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COMMITTEE ON EMPOWERMENT OF WOMEN
(2002-2003)

(THIRTEENTH LOK SABHA)

HEALTH AND FAMILY WELFARE PROGRAMMES FOR WOMEN

MINISTRY OF HEALTH AND FAMILY WELFARE
(DEPARTMENT OF HEALTH, DEPARTMENT OF FAMILY WELFARE AND DEPARTMENT OF INDIAN SYSTEMS OF MEDICINE AND HOMEOPATHY)

[Action Taken on Fourth Report of Committee on Empowerment of Women (Thirteenth Lok Sabha)]

THIRTEENTH REPORT

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LOK SABHA SECRETARIAT
NEW DELHI

March, 2003/ Chaitra, 1925 (Saka)

E.W.C. No. 15

THIRTEENTH REPORT

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(2002-2003)

(THIRTEENTH LOK SABHA)

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[Action Taken on Fourth Report of Committee on Empowerment of Women (Thirteenth Lok Sabha)]

Presented to Lok Sabha on _____

Laid in Rajya Sabha on _____

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LOK SABHA SECRETARIAT
NEW DELHI

March, 2003/ Chaitra 1925 (Saka)

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COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN
(2002-2003)

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2. Dr. (Smt.) Anita Arya
3. Smt.Jayashree Banerjee
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29. Miss Mabel Rebello
30. Smt. Savita Sharda

SECRETARIAT

1.	Shri P.D.T. Achary	-	Additional Secretary
2.	Shri K.V.Rao	-	Joint Secretary
2.	Shri Ashok Sarin	-	Deputy Secretary
3.	Smt. Veena Sharma	-	Under Secretary

* Nominated to the Committee w.e.f. 20th May, 2002

** Nominated as Member of the Committee w.e.f. 28th August, 2002 *vice* Shri N.T.Shanmugam, MP ceased to be a Member of the Committee on his appointment as Minister.

INTRODUCTION

I, the Chairperson of Committee on Empowerment of Women, having been authorised by the Committee to present the Report on their behalf, present the Thirteenth Report (Thirteenth Lok Sabha) on the Action Taken by the Government on the recommendations contained in the Fourth Report of the Committee on Empowerment of Women (Thirteenth Lok Sabha) on 'Health and Family Welfare Programmes for Women' relating to the Ministry of Health and Family Welfare (Department of Health, Department of Family Welfare and Department of Indian Systems of Medicine and Homeopathy).

2. The Fourth Report (Thirteenth Lok Sabha) of the Committee on Empowerment of Women was presented to Lok Sabha on 30th August, 2001. Replies of the Government to all the Observations/Recommendations contained in the Report have been received.

3. A Sub-Committee was constituted to examine and process the replies in detail. The Sub-Committee after examining the replies sought clarification from the concerned Ministry on some of the points. The Members of the Sub-Committee were:-

1. Dr. (Smt.) V.Saroja - **Convenor**
2. Dr. (Smt.) Anita Arya
3. Smt. Renuka Chowdhury
4. Shri Bishnu Pada Ray
5. **Smt. Jayaben B.Thakkar**
6. Smt. Shabana Azmi
7. Smt. Gurcharan Kaur

4. The Draft Report was considered and adopted by the Committee on Empowerment of Women (2002-2003) at their sitting held on 27th March, 2003. The Minutes of the sittings form Part II of the Report.

5. For facility of reference and convenience, the Observations/Recommendations of the Committee have been printed in thick type in the body of the Report and have also been reproduced in a consolidated form in Appendix – I of the Report.

6. An Analysis of the Action Taken by the Government on the recommendations contained in the Fourth Report (Thirteenth Lok Sabha) of the Committee is given at Appendix II.

NEW DELHI;
March 25, 2003
Chaitra 4, 1925 (Saka)

MARGARET ALVA
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN.

CHAPTER I

REPORT

1.1 This Report of the Committee deals with the action taken by the Government on the recommendations contained in the Fourth Report (Thirteenth Lok Sabha) of the Committee on Empowerment of Women relating to the Ministry of Health and Family Welfare (Department of Health, Department of Family Welfare and Department of Indian System of Medicines and Homeopathy).

1.2 The Fourth Report of the Committee was presented to Lok Sabha on 30th August, 2001. Replies of Government in respect of all recommendations have been received and are categorised as under:

(i) Observations/Recommendations which have been accepted by the Government:

Para Nos:- 1.20, 1.21, 1.22, 1.23, 1.24, 1.25, 1.26, 1.27, 2.25, 2.26, 2.29, 2.30, 2.31, 2.33, 2.34, 2.35, 2.36, 2.37, 2.38, 2.39, 2.40, 2.41, 2.43, 2.44, 2.45, 3.43, 3.44, 3.45, 3.46, 3.47, 3.48, 3.49, 3.50, 3.51, 3.55, 3.56, 3.57, 3.58, 3.59, 3.60, 3.62**,** 3.65, 3.66, 3.67, 3.68, 3.69, 3.70, 4.15, 4.16, 4.17, 4.18, 4.19, 4.20, 4.21, 4.22, 4.24

(ii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government:

Para Nos. 2.27, 2.28, 3.64, 4.23

(iii) Observations/Recommendations, replies to which have not been accepted by the Committee and which require reiteration.

Para Nos:- 2.32, 2.42, 3.52, 3.53, 3.54, 3.61, 3.63, 4.14,

(iv) Observations/Recommendations in respect of which the Government have furnished interim replies.

Paragraph Nos:- Nil

1.3 **The Committee desire that replies in respect of recommendations contained in Chapter I should be furnished to the Committee expeditiously.**

1.4 The Committee will now deal with those actions taken replies of the Government, which need reiteration or merit comments.

Emphasis on holistic health care for Women

Recommendation (Para No.1.26)

1.5 In the aforesaid paragraph, the Committee had opined that there was growing awareness in the country that population stabilisation was among the most critical issues. But measures for improving the health and nutrition status of women and children should be the priority of the Government in the immediate future. The Committee had noted that child survival rates were directly linked to falling birth rate. Anaemia, Urinary Tract Infections, malnutrition, repeated childbirths, adolescent marriages and overwork took the toll of women's lives, but their health and nutritional needs received little focus. All health care programmes for women were tailored for pregnant and nursing mothers or achieving population stabilization. This approach needed to be changed and women's holistic health care emphasised. Further the Committee were of the opinion that women's health was important in itself, not just her reproductive health. Special efforts were needed to empower women so that she, along with her partner could choose how many children they should have and how they should be spaced.

1.6 The Department of Family Welfare in their Action Taken reply have stated that the Reproductive and Child Health (RCH) outreach scheme is being implemented to improve the delivery of maternal and child health services in remote areas and urban slums. The Department have stated that the salient features of the RCH Outreach Scheme is, strengthening of the services by providing inputs to increase coverage and

improve quality of immunisation, child health interventions and maternal health services by addressing gaps in the service delivery and improving outreach and creating demand for Information, Education and Communication (IEC) and social mobilisation in urban and rural areas within the districts.

1.7 According to the Department services provided in the Outreach session include:

Beneficiaries	Services to be provided
Pregnant Women	**Early Registration of Pregnancies, ANC, Tetanus Toxiod, Tab. IFA (Large), PNC, Referral for women with complications of pregnancy and those needing emergency care. Counselling on place of delivery, complications of pregnancy, breastfeeding and care of newborn.**
Infants upto 1 year	**Complete immunisation for 6 VPDs and Give 1st dose of Vitamin A.**
Children 1-3 years	**Booster dose of DPT/OPV, 2nd to 5th dose of Vitamin A. Tab IFA (small) to children with clinical aneamia.**
All Children below 5 years	**Case management of those suffering from diarrhea and pneumonia, providing counselling to all mothers on home management and when and where to refer and organising ORS depot at the session site village.**
for Women 15-45 years	**Counselling on birth spacing as a health measure, information on use of contraceptives and availability of contraception and MTP services**

1.8 The Department have also stated that steps have been taken by Government for increasing awareness about various population stabilisation strategies and Reproductive and Child Health (RCH) Programme by vigorous publicity efforts. An intensive campaign has been launched to create knowledge on family planning methods and techniques through electronic and print media. The “healthy mother- healthy child” messages are broadcast on AIR in the form of audio-jingle spots before the Morning and Evening National News, while before and after Regional News in the afternoon one spot on No-Scalpel Vasectomy is broadcast.

1.9 The Department have further clarified that films on Reproductive & Child Health have been made by eminent producers to improve mass awareness on family welfare programme. The media units viz. Directorate of Audio Visual Publicity, Song & Drama Division and Directorate of Field Publicity are also carrying out publicity on Reproductive and Child Health (RCH) themes through exhibitions, theatre plays, seminars/workshops and video programmes. Parivar Kalyan and Swasthya Melas are also being organised in different States to increase awareness and provide medical services to the people at their doorsteps.

