the reasons causing the dropout.

Reply of the Government

Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 80)

Need for surprise inspection to ensure availability of drug kits.

As per the programme, ASHA is given a drug kit containing generic AYUSH and allopathic formulations for common ailments and the kit is supposed to be replenished from time to time. The kit consists of various first-aid paraphernalia, such as bandages and cotton, oral rehydration salts, antifungal ointment, gentamycin eye drops, etc. However, the Committee while interacting with ASHAs and ASHA Mentoring Groups find that the drug

kits are often kept locked in the sub centres and not handed over to ASHAs. The Committee also note that the drug kits are seldom replenished from time to time. The Committee strongly feel that the availability of drug kit with ASHAs is an important component of the programme, which has been ignored. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should instruct the health departments of respective States to conduct surprise inspections to ensure that drug kits with stipulated drugs are available with ASHAs and they are replenished periodically.

Reply of the Government

The Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 81)

Need to assess the present workload of ASHAs

ASHA being a health activist and a prominent functionary under NRHM, has been assigned the task to liaison between the people of her village and the health services. In view of her role as a health activist she has been assigned a wide range of functions such as: creating health awareness, counseling women regarding safe health practices, mobilize the community, coordinate with Village Health and Sanitation Committee and Gram Sabha, arrange escort/accompany pregnant women to health centres, provide primary medical care for minor ailments, etc. The Ministry has stated that there are two types of work assigned to ASHAs, one is performed in addition to her daily livelihood tasks and another for which she is compensated because she spends a much larger time. However, in view of the wide range of functions and tasks expected from ASHAs, the Committee feel that it is humanly not possible for the ASHA to perform the assigned duties in eight to twelve hours a week. The Committee, therefore, desire that the functions like role in village health plan and involvement in the construction of household toilets should be removed from the responsibilities assigned to ASHAs. At the same time, a systematic survey should be conducted to assess the present workload and incentives stipulated for services rendered by ASHAs. To increase the efficiency and bring down the workload, the Committee also recommend that the number of population each ASHA caters to may be brought down from the existing norm of 1000 to 700. In case the Government assigns any additional function to ASHAs, a separate cadre should be created so that ASHAs are not overburdened or their efficiency is affected.

Reply of the Government

The Village Health Plan should be seen as a useful tool to enable the ASHA in organizing her own work. It builds her capacity and empowers her. While the accountability for the village health planning rests with the Village Health and Sanitation Committee, removing the ASHA will reduce her ability to carry out her other activities effectively. So long as the function of household toilet construction is undertaken on a voluntary basis and targets are not set, the ASHA should be allowed to access the entitlement that this function entails. Moreover, the role of ASHA is limited to encouraging and inducing people which leads to better health indicator and is therefore not contrary to the role envisaged for her.

NHSRC has already conducted an evaluation of ASHA program in eight states which covered these parameters. As per the evaluation, majority of ASHAs spend 3 to 5 hours daily on ASHA work. Regarding reducing the population each ASHA caters from 1000 to 700, the States may take a call depending on the local situation. The ASHA evaluation conducted by NHSRC shows that in AP, Assam, Bihar and Kerala, about half of the ASHAs cover a population of less than 1000. Orissa has recently revised its norms to ensure that in difficult districts, there is one ASHA per every 300 population. In West Bengal, the density of population facilitates larger population coverage by the ASHA. Rajasthan follows the norm of one ASHA per Anganwadi centre. Jharkhand initially adopted the hamlet based norm, but later moved to the one ASHA per village norm. Such flexibility with the States is necessary in view of diversity and requirements. Reducing the population covered by each ASHA will also reduce the amount of incentives per month and may adversely affect the program and their motivation to continue as ASHA. Relaxation of norms can be considered only in remote, hilly and tribal area where the population is sparse and thinly spread.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 85)

Payment pattern to be periodically reviewed and facilitator to be held accountable for non/late payments

The Committee while interacting with ASHAs and ASHA Mentoring Groups found that non-payment and delay in payment for institutional deliveries is a common practice. The Committee also note that oral complaints about non-payment of incentives have been made to visiting teams in the States but no written reports have been received. The Committee opine that such practices like delay and non-payment of incentives is not only exploitative in nature but it also defeats the very purpose of the scheme itself. Non-payment and delayed payment de-motivates the ASHA from performing her assigned duties. ASHA being one of the most important functionaries under NRHM who acts as a link between the

community and health services needs to be timely compensated for the services rendered by her. The Committee, therefore, desire that there should be periodical review by the Ministry of Health and Family Welfare to ensure that there is no laxity in payment of incentives to ASHAs for the services rendered by them. The Committee further recommend that facilitators appointed to facilitate the payment to ASHAs should be held accountable for such lapses.

