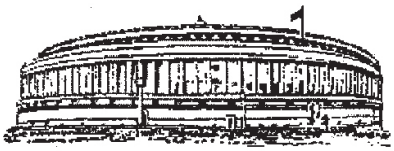

04

PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN
(2009-2010)

(FIFTEENTH LOK SABHA)

FOURTH REPORT

'WORKING CONDITIONS OF ASHAs'

LOK SABHA SECRETARIAT,
NEW DELHI

August, 2010/Shravana, 1932 (Saka)

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Presented to Lok Sabha on 26th August, 2010
Laid in Rajya Sabha on 26th August, 2010

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INTRODUCTION

I, the Chairperson of the Committee on Empowerment of Women (2009-2010) having been authorised by the Committee to submit the Report on their behalf, present this Fourth Report (Fifteenth Lok Sabha) of the Committee on the subject 'Working Conditions of ASHAs'.

2. The Report is based on the inputs received from the Ministry of Health and Family Welfare. The Committee on Empowerment of Women took oral evidence of the representatives of the Ministry of Health and Family Welfare on 5th April, 2010. The Committee also had interaction with NGOs working with ASHAs and ASHA Workers on 15th March, 2010.

3. The Draft Report was considered and adopted by the Committee at their sitting held on 5th August, 2010. The Minutes of the sittings form Part II of the Report.

4. The Committee wish to express their thanks to the Ministry of Health and Family Welfare for placing before them material and information in connection with the examination of the subject and giving evidence before them.

5. For facility of reference, the Observations and Recommendations of the Committee have been printed in thick type in the body of the Report.

NEW DELHI
20 August , 2010
29 Shravana, 1932 (Saka)

SMT. CHANDRESH KUMARI
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

A. INTRODUCTORY

1. India the second most populous country of the world has a diverse socio-political-demographic profile along with widening economic, regional and gender disparities posing formidable challenges for the primary health services. India's achievement in the field of health services leaves much to be desired and the burden of disease among the Indian population remains high. Infant, children and maternal mortality affect millions of children and women. Infectious diseases such as malaria and TB are re-emerging as epidemic and there is growing presence of HIV/AIDS. To improve the prevailing situation the problem of rural health needs to be addressed both at the macro and micro level. The rural population work in most hazardous atmosphere and abysmal living conditions. Unsafe and unhygienic birth practices, unclear water, poor nutrition, subhuman habitats and degraded environmental conditions are challenges to the public health system. Although there is an extensive primary health care infrastructure put in place by the Government, it appears to be inadequate in terms of population coverage, especially in rural areas.

2. The concept of primary health is one of the cardinal features of the overall development strategy of any country. In the process to strengthen primary health services, it is very important to integrate the grass root level health workers with the community and establish a functional interface between them. This involves placing a community selected person from the village and providing them with essential training so that the community can cope more effectively with its health problems. The approach demands a paradigm shift from biomedical model to a socio-cultural model.

B. NATIONAL RURAL HEALTH MISSION (NRHM)

3. In view of the health problems being experienced at the grass root level, the National Rural Health Mission (NRHM) was launched by the Government on April 12, 2005 as an effort toward improved public health services with special focus on States that are lagging behind. The goal of the mission is to improve the availability of and access to quality healthcare for people, especially for those residing in rural areas, thereby bridging urban-rural disparities. The primary objectives envisioned to be accomplished under the NRHM are given below:

i. To provide effective health care to rural population throughout the country.
ii. Commitment of the Central Government to raise public spending on health from 0.9 percent to 2 to 3 percent of GDP.
iii. To undertake architectural correction of the health system to enable it to handle effectively increased allocations.
iv. To promote policies that strengthen public health management and service delivery in the country.
v. To revitalize local health traditions and main-stream Ayurveda, Yoga, Unani, Sidha and Homeopathy (AYUSH) treatments into public health systems.
vi. Decentralized programs for district management of health.
vii. To define time bound goals and report publicly on their progress.
viii. To improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

4. The vision of NRHM involves strengthening the community at grass root level so that there is better interface between primary health services and the rural population. This involves enhancing capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services through continued training. Another component of its core strategy is to

install a female health activist at the village level to ensure household level acces to health care. The components of the Action Plan envisaged under NRHM are listed as under:-

i. Accredited Social Health Activists (ASHAs) to be provided for every village with a population of 1000 people.

ii. Each sub-centre to be given an United Fund for local action at the rate of Rs. 10,000 per year.

iii. PHCs to be strengthened to improve the quality of preventive, promotive, curative, supervisory and outreach services.

iv. Existing 3,222 CHCs to be converted into 24-hour First Referral Units (FRUs) with posting of anesthetists.

v. District Health Plan to be prepared by collating Village Health Plans integrating health related sectors.

vi. Converging Hygiene and Sanitation under NRHM

vii. National Disease Control Programs for malaria, TB, Kala Azar, filaria, blindness and iodine deficiency and Integrated Disease Surveillance Programme shall be integrated under NRHM for improved delivery.

viii. Regulation of private sector by means of Public Private Partnership because it provides 75 percent of health services in the country.

ix. Services of health care to be standardized and costing to be done periodically by a committee of Experts in each State.

x. Reorienting Medical Education to support and include rural health issues in the health/medical and paramedical education facilities to be created in States as and when needed.

5. The representative of the Ministry of Health and Family Welfare while tendering oral evidence commented on the shift in the health situation post 2005 and stated as under:

> "…….before 2005 the entire health system did not really look at community involvement in health. The community was out. It was a top-driven Centrally-sponsored programme. We designed in the Ministry what should be done by whom, where and how, and how

much has to be paid for what. That was the design. There was a basis for it inasmuch as we were trying to control our infectious diseases, bring down MMR, IMR and TFR and it was seen that the Central Government has the role and the mandate to do so. So, we designed it and we did everything without necessarily looking at the community. So, the Health Ministry is the only Ministry which did not really involve the community in this process."

The Secretary of the Ministry further stated:

"ASHA came as, a reflection of that particular crisis that while we had facilities – we had set up subcentres for public health, primary healthcare centres, CHCs and District hospitals – the uptake from the community was low. In fact, the National Health Policy of 2000 had observed that not more than 10 per cent to 20 per cent was the utilization. Yes, it was partly because of vacancies of doctors and non-availability of drugs, etc. But unless and until there is demand side pressure and there is community involvement, the system does not necessarily work. So, it is a two-way process. Today if you go to any hospital in Bihar, Madhya Pradesh or any place, you will find a huge demand from the side of pregnant women. It is not possible for a doctor to now stay away for work without being noticed. Before anybody came, whether he was in the PHC or not in the PHC, there was no accountability. To that extent, our bitterest critics, many of the NGOs, had conceded one thing that ASHA is the base of NRHM and ASHA has made a difference."

C. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

6. Accredited Social Health Activist (ASHA) is one of the core strategies under NRHM to promote health care at house hold level. Since 2005 ASHA program has expanded to the 32 states except Dadra and Nagar Haveli, Goa and Puduchery, which have not opted for the ASHA programme under NRHM. ASHA acts as 'Bridge' between the rural people and health services outlets with a central role in achieving national health and population policy goals. Total number of ASHAs in the country (state wise) is given at **Annexure I.** Over a period of time ASHAs drop out of the programme and new ASHAs are selected from the panel of three names previously prepared on the recommendation of the Gram Sabha. The data regarding ASHA drop outs has not been compiled by any

state as yet and no study on the status and reasons for drop outs has been conducted. The Ministry in their post evidence information has submitted that a study is being undertaken by NHSRC and some states have started compiling this data.

7. ASHA has been established as a part time volunteer working at the community level, as a link between the community and the health system. She is not a full time worker of the health sector. She is a resident in the village, and is expected to have her own occupation for livelihood, while working as a volunteer under National Rural Health Mission. Therefore, she is given only as much work as can be done voluntarily. When her work as ASHA requires her to leave her daily job and travel to training camps, hospital etc., she is compensated for wage loss. In addition, an incentive is provided for each task that she carries out.

8. Regarding community mobilization and their participation in the health process, the representative of the Ministry while tendering oral evidence before the Committee stated as under:

> "…….Community empowerment is a very long process. ……..In Andhra Pradesh, if you go to any village you will find very empowered women being able to talk very confidently but it has taken them 20 years, not one or two days. Even in Rajasthan, the Sathins were very very powerful at one point. It took a good ten to fifteen years before the Sathin was able to take on issues and talk with such confidence. Same is the case with Kudambasree in Kerala and Mitanin in Chhattisgarh. I think almost eight years of very dedicated work has gone to make Mitanins what they are today."

9. The major arrangements through which community process is strengthened are stated as under:

i. The ASHA programme
ii. The Village Health and Sanitation Committee (VHSC).
iii. The Un-tied fund provided to the sub-center and the VHSC and the space provided for public participation in making decisions.
iv. The Rogi Kalyan Samitis (RKS) (or Hospital development committees) as a vehicle for public participation in facility management and the provision of un-tied funds for this purpose.

v. The district health societies and the district health planning process.
vi. The Community Monitoring Programme.
vii. The involvement of NGOs in the mother NGO programme and in public-private partnerships of different sorts.

10. Going by national and international experience, community health worker programmes have the potential to make a significant and positive contribution to community health and awareness and impact favourably on major indicators like child survival. There is a need, therefore, to strengthen the ASHA programme and other communitisation initiatives so that much greater outcomes are realized.

11. The responsibilities defined for Anganwadi Workers (AWWs) under Integrated Child Development Scheme (ICDS) does not allow her to take up the responsibility of a change agent on health in a village. Thus, a new brand of community based functionary named ASHA was conceptualized.

12. As per the provisions under NRHM, at least one ASHA is to be provided for every population of 1000 people. Theoretically, she is supposed to have passed at least 8th Grade, but in practice, the one with the highest level of schooling is nominated by Gram Panchayat. The ASHAs generally undergo a 23 days classroom training session where they are imparted training in dressing wounds, dispensing medicines for oral rehydration, cough, cold, fever and identification of diseases like TB; pre-natal and post natal care and community mobilization. States are allowed to make modifications in the prototype training material developed at the national level. Training of trainers using both distance learning model as well as with the help of NGOs, ICDS training centres, State Health Institutes and so on are provided. The training, incentives and medical kits for ASHA is funded by the Central Government and the remaining expenses managed under the financial envelope given to the States under NRHM. She is given a drug kit containing generic AYUSH and allopathic formulations for common ailments and the kit is 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, antiseptic benzene benzoate.

13. The Committee while interacting with ASHAs and ASHA Mentoring Group were informed that the drug kits are often locked in the sub centres and not handed over to ASHA. However, the Ministry had denied it stating that no such complaint has been received by the Ministry of Health and Family Welfare.

(i) Role and Responsibilities

14. ASHA being a health activist and a prominent functionary under the NRHM has been assigned the task to liaison with people of her village and the ANM and the doctor of the PHC as and when the situation demands. It is envisaged that the presence of an ASHA will reduce the burden of the ANM and increase the outreach of health services, thus improving the public health care specifically for the marginalized population. Her roles and responsibilities are defined as follows:

i) To create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

ii) Counselling women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

iii) Mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the Government.

iv) Work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan.

v) Arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e.

Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).

vi) Provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She provides Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.

vii) Act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.

viii) Inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.

ix) Promote construction of household toilets under Total Sanitation Campaign.

15. The Ministry has submitted that the role of ASHAs as service provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.

16. In view of the roles and responsibilities entrusted with ASHAs, the Committee desired to know whether it is feasible to have one ASHA per 1000 population. The Ministry has stated that the rationale for allocation of one ASHA per 1000 population (when the village is compact and the households not dispersed) is to ensure that an ASHA does not spend more than 2-3 hours per day on her work, not have her regular livelihood affected, and also have a sufficient case load to be able to earn adequate financial incentive. Where the population exceeds 1000 a second ASHA is considered. Where habitation is widely dispersed, one ASHA per habitation is appointed. In this case she has a lower caseload and a lower incentive and she spends less time on her work, leaving more time for her regular livelihood activities. In tribal, hilly and desert

area and depending on the workload, the norm has been relaxed. States like Chhatisgarh and Jharkhand have relaxed the norm considering their geography and habitation pattern.

17. However considering the wide range of functions and tasks expected from ASHAs right from knowing/sensitizing the village population of about 1000 people to escorting them to hospitals on emergencies, the Committee felt it is humanly not possible to perform the duties in eight to twelve hours a week. The Ministry in this regard has stated that there are two types of work - one which is done part time in addition to her daily livelihood tasks and another where she has to be given wage loss compensation because she has to spend a much larger time, even the whole day on the task. In the latter case she is compensated on fixed rates. For example – Attending the Village Health and Nutrition Day (VHND) or immunization session once a month (Rs. 150/ day); to escort women to institution for delivery twice or thrice a month (Rs. 250 for transport, Rs. 150 for her escort function and other Rs. 200 as motivation incentive); attending a training programme – Rs. 100 per day ; attending Pulse Polio programme Rs. 75 per day.

18. On being pointed out about the excessive responsibilities entrusted with ASHAs, the representative of the Ministry submitted as under:

> "On the workload in theory it looks as if she has got almost eight hours fully-packed day and night work. But today we are coming up with operation guidelines……We have realized in our working over this programme that we need to limit her role, make it absolutely focused on maternal and child health which really reduces her work to three mothers in a Northern State where crude birth rate is 30 per thousand.In a Northern State where the crude birth rate is thirty per thousand, it will be three mothers, three pregnant women a month. Once a month she has to do immunization where she is paid Rs. 50 for mobilizing the children along with anganwadi worker, whose primary duty is also to help her in the immunization and the ANM has to do that. These are the two primary works. The Dots which is 1.5 per cent in a village per thousand may be having TB in which case she will just ensure that he is taking drugs. So, this is the profile of her work. She does not have more than just three hours plus one day. We calculated that.