1.10 In their Original Report, the Committee had opined that measures for improving the health and nutritional status of women and children should be the priority of the Government in the immediate future. It was pointed out that anaemia, urinary tract infections, malnutrition, repeated child births, adolescent marriages and overwork took the toll of women's lives while their health and nutritional needs received little focus. All Health Care Programmes for Women were tailored for pregnant and nursing mothers or for achieving population stabilisation. The Committee therefore, felt that this approach needed to be changed and women's holistic health care emphasised.

1.11 The Department of Family Welfare in their Action Taken reply have stated that the Reproductive and Child Health Scheme (RCH) is being implemented by the Department to improve the delivery of maternal and child health services in remote areas and urban slums. The services provided under the programme include early registration of pregnancies and referral services for women with complications of pregnancies, complete immunisation for infants upto one year and counselling of women of 15-45 age group on the family welfare services. The Committee find that in the services provided under the RCH Programme, the focus continues to be on the reproductive age group. The general or holistic health care of women especially health needs of adolescent girls and peri and post-menopausal women are not given priority under the existing health programmes. The Committee feel that apart from addressing the health needs of women in the reproductive age group, adequate emphasis should be given for improving the health care of adolescent girls and aged women. While reiterating the earlier Recommendation, the Committee urge the Government to take a fresh look at the existing Schemes/Programmes for health care for women in order to adequately focus on promoting not only the reproductive health of women but also of their general health from birth through old-age with particular emphasis on some common health problems faced by women such as malnutrition, aneamia, urinary tract infection, depression etc.

1.12 The Committee also note that several schemes are underway to disseminate information to improve mass awareness on family planning programmes and on reproductive and child health care schemes through electronic and print media. The Committee feel that unless the IEC messages enable behavioural change, they are unlikely to have any impact. The Committee, therefore desire that measures should be taken by the Department to review and assess the impact of schemes being

implemented for improving awareness of women regarding their health and family welfare schemes. The study should also assess how far these schemes are able to bring attitudinal and behavioural change in women especially in the rural areas.

Proper Monitoring and Utilisation of financial assistance released to States

Recommendation (Para No. 2.26)

1.13 The Committee in their Original Report had found that there had been a steady increase in budget allocation of the Department of Health from Rs. 897.34 crores in the Seventh Plan to Rs. 5118.19 crores in the Ninth Plan. Further, the Government also received external assistance from various bilateral and multilateral agencies for implementing the National Programmes. The Committee had agreed that massive health investment was required for creating awareness and sensitising the masses to various health programmes as well as to the importance of the preventive aspect of health care. The Committee had, therefore, recommended that the Planning Commission and Ministry of Finance should step up the budget allocation for health services. The Committee had desired that the Government should also ensure that the existing infrastructure was fully operationalised by ensuring close and constant cooperation of the State Governments, NGOs, Self Help Groups, Voluntary Organisations as well as Panchayati Raj Institutions.

1.14 In their Action Taken reply the Department of Health have stated that according to the Draft National Health Policy, 2002, emphasis would be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government. Against this backdrop, every effort is being made to ensure that adequate funds are made available not only at the Central level but also at the State level within the existing financial constraints. The Department have further stated that during the annual plan discussions, all the States are requested to ensure that they provide optimum outlays for the health sector especially for primary health care. Efforts to ensure operationalisation of the existing infrastructure are continuously being made. Involvement of NGOs and Panchayati Raj Institutions is being encouraged. Assistance of NGOs/Voluntary Organisations working with women's groups is being mobilized for implementing community intervention programmes especially in the case of HIV/AIDS, Blindness and Leprosy. Certain NGOs selected by State Governments are provided free drugs and also given grant-in-aid for operational expenses. The NGOs are expected to help identify affected persons and motivate and counsel them for early treatment and follow-up. Involvement of Panchayats for providing training and access to health care services is being explored. According to the Department of Health, in Kerala, the State Government has devolved 30 to 40% of its State budget to Panchayats. under

different programmes. Training and sensitization of Panchayat leaders for their cooperation which is crucial for the success of any disease control programme, is being undertaken.

1.15 In reply to a question, the Department have stated that the Tenth Plan Outlay for Department of Health has been enhanced from Rs. 5118 crores during the 9th Plan period to Rs. 9253 crores during the 10th Plan period registering an increase of 81%. As regards the response of the State Governments for making provision of optimum outlays for the primary health sector, the Department have replied that the Planning Commission has made all efforts to impress on the States the need to increase the outlays for the health sectors. Every effort is made to provide a progressive increase in outlays by the Planning Commission for the three Departments and also as Additional Central Assistance (ACA).

1.16 The Committee in their Original Report had observed that massive health investment was required for creating awareness and sensitising the masses to various health programmes as well as to the importance of the preventive aspect of health care. The Committee had, therefore, recommended that the Planning Commission and Ministry of Finance should step up the budget allocation for health services. In their Action Taken reply the Department of Health have stated that the draft National Health Policy, 2000, emphasises on increasing the aggregate public health investment through a substantially increased contribution by the Central Government. The Department have also stated that efforts are being made to ensure that adequate funds are made available not only at the Central level but also at the State level within the existing financial constraints. Further, during the annual plan discussion, all the States are stated to be requested to provide optimum outlays for the health sector, especially for primary health.

1.17 The Outlay for the Department of Health is stated to have been enhanced from Rs. 5118 crore during the Ninth Plan period to Rs. 9253 crore during the Tenth Plan period registering an increase of 81%. Further, the Committee have been informed that every effort is made to provide a progressive increase in outlays by the Planning Commission for the three Departments and also as

Additional Central Assistance (ACA). Although the budget allocation for the Tenth Plan for health services has been increased, the Committee feel that it is not adequate to improve the health delivery system and bridge the gaps from the grass-root level to the district level. Funds are not only required for treatment of diseases but also for creating awareness and sensitising the masses to various health programmes and determinants as well as to the preventive aspects of health care. The Committee are of the view that for this purpose the Central Government should continue to impress upon the States the need to allocate a fixed percentage of their outlay for the health sector.

1.18 The Committee also desire that the Department of Health should develop a proper mechanism in co-ordination with the Planning Commission to ensure proper utilisation of the financial assistance released to the States and ensure that there is no slippage/diversion of the funds in the States. It must also be ensured that investments that are being made for upgradation of health facilities are actually improving the access to and quality of health services and infrastructural facilities in the States.

1.19 The Committee are, concerned to note that the level of community involvement in infrastructure in the Country is low. In this regard, the Committee have been informed that in Kerala, the devolution of 30% to 40% of the State Budget to panchayats has enabled improved quality of services through better physical infrastructure. The Committee, therefore, desire that the Department of Health should impress upon the other States/UT Administration, the need to devolve fiscal powers to the Panchayats for supervision and maintenance of primary health infrastructure. Further, NGOs should also be involved and encouraged to participate in the working groups for planning health services including infrastructure improvements at district and block level.

<u>Implementation of urgent intervention Strategies to combat HIV/AIDS</u>

(Recommendation Para No. 2.32)

1.20 In the aforesaid paragraph, the Committee had expressed great concern over the alarming increase in the number of HIV positive cases in the Country. The Committee had felt that identification of target population, providing proper and timely counselling, increasing public awareness and community support,

improving blood safety and controlling Sexually Transmitted Diseases were some of the measures, which if implemented, could result in arresting the increasing spread of AIDS.

1.21 In the Action Taken reply the Department have stated that the National Aids Control Programme Phase-II is a comprehensive programme for the prevention and control of HIV/AIDS in the country. The programme has five components which include priority interventions among marginalised and vulnerable population, provision of STD services, comprehensive awareness programme, establishing voluntary counselling and testing centres, modernisation of blood banks to ensure blood safety, care and support through free drugs for opportunistic infections, establishing community care centres through NGOs and developing a multi-sectoral response by working partner Ministries such as Railways, Defence, Labour etc.

1.22 The Committee note that the National AIDS Control Programme –Phase II is being implemented by the Department for prevention and control of AIDS/HIV in the country. The Committee are, however, of the opinion that the implementation of the components of NACP Programme by the Department such as provision of STD services, awareness programmes, voluntary counselling and testing centres are not adequate in view of the alarming increase of HIV/AIDS cases in the country. The Department should consider urgent intervention strategies by integrating prevention, care and support which should extend from giving people access to diagnostic tests and condoms, to stepping up the treatment and prevention of other sexually transferred diseases. Adequate attention should also be given by the Department to improve access to proven HIV prevention interventions among the 'mobile' and vulnerable sections of the population.