Reply of the Government

Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 86)

Payment to be made through bank/post office accounts

The Committee find that cash payment of incentives have led to corrupt practices leading to delay in payment or non-payment of incentives. The Committee note that cash payment is done where a bank or a post office is not within easy reach. Further, the Central Government has advised the State governments to create a permanent advance of Rs. 5000 at the level of sub-centre in the joint account of ANM and Sarpanch to facilitate performance based incentives. The Committee feel that unless ASHAs have their bank/post office accounts and the payment process is streamlined, it is very difficult to facilitate payment of performance based incentives. The Committee, therefore, recommend that earnest steps should be initiated by Ministry of Health and Family Welfare for opening bank accounts for ASHAs so that the corrupt practices in payment of incentives can be done away with. A database should be created regarding the number of ASHAs not having bank/post office accounts and a special drive should be initiated by the Health Departments of State Governments in this regard. This will certainly minimize the corruption level in the payment of performance based incentives to ASHAs and motivate them further.

Reply of the Government

Ministry has requested the State Governments vide letter dated 4th February, 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 87)

87. Need for a monitoring body to check non-payment of incentives

The Committee while interacting with ASHAs and ASHA Mentoring Groups were surprised to note that in case of still birth, ASHA is denied payment of Rs. 600/- for facilitating institutional delivery. The Ministry of Health and Family Welfare have, however, denied the same as no written complaint has been received in this regard. The Committee feel that non-payment of incentive of Rs. 600/-, in case of still birth may not be a regular practice but it also cannot be denied that such incidents of harassment of ASHAs do take place from time to time. The Committee, therefore, recommend that a monitoring body should be constituted at the State level so that such practices can be checked. The Committee further desire that the monitoring body should also have a forum at the district level, where ASHAs can make representations about such practices when they are denied their dues.

Reply of the Government

Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 88)

88. Construction of Rest Rooms for ASHAs at Health Centres.

The Committee note that one of the problems being faced by ASHA is the lack of rest rooms facility for them at the PHCs/CHCs and in District Health Centres. The Committee have been informed that States like Arunachal Pradesh and Chattisgarh have established a help desk for ASHAs at health centres. In Orissa, ASHA Gruha (rest house) for ASHAs accompanying mothers to the institution for deliveries have been established. The Committee feel that availability of rest rooms for ASHAs at the health centres is an important component to facilitate ASHAs in performing their responsibilities. Since ASHA has to accompany pregnant mothers to health centres in odd hours and often stay back in the night it becomes necessary to have rest rooms for them to ensure their security. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue directives to all State Governments in this regard and ensure that rest rooms for ASHAs are established at the District Health Centres and at other levels at the earliest. The Committee further desire that instructions should be issued so that a part of the funds allocated for ASHA programme is specifically utilized towards constructing such rest rooms.

Reply of the Government

Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 89)

Cost of organizing transport for pregnant woman to health facility to be paid separately

The Committee note that there is lack of adequate transport facilities to transport pregnant women to health facilities. They feel that the transport of a pregnant woman to the hospital is very crucial and any delay may lead to casualty of both mother and child. The Committee find that under the Janani Suraksha Yojana (JSY), an amount of Rs. 250/- is earmarked from the total available incentive package of Rs. 600 provided to ASHAs in low performing States, if she organizes the transport for taking a pregnant woman to the health facility. The Committee feel that the cost of organizing the transport of a pregnant woman should not be met from the incentive given to ASHAs. They therefore, recommend that the ASHA should be paid an amount of Rs. 250/- separately if she organizes the transport and the payment should be made promptly and fully. The Committee also recommend that the Central Government should direct the State Governments to issue free bus passes to ASHAs so that they can commute to PHCs, CHCs and District Hospitals free of cost and discharge their responsibilities in an effective manner.

Reply of the Government

The ASHA incentive for JSY in the rural areas of low performing States has three components:

- Rs. 200 as an incentive for motivating the mother for institutional delivery.
- Rs. 250 for organizing the transport.
- Rs. 150 only if she serves as a birth companion.

