GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF HEALTH AND FAMILY WELFARE

LOK SABHA
UNSTARRED QUESTION NO. 2364
TO BE ANSWERED ON 9TH MARCH, 2018

SUB-CENTRES IN PUBLIC HEALTH SYSTEM

2364. SHRI PARTHA PRATIM RAY:

Will the Minister of **HEALTH AND FAMILY WELFARE** be pleased to state:

(a) whether the existing sub-centres are sufficient to serve the public health system in the country;

(b) if so, the details thereof along with the number of sub-centres presently functioning in the country, State/UT-wise;

(c) whether there are any job charts for Health Assistant (Female), ANM and ASHA workers of a sub-centre and if so, the details thereof; and

(d) whether the Government has any plan to increase the honorarium of ASHA workers and if so, the details thereof?

ANSWER
THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE
(SHRI ASHWINI KUMAR CHOUBEY)

(a) and (b): There is some shortfall in some States/UTs in the number of sub-centres in the country. The number of sub-centres presently functioning in the country along with shortfall, State/UT-wise is placed at **Annexure-I.**

(c) Roles and responsibilities/job charts have been prepared for service providers at the sub-center – including ANM. The IPHS Guidelines for sub-centres (Revised 2012) lays down the roles and responsibilities of ANMs, which are available at http://www.nhm.gov.in/nhm/nrhm/guidelines/indian-public-health-standards.html. In addition, prototype job charts and weekly work plans have also been provided in the Ministry of Health and Family Welfare 'Guidebook for enhancing performance of Multi-purpose worker (Female) 2014' which is available at 'http://nhsrcindia.org/category-detail/policy-and-guidelines/ODY='

ASHA is a community level voluntary health worker, who is trained and supported to play a set of healthcare support roles in her community. The roles and responsibilities of ASHA as per the ASHA Guidelines released by the GoI are at **Annexure-II.**

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(d): ASHAs are envisaged as Voluntary Health activists who received only task/activity based incentives and no deductions are made at national level.

The incentives to ASHAs finalized at the national level are regularly reviewed by the Government and activities for which ASHAs would get incentives are expanded from time to time. In 2013, ASHA incentives were enhanced for many activities and new incentives for routine and recurring activities were introduced to ensure that ASHAs get at least Rs 1000/- per month. Thereafter, the Mission Steering Group of NHM approved incentives for ASHAs at the rate of Rs.100 for notification if the suspect referred is diagnosed to be TB patient by MO/Lab in 2014, Rs 100/- per round during Indoor Residual Spray i.e. Rs 200 in total for two rounds Indoor Residual Spray, in 2015 and Rs. 150/case for escorting or facilitating beneficiary to the health facility for the Post Abortion IUCD insertion, in 2017.

Many States are also paying fixed monthly honorarium out of their State Budget. List of State specific ASHA incentives/ fixed honorarium are at **Annexure-III.**