1.23 The Committee find that despite the public awareness programmes and other preventive measures being undertaken by the Department, ignorance, social ostracisation and inadequate medical care still remain major concerns. One of the biggest challenges is the stigma and discrimination towards People living with HIV/AIDS by the community and medical practitioners. The Committee feel that immediate steps should be taken by the Department to remove the stigma and discrimination associated with this disease which in the view of the Committee lead to major violations of human rights. The Committee suggest that Health care providers must be oriented to universal precautions, exposed to training

programs for attitudinal change regarding HIV/AIDS so that they are able to address this menace even at the grass-root level and in remote villages.

Interventions for women specific diseases

Recommendation (Para No. 2.37)

1.24 The Committee in their Original Report had observed that the Department had admitted that various Disease Control Programmes were being implemented throughout the Country as National Programmes for the population as a whole, without any specific allocation for women. The Committee had pointed out that certain areas of women's health, however, required specific interventions especially for those disabilities and morbidities which were gender specific such as cervical and breast cancer. The main constraints were stated to be inadequate funding and inadequate development of gender perspective in programme formulation. The Committee had felt that apart from properly implementing the various health schemes taken up by the Department of Health (of which the women would also be beneficiaries) a separate allocation for women in the annual plan would have gone a long way in launching interventions specially required for women.

1.25 The Department in their action taken reply have stated that separate allocation for women in National Disease Control Programmes implemented by them such as for control of Malaria, TB, Blindness, Leprosy and AIDS is not practical as all these diseases are gender neutral. The various Policy initiatives contained in the Draft Policy in regard to the expansion of primary health sector infrastructure will also facilitate the increased access of women to basic health care. The Department have further stated that in the case of cancer, women patients are equal beneficiaries at all centres having teletherapy facilities as well as Regional Cancer Centres. Modified District Cancer Control Programme has now been initiated which specifically targetted women in 60 blocks in the four States. The target group for this programme is 20-65 years. The release of a postage stamps on 7th November, 2001 depicting a woman carrying out 'self breast examination' is an example of Government's sincerity regarding women related cancers.

1.26 The Committee are not convinced by the reply of the Department that separate allocation for women in National Disease Control Programmes implemented by them such as for control of Malaria, TB, Blindness, Leprosy and AIDs is not practical as all these diseases are gender neutral. The Committee feel that the impact of all communicable and non-communicable diseases is not gender neutral. Besides the disabilities and morbidities such as cervical and breast cancer which are gender specific, other diseases/disabilities such as Urinary Tract Infection, Anaemia, malnutrition etc. also impact women's health. Thus, developing gender specific strategies in combating

health problems is an essential pre-requisite. The Committee, therefore, reiterate that a separate allocation for women in the annual plan is necessary which would go a long way in launching interventions specially required for women.

1.27 The Committee also desire that steps should be taken for gender sensitization of health workers, managers and grass-root workers which is critical for management and implementation of health programmes for women. The Committee also desire that obtaining gender disaggregated data and clear analysis should be made mandatory for any review or assessment or research study on these programmes.

Improvement in condition of Government Hospitals

Recommendation (Para No. 2.42)

1.28 In the original Report, the Committee had observed that the demand and supply of health facilities was highly skewed. There was urgent need to improve the conditions of the Government hospitals by making available doctors, para-medical staff, requisite medicines and necessary medical equipments. The Committee had felt that not only was there need for more doctors and nurses but the norms for doctor patient ratio and nurse patient ratio needed to be reviewed and appropriate steps taken to provide medical staff as per those norms. The Committee had observed that the emergency wards of Government hospitals in major cites were managed by junior doctors while the senior doctors had to be called, if need arises and had desired that the Government should take appropriate steps to ensure the presence of senior doctors round the clock in each discipline in the emergency wards of major Hospitals.

1.29 In the Action Taken reply the Department have stated that the gap in demand and supply of health facilities in terms of personnel, equipment and medicines is well recognised. Schemes such as establishment of Medical Grants Commission for providing grants to medical colleges, scheme for providing essential drugs to primary health centres and scheme for urban health for setting up an organised urban primary health care structure have been initiated during the 10^{th} plan to bridge this gap to the extent feasible. The Department have further stated that nurse-patient ratio has already been fixed by the Indian Nursing Council. Review of this ratio is not considered necessary at this stage. State Governments have been advised to implement the nurse – patient ratio. There are no Internationally recognised norms for doctor-patient ratio. Staffing of emergency services in Government hospitals differs from hospital to hospital depending upon the requirement. Senior residents who are well qualified are available round the clock for emergency duties in Government hospitals. Senior faculty members

who have been provided residence in the hospital vicinity are available on call duty. In addition, one specialist each from medicine and surgery along with those of Orthopaedics, Paediatrics, Neurology etc. are also available round the clock in the Emergency Ward in certain Government hospitals.

1.30 In response to a query about the steps taken by the Department to ensure the availability of senior doctors in tertiary centres, the Department have stated that adequate measures are taken for ensuring availability of senior doctors in Central Government Hospitals. Presently, senior doctors in each Department are available in the Central Government Hospitals. They either remain available on duty round the clock or on immediate call basis. Normally most hospitals have housing in the campus for almost all senior doctors in all specialties. These senior doctors are constantly put on duty in their units, provided with pagers for fast communication and are immediately available to look after any emergency.

1.31 The Committee in their Original Report had observed that there was urgent need to improve the conditions of the Government hospitals by making available doctors, para-medical staff, requisite medicines and necessary medical equipments. Not only was there need for more doctors and nurses but the norms for doctor patient ratio and nurse patient ratio needed to be reviewed and appropriate steps taken to provide medical staff as per those norms. In their Action Taken reply the Department have conceded the fact that there is a gap in demand and supply of health facilities in terms of personnel, equipment and medicines. Schemes such as establishment of Medical Grants Commission for providing grants to medical colleges, scheme for providing essential drugs to primary health centres and scheme of urban health for setting up an organised urban primary health care structure have been initiated during the 10th Plan to bridge this gap to the extent feasible. The Committee fail to understand why such schemes have been initiated so late (in the Tenth Plan) when the urban primary health care infrastructure including Government Hospitals have remained plagued by shortage of medicines, doctors and equipments for years.

1.32 The Committee had earlier pointed out that the emergency wards of Government hospitals in major cites were managed by junior doctors and the senior doctors had to be called, if need arose. The Committee had, therefore, desired that the Government should take appropriate steps to ensure the presence of senior doctors round the clock in each discipline in the Emergency Wards of major Hospitals. In this connection, the Department have stated that staffing of emergency services in Government hospitals differs from hospital to hospital depending upon the requirement. Senior resident doctors who are well qualified are available round the clock for emergency duties in Government hospitals. Further, senior resident doctors and one specialist each from medicine and surgery are also available round the clock in Emergency Wards in certain Government hospitals. However, despite these claims of the Department, it is generally seen that Emergency Wards are always managed by Junior doctors and Senior Resident/Specialists are either not bothered or arrive

considerably late. This usually compels the relatives of patients to rush to private hospitals for prompt treatment. It is, therefore, of paramount importance that there ought to be a system to ensure availability of Senior doctors regularly in Emergency Wards. This can only be possible if the Senior Doctors/Specialists in each discipline are present round the clock so that best possible medical treatment is made available to patients who are rushed to emergency wards in serious/critical conditions.

1.33 The Committee also desire that measures need to be taken to ensure accountability among Doctors and other Para-Medics to enable them to be responsive to the patients admitted. The Committee also feel that the public at large should be made aware of the availability of the health care facilities at Government Institutions and their rights as patients seeking treatment which will serve as a deterrent to irresponsible and errant Doctors. The Committee would like to be apprised of the precise steps taken in this regard.

Provision for sterilisation facilities in each of the Primary Health Centres

Recommendation (Para No. 3.52)

1.34 The Committee were of the view that rather than implementing the same strategy or following the same policies, newer intervention strategies needed to be planned and vigorously implemented to ensure a rapid decline in fertility rate in the immediate future. The Committee had recommended that sterilisation facilities should be made available in each of the PHSCs, PHCs, Community Health Centres, etc. The Committee had desired that the outreach of the Family Planning Services should be increased by involving NGOs and Health volunteers and through community based distribution of contraceptives. Lastly, the Committee had felt that there should be proper emphasis on programmes for training and skill development of both the Medical Officers and Health workers of both Government and voluntary agencies involved in the delivery of family welfare services, with respect to special procedures such as IUD insertions, sterilisation and also administering of oral contraceptives.

1.35 In their Action Taken reply, the Department of Family Welfare have stated that various categories of health functionaries are being trained through the following kinds of training:-

(i) Awareness Generation Training.

(ii) Integrated Skill Training.

(ii) Specialized Skill Training

(iii) Specialized Management Training

(iv) Training in Communication.