The division of the incentive needs to be uniformly implemented. So incentive for ASHA is Rs.200 and not Rs.600. Rs.250 is already provided for organizing transport.

After discussions during the oral evidence before the Committee, Secretary HFW, vide D.O. Letter dated 24th April, 2010 has already requested the State Health Secretaries of States to consider giving Photo ID

cards and bus passes to ASHAs to make ASHA more effective. The request has been reiterated vide letter dated 4th February 2011.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 90)

Need to organize ASHA Sammelans and ASHA Diwas every three months at the District level.

ASHA under NRHM is instrumental in strengthening community participation in all health programmes. The Committee find that in view of the role and responsibilities entrusted to ASHAs, ASHA Sammelans and ASHA Diwas are organized in Assam, Chattisgarh, Orissa and Uttar Pradesh to give better exposure to ASHAs. The Committee appreciate the efforts made by these States towards providing better exposure to ASHAs. The Committee feel that bridging the gap between rural community and the health services is a challenging task and it demands all round exposure of the ASHAs. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue directives to State Governments to organize such ASHA Sammelans and ASHA Diwas at least once in three months where ASHAs from all the villages can assemble at the District level and interact with each other. Through these activities the Health Department of the States will have an opportunity to evaluate their performance and also solve the problems being faced by them.

Reply of the Government

Ministry has requested the State Governments vide letter dated 4th February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 92)

92. Need to provide Social Security and Insurance Cover to ASHAs

The Committee feel that except Chattisgarh, Punjab and Haryana, social security or insurance cover has not been extended to ASHAs. The State of Chattisgarh covers ASHAs under Mukhyamantri Mitanin Kosh Scheme. Similarly, in Punjab and Haryana, they are covered under Rashtriya Swasthya Bima Yojana (RSBY). However, the Committee feel that ASHAs should be provided with social security benefit and brought under the insurance cover as has been extended to Anganwadi workers. Such a step will motivate them further to perform their duties and responsibilities better. Such benefits will also improve their working conditions and will have an impact on the overall outcome of the ASHA programme and NRHM. The

Committee, therefore, recommend that the Ministry of Health and Family Welfare in coordination with the Ministries concerned should work out a proposal to provide insurance cover to ASHAs as in the case of Anganwadi Workers under Anganwadi Karyakartari Bima Yojana. The Committee also desire that State Governments should be instructed to provide social security benefits to ASHAs as it is being practised in Chhattisgarh, Punjab and Haryana.

Reply of the Government

Ministry has requested the States to give priority in providing insurance cover or social security benefit under RSBY to all eligible ASHAs.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 93)

Need to issue identity cards to ASHAs to establish their credentials.

The Committee find that ASHAs face a major problem of not being recognized as they are not issued any identity card or an appointment letter whereby they can establish their credentials. The Committee note that often ASHAs are maltreated at health centres by Doctors and staff because they do not have any identification proof. Since ASHAs do not have any identity proof, all the entries are made in the name of ANMs under whom they are supposed to work. The Committee feel that such practices not only cause exploitation of ASHAs but also acts as a disincentive to them, which further affects their performance levels. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should take earnest steps to ensure that the health department in the respective States issue identity cards to ASHAs.

Reply of the Government

Ministry has requested the State Governments vide letter dated 4th February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 96)

ASHAs to be given quota in admission to Nursing Schools/Colleges.

The Committee note that States such as Chattisgarh has taken a decision to give priority to ASHAs while appointing ANMs. The Committee feel that in view of the functions being performed by ASHAs and ANMs it is a positive step. The Committee desire that the Ministry should issue directives

to the State Government to give preferential treatment to ASHAs who have served 10 years or more while selecting candidates for appointment of ANMs. The Committee also feel that for providing better career progression opportunities to ASHAs, a stipulated number of seats in the nursing schools/colleges should be earmarked for ASHAs. The Committee, therefore, recommend that State Governments should be directed to take steps to earmark 10% of seats in nursing schools/colleges for ASHAs, who have the required educational qualification and at least 5 years of experience.

Reply of the Government

Ministry has requested the State Governments vide letter dated 4th February 2011 to take action in the matter immediately.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 97)

Need to provide better communication tools to ASHAs to create public health awareness.