Now, we want to involve her in neo-natal care. This is something which we very much want ASHA to be involved in. It will require two to three hours of work a day."

19. The Ministry has further added that her home visit is done part time. This is limited work done at her convenience and not necessarily structured on a schedule. Others may visit her also. This is for health education, promoting immunization, antenatal care, institutional delivery and for utilizing her drug kit to attend to local health needs in a limited manner. Other work like DOT provision, motivating for cataract surgery, promotion for family planning do not lead to wage loss and they all have fixed incentive per case. However, no survey has been conducted to evaluate the workload of ASHAs.

20. The Committee further desired to know whether ASHAs are expected to take up many other duties unrelated to NRHM work. Replying to the query the Ministry has submitted that there is no such report from most States. However, one study in Rajasthan where the ASHA (referred to as ASHA Sahayogini) is paid a fixed monthly remuneration from the Department of Women and Child Development and a fixed incentive by the DHFW (from NRHM) suggests that the ASHA is being given tasks beyond her regular job description by the ANM and AWW.

(ii) Selection of ASHAs

21. The selection and training process of ASHA is given due attention by the concerned State to ensure that at least 40 percent of the envisaged ASHAs in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs are subsequently selected and trained during second and third year.

Criteria for Selection

22. ASHA must be primarily a woman resident of the village - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs. Some of the criterion enlisted in the guidelines is stated as under:

i) ASHA should have effective communication skills, leadership qualities and be able to reach out to the community.

ii) She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available.

23. The Ministry has also stated that adequate representation from disadvantaged population groups should be ensured to serve such groups better. Regarding representation from disadvantaged population groups, the Committee desired to know whether any data has been kept to ascertain the representation of SCs and STs among ASHAs. The Ministry in this regard has submitted that an evaluation study is being conducted but so far no data is being maintained regarding representation of SCs and STs among ASHAs.

Selection Process

24. The District Health Society under NRHM oversees the selection process of ASHAs. The Society designates a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved. The Nodal Officer acts as a link with the NGOs and with other departments. The District Health Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process, organizing training for Trainers and ASHA as per the guidelines of the scheme.

25. The Block Nodal Officer identifies 10 or more Facilitators in each Block so that one facilitator covers about 10 villages. The facilitators are preferably women from local NGOs; Community based groups, Mahila Samakhyas, Anganwadis or Civil Society Institutions. In case none of these are available in the area, the officers of other Departments at the block or village level/local school teachers may be taken as facilitators.

26. These facilitators are put through an orientation programme about the scheme in a 2-day workshop which is held at the district level under supervision of the District Nodal Officer. The facilitators are briefed by District Nodal Officer

and Block Nodal Officers on the selection criteria and importance of proper selection in effective achievement of the objectives of the same and also the role of facilitators and Block Nodal Officers.

27. The facilitators are required to interact with community by conducting Focused Group Discussions (FGDs)/workshops of local Self Help Groups. This would lead to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. During the said interaction three names are shortlisted from each village.

28. Subsequently, a meeting of the Gram Sabha is convened to select one out of the three shortlisted names. The Village Health Committee enters into an agreement with the ASHA as in the case of the Village Education Committee and Sahayogini in Sarva Shiksha Abhiyan and the names are forwarded by the Gram Panchayat to the District Nodal Officer for record. State Governments have the freedom to modify these guidelines except that no change may be done in the basic criteria of ASHA being a woman volunteer with minimum education up to VIII class and that she would be a resident of the village. In case any of the selection criteria or guidelines is modified, these should be widely disseminated in local languages.

29. Regarding the selection criterion the Committee desired to know the rationale behind having married/widowed/divorced women as ASHAs. The Ministry in their replies has submitted that an unmarried young woman is likely to move away after marriage. It takes time for ASHA to become effective. A married/divorced/widowed woman is more likely to stay on in the same village. Also her credibility in motivating and counseling mothers and families on health issues, specifically on those related to maternal and child health, is seen to be higher, especially in rural areas. The Committee further desired to know how strictly the norm is being followed and whether there have been instances when women other than married/widowed/divorced have volunteered for ASHA. The Ministry further submitted that Instances have been reported from some States where women other than married/widowed/divorced have been selected as ASHAs. The ASHA selection guidelines are flexible enough for this.

(iii) Remuneration and Incentives to ASHAs

30. ASHA being an honorary volunteer does not receive any salary or honorarium. Her work is so tailored that it does not interfere with her normal livelihood. However, ASHA is compensated for her time in the following situations:

i. For the duration of her training both in terms of TA and DA. (so that her loss of livelihood for those days is partly compensated)

ii. For participating in the monthly/bi-monthly training, as the case may be. The payment for attending training module is made at the venue of the training when ASHAs come for regular training sessions and meetings.

iii. Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such task is assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position. .

31. Regarding the amount given to ASHA as cash benefit for bringing a pregnant women to a health institution for delivery, in low/high performing States in rural/urban areas, the Ministry has furnished the following information.

Institutional deliveries in	ASHA package – Rural	ASHA package- Urban
Low Performing States	Rs. 600: (Rs. 200 for motivation, Rs. 250 for transport and Rs. 150 if she stays with the mother)	Rs. 200
High Performing States	Rs. 200	Rs. 200
Home deliveries	Nil	Nil

32. The Ministry has further stated that the monthly incentive varies from State to State, based on the incentive package and the population coverage. Some of the studies and surveys conducted regarding monthly incentives are quoted below:-

i. In Orissa, Angul district reports the following:

Income Range (Rs.) (Oct 09-Dec 09)	No. of ASHA: 372	Percent %
<500	97	26
501-1000	101	27
1001-1500	69	19
1501-2000	46	12
2000-2500	31	8
>2500	28	8
Total	372	100

ii. In West Bengal an ASHA receives Rs. 800 as a fixed sum and performance based incentive over and above this.

iii. In Rajasthan the ASHA Sahayogini receives Rs. 950 (Rs. 500 per month through Department of Woman & Child Development and Rs. 450 per month by DMHS) with additional performance based incentives.

iv. In Andhra Pradesh a survey of 919 ASHA showed that they earned on an average Rs. 545 (range of Rs. 200-1875).