1.36 The Department have stated that Awareness Generation Training, however, has been discontinued from 31.12.2000. It has further been stated that the training modules /guidelines/ facilitators guide for various types of trainings have been prepared and are in use. The Department have further stated that for effective monitoring of the training programmes 18 Consultants have been provided to NIHFW besides the supervisory support provided by the CTIs. Comprehensive Training Plans (CTPs) duly approved by respective State Authorities have been submitted to NIHFW and based on these, NIHFW is releasing funds annually. An amount of Rs. 40 Crores has been earmarked for this purpose during 2001-2002.

1.37 In reply to a query on the action taken by the Department to provide sterilisation facilities in each of the PHCs, CHCs etc., the Department have stated that the basic requirements for improving sterilisation facilities in PHCs, CHCs and Sub-Centres are as follows:

a) Availability of appropriate infrastructure including labour room, operation theatre etc.
b) Availability of qualified staff for conducting sterilisation operations.
c) Refresher training for doctors and nurses.
d) Availability of drugs, equipment and supplies
e) Water and electric supplies.

1.38 According to the Department, to strengthen primary health infrastructure, all States are being provided Rs. 10 lakhs/CHCs for Civil Works under RCH to upgrade/construct facilities such as operation theatre, labour room and provision for water and electricity supply wherever not available. To ensure availability of trained staff the Government is providing funds to the States to employ additional ANMs, Lady Doctors, Gynaecologists , anaesthetists etc. on contract basis. Drugs, equipment and supplies are being provided to Sub-Centres, PHCs and FRUs skill based inservice

training , besides training in no-scalpel vasectomy to doctors, ANMs and other functionaries.

1.39 The Committee had earlier observed that instead of implementing the same strategy/policies, newer intervention strategies needed to be planned and vigorously implemented, so as to see a rapid decline in fertility rate in the immediate future. However, the Department of Family Welfare in their Action Taken reply has remained silent on this issue. This shows the lack of seriousness on the part of the Department in dealing with this important recommendation of the Committee. The Committee would have appreciated if the Department of Family Welfare had spelt out clearly whether they are considering new intervention strategies to achieve immediate reduction in the fertility rate. The Committee while reiterating their earlier recommendation desire that the Department of Family Welfare should undertake a mid term appraisal / review of all the programmes for population stabilisation being implemented by them and should impress upon all States/Union Territories to submit a report to the Department on the performance of each Scheme/Programme for population stabilisation in their respective States and the achievement of physical and financial targets etc. The Department should also conduct first-hand/field visits of its senior officials to States/Union Territories to assess the extent to which the programmes are achieving the desired objectives.

1.40 The Committee had also recommended that sterilisation facilities should be made available in each of the PHSCs, PHCs, CHCs etc. The Committee had further desired that the outreach of the Family Planning services should be increased by involvement of NGOs, Health Volunteers and through community based distribution of contraceptives. The Department have replied that all States are being provided Rs. 10 lakhs for civil works under RCH to upgrade sterilisation facilities in Primary Health Centres besides providing additional ANMs, drugs, equipment supplies etc. However, the Committee are constrained to note that despite claims of the Department, availability of basic facilities for sterilisation are not available in most PHCs in many States. A news item recently published claims that in Uttar Pradesh for instance health centres use crude methods such as bicycle pumps for laproscopy in place of the high-precision equipments

required for the purpose. The Committee were anguished to note that besides the cycle pump being used as a standard substitute for the medical pump, the same syringe and gloves were being used for upto 50 patients in these camps in almost all the Primary Health Centres in Western Uttar Pradesh. This flouts all the guidelines issued by the Union Health Ministry in October, 1999 prescribing standards for sterilisaton. The Committee therefore, desire that the Department of Family Welfare should seek reports from other States/UTs on whether such practices are being followed there and also urge upon them to take necessary remedial action to punish those responsible for this inhuman act. In addition, the Department should impress upon all the States/UTs to implement the guidelines issued by the Union Health Ministry in October, 1999 for conduct of sterilization in the primary health centres.

1.41 **The Committee also note that various programmes are being implemented by the Department for training of health personnel with focus on skill upgradation. The Department have however stated that Awareness Generation Traning has been discontinued from 31.12.2000 without furnishing any reasons as to why this has been done. The Committee would like to know the reason as to why this Training programme has been discontinued. The Committee also desire that while various training programmes have been initiated by the Department, the Department should also take steps to assess the impact and efficiency of the training programmes to see whether the programmes are able to address the various facets of training required to improve women's health such as technical competence, behavioral change techniques, attitudinal change etc.**

Slow rate of increase in percentage of male Sterilization

Recommendation (Para Nos. 3.53 and 3.54)

1.42 The Committee in their earlier Report had noted that the proportion of tubectomy acceptors to total sterilization had been approximately 98% compared to only 2% of vasectomy acceptors which showed that till now the entire burden of sterilization had fallen on the women, even though, studies had shown that sterilization on men was less complicated. The Committee had therefore urged upon the Department of Family Welfare to initiate necessary changes in policy formulation and strategy implementation

so as to involve more males in the family planning exercise. The Committee had felt that counselling of couples in this regard would go a long way in encouraging male sterilisation and desired that the type and quantum of incentives given for male sterilization should be enhanced in order to encourage more men to opt for sterilization.

1.43 The Committee in their Original Report had also observed that the prime reasons cited by the Department for such low rate of male sterilization viz. fear of weakness (66%), fear of operation (13%) and method failure (6%), could have been easily tackled through an effective Information, Education and Communication (IEC) strategy. The Committee had observed that the fact that such misconception had been allowed to prevail for so long without any counter strategy on the part of the Government and the Department, exposed their gender bias and callous and casual approach to the matter.

1.44 In the action taken reply the Department have stated that since the launch of No-Scalpel Vasectomy Project to promote male participation in the Family Welfare programme by the Department in January 1998, the number of male sterilisations had gradually increased from 1.7% in 1997 to 2.3% in 2000. The project till date has been implemented in 20 States.

1.45 According to the Department, an approach paper has been moved for establishing male Reproductive Health centres in the tenth five year plan. Till date there are no centres where men can go to get their problems on impotency, infertility, family planning or any other sexual disorder addressed. These centres will help to motivate men to come forward and to accept Family planning by addressing their problems.

1.46 The Department have further stated that with regard to dispelling fears on male sterilisation the NSV project has developed new IEC materials on NSV. These are mainly a) NSV training b) advocacy video c) NSV audio d) NSV print materials. These IEC materials have been developed after research by Ms Thomson Social with the help of UNFPA and are to be distributed to the States for publicity. It is hoped that with NSV IEC material in place the fear and misconception on male sterilisation will be dispelled.

1.47 In reply to a query, the Department have stated that the measures taken by the Department to involve more males in the family welfare programme are as follows:-

I. A new initiative on promotion of Male Participation under Men in Planned Parenthood has been launched by the Department in the Tenth Five Year Plan. The Goal of the Scheme is to promote gender equity and equality and enable men to take responsibility for their sexual reproductive behaviour and their social and family roles. The objectives of the Scheme as furnished by the Department are :-

i) Increasing men's knowledge and support of women's sexual and reproductive health issues and of children's well being, with equal regard for female and male children.

ii) Meeting the reproductive and sexual health needs of men (in addition to those of women).

iii) Promoting women's and men's partnership in shared reproductive health decision-making.

iv) Preparing adolescent boys for responsible adulthood.

II. Another initiative under taken by the Department is the promotion of No. Scalpel Vasectomy project to promote male participation. No Scalpel Vasectomy (NSV) is one of the most effective contraceptive methods available for males. It is an improvement on the conventional vasectomy with practically no side effects or complications. This project is to help men adopt male sterlization and thus promote male participation in the Family Welfare Programme. Ensuring the dissemination of this new NSV technique up to the peripheral level will promote higher levels of male sterilization in the country.

1.48 According to the Department training programmes are organised upon the request of the States. On request from States, funds are released to the State for such training . Till date 299 NSY training programmes have been held under the project in the Country (average of 5-6 training sessions every month). 1,52879 acceptors have undergone NO-Scalpel Vasectomy operation (average of 2955 NSV operations every month), 1156 doctors trained in the technique of No-Scalpel Vasectomy (average of 22 doctors every month i.e. almost one doctor being trained every day if Sunday's & holiday's are excluded). Out of these 1156 doctors trained, 1056 doctors have been certified as NSV providers (to promote NSV services to

public), 49 doctors have been certified as NSV State Trainers and 51 doctors have been certified as District Trainers. These certified trainers are to take over the training of other medical personnel in their respective States and Districts. This is to help decentralize the NSV training and to make the States & Districts self sufficient in their NSV staff needs. It will also ensure that the NSV technique at the peripheral level will help increase the acceptance of male sterilization in the country. The percentage of male sterilization has increased from 1.8% in 1997 to 2.46% in 2002 after the introduction of the project in 1998.