The Committee note that one of the primary responsibilities entrusted to ASHA is to create public health awareness and to provide information to the community on determinants of health. ASHA has been so far able to communicate effectively on a one-to-one basis through interpersonal communication. The Committee also note that organizing health education sessions in large community requires support from the Village Health and Sanitation Committee and effective communication tools to reach out to the community. The Committee strongly feel that mere posters about pregnant women, tuberculosis and malaria are not sufficient to reach out to the community in order to create awareness. The Committee desire that the Ministry of Health and Family Welfare should in conjunction with State Governments should devise new and innovative communication tools apart from posters to create awareness among the people about various health issues.

Reply of the Government

A communication kit for the ASHA to improve health education for the community has been developed. The contents of the kit include Flip books, Posters, Checklists, Situation Cards, Film DVD and Discussion Guide, ASHA Song CD and Lyrics and Pregnancy Wheel.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

(Recommendation Para No. 98)

State Governments to be urged upon to complete training modules within a time frame.

In view of the wide range of role and responsibilities assigned to ASHAs, their capacity building becomes one of the most important aspects which is crucial for the success of the NRHM programme. Training modules have been designed to equip ASHAs with necessary knowledge and skills resulting in achievement of the programme's objective. Capacity building is seen as a continuous process. The induction training of ASHA is completed in five modules spread over 23 days. However, the Committee are concerned to note that all States have not been able to completely cover all the training modules when they train the ASHAs. The Committee feel that if the training modules are not completely covered on time, it will defeat the very purpose of ASHA programme itself. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue special instructions to the State Governments that are lagging behind to completely cover all the training modules when they train the ASHAs and they should be given a timeframe to complete the induction training modules for ASHAs. The Committee, also recommend that after completing the module IV of training and before handing over the medicine kits to ASHAs it should be ensured that Doctors have duly verified that ASHA workers are able to identify and administer medicines contained/available in the drug kit for specific ailments as per prescribed dosages. The Committee also feel that ASHAs are not trained to handle emergency situations while taking the pregnant mother to the hospital for delivery. The Committee, therefore recommend that the training modules II and III itself should have a component on child birth so that she can handle emergency situations as and when they arise.

Reply of the Government

The majority of the high focus states except Bihar have completed training in Modules 1-4. Bihar is expected to complete the training within the next quarter. States have been asked to complete training of all ASHAs till 5th Module immediately.

This is covered in the training module and the certificate awarded on completion of training should be considered as sufficient in the matter.

ASHA is being trained in recognition of initiation of pregnancy and actions to be taken thereof. DDK is provided in the ASHA drug kit for clean deliveries in case of emergency.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

CHAPTER III

OBSERVATIONS/RECOMMENDATIONS WHICH THE COMMITTEE DO NOT DESIRE TO PURSUE IN VIEW OF THE REPLIES OF THE GOVERNMENT

Recommendation Para No. 83

Need for survey to ascertain representation of SC/ST and OBCs among ASHAs

Since the advent of National Rural Health Mission (NRHM) and the ASHA programme in 2005, it has been now almost five years. The Committee take serious note of the fact that no data has been kept by the government indicating the representation of SCs, STs and OBCs among ASHAs. The Committee feel that adequate representation of the marginalized sections in the society i.e. SCs, STs and OBCs among ASHAs is an important component that has been ignored by the Government. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue directives to the respective State Governments to conduct a survey to find out the representation of SCs, STs and OBCs among ASHAs and take adequate measures to ensure that these communities are adequately represented depending upon their population.

Reply of the Government

Ministry has requested the State Governments vide letter dated 1st February 2011 to take action in the matter immediately. However, it may be mentioned that the work of ASHA is of voluntary nature and women willing to volunteer have to be selected, irrespective of their caste and creed.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

CHAPTER IV

OBSERVATIONS/RECOMMENDATIONS IN RESPECT OF WHICH REPLIES OF THE GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE

Need to revise qualification and method of appointment of ASHAs.

(Recommendation Para No. 79)

The Committee note that ASHA primarily is a woman resident of the village (married, widowed, divorced) and preferably in the age group of 25 to 45 years and she is required to have formal education upto 8th Standard. The Committee also note that the final selection of ASHA is made by Gram Sabha out of three names shortlisted by Block Nodal officer and facilitators. The Committee feel that the educational qualification for the appointment of ASHAs i.e. 8th standard is not enough to render primary medical help for minor ailments. The Committee, therefore, recommend that the educational qualification for ASHAs may be increased to 10th Standard for future appointments and no relaxation should be made in the educational qualification by the State Government without the consent of the Central Government. The Committee also feel that to rule out favouratism and nepotism in the selection of ASHAs by gram sabhas, the process of selection may be monitored by block level and district level officers.