33. The Ministry further stated that the Mission Steering Group (MSG) of the NRHM had recommended that ASHA be given a fixed remuneration to serve as a retainership and to incentivize for tasks such as home visits and managing drug kits, which are not measurable. However, this has not been approved by the Ministry of Finance. The Committee in this regard desired to know the rationale behind not accepting the recommendation of MSG. The Ministry has stated that the proposal to fix remuneration runs contrary to the approach of the performance-linked remuneration adopted by department and approved by cabinet.

34. While clarifying further on the proposal to offer fixed remuneration to ASHAs, the representative of the Ministry during evidence stated as under:

> "After wide consultations we had with the civil society when NRHM was designed, we have conceived ASHA and everyone was very particular that ASHA should be only a community worker and must not be paid a salary. In fact, even in the MSG Bill this suggestion was made by an honorable Member but all the civil society members in unison said that she should not be paid a salary."

35. On being asked whether complaints have been received regarding non-payment/delay in payment of incentives for institutional deliveries, the Ministry has submitted that Common Review Missions and monitoring visits have highlighted issues of delays and non payment of incentives. However, data from more recent ASHA and JSY assessments show that States have begun to streamline the procedures for payment of incentives to ASHA. Several States now have a system of cheque payments and also E- transfer of funds entitled to them. Regarding corruption in the payment process, the Ministry has further added that few ASHA workers have complained about non payment to their visiting teams in the States. However, no written reports have been received.

36. The Committee desired to know whether there is demand to make payments through banks in order to avoid corruption. The Ministry in this regard stated that Cash payment is done in cases where a bank or a post office is not within easy distance.The general principle however is to encourage payment by cheque/bank transfer. The Committee further desire to know what measures have been taken by the Government to streamline the procedures for payment of incentives to ASHA. The Ministry in their post evidence replies stated that the States have been advised 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 payment, which is not covered under existing approved programme. Further, it has been informed that guidelines regarding E-Transfer of incentives to ASHA's account directly have been issued to the States.

37. The Committee, while interacting with NGOs working with ASHAs, were informed that in case of still birth, ASHA is denied payment of Rs. 600 for facilitating institutional delivery. However, the same has been denied by the Ministry in the post evidence replies submitted to the Committee.

(iv) Facilities offered to ASHAs

38. The States like Arunachal Pradesh and Chhatisgarh have a help desk for ASHAs in health facilities to improve access for care seeking. In Orissa ASHA Gruha (rest house) for the ASHA accompanying the mothers to the institution have been established. In other States either new rooms are being constructed or spaces are being allocated within existing facilities for such purposes.

39. Elaborating further on the facilities being offered to ASHAs, the representative of the Ministry stated as under:

> "In fact, the States took it up before even we had worked on any Central design on this. Orissa was the first State which started constructing ASHA Grahas or Homes. It is a two-room unit they have constructed in district hospitals…… in 2010-2011 more than 12 States have asked for ASHA Homes in government hospitals."

40. Adding further to the facilities being offered to ASHAs, the Ministry has stated that under Janani Suraksha Yojana (JSY) an amount of Rs. 250 is provided to the ASHA if she organizes the transport in low performing States in rural areas for transport of pregnant women to health facilities. The States of Manipur, Orissa and Assam have provided bicycles to the ASHA to improve mobility. Mobiles to facilitate ASHA communication have been proposed, but so far not implemented in any State.

41. Clarifying further on transport facility/ incentives available to ASHAs the Ministry during the oral evidence stated as under:

> "in the low-performing States, there is a package of Rs. 600 which the ASHAs get; Rs. 200 is for the ASHA to promote an institutional delivery, and Rs. 150 if she accompanies the women to the facility and brings her back to home and Rs. 250 is provided for referral transport of the women to the facility. In many States like Madhya

Pradesh and Orissa, they have started something called 'Janani Express'. They have pooled in the referral transport money. The pregnant woman's household has that mobile number of the ambulance which you can ask for. Another ten States have gone in for 102, 108 and 104 and other models to provide emergency transport."

42. In order to give better exposure to ASHAs in some States like Assam, Chhatisgarh, Orissa and Uttar Pradesh ASHA Sammelans are being organized annually. Several States organize an ASHA Diwas, periodically. In many states district and block level events are held but states do not report on these events since the management of these events have been decentralized to the state level.

43. The Committee have been informed that to encourage ASHAs few states like Assam, Orissa, Uttarakhand have recognized the contribution of ASHA's by conferring ASHA awards. This activity is decentralized to the State level and is not reported. Some more States are also in the process of instituting these awards.

44. The Committee desired to know whether ASHAs are being covered under any social security schemes. Replying to the query the Ministry stated that Chhattisgarh covers ASHA's under Mukhyamantri Mitanin Kosh scheme. There are no other reported instances of ASHA being covered under social security schemes; however insurance coverage is being considered. The Ministry has further stated that it is up to the states to take a view in the matter. In Chhattisgarh State has established the Mukhymantri Mitanin Welfare Kosh. In Kerala and Punjab, Rashtriya Swasthya Bima Yojana (RSBY) cover is provided to ASHAs.

45. The Committee were informed by the representatives of ASHAs during interaction that they face the major problem of not being recognized as they have not been issued any identity card or appointment letter whereby they can establish their credentials. The Committee in this regard desired to know whether ASHAs are provided with identity cards to establish their credentials. The Ministry in this context has informed that some of states like Haryana, UP, Uttrakhand,

Chhattisgarh, Orissa, Assam, Manipur, Sikkim, Tripura and Arunachal Pradesh have issued I-Card to ASHAs. The Ministry has further stated that guidelines have been issued to all States in this regard.

(v) Funds

46. The fund for making the payments to ASHA flows from Centre to States through State Committee on Voluntary Action (SCOVA) mechanism and from State SCOVAs to District Health Societies. The District Health Societies further disburses the funds. As submitted by the Ministry, SCOVA in all states have been renamed or reorganized as State Health Society. This is a body usually chaired by the State Health Secretary or Chief Secretary and has both official and non-official members. It acts as a governance structure for NRHM funds. Funds for ASHA programme including their training modules are allocated under NRHM flexible pool, to State Health Society (SHS) and from SHS to the District Health Societies (DHS). The DHS further disburses the funds to block health official, who makes the payment to ASHA directly or through the joint account of ANM and gram pradhan.

47. The compensation to ASHA based on measurable outputs is given under the overall supervision and control by Panchayat. For this purpose a revolving fund is kept at Panchayat. The guidelines for such compensation is provided by the District Health Mission, led by the Zila Parishad. The national programmes/schemes have in-built provisions for the payment of compensation. These compensations are made in accordance with the programme guidelines.

48. The year wise allocation and utilization of funds for the last three years as furnished by the Ministry is at **Annexure II.**

49. The Committee desired to know whether there are any complaints regarding shortage of funds by the State and District Health Societies. Replying to the query the Ministry has stated that there is no absolute shortage of funds but gaps and delays have been reported especially from Bihar and Jharkhand. Adding further, the Ministry in their post evidence replies has stated that the tally

system is in the place in all the districts of Bihar and Jharkhand, which will facilitate faster accounting.