1.49 The Committee in their Original Report had noted that proportion of tubectomy acceptors to total sterilisation have been approximately 98% as compared to only 2% of vasectomy acceptors. The Committee had, therefore urged upon the Department of Family Welfare to initiate necessary changes in the policy formulation and strategy implementation so as to involve more male in the family planning exercise. The Committee are informed that a number of measures have been taken by the Department of Family Welfare so far for involving of males in the family planning exercise. The Committee are, however, constrained to note that the percentage of male sterilisation has increased from 1.8% in 1997 to only 2.46% in 2002. The Committee feel that the pace of increase of male sterilisation is abysmally low and that at this rate it will take many years to achieve a substantial increase in male participation in the family planning exercise.

1.50 The Committee note that a new initiative on promotion of male participation under Men in Planned Parenthood has been launched by the Department in the Tenth Five Year Plan. The goal of this new initiative is to promote gender equity and equality and enable men to take responsibility for their sexual reproductive behaviour and their social and family roles. The Department have also stated that another initiative undertaken by the Department is the promotion of 'No-Scalpel Vasectomy Project' to promote male participation. The project is being funded by UNFPA with the Government of India providing centres for training and making available necessary infrastructure at the training sites. While such initiatives are laudable, the Committee feel that they are not sufficient . What is of utmost importance is timely and proper implementation of such initiatives. The Committee also desire that more interpersonal communication should be

undertaken and the focus should be on making men aware of their responsibility and to project NSV as one of the components of male responsibility to ensure better women's health.

1.51 The Committee note that the training provided under the No-Scalpel Vasectomy Programme is organised upon the request of the States. When a request is received , funds are released to the State for each training session . The Committee feel that the Department should impress upon all the States/UTs, especially, the under developed States with high growth rate of population, to send proposals for organisation of training programmes on No-Scalpel Vasectomy in their respective States/UTs. The Committee are disappointed to note that till date only 299 NSV training sessions have been held under the project in the country since its introduction in 1998. The Committee are of the opinion that as training in new NSV technique is integral to the spread and reach of the programme which in turn will enhance the rate of male sterilisation, the Department should ensure that the States/UTs take steps to organise greater number of training programmes , especially in the remote villages and districts and at the grassroot level. Being the nodal Department, senior level officials of the Department of Family Welfare should also undertake monitoring visits to the NSV training centres in the States and Districts to assess the facilities and quality of training.

1.52 The Committee had observed that the counselling of couples would go a long way in encouraging male sterilization. The Committee had also suggested that the type and quantum of incentives given for male sterilization should be enhanced in order to encourage more men to opt for sterilization. The Committee are at a loss to understand as to why the Department have not furnished any comments to this important recommendation made by the Committee which only goes to prove the casual approach of the Department in dealing with this recommendation. The Committee would like to be apprised of the specific steps taken by the Department to increase the availability of counselling facilities. The Committee while reiterating their earlier recommendation also desire the Department to seriously examine the issue of increasing incentives for male

sterilization to achieve substantial increase in the rate of male participation in the family planning exercise.

Implementation of the PNDT Amendment Bill, 2002.

Recommendation (Para No. 3.57)

1.53 The Committee in their earlier Report had noted that despite having passed a law to check female foeticide, the girl child was being denied birth by using modern scientific devices, and female foeticide still continued unabated. In spite of the existence of appropriate authorities and advisory committees set up for monitoring the progress of implementation of the Act, very few cases of female foeticide had been reported. The Committee had felt that innovative strategies and programmes for awareness and for advocacy were needed to stop this practice. The Committee had desired that the Government should also examine the loopholes in the existing rules to enforce strict compliance of the provisions of the Act.

1.54 The Department in their reply have stated that with a view to containing the menace of female foeticide the Government has brought into force the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PNDT Act) with effect from 1.1.1996. Under the PNDT Act, the Central Supervisory Board has been constituted under the Chairmanship of Minister for Health & Family Welfare. The Board has met six times. The last meeting was held on 18.10.2001. Appropriate Authorities and Advisory Committees have also been constituted in all States and UTs for implementing the PNDT Act. Supreme Court of India is monitoring implementation of the PNDT Act almost every month.

1.55 According to the Department, the Central Supervisory Board (CSB) has constituted two sub-committees viz. (i) Technical Sub-Committee for considering amendments to the PNDT Act keeping in view the emerging technologies and difficulties experienced in the implementation of the Act and (ii) Sub-Committee on Implementation Strategy for implementing the Act for curbing female foeticide. Both the Committees have already met three times.

1.56 The Department have further stated that In the last meeting of the CSB certain amendments to the PNDT Act/Rules have been finalized after taking into account the views

of various organizations, members of the Sub-Committees, experts and States/UTs. Draft Cabinet Note for carrying out the amendments to the PNDT Act has been circulated to various Ministries/Departments of the Central Government, such as Legislative Department, Department of Legal Affairs, Department of Women & Child Development, Ministry of Social Justice & Empowerment, Ministry of Home Affairs, Ministry of Finance. On receipt of their comments the same will be placed before the Cabinet for bringing an amending Bill.* .

The CSB has also constituted two subgroups viz. (i) for considering the proposals for research studies on sex ratio and female foeticide and (ii) for considering the proposals for creating video films, TV spots etc. Some Projects

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***The Amendment Act has since been passed.**

have been approved for funding for creation of awareness about the provisions of PNDT Act . A National Inspection and Monitoring Committee has been set up to keep a constant watch on all States and UTs for implementation of the PNDT Act and compliance of the directions of the Supreme Court of India.

1.57 The Committee observe that the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 was brought into force in 1996 to regulate the misuse of pre-natal diagnostic techniques for determination of sex of the foetus. However, despite the existence of the Act, this technology is being misused on a large scale for sex determination leading to female foeticide and precipitating a severe imbalance in the sex ratio (females per 1000 males) as reflected in Census 2001 for some States/UTs viz. Punjab (874), Haryana (861), Delhi (821), Uttar Pradesh (898), Madhya Pradesh (920), Gujarat (921) and Maharashtra (922).

Consequently it became necessary to enact and implement a legislation that will ban the use of both sex selection techniques prior to conception as well as the misuse of pre-natal diagnostic techniques for sex-selection abortions. With this in view, the Government introduced the Pre-natal Diagnostic Techniques

(Regulation and Prevention of Misuse) Amendment Bill, 2002 after detailed deliberations in various meetings of the Technical Sub-Committee constituted for this purpose and later by the Central Supervisory Board, the apex body constituted at the Central level. The Committee on Empowerment of Women had also taken up for consideration the provisions of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Bill, 2002 and interacted with a number of NGOs, Women Activists, Officials and Doctors .The Committee thereafter finalised their suggestions on the said Bill in the light of the amendments/objections it received and forwarded a copy of their suggestions to the Minister for Health and Family Welfare for consideration and necessary action.

Now that the Amendment Bill has been passed by both the Houses of Parliament, the Committee hope that the Government would take immediate and effective steps to implement the provisions of the PNDT Amendment Bill, 2002 in letter and spirit throughout the country and especially in the 7 States (Punjab, Haryana, Delhi, Uttar Pradesh, Madhya Pradesh, Gujarat, Maharashtra) where there is a steady decline in the sex ratio. The Committee also desire that a proper mechanism should be put in place by the Department to ensure that the punishments prescribed under the Bill are implemented strictly which will minimise violations and also serve as a deterrent to unethical doctors against carrying out such practices in the larger interests of society.

<u>Operationalisation and Removal of backlog in establishment of primary health centres</u>

Recommendation (Para Nos. 3.61 and 3.63)

1.58 In the Original Report, the Committee had pointed out that despite the steps taken by the Government, the state of Primary Health Centres was dismal. Obviously, the steps initiated by Government had not resulted in actual improvement of PHCs. The Committee during its Study tours to some States had observed the condition of the Primary Health Centres and their poor maintenance. Some of these were set up in dilapidated buildings with no infrastructure, like electricity, beds, furniture and telephone facilities. They lacked the necessary hygiene. At some centres there was no separate ward for female patients and only one doctor was posted on rotation basis to attend to all the patients. Also there was acute shortage of essential drugs and other material. The

result was that these Centres were unable to meet the basic health service needs of the community. It was therefore, necessary that the PHSC, PHC and Community Health Centres should be fully operationalised by providing necessary facilities including buildings and residential quarters, filling-up of all vacant posts and ensuring supply of essential drugs, dressings and other consumables.

1.59 The Committee had observed that to improve the outreach and quality of the family welfare services, a time bound programme should be launched by the Department to remove the backlog of establishment of sub-centres and primary health centres. Special area projects, community donations and adoption of cheaper and appropriate technology for construction should be used for removing the backlog in physical facilities.