Reply of the Government

States need flexibility in ASHA selection to ensure meeting the criteria of local selection, and representation of marginalized communities. Making 10th Standard as mandatory minimum educational qualification of ASHA without giving any flexibility to the State Government may result in poor coverage of ASHA in areas where they are needed the most i.e. amongst the marginalized communities. As per the recent evaluation conducted by the National Health Systems Resource Centre (NHSRC) the mandatory requirement of Class X in West Bengal has meant that in tribal blocks of West Bengal, no ASHA have been selected. In Kerala, in selected tribal blocks, because of the paucity of candidates that meet the educational qualification, ASHAs are not selected from the local community. So the minimum qualification should remain Class VIII pass. In many places, women with much higher educational qualification also are working as ASHAs. State Governments have been advised to enforce the Class VIII pass criteria in selection of ASHAs and not to relax any condition without prior approval of the Government of India.

As per the guidelines for selection of ASHA issued by the Ministry, District Health Society is required to oversee the process of selection of ASHAs. The Society has to designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved."

Comments of the Committee

Please refer to the comments of the Committee at para no. 7 of the Chapter I of the Report

(Recommendation Para No. 82)

The incentive for taking pregnant woman to the hospital to be enhanced and paid at different stages.

ASHA being the primary health functionary at the grass root level is engaged in bridging the gap between the health facilities and the masses. However, the Committee note that due to the excess workload on ASHA, they are unable to discharge all the duties assigned to them. The Committee also note that aspects concerning delivery of child are often looked after and handled by midwives in the villages which is an age old practice. The Committee, therefore, recommend that alongwith ASHAs, the midwives in the village should also be given training to facilitate safe child birth. This will ease ASHAs of the excessive workload and also lead to safe child birth. The Committee further recommend that the incentive to ASHAs for taking pregnant woman should be structured in a way that she is taken at four stages to the hospital i.e in the 4^{th} and 7^{th} month of pregnancy, at the time of delivery and finally one month after delivery for post natal checkup. The incentive for taking the mother to the hospital should be paid at each stage i.e. Rs 250 at the 1^{st}, 2^{nd} and 4^{th} stage and Rs 600 at the time of delivery i.e. the 3^{rd} stage. The pregnant woman should be tested for sugar, hypertension etc. Such an arrangement will help in idenfying complicated cases of delivery and in turn reduce the Maternal Mortality Rate.

Reply of the Government

ASHA is not trained to conduct any delivery. The policy of Ministry is to ensure safe deliveries by skilled Birth Attendants (SBAs). National Population Policy, 2000 envisaged that by the year 2010, 80% institutional delivery and 100% deliveries by SBA should take place. But in the remote tribal and remote hilly villages, wherever it is not possible to reach the pregnant woman quickly to health facility or ANM quickly to the village, the traditional birth attendants can be provided with training and also clean delivery units.

The restructuring of incentives in four stages to cover pregnancy, delivery, and the postpartum period will be difficult to administer and will also multiply the existing workload on the system. ASHA get only Rs. 200 as incentive and it will not be possible to increase the incentive to such an extent as recommended.

These tests are already part of ANC

Comments of the Committee

Please refer to the comments of the Committee at para no. 10 of the Chapter I of the Report

Annual ASHA Awards.

(Recommendation Para No.91)

ASHA being a community health worker is selflessly involved in serving the society. The Committee feel that mere performance based incentive is not sufficient to compensate her for the services rendered by them. The Committee have been informed that few States like Assam, Orissa, Uttarakhand have recognized the contributions of ASHAs by conferring ASHA awards. The Committee feel that it is a positive step taken by these State Governments which should be replicated in other States and the Central Government should also institute ASHA Awards. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should issue directives to concerned State Governments to institute such ASHA awards and the Union Ministry should also institute annual ASHA Awards to recognize the contributions made by ASHAs.

Reply of the Government

Ministry has requested the State Governments vide letter dated 4th February 2011 to take action in the matter immediately. At the Central level, it may not be possible to institute ASHA awards

Comments of the Committee

Please refer to the comments of the Committee at para no. 13 of the Chapter I of the Report

Steps to be taken to avoid under utilization of funds.