50. In view of allocation and utilization of funds, the Committee desired to know whether there have been instances when funds allocated for ASHA programme have been diverted for other programs by the State Governments. The Ministry in this regard has furnished that there has been no such instance in the knowledge of GOI. In any case, funds are released against the entire Program Implementation Plan of the States and not separately for each activity.

(vi) Integration with AWWs and ANMs

51. Anganwadi Workers (AWWs) and Auxiliary Nurse Midwife (ANMs) act as a resource persons for the training of ASHA. AWWs guide ASHA in performing the following activities:

i. Organizing Health Day once/twice a month. On health day, the women, adolescent girls and children from the village are mobilized for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunization etc. AWWs inform ANM to participate & guide organizing the Health Days at Anganwadi Centre (AWC).

ii. Information, Education and Communication (IEC) activity through display of posters, folk dances etc. to sensitize the beneficiaries on health related issues.

iii. Anganwadi worker acts as depot holder for drug kits and issue it to ASHA. The replacement of the consumed drugs is also to be done through AWW.

iv. AWW update the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.

v. ASHAs support the AWW in mobilizing pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific

days of immunization, health checkups/health days etc. to Anganwadi Centres.

52. As furnished by the Ministry, listed below are the activities performed by ASHAs under the guidance of Auxiliary Nurse Midwife (ANM):

i. ANM holds weekly/fortnightly meeting with ASHA and discuss the activities undertaken during the week/fortnight. She guides her in case ASHA encounters any problem during the performance of her activity.

ii. ANMs inform ASHA regarding date and time of the outreach session and also guide her for bringing the beneficiary to the outreach session.

iii. ANMs participate & guide in organizing the Health Days at AWC.

iv. ANM is helped by ASHA in updating eligible couple register of the village concerned.

v. ASHA helps ANMs in motivating pregnant women for coming to sub centre for initial checkups. She also help ANMs in bringing married couples to sub centres for adopting family planning.

vi. ANMs guide ASHA in motivating pregnant women for taking full course of IFA Tablets and TT Injections etc.

vii. ANMs also orient ASHA on the dose schedule and side effects of oral pills.

viii. ANMs educate ASHA on danger signs of pregnancy and labour so that she can timely identify and help the beneficiary in getting further treatment.

ix. ANMs inform ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

53. The Committee while interacting with ASHAs found that Anganwadi workers and ASHAs often compete for the same activities which are incentivized such as motivating women to access institutional delivery or sterilization. The

Committee desired to know whether efforts have been made to resolve the conflict of interest between ASHAs and Anganwadi workers. The Ministry in this regard has submitted that only ASHAs are incentivized for institutional deliveries under JSY. AWWs perform such role in those places only where ASHAs have not been selected. Conflict of interest does not arise in these situations. However, for sterilization, ASHA, ANM and AWW are eligible for the incentive.

54. The Committee also noted that ASHA is supposed to report to ANM and AWW. In the process, she has been reduced to an adjunct to AWWs and ANMs. The Ministry in this regard has submitted that clear guidelines have been issued, and thus, ASHA is not an adjunct to anyone. She is community volunteer and mainly responsible to Community. Roles of ASHA, AWW and ANM are clearly defined. ANM is to support ASHAs as per need.

55. Considering the role of ASHAs, AWWs and ANMs and the coordination among them while executing their responsibilities, the Committee desired to know whether ASHAs are given preferential treatment while appointing ANMs. Replying to the query the Ministry has stated that it is up to the States to take a decision on this issue, State like Chhattisgarh have taken decision to give priority to ASHAs in selection of ANM course. The Ministry has been advocating local criteria in selection of ASHAs.

(vii) ASHA and Awareness Level

56. ASHAs have been entrusted with the responsibility to create awareness and provide information to the community on determinants of health. In this regard, the Committee desired to know how far ASHAs have been able to discharge their duty of creating awareness among the community regarding health services. The Ministry in this context has stated that evaluation reports demonstrate that awareness of communities on health services particularly immunization and institutional delivery including antenatal care has risen substantially. Adding further to their response, the Ministry has stated that the task of mobilizing women and children and enabling services at the Village Health and Nutrition Day (VHND) often serves as a forum for increasing health awareness. ASHA is able to communicate effectively on a one-to-one basis

through interpersonal communication. Organizing health education sessions in the larger community requires much more support for the ASHA from members of the Village Health and Sanitation Committees (VHSC), which are just getting of the ground. Communication kits and Radio programmes centered around ASHA have helped in many States.

57. The Committee while interacting with ASHAs noted that one of the problems being faced by ASHA is lack of communication tools to create awareness in the community. Some of the tools available with them are posters relating to pregnant women, tuberculosis, malaria etc. The Committee desired to know whether such tools are sufficient to create awareness in the community. The Ministry responding to the query has submitted that State provides IEC material to ASHAs as per program requirement. States are constantly encouraged to provide adequate Behavioural change Communication material to ASHAs.

(viii) Training Programmes for ASHAs

58. The capacity building of ASHA is critical in enhancing her effectiveness. The training modules have been designed to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Capacity building of ASHA is seen as a continuous process. Mentioned below is the training strategy that is being followed to train ASHA as a community health activist.

Induction Training:

59. After selection, ASHAs undergo a series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering the range of functions and tasks to be performed, induction training is to be completed in 23 days spread over a period of 12 months. The first round may be of seven days, followed by another four rounds of training, each lasting for four days to complete induction training. Elaborating further on the training programme, the Ministry has submitted that the 23 days training programme is spread over five modules, thus: (7 + 4 + 4 + 4 +4). Module I

enables ASHA to understand basic information about NRHM concept, ASHA programme and others. Modules II,III and IV are on maternal and child health, family planning, RTI/STI, HIV AIDS and ARSH, National Health Programme, AYUSH and management of minor illness respectively. Module V focuses on enabling ASHA to understand her role as an activist, including leadership training and understanding the issues of health rights. States have adapted the centrally developed modules based on their context.

Training materials:

60. Training material is prepared according to the roles and responsibilities that ASHA is required to perform. The training materials produced at the national level is in the form of a general prototype which States can modify and adapt as per local needs. The training material include facilitator's guide, training aids and resource material for ASHAs

Periodic Trainings:

61. After the induction training, periodic re-training is held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions are held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity is also used for replenishments of supplies and payment of performance linked incentives. ASHAs are compensated for attending these meetings.

On-the-job Training:

62. ASHA needs to have on the job support so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection, training and post training follow up. Similarly, block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.