1.60 In their Action Taken note the Department of Family Welfare have stated that the Government is aware of the gaps in primary health care infrastructure in States. Government endeavors to improve the situation through a number of programmes under the State Health Systems Projects. Community Health Centres and District Hospitals are being upgraded and better equipped. Under the Pradhan Mantri Gramodaya Yojana (PMGY) specific funds have been provided to the States for repair and renovation of health care institutions, purchase of drugs (including ISM&H drugs) and for essential consumables & contingencies. One of the main activities of Area Projects, being implemented in various States, includes construction of buildings for sub centres, primary health centres and community health centres. Under Reproductive and Child Health (RCH) Programme (Major Civil Works) efforts are being made to strengthen the primary health care institutions through provision of equipments, medicines and vaccines; repair / construction of OT / labour rooms and upgradation of water and electric supply. It also makes provision for contractual appointments of essential staff.

1.61 Regarding the removal of backlog in establishment of Primary Health Centres and Sub-Centres, the Department in its Action Taken reply have stated that as a matter of fact, the non achievement of targets, in establishment of Sub Centres and Primary Health Centres by the States is due to financial constraints and that now the stress is on strengthening of existing infrastructure.

1.62 In a subsequent communication regarding the steps taken for operationalisation of primary health care infrastructure, the Department have stated that under RCH Programmes, primary health infrastructure is being strengthened through Minor and Major Civil works. Under Minor Civil Works all States have been provided funds @ Rs. 10 lakhs per district for minor repairs in primary health infrastructure. Under Major Civil Work funds are being provided to the States @ Rs. 10 lakhs per CHC to undertake construction/repair operation theatre, labour room and for upgradation of water and electric supply. Under Area Project and RCH sub-project, primary health and training infrastructure is being strengthened. Drugs, supplies and equipment are being provided under RCH Programme. Funds have also been provided under RCH Programme. Funds have also been provided under PMGY and under Basic Minimum Service Programme to strengthen primary health infrastructure and ensure availability of medicines in PHC, CHC , Sub-centres etc.

1.63 The Committee in their earlier Report had pointed out that despite the steps taken by the Government, the state of Primary Health Centres was dismal. During their study tours , the Committee had observed the poor maintenance of the Centres. The Committee had noted that some of these were set up in dilapidated buildings with no infrastructure, like electricity, beds, furniture and telephone facilities and lacked necessary hygiene. The Committee had noted that these Centres were unable to meet the basic health service needs of the community. The Committee had therefore desired that the PHSC, PHC and Community Health Centres should be fully operationalised by providing necessary facilities including buildings and residential quarters, filling-up of all vacant posts and ensuring supply of essential drugs, dressings and other consumables.

1.64 The Department have conceded that they are aware of the gaps in primary health care infrastructure in the States. In their Action Taken reply the Department have stated that Government endeavors to improve the situation through a number of programmes under the State Health Systems Projects. The Department have stated that Community Health Centres and District Hospitals are being upgraded and better equipped. Under the Pradhan Mantri Gramodaya Yojana (PMGY) specific funds have been provided to the States for repair and renovation of health care institutions, purchase of drugs (including ISM&H drugs)

and for essential consumables & contingencies. However, despite these steps having been taken by the Department, the condition of Primary Health Centres does not appear to have improved much. The contention of the Department of Health and the Department of Family Welfare that recently the stress has been on strengthening of existing infrastructure is unacceptable as the Committee found pathetic conditions of facilities in Primary Health Centres visited by them in various States before and after the presentation of the Committee's Original Report.

1.65 The Committee during their recent tour to Udaipur found lack of infrastructure facilities, trained personnel, drugs, medicines, supplies and appropriate equipment in these Centres. In the Centres visited by the Committee, it was pointed out that there was only one Lady Doctor who was handling all the general cases as well as cases of deliveries and abortions. In her absence, nurse and ANMs looked after emergency cases. The Committee were informed that there was no regular female staff nurse. Though there were posts of 2 nurses, only one male nurse was working who also was appointed on contract basis. It was further pointed out that there was acute water problem in the Centre. There was no X-Ray machine in the room allocated for the purpose. The Committee feel that as Primary Health Centres and Sub-Centres constitute the core of the primary health care system in the country, prompt and immediate improvement in the facilities at Primary Health Centres is absolutely essential for achieving the objective of taking primary health care to the door steps of the people.

1.66 The Committee had desired that in order to improve the outreach and quality of the family welfare services, a time bound programme should be launched by the Department to remove the backlog of establishment of sub-centres and primary health centres. The Committee are however not inclined to accept the reply of the Department that the non achievement of targets, in establishment of sub centres and primary health centres by the States is due to financial constraints. The Committee are of the opinion that the Department have not seriously examined the alternatives suggested by the Committee for improving the outreach and quality of the Family Welfare services such as special area projects, community donations and adoption of cheaper and appropriate

technology for construction which would have helped the Department to a great extent to overcome the financial constraints. The Committee are aware that , the budgetary provision for the Annual Plans for the Department have been increasing every year. The Committee expect that the enhanced allocation will be utilised by the Department to meet the requirements for improvement of the primary health care infrastructure.

Delay in integration of ISM&H component in the public health delivery system.
Recommendation (Para No. 4.14)

1.67 In the aforesaid para the Committee have noted that the Department of Indian Systems of Medicine and Homoeopathy have admitted that there had been very little progress towards integration of ISM&H with the modern systems of medicine as envisaged under the National Health Policy of 1983. Although some State Govts. like Maharashtra and Gujarat did post Ayurvedic doctors in the primary health centres, this has not been done by all the States in a systematic manner. The Committee were of the view that the Department could not escape its responsibility in this regard by saying that huge investment is necessary for developing the necessary infrastructure for integration of these systems with modern medicine.

1.68 The Department of Indian System of Medicine and Homeopathy in their Action Taken reply state that in addition to Maharastra and Gujarat , Rajasthan has recruited a good number of Ayurveda Physicians . Himachal has posted a number of Ayurveda physicians to PHCs. The States have been advised to post ISM physicians, stock medicines included in essential drug list; enhance budget for the purchase of medicines and also use PMGY funds for procurement of ISM &H drugs.

1.69 In reply to a question, the Department have stated that they had been repeatedly advising the State Governments, to integrate ISM&H in health care delivery systems. Some States have taken concrete steps, as already intimated to the Committee. However, there is no positive response from other States. This Department is preparing a Central Scheme to assist State Governments to create ISM&H wings in their District Hospitals and other allopathic hospitals. It is expected that the said scheme will be implemented during the current financial year. The Department have added that it will again write to States and impress upon them to further integrate ISM&H keeping in view the recommendations of the Committee.

1.70 The Committee in their Original Report were concerned to note that there had been very little progress towards integration of ISM&H with the modern systems of medicine as envisaged under the National Health Policy of 1983. Although some State Govts did post Ayurvedic doctors in the primary health centres, this has not been done by all the States in a systematic manner. The Committee were of the view that the Department could not escape its responsibility in this regard by saying that huge investment is necessary for developing the necessary infrastructure for integration of these systems with modern medicine. The Committee regret to note that even after nearly one and half years of presentation of the Committee's Report to the Parliament, only four States viz. Maharashtra, Gujarat, Rajasthan and Himachal Pradesh have recruited and posted Ayurveda Physicians to Primary Health Centres. The Committee had expected that the Department, after being reminded about the little progress made in this regard would have taken concrete steps to impress upon the remaining States/UTs the need for incorporation of ISM&H component in the public health delivery system in their respective States. The Committee also note that there is no positive response from the remaining States in this regard. The Committee feel that the Ministry should have tried to ascertain the reasons as to why the remaining States have still not taken adequate and effective steps for inclusion of Indian Systems of Medicine and Homeopathy in the health care institutions in their States.

1.71 The Committee while reiterating their earlier recommendation desire that the Department should take immediate and prompt steps to take up the matter with the concerned States at an appropriate level and ensure that there is an ISM&H component in the State level public health institutions as well as the public health delivery systems set up by the Government of India. The Committee desire to be apprised of the specific steps taken by the Department in this regard.

General suggestions for improvement in health care facilities for women.

The Committee desire the Government to consider the following suggestions also in consultation and coordination with the State Governments for improvement in the health care facilities for women.

1. Greater clarity is needed on the specific measures to be taken to ensure that women's health concerns and their poor access to health care are taken into consideration. Mechanisms should be instituted so that providers are aware of such specific concerns and women are aware of such policies to ensure proper health care for them.

2. Measures must be taken to ensure that there are no delays in procurement of drugs, supplies, equipments etc which have been quoted by the Department of Health as being responsible for non-utilisation of funds for major National Programmes.

3. Urgent Steps should be taken to ensure availability of lady doctors in rural areas to ensure women's access to health care. Field reality is that there are very few lady doctors at district levels and below, and the situation is worse in the socio-economically backward states. These States need to be pressurised upon to pay adequate attention to this aspect.