Annexure-I

SHORTFALL IN SUB-CENTRES AS PER 2011 POPULATION IN INDIA (As on 31st March, 2017)							
S.No.	**State/ UT**	**Total Population in Rural Areas**	**Tribal Population in Rural Areas**	**Sub Centres**			
				Required	**In Position**	**Shortfall**	**% Shortfall**
1	Andhra Pradesh	34776389	2293102	7261	7458	*	*
2	Arunachal Pradesh	1066358	789846	318	312	6	2
3	Assam	26807034	3665405	5850	4621	1229	21
4	Bihar	92341436	1270851	18637	9949	8688	47
5	Chhattisgarh	19607961	7231082	4885	5186	*	*
6	Goa	551731	87639	122	214	*	*
7	Gujarat	34694609	8021848	8008	9082	*	*
8	Haryana	16509359	0	3301	2589	712	22
9	Himachal Pradesh	6176050	374392	1285	2083	*	*
10	Jammu & Kashmir	9108060	1406833	2009	2967	*	*
11	Jharkhand	25055073	7868150	6060	3848	2212	37
12	Karnataka	37469335	3429791	7951	9381	*	*
13	Kerala	17471135	433092	3551	5380	*	*
14	Madhya Pradesh	52557404	14276874	12415	9192	3223	26
15	Maharashtra	61556074	9006077	13512	10580	2932	22
16	Manipur	2021640	791126	509	421	88	17
17	Meghalaya	2371439	2136891	759	436	323	43
18	Mizoram	525435	507467	172	370	*	*
19	Nagaland	1407536	1306838	455	396	59	13
20	Odisha	34970562	8994967	8193	6688	1505	18
21	Punjab	17344192	0	3468	2950	518	15
22	Rajasthan	51500352	8693123	11459	14406	*	*
23	Sikkim	456999	167146	113	147	*	*
24	Tamil Nadu	37229590	660280	7533	8712	*	*
25	Telangana	21585313	2939027	4708	4797	*	*
26	Tripura	2712464	1117566	691	987	*	*
27	Uttarakhand	7036954	264819	1442	1847	*	*
28	Uttar Pradesh	155317278	1031076	31200	20521	10679	34
29	West Bengal	62183113	4855115	13083	10369	2714	21
30	A & N Islands	237093	26715	50	123	*	*
31	Chandigarh	28991	0	5	17	*	*
32	D & N Haveli	183114	150944	56	71	-15	-27
33	Daman & Diu	60396	7617	13	26	*	*
34	Delhi	419042	0	83	10	73	88
35	Lakshadweep	14141	13463	4	14	*	*
36	Puducherry	395200	0	79	81	*	*
	All India/ Total	**833748852**	**93819162**	**179240**	**156231**	**34946**	**19**

Notes: The requirement is calculated using the prescribed norms on the basis of rural population from Census, 2011. All India shortfall is derived by adding state-wise figures of shortfall ignoring the existing surplus in some of the states.

**: Surplus*

Annexure-II

Roles and Responsibilities of an ASHA

The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements.

Her roles and responsibilities would be as follows:

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely use of health services.
- She will counsel women and families 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.
- ASHAwillmobilizethecommunityandfacilitatepeople'saccesstohealthandhealthrelated services available at the village/sub-centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will work with the Village Health, Sanitation and Nutrition Committee to develop a comprehensive village health plan, and promote convergent action by the committee on social determinants of health. In support with VHSNC, ASHAs will assist and mobilize the community for action against gender based violence.
- She will 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).
- ASHA will provide community level curative care for minor ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses and first aid. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential health products appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.
- TheASHA'sroleasacareprovidercanbeenhancedbasedonstateneeds.Statescanexplore the possibility of graded training to the ASHA to provide palliative care, screening for non-communicable diseases, childhood disability, mental health, geriatric care and others.
- TheASHAwillprovideinformationonaboutthebirthsanddeathsinhervillageandanyunusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health

Centre. She will promote construction of household toilets under Total Sanitation Campaign.

The ASHA will fulfill her role through five activities:

1. Home Visits: For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non-communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.
2. Attending the Village Health and Nutrition Day (VHND): The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Aganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.
3. Visits to the health facility: This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The ASHA is expected to attend the monthly review meeting held at the PHC.
4. Holding village level meeting: As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.
5. Maintain records: Maintaining records which help her in organizing her work and help her to plan better for the health of the people.

Annexure-III

Other State Specific Incentives for ASHAs

1. Chhattisgarh gives 50% of matching amount of the incentives over and above the incentives earned by an ASHA as a top up on an annual basis
2. Haryana (Rs. 1000/month)
3. Kerala (Rs.1500/month, Rajasthan (Rs. 1600/month through ICDS),
4. Karnataka (Rs. 3500/month – recently introduced replacing the top up incentive)
5. Sikkim (Rs. 3000/month)
6. Meghalaya and Tripura provide 100%matching amount of the incentives over and above the incentives earned by an ASHA as a top up on an annual basis.
7. West Bengal (Rs. 2000/month).
8. Recently states of Gujarat, Telangana and Uttrakhand have also introduced incentives from state funds but modalities of payment are not available.