Training of trainers :

63. The Block trainers (who are the members of identified block training teams) are required to spend at least the same number of days in acquiring knowledge and skills as ASHAs. These trainers are largely women and chosen by block nodal officer. The block teams are trained by a district trainer's team who are in turn trained by the State training team. The duration of Training of Trainers for District Training Teams (DTT) and State Training Teams (STT) is finalized by the States depending on the profile of the members to be selected as DTT and STT.

Constitution of Training teams:

64. Each State, district and block have a training team compromising of three-four members. Existing NGOs especially those working on community health issues at the district/block level are also entrusted with the responsibility for identifying trainers and conducting *Training of Trainers*. The trainers are paid compensation for the days they spend on acquiring or imparting training –both camp based training and on the job training. Similar guideline applies to the district level also where trainers are drawn in from Programme Managers and NGOs. The State Institutes of Health and Family Welfare along with reputed and experienced NGOs form training teams at the state level. State level training structures are used for trainings under various National Health and Family Welfare Programmes.

65. In view of the submission of the Ministry that State Institute of Health and Family Welfare along with reputed and experienced NGOs form training team at the State level, the Committee desired to know about the mode of selection of such NGOs that are involved in forming training teams at State level. The Ministry in this regard stated that the situation varies from State to State. Agencies such as SHRC, SIHFW, RRC are involved in the selection and constitution of the training team. Mother NGOs (MNGOs) already working as part of the GOI's NGO scheme are also given priority in being selected as training institutes.

Continuing Education and skill upgradation:

66. A resource agency in the district of state (preferably an NGO) is identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes develops relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an eventual certification.

Venue of training :

67. The choice of venue is close to their habitation and the training group is not more than 25 to 30. Mostly, the PHC or Panchayat Bhavan is used as training venues.

National Level:

68. At national level the NIHFW in coordination with the National Rural Health Mission & its technical support teams and the Training Division of the Ministry coordinate and organize periodic evaluation of the training programmes. The findings of these concurrent evaluations is shared with State Governments.

State level:

69. At State level, the State Institute of Health and Family Welfare (SIHFW) in coordination with the State Training Cell of Directorate of Family Welfare oversees the process of training, monitoring and organizing concurrent evaluation of training programme.

70. In view of changing time and space, the Committee desired to know whether the Government has evaluated the present training Modules for ASHA. The Ministry in this regard has stated that new Modules are developed as the need arises. Chhattisgarh has already developed 12 training modules. At the national level, Modules 6 and 7 for ASHA are being finalized. As the role of ASHA begins to expand to include first contact care, she will be required to be skilled in certain key areas. Thus modules 6 and 7 focus on building ASHAs competence in the areas of maternal health, newborn health, management of childhood illnesses and nutrition. Kerala is developing modules on non communicable diseases.

71. The Ministry in their post evidence reply has stated that Bihar is lagging behind in ASHA training as the State outsourced training activity to Public Health Engineering Department's agency (PRANJAL). The Agency has not been able to upscale the training programme as proposed. The other States that have not been able to complete the training modules are Kerala, Punjab and West Bengal.

72. Regarding evaluation of training modules, the Committee have been informed that NIHFW in coordination with NRHM coordinates and organizes periodic evaluation of training programmes. The Committee desired to know the detail of such studies conducted. The Ministry in this context has submitted that NIHFW does not organize periodic evaluation of the training programme for ASHA. However, NIHFW does support various training programmes for ASHA. The Ministry has further submitted a list of state level survey conducted to evaluate the ASHA programme.

i NRHM Evaluation by International Advisory Panel (2009)

ii Evaluation of ASHA in Andhra Pradesh by P. Satya Sekhar and Anil Punetha (2009)

iii Assessment of ASHA & JSY in Rajasthan by CORT (2007)

iv Assessment of ASHA & JSY in Madhya Pradesh by CORT (2007)

v Assessment of ASHA & JSY in Orissa by CORT (2007)

vi Concurrent Evaluation of JSY in Bihar, MP, Orissa, Rajasthan and UP by GFK, MODE (2009).

Vii RAHI-Phase 1 (Appraisal)- Health and Population: Perspective and Issues (NIHFW)

viii JSY study in Rajasthan by R.K.Sharma, Mohanlal Sukhadia University, Rajasthan (2007-08)

73. State wise details of training programme for the last three years as furnished by the Ministry is at **Annexure III.**

(ix) Performance of ASHAs

74. The success of ASHA scheme depends on how well the scheme is implemented and monitored. Another important factor is the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. In view of performance and success of the Scheme, the Committee desired to know how far the ASHA programme has been instrumental in bridging the gap between the rural population and the health service outlets. The Ministry in this context has stated that findings from evaluation reports demonstrate that the ASHA has been able to enable increasing access to health facilities and outreach services provided by the health system by motivating communities to attend monthly service provision days and through facilitating transport and escorting women to reach facilities. The Ministry has further added ASHA being the co-convener of the Village Health and Sanitation Committee (VHSC) in most of the States. The VHSC is responsible for community monitoring and village health planning. By virtue of her position in the VHSC, ASHA is well placed to motivate the community in taking an active role in the design, implementation, and monitoring of health programmes.

75. The Committee further desired to know what has been the assessment on the performance of ASHAs under the JSY. The Ministry replying to the query has submitted that several State and district specific evaluations across the States and the Common Review Missions (CRM) led by the MOH&FW suggest that ASHA has had a significant role in influencing pregnant women to access the entitlements available under JSY by motivating them to seek delivery in institutions. There is positive correlation between presence of ASHA and rise in institutional deliveries. The Common Review Mission of 2009 also suggests that ASHA have been instrumental in increasing institutional deliveries in the States. Mothers being accompanied to health facilities in the State of Orissa is 92.5% (2008), 80% in Assam and in Rajasthan 7% of ASHAs accompanied mothers to the institution for delivery.

76. Elaborating further on the performance of ASHA, the representative of the Ministry during the evidence stated as under:

> "……..please do not be harsh on this ASHA scheme. It takes time. The point is we are on the right track. I think what is needed to be done has been done. But we ourselves in the process of rolling it out year by year are gaining experience on what more we need to do to strengthen this. We have enough critics within the medical system who would like it to go because ASHA today is making the health system accountable……in 1976 we had come up with the Village Health Guide which is a similar expression that there should be community worker. The medical system killed it. The issue is that we need to nurture ASHA as a programme and we need to strengthen it. After all in Garhchiroli in thirty villages after the last 15 years or twenty years it is showing results today. What we are pleading is that we need time. As long as we are in the right direction allow us and encourage us and see that we further improve our policy mix."

77. Regarding evaluation studies conducted to ascertain the performance of the Scheme, the representative of the Ministry stated as under:

> "……some of the studies which have been done have looked not only at the ASHA programme, but the larger areas of maternal and child health……..In eight States studies were conducted to look at the JSY and its performance. Among other things, it also covered the role of the ASHA…….The International Advisory Panel on the National Rural Health Mission, Shri Jasbir and Nirupam Bajpai has just published a book which again looked again at ASHA based on three States. They have looked at UP, Madhya Pradesh and Rajasthan."