(Recommendation Para No. 94)

The funding of ASHA programme flows from Centre to State and then to the District Health Societies (DHS). The DHS further disburses the funds to block health officials, who make payment to ASHA directly or through joint

account of ANM and Gram Pradhan. The compensation to ASHA based on measurable outputs is given under the overall supervision and control by Panchayat. The Committee observe that there is a wide gap in the funds allocated and utilized. For instance, in the year 2007-08, in high focus States, the amount allocated was Rs. 158.42 crore, whereas only Rs. 90.88 crore was utilized. Similarly, in 2008-09 only Rs. 135.17 crore was utilized out of Rs. 243.62 crore allocated. The Committee also note that though there is no receipt of reports about utilisation of funds, gaps and delays from Bihar and Jharkhand. The Committee feel that the Ministry of Health and Family Welfare should ascertain the reasons for under-utilization of funds. The Committee, therefore, recommend that a study should be conducted to establish the reasons for under-utilization of funds specially in the case of high focus States. The Committee also desire that steps should be taken to ensue that there is no shortage, delay or gaps in allocation of funds especially in the case of Bihar and Jharkhand.

Reply of the Government

Low fund utilization for ASHA has been due to delays in training and establishing support structures. With states accelerating the trainings and setting up support structures, the expenditure pattern is likely to show an upward trend. National Health Systems Resource Centre (NHSRC) has been asked to conduct the study on the issue.

ASHA is one of the non-negotiable core activity under NRHM and allocation is made under the same as per norms. Funds are allocated to all States including Bihar and Jharkhand based on fixed norms. Allocation is done based on the Annual Program Implementation Plan submitted by the State and discussions on the same in the meeting of National Program Coordination Committee (NPCC).

Comments of the Committee

Please refer to the comments of the Committee at para no. 16 of the Chapter I of the Report.

Proper delineation of functions assigned to ASHAs and ANMs.

(Recommendation Para No. 95)

ASHA being an honorary volunteer is placed at the lowest rung in the hierarchy of the medical service and she is supposed to report to ANM and Anganwadi Workers (AWWs). The role of ASHAs, ANMs and AWWs is defined and they are required to work in close coordination with each other. However, the Committee note that ASHAs, ANMs and AWWs often compete for the same activities which are incentivized such as motivating women to access institutional delivery or sterilization. The Committee feel that such conflict of interest between ASHAs, ANMs and AWWs not only de-motivates

these functionaries but also affect the health services that are envisaged to be undertaken by them. The Committee, therefore, recommend that the guidelines defining the functions of ANMs and ASHAs should be revisited and their roles and responsibilities should be properly delineated within three months from the date of presentation of the Report. The Committee further note that ASHAs are often attached with other Government schemes. For instance, in Rajasthan, ASHAs have been involved in the Integrated Child Development Scheme (ICDS). Their involvement outside the ASHA programme such as ICDS leads to clash between ASHAs and Anganwadi Workers (AWWs) and often harassment by Child Development Project Officers (CDPOs). The Committee, therefore, recommend that the Government should ensure that ASHAs are not attached to other schemes as it hinders the smooth functioning of ASHA programme.

Reply of the Government

There are clear guidelines on the role of ASHA and ANM. Attachment of ASHAs to other schemes is not a general practice and has been reported only in Rajasthan. In Rajasthan, AWW helpers have been designated as ASHA Sahyoginis.

Comments of the Committee

Please refer to the comments of the Committee at para no. 19 of the Chapter I of the Report

CHAPTER V

OBSERVATIONS/RECOMMENDATIONS IN RESPECT OF WHICH THE GOVERNMENT HAVE FURNISHED INTERIM REPLIES.

Fixed monthly remuneration apart from performance based incentive.