4. One of the biggest hurdles in reducing maternal mortality rates is the lack of specialists (anesthetists and obstetricians) particularly in rural and semi-urban areas for conducting caesarian sections/ vacuum or forceps for obstetric emergencies. This requirement needs to be addressed.

5. To combat Iron Deficiency , Anaemia, consumption of Iron Folic Acid tablets should be ensured among women. The role of nutrition education to overcome Iron Deficiency , Anaemia should be popularized. Constraints in the supply of IFA Tablet should be removed.

6. Adolescent health clinics should be set up and health providers should be trained in the specifics of adolescent health.

7. Ministry of Health and Family Welfare should collaborate with the concerned Ministries e.g Ministry of Human Resource Development, Ministry of Social Justice and Empowerment and Ministry of Finance and Company Affairs to ensure that the programmes of these Ministries recognise the gravity of maternal mortality and tailor their programmes to address issues of empowering women which could affect some of the determinants of maternal mortality.

8. To deal with the growing incidence of mother to child transmission (MTCT) of HIV/AIDS virus, measures should be taken to establish care and support centres in the community, particularly in the high prevalence areas.

9. To make the Mental Health Programme effective, outreach mechanism should be put in place so that men and women are aware that such programmes exist. Health workers should be provided with sensitization and training so that they are alive to the issue of mental disorders.

10. Preventive health care must be promoted through Anganwadis , Schools , PHCs , NGOs, and community awareness campaigns.

CHAPTER – II

RECOMMENDATIONS / OBSERVATIONS WHICH HAVE BEEN ACCEPTED BY THE GOVERNMENT

Recommendation

The Committee note with concern that rapid growth of population has serious implications on socio-economic development and preservation of the environment. The Country, in spite of five decades of concerted development efforts has found it difficult to provide adequate food and nutrition, housing, education, health care, employment and other basic amenities of life to millions of people. There is also serious pressure on the Country's natural resources causing deforestation, desertification, air and water pollution. Population stabilisation should therefore be a key factor in the Country's developmental programmes.

(Para No. 1.20)

Reply of Department of Family Welfare

Stabilizing population is an essential requirement for promoting sustainable development with more equitable distribution. Keeping this in view Govt. adopted National Population Policy 2000 (NPP-2000) in February 2000. This policy brought in an inter-sectoral agenda for holistic, integrated reproductive health care. It clarified the linkages between health determinants, on the one hand, such as the need for an enhanced package of services [equipped and fully trained mid-wives, technically sound facilities for neo-natal care, multiple sites for access to Counselling and contraceptives] and non-health determinants on the other hand, such as the age at marriage, education, employment, and registration of births, deaths and marriages.

The goals and objectives of the National Population Policy, 2000 aim at achieving family well - being through a multi-sectoral agenda that provides for an enhanced package of services whose delivery in the field must converge at community and household levels.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee regret to observe that desired results with regard to population stabilisation have not been achieved as per the demographic targets and objectives laid down in the National Health Policy, 1983. Population growth remains a formidable challenge even today, demanding consistent and concerted efforts to achieve population stabilisation. Crude birth rate which was to be brought down to 21 per thousand by 2000 is still at 26.1 per thousand in 1999. Similarly, the Maternal Mortality Rate stood at 4 per thousand in 1997 against the projected target of 2 per thousand by 2000 AD. It is a

matter of deep regret that 54 years after independence we have been unable to provide safe motherhood to our women. Experts have estimated that 70% of deaths due to pregnancy are entirely preventable. In one week in India, we loose more women to pregnancy related issues than all of Europe in a whole year.

(Para No. 1.21)

Reply of Department of Family Welfare

The National Health Policy(NHP), 1983 laid down certain demographic goals to be achieved by 2000. The achievements vis-a vis the goals are given in the following Table:

S. No.	Demographic	NHP-83 Indicator Goals	Achievements
1.	CBR	21	25.8 (SRS-2000)
2.	TFR	2.3	2.8 (NFHS-II)
3.	CPR	60%	48.6% (NFHS-II)
4.	MMR	400	407 (SRS 1998)
5.	IMR	<60	68 (NFHS-II)
6.	Immunisation	100%	56% (WHO/UNICEF2000)
	Measles		56%
	DPT		64%
	Polio		72%
	BCG		73%
7.	Ante-natal Care	100%	(NFHS-II)
	3ANC (%)		43.8%
	IFA (%)		47.5%
	2TT (%)		66.8%

8. Deliveries by Trained birth Attendants.	100%	42.3% (NFHS-II)

Note: NFHS-II was conducted during 1998-99

It is now well established that desired results with regard to family welfare programmes will be achieved only when child survival issues, maternal health issues and contraception issues are addressed simultaneously and effectively. This is because only when children are healthy and their longevity is assured, parents entertain ideas about limiting the family size, in turn the greatest assurance about survival and well being of children is the health of mother. There have been many Schemes in the Family Welfare programme keeping in view providing safe motherhood to women. The following initiatives relating to maternal health have been taken by the Department of Family Welfare during the last two years: -

Maternal Health

- Promoting 24 hour delivery service at Primary Health Centres (PHCs) and Community Health Centres (CHCs)
- Contractual appointment of additional ANMs
- Contractual appointment of Staff Nurses and Laboratory Technicians
- Providing referral transport to indigent families for obstetrics emergencies
- Training of traditional birth attendants
- Providing safe motherhood consultant in PHCs, CHCs and sub-district hospitals
- Providing private anesthetists for attending to emergency obstetric cases at First Referral Units (FRUs)
- Integrated financial envelop for providing flexibility to better performing states to enable them to design package of interventions to address problems of maternal health care
- Reproductive and Child Health Camps for improving access of services of specialists like gynecologists and pediatricians
- Development of cadre of nurse midwives in public and private sector

- Training programme for doctors for providing anesthesia
- In-service training of para-medical staff

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The National Family Welfare Programme which is more than five decades old, has however, not yielded the desired results in controlling population growth. Consequently the review and proper implementation of population programmes and strategies has assumed greater urgency.

(Para No. 1.22)

Reply of Department of Family Welfare

Apart from the mechanism developed in the Department for monitoring and evaluation for the family welfare programme as envisaged in the National Population Policy, 2000, a National Commission on Population has been constituted under the chairmanship of Hon'ble Prime Minister to monitor & review the proper implementation of National Population Policy and its strategies.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Northern States and Union Territories such as Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Haryana, Gujarat and Dadra & Nagar Haveli have high birth and death rates as also high infant mortality rates, low levels of literacy and lower age of marriages and low acceptance of family planning. The Committee feel that in these States, the multi-pronged approach of accelerating the pace of socio-economic development, minimizing the gender gap in literacy and health care and strengthening the quality and out-reach of family welfare services through an efficient delivery system is called for. The socio-economic development in these States need to be addressed urgently. Revised strategies and area specific plans of action which have the potential to work within the limitations existing in these States should be evolved. These States should receive priority for area specific projects, special support for morbidity, IEC and Training Programmes as well as for

encouraging and strengthening the State level NGOs. District and Block level differential programmes should be similarly drawn up by the States keeping in view their special requirements.

(Para No. 1.23)

Reply of Department of Family Welfare

To enhance and accelerate performance in states with currently below average socio-demographic indices, an Empowered Action Group (EAG) has been constituted in the Ministry of Health and Family Welfare for preparation of area specific programmes with special emphasis on states that are lagging behind. A detailed database for eight states i.e. MP, UP, Bihar, Rajasthan, Orissa, Chhattisgarh, Uttaranchal and Jharkhand has been compiled by the Department of Family Welfare to help guide the assessment of community needs. This will direct a more rational allocation of resources in terms of reproductive health care products, services as well as public – NGO – private partnerships. Additionally, a Core Group on Behavioral Change Strategies for the EAG states has been constituted in October 2001 to develop state specific strategies that will accelerate changes in health seeking behaviour, and focus upon capacity development at sub-district levels, with community service providers and opinion leaders.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

Though the Maternal Mortality Rate (MMR) has come down from 437 in 1992-93 to 408 in 1997 per 100,000 live births it is still incredibly high when compared to current Indices in other Asian Countries. Similarly though the Infant Mortality Rate (IMR) has decreased from 146 per 1000 births in 1951 to 72 per 1000 births (1997), it is still very high.