OBSERVATIONS/RECOMMENDATIONS

***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.

79. *Need to revise qualification and method of appointment of ASHAs.*

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.

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.

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.

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 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 idenfying complicated cases of delivery and in turn reduce the Maternal Mortality Rate.

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.

84. *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.

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.

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.

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.

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.

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.

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.

91. ***Annual ASHA Awards.***

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.

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.

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.

94. *Steps to be taken to avoid under utilization of funds.*

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.

95. *Proper delineation of functions assigned to ASHAs and ANMs.*

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.

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.

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.

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.

NEW DELHI **SMT. CHANDRESH KUMARI**
20 August, 2010 **CHAIRPERSON**
29 Shravana 1932 (Saka) **COMMITTEE ON EMPOWERMENT OF WOMEN**

Annexure I

THE TOTAL NUMBER OF ASHAS IN THE COUNTRY (STATE WISE)

S.No.	Name of State	Number of Selected ASHAs (Feb.2010)
A	**EAG states**	
1	Bihar	71395
2	Chhattisgarh	60092
3	Jharkhand	40788
4	Madhya Pradesh	43792
5	Orissa	34252
6	Rajasthan	43742
7	Uttarakhand	9408
8	Uttar Pradesh	136182
	Total (A)	**438651**
B	**NE EAGs states**	
9	Arunachal Pradesh	3599
10	Assam	28798
11	Manipur	3878
12	Meghalaya	6258
13	Mizoram	975
14	Nagaland	1700
15	Sikkim	637
16	Tripura	7362
	Total (B)	**53207**
C	**Non-High Focus states**	
17	Andhra Pradesh	70700
18	Delhi	2266
19	J&K	9500
20	Gujarat	25861
21	Haryana	12753
22	Himachal Pradesh	2393
23	Karnataka	39000
24	Kerala	30909
25	Maharashtra	60457
26	Punjab	17056
27	Tamilnadu	2650
28	West Bengal	23518
	Total (C)	**297063**
D	**Union Territories (UTs)**	
29	Andaman & Nicobar Islands	65
30	Chandigarh	200
31	Daman & Diu	107
32	Lakshadweep	85
	Total (D)	**564**
	Total (A +B+C+D)	**789485**

(Source: ASHA Matrix, NHSRC monthly compilation of ASHA data from the states)

ANNEXURE-II

Statement showing Expenditure Against Approved PIP ASHA for the F.Ys. 2006-2007 to 2009-2010 (Upto 31.03.2010)

Rs. In Crores

Sl.No.	State	ASHA					
		2007-08		2008-09		2009-10	
		PIP	Exp	PIP	Exp	PIP	Exp
A. High Focus States							
1	Bihar	24.99	6.57	25.58	7.36	56.03	13.59
2	Chattisgarh	17.70	20.12	17.70	6.58	17.70	12.21
3	Himachal Pradesh	4.15	0.33	1.80	0.21	0.00	0.00
4	J&K	5.60	4.92	3.49	2.17	4.21	0.07
5	Jharkhand	27.75	9.40	19.07	18.96	8.30	0.06
6	Madhya Pradesh	10.91	13.22	24.67	8.20	39.87	5.24
7	Orissa	16.65	5.93	13.12	9.58	25.00	9.69
8	Rajasthan	19.10	12.80	12.23	12.88	41.50	8.88
9	Uttar Pradesh	28.78	12.14	116.11	65.06	135.00	45.20
10	Uttarakhand	2.79	5.44	9.85	4.18	9.85	1.00
	Sub Total	**158.42**	**90.88**	**243.62**	**135.17**	**337.45**	**96.18**
B. NE States							
11	Arunachal Pradesh	1.20	3.08	3.86	1.49	3.86	2.48
12	Assam	10.52	53.56	29.69	6.45	29.69	29.33
13	Manipur	0.00	0.39	1.28	0.91	3.88	0.73
14	Meghalaya	1.16	0.05	6.18	2.24	6.25	0.69
15	Mizoram	0.02	0.05	0.94	0.92	0.94	0.26
16	Nagaland	0.83	0.44	1.00	0.97	1.70	0.97
17	Sikkim	0.18	0.22	0.28	0.12	0.71	0.29
18	Tripura	4.76	0.95	6.63	4.49	5.26	2.08
	Sub Total	**18.67**	**58.75**	**49.87**	**17.60**	**52.30**	**36.83**
C. Non-High Focus States							
19	Andhra Pradesh	0.00	12.83	0.00	27.56	8.50	9.74
20	Goa	0.00	0.00	0.00	0.00	0.00	0.00
21	Gujarat	4.85	0.87	11.00	14.40	25.38	28.63
22	Haryana	0.00	3.46	0.00	0.22	10.64	2.31
23	Karnatka	0.00	0.63	7.71	6.34	34.66	32.86
24	Kerala	0.57	33.62	5.00	22.12	21.17	14.26
25	Maharashtra	3.36	25.83	16.34	6.19	41.77	8.65
26	Punjab	0.00	0.38	0.00	0.78	4.49	4.08
27	Tamilnadu	0.08	6.97	0.00	20.28	0.00	10.18
28	West Bengal	11.20	4.96	5.17	1.70	5.72	12.30
	Sub Total	**20.06**	**89.56**	**45.22**	**99.59**	**152.32**	**123.01**
D. Small States/UTs							
29	Andaman & Nicobar	0.02	0.00	0.04	0.03	0.04	0.04
30	Chandigarh	0.00	0.00	0.00	0.00	0.12	0.00
31	Dadar & Nagar	0.00	0.02	0.07	0.10	0.04	0.01
32	Daman	0.00	0.10	0.00	0.04	0.02	0.00
33	Delhi	0.00	0.00	14.72	2.62	19.04	1.74
34	Lakshadeep	0.07	0.05	0.00	0.13	0.07	0.00
35	Puducherry	0.00	0.45	0.00	0.09	0.00	0.00
	Sub Total	**0.09**	**0.62**	**14.82**	**3.01**	**19.32**	**1.79**
	Grand Total	197.24	239.81	353.54	255.37	561.40	257.81

* Expenditure for the F.Y. 2009-10 is upto IIIrd Quarter.

PIP : Project Implementation Plan.