ASHA being an honorary volunteer does not receive any salary or honorarium. She is compensated for her time both in terms of TA and DA, so that their livelihood for the days they work is partly compensated. Further, ASHA is paid for participating in the monthly/bi-monthly training programmes. The monthly incentive varies from State to State based on the incentive package and the population coverage. For instance, in Angul district of Orissa the number of ASHAs getting a monthly incentive between Rs. 500-1000 is 97; Rs. 1001-1500 is 101; Rs. 1501-2000 is 46; Rs. 2000-2500 is 31 and above Rs. 2500 is 28. In view of the uneven incentive pattern, the Mission Steering Group (MSG) of NRHM recommended that ASHA be given fixed remuneration to serve as a retainership and to incentivize tasks such as home visits and managing drug kits which are not measurable. However, the proposal has not been approved by the Ministry of Finance citing the reason that the proposal to fix remuneration runs contrary to the approach of the performance linked remuneration adopted by the department and approved by the Cabinet. The Committee take serious note of the rejection of the proposal to pay fixed remuneration to ASHAs. The Committee strongly feel that in view of the responsibilities entrusted with ASHAs and the erratic pattern of incentives paid to them, it is necessary that they are also paid some fixed monthly remuneration which is uniform throughout the country in addition to the usual incentives. The Committee also feel that the amount of time ASHAs are required to devote leaves them with very less time to earn their livelihood, which again justifies a fixed remuneration for them. The Committee, therefore, recommend that the Ministry of Health and Family Welfare should take up the matter with the Ministry of Finance and work out a plan at the earliest, so that a fixed monthly amount as recommended by the Mission Steering Group is paid to ASHAs.

Reply of the Government

This was not agreed to by the Finance Ministry because the concept of fixed remuneration runs contrary to the concept of performance based incentives adopted by the department and approved by the cabinet. Payment of fixed remuneration doesn't justify the concept of ASHA working as an

activist and as a volunteer. However, matter will be placed before MSG again and based on the direction of MSG, further action will be taken.

(Ministry of Health and Family Welfare's O.M No. H.11014(2)/ 2010-NRHM-I dated 23-03-2011)

NEW DELHI
6th September, 2011
16 Bhadra, 1933 (Saka)

SMT. CHANDRESH KUMARI
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

APPENDIX I

MINUTES
COMMITTEE ON EMPOWERMENT OF WOMEN (2010-2011)

Thirteenth Sitting
(06.09.2011)

The Committee sat on Tuesday, the 6th September, 2011 from 1530 hrs. to 1630 hrs. in the Chamber of Hon'ble Chairperson, Committee on Empowerment of Women, Room 130, Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Shrimati Ashwamedh Devi
3. Shrimati Rama Devi
4. Shrimati Jyoti Dhurve
5. Shrimati Priya Dutt
6. Shri T.K.S. Elangovan
7. Shrimati Sumitra Mahajan
8. Dr. Jyoti Mirdha
9. Kumari Meenakshi Natarajan
10. Shrimati Mausam Noor
11. Shrimati Sushila Saroj
12. Shrimati Rajesh Nandini Singh
13. Shri Uma Shankar Singh
14. Shrimati Annu Tandon
15. Shrimati Seema Upadhyay

RAJYA SABHA

16. Shrimati Naznin Faruque
17. Shri Jabir Husain
18. Shri Ambeth Rajan
19. Shrimati Maya Singh
20. Dr. Prabha Thakur

SECRETARIAT

1.	Ms. Vijaya Moorthy	Joint Secretary
2.	Shri C.S. Joon	Director
3.	Smt. Mamta Kemwal	Deputy Secretary
4.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, Chairperson welcomed the Members to the sitting of the Committee. The Committee, then, took up for consideration the draft Action Taken Report on the action taken by the Government on the recommendations contained in their Fourth Report (Fifteenth Lok Sabha) on the subject 'Working Conditions of ASHAs'. After some deliberations, the Committee adopted the draft Report with some changes and authorised the Chairperson to finalise the Report and present the same to the Parliament.

The Committee then adjourned.

APPENDIX II

(Vide Para 4 of the Introduction)

ANALYSIS OF ACTION TAKEN BY GOVERNMENT ON THE RECOMMENDATIONS CONTAINED IN THE FOURTH REPORT (FIFTEENTH LOK SABHA) OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2010-2011) ON 'WORKING CONDITIONS OF ASHAs'

(i)	Total No. of Recommendations	21
(ii)	Observations/Recommendations which have been accepted by the Government:	14
	Recommendation Para Nos. 78, 80, 81, 85, 86, 87, 88, 89, 90, 92, 93, 96, 97 and 98	
	Percentage to Total	66.67%
(iii)	Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government	01
	Recommendation Para No. 83	
	Percentage to Total	4.76%
(iv)	Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee	05
	Recommendation Para Nos. 79, 82, 91, 94 and 95	
	Percentage to Total	23.81%
(v)	Observations/Recommendations in respect of which the Government have furnished interim replies:	01
	Recommendation Para No. 84	
	Percentage to Total	4.76%

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