Annexure : III

STATE WISE AND MODULE WISE TRAINING STATUS OF ASHAS

State		Module				
		Mod-1	Mod-2	Mod-3	Mod-4	Mod-5
EAG States	**Bihar**	69402	20225	20225	20225	0
	Chhattisgarh*	6092	60092	60092	60092	60092
	Jharkhand	40115	39482	39214	35675	0
	MP	41651	35764	34421	26820	0
	Orissa	34117	33910	33910	33910	23976
	Rajasthan	40310	40310	40310	40310	0
	UP	135191	12843	12843	12843	0
	Uttarakhand	9408	9408	9408	9408	8668
NE States	**Assam**	26225	26225	26225	26225	20272
	Arunachal	3246	2092	2068	1528	918
	Manipur	3878	3878	3878	3878	3878
	Meghalaya	6175	6175	6175	6175	1808
	Mizoram	943	943	943	943	0
	Nagaland	1700	1700	1700	1700	1700
	Sikkim	637	637	637	637	621
	Tripura	7362	7362	7362	7362	7362
Other States	**Andhra Pradesh**	70700	70700	70700	70700	70700
	Delhi	2266	2266	2266	2266	0
	Gujarat	21257	15516	13447	12413	0
	Haryana	14000	14000	14000	14000	0
	Himachal Pradesh	0	0	0	0	0
	J & K	9500	8930	8930	8930	0
	Karnataka	39000	39000	39000	39000	0
	Kerala	27904	20354	8771	0	0
	Maharashtra	60457	32602	32602	32602	0
	Punjab	13797	3503	3503	0	0
	Tamil Nadu	0	0	0	0	0
	West Bengal	16481	11967	9698	9075	7842
	A & D	0	0	0	0	0
UTs	**Chandigarh**	0	0	0	0	0
	D & D	0	0	0	0	0
	Lakshadweep	0	0	0	0	0
	Dadra &Nagar	NA	NA	NA	NA	NA

Annexure IV

MINUTES

COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)

Tenth Sitting
(15.03.2010)

The Committee sat on Monday, the 15th March, 2010 from 1530 hrs. to 1700 hrs. in Room No. 139, Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Ashwamedh Devi
3. Smt. Rama Devi
4. Smt. Jyoti Dhurve
5. Smt. Sumitra Mahajan
6. Smt. Jayshreeben Kanubhai Patel
7. Smt. Sushila Saroj
8. Smt. Yashodhara Raje Scindia
9. Smt. Rajesh Nandini Singh

RAJYA SABHA

10. Smt. Brinda Karat
11. Dr. Prabha Thakur

WITNESSES

1. Smt. Ranjana Nirula
   Convenor
   All India Coordination Committee for ASHAs
2. Smt. Surekha,
   General Secretary
   ASHA Workers Union Haryana
3. Smt. Suman Sharma
   President, ASHA Workers Union Haryana
4. Smt. Sunita, ASHA Worker
5. Ms. Seema Gupta,
   Senior Manager, Voluntary Health Association of India
6. Dr. Sunita Abraham
   Head, Community Health Department, Christian Medical Association of India
7. Ms. Evangeline
   Project Director, Christian Medical Association of India

SECRETARIAT

1.	Shri C.S. Joon	Director
2.	Smt. Mamta Kemwal	Deputy Secretary
3.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee to the sitting.

3. Thereafter, the Committee had interactions with ASHA workers and representatives of the organizations working among them on the working conditions of ASHAs. Some of the issues that came up during the discussion were: irregular payment of incentives; delay in payment by six-seven months; absence of any type of travelling allowance for routine work; harassment by administration, PHCs and Panchayats; non-availability of medical kits; etc. The ASHAs also expressed their concern over their being treated as someone subservient to the ANMs and desired that a fixed remuneration be paid to them on a monthly basis.

4. A verbatim record of the proceedings has been kept.

The Committee then adjourned.

Annexure V

MINUTES
COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)
Eleventh Sitting
(05.04.2010)

The Committee sat on Monday, the 5th April, 2010 from 1130 hrs. to 1330 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Shruti Choudhry
3. Smt. Ashwamedh Devi
4. Smt. Rama Devi
5. Smt. Jyoti Dhurve
6. Smt.Sumitra Mahajan
7. Dr. Jyoti Mirdha
8. Shri Sidhant Mohapatra
9. Kumari Meenakshi Natrajan
10. Kumari Mausam Noor
11. Smt. Sushila Saroj
12. Smt. Yashodhara Raje Scindia
13. Smt. Seema Upadhyay

RAJYA SABHA

14. Smt. Shobhana Bhartia
15. Shri Jabir Hussain
16. Smt. Brinda Karat
17. Smt. Maya Singh
18. Smt. Vasanthi Stanley
19. Dr. C.P.Thakur

WITNESSES

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE

1.	Ms. K. Sujatha Rao	Secretary
2.	Shri P.K. Pradhan	Additional Secretary
3.	Shri Amarjeet Sinha	Joint Secretary

SECRETARIAT

1.	Shri S Bal Shekar	Joint Secretary
2.	Shri C.S. Joon	Director
3.	Smt. Mamta Kemwal	Deputy Secretary

2. At the outset, the Chairperson welcomed the representatives of the Ministry of Health and Family Welfare to the sitting of the Committee.

3. Thereafter, the representatives of the Ministry gave a brief presentation and tendered oral evidence on the subject 'Working Conditions of ASHAs' before the Committee. The main issues which came up for discussion during the course of evidence included irregular payment of incentives to ASHAs; payment of monthly honorarium as per minimum wages; rest rooms for ASHAs at PHCs, CHCs and Hospitals; availability of medical kits and medicines on regular basis; ID Cards and transport passes for ASHAs; improved training programme and preferential treatment to ASHAs while appointing ANMs, etc.

4. Members sought clarifications on different points, some of which were replied to by the representatives. The Ministry was also asked to furnish written replies to the remaining queries.

5. A verbatim record of the proceedings of the sitting has been kept.

The Committee then adjourned.

Annexure VI

Excerpts of Minutes
COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)
Nineteenth Sitting
(05.08.2010)

The Committee sat on Thursday, the 5th August, 2010 from 1500 hrs. to 1700 hrs. in Committee Room 'D', Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS
LOK SABHA

2. Smt. Shruti Choudhry
3. Smt. Rama Devi
4. Smt. Jyoti Dhurve
5. Smt. Priya Dutt
6. Smt. Jyoti Mirdha
7. Shri Sidhant Mohapatra
8. Smt. Supriya sule
9. Smt. Annu Tandon

RAJYA SABHA

10. Smt. Shobhana Bhartia
11. Shri Jabir Husain
12. Smt. Brinda Karat
13. Smt. Vasanthi Stanley
14. Dr. Prabha Thakur

SECRETARIAT

1.	Shri S.Bal Shekar	Additional Secretary
2.	Shri C.S. Joon	Director
3.	Smt. Mamta Kemwal	Deputy Secretary
4.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee to the sitting.

3. The Committee then took up for consideration the draft Report on the subject **'Working Conditions of ASHAs'**. After some deliberations, the Committee authorised the Chairperson to finalise the Report and present the same to the Parliament.

4. X X X X X X

5. A verbatim record of the proceedings has been kept.

The Committee then adjourned.

Matters not pertaining to the subject