(Para No. 1.24)

Reply of Department of Family Welfare

The intiatives taken in this regard during the last two years are briefly mentioned below:

Maternal Health

- **Promoting 24 hour delivery service at Primary Health Centres (PHCs) and Community Health Centres (CHCs)**
- **Contractual appointment of additional ANMs**
- **Contractual appointment of Staff Nurses and Laboratory Technicians**
- **Providing referral transport to indigent families for obstetrics emergencies**
- **Training of traditional birth attendants (dais)**
- **Providing safe motherhood consultant in PHCs, CHCs and sub-district hospitals**
- **Providing private anesthetists for attending to emergency obstetric cases at First Referral Units (FRUs)**
- **Integrated financial envelop for providing flexibility to better performing states to enable them to design package of interventions to address problems of maternal health care**
- **Reproductive and Child Health Camps for improving access of services of specialists like gynecologists and pediatricians**
- **Development of cadre of nurse midwives in public and private sector**
- **Training programme for doctors for providing anaesthesia**
- **In-service training of para-medical staff**

2. Child Health

- Immunisation strengthening activities
- Operationalisation of district new born care
- Home based neo-natal care
- RCH outreach services for remote and comparatively weaker districts and urban slums
- Border district cluster strategy
- Integrated management of child illness
- Introduction of Hepatitis-B Vaccine to infants along with primary doses of DPT vaccine
- Development of a cadre of community based mid-wives
- Setting up of adolescent health clinics

Eradication of polio by 2004.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

In this connection the Committee note that a 'National Population Policy', 2000 has been evolved and adopted by the Government, the immediate objective of which is to address the unmet needs of contraceptive, health infrastructure, health

personnel and provision of integrated service delivery for basic reproductive and child health care. The medium term objective is to bring the total fertility rate to replacement level by 2010 through vigorous implementation of sectoral operational strategies and its long-term objective is to achieve a stable population by 2045. It has to be emphasised that concentration on merely bringing down total fertility rates does not lead to an automatic reduction in poverty. Unless simultaneous investments are made in the social sectors – education and health desired results would not be achieved. The National Population Policy, 2000 needs to be implemented by the Government on a war footing by taking prompt and appropriate measures in consultation and coordination with State Governments, NGOs, Self Help Groups and the active involvement of village panchayats. The Committee cannot but emphasize the need for regular assessment, evaluation and monitoring of the performance of family welfare programmes. It is important to monitor and periodically review the success of the efforts made and the results achieved. The programme should be adequately funded in view of its critical importance to national development. Priority in allocation of funds should be given for improving the health care infrastructure, preventive and promotive services such as ante natal and postnatal care for women, immunisation of children and contraception. Planning Commission should consider the allocation of more funds to States that are lagging behind for population stabilisation activities, so that funds constraints do not in any way retard the implementation of programmes. The Committee would like to be informed of the precise steps taken in pursuance of this policy.

(Para No. 1.25)

Reply of Department of Family Welfare

Population Stabilisation is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe deinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communication.

The following major instruments have been set up to oversee the implementation of NPP 2000:

1. National Commission on Population The National Commission on Population (NCP) was constituted on 11th May 2000 under the chairmanship of Hon'ble Prime Minister of India and Deputy Chairman, Planning Commission as Vice Chairman. Its duties and functions are:

(i) To review, monitor and give directions for the implementation of the National Population Policy with a view to meeting the goals set out in the Policy.

(ii) To promote synergy between demographic, educational, environmental and developmental programmes so as to hasten population stabilization.

(iii) To promote inter-sectoral coordination in planning and implementation across government agencies of the Central and State Governments, to involve the civil society and the private sector and to explore the possibilities of international cooperation in support of the goals set out in the Policy.

(iv) To facilitate the development of a vigorous people's movement in support of this national effort.

The first meeting of the Commission was held on 22.7.2000.

2. Empowered Action Group (EAG) was constituted in the Department of Family Welfare, Ministry of Health and Family Welfare on 20th March 2001 with the Minister of Health and Family Welfare in the chair. The Empowered Action Group (EAG) will focus attention on states, regions and districts, which have remained under-served, and are deficient in the achievement of national socio-demographic goals. The EAG will facilitate the preparation of area specific programmes to address the unmet need for supplies, services, health care providers and health infra-structure not only in the 8 States identified as defined in health indicators (UP, MP, Bihar, Rajasthan, Orissa, Uttaranchal, Chhattisgarh and Jharkhand) but also for instance, in the North East and in Jammu and Kashmir, as well as in other certain identified pockets in other states. The first meeting of the EAG was held on 18th June 2001. The second meeting was held on 13th December 2001.

As regards funding the population stabilisation programme it may be mentioned that the budgetary provisions for the Annual Plans has been increasing every year, as may be

seen from the following Table, yet the allocations have not been found to be adequate to meet the existing cost of maintenance of infrastructure.

Annual Plan-Year	**B.E.(Outlay)**Rs.in Crore
1997-98	1829.35
1998-99	2253.00
1999-2000	2920.00
2000-2001	3520.00
2001-2002	4210.00
2002-2003	4930.00

The tenth Plan outlay has been fixed at Rs.27000 Cr. As compared to Rs.15120 Cr. In the ninth PlanIt is expected that the enhanced allocation will meet the requirements to larg extent for the strategies as enumerated in the NPP-2000.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Committee are of the opinion that there is a growing awareness in the Country that population stabilisation is among the most critical issues. But measures for improving the health and nutrition status of women and children should be the priority of the Government in the immediate future. It is to be noted that child survival rates are directly linked to the falling birth rate. Anaemia, Urinary Tract Infections, malnutrition, repeated childbirths, adolescent marriages and overwork take the toll of women's lives. But their health and nutritional needs receive little focus. All health care programmes for women are tailored for pregnant and nursing mothers or achieving population

stabilization. This approach needs to be changed and women's holistic health care emphasised. It must be recognized that women's health is important in itself, not just her reproductive health. Special efforts need to be made to empower women so that she, along with her partner can choose how many children they should have and how they should be spaced.

(Para No. 1.26)

Reply of Department of Family Welfare

The following steps have been taken by Government for increasing awareness about various population stabilisation strategies and Reproductive and Child Health (RCH) Programme by vigorous publicity efforts:

An intensive campaign has been launched to create knowledge on family planning methods and techniques through electronic and print media.

The healthy mother-healthy child messages are broadcast from AIR in the form of audio jingle spots before the Morning and Evening National news. Before and after Regional News one spot on No Scalpel Vasectomy is broadcast in the afternoon.

36 kendras of All India Radio have been asked to broadcast the messages of Reproductive and Child Health. Video spots on Reproductive and Child Health (R.C.H.) are being telecast before the national news at 8.00 p.m. also a 30 minute based programme "Lok Jhankar" is broadcast on every Thursday and Sunday through 22 Vividh Bharti Kendras of AIR.

Films on Reproductive & Child Health have been made by eminent producers to improve mass awareness on family welfare programme. Regular articles on RCH themes are being published in in-house publications- 'Hamara Ghar' in Hindi and 'Reproductive & Child Health Newsletter' in English.

The media units viz. Directorate of Audio Visual Publicity, Song & Drama Division and Directorate of Field Publicity are also carrying out publicity on Reproductive and

Child Health (RCH) themes through exhibitions, theatre plays, seminars/workshops and video programmes.

Parivar Kalyan and Swasthya Melas are also being organised in different States to increase awareness and provide medical services to the people at their doorsteps.

Further Reply of Department

Services provided in the Outreach session include:

Beneficiaries	Services to be provided
Pregnant Women	**Early Registration of Pregnancies, ANC, Tetanus Toxiod, Tab. IFA (Large), PNC, Referral for women with complications of pregnancy and those needing emergency care. Counselling on place of delivery, complications of pregnancy, breastfeeding and care of newborn.**
Infants upto 1 year	**Complete immunisation for 6 VPDs and Give 1st dose of Vitamin A.**
Children 1-3 years	**Booster dose of DPT/OPV, 2nd to 5th dose of Vitamin A. Tab IFA (small) to children with clinical aneamia.**
All Children below 5 years	**Case management of those suffering from diarrhea and pneumonia, providing counselling to all mothers on home management and when and where to refer and organising ORS depot at the session site village.**
for Women 15-45 years	**Counselling on birth spacing as a health measure, information on use of contraceptives and availability of contraception and MTP services**

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

However, it is a matter of deep concern that in spite of the fact that the National Policy on Population speaks of a target free approach and has eschewed disincentives as part of the population programme, a number of States have already put into place disincentives which

threaten to impact on the poorer sections of the society and will add to their sufferings. Whilst recognizing the urgent need for population stabilisation, the Committee feel this should be done in a gender just manner without violating the rights of the least privileged sections of our society.

(Para No. 1.27)

Reply of Department of Family Welfare

All the States/UT Governments have been advised by Central Government to follow the general approach of the National Population Policy about voluntariness, freedom of choice and target free approach, while formulating their State Policies. Since the National Policy does not provide for any co-ercive measures, the States also have been advised to avoid it. Various initiatives undertaken under Maternal Health programmes in pursuance of NPP,2000 are being certainly carried out in a gender just manner without violating the rights of the least privileged section of the society.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Committee note that control of infectious diseases like Malaria, TB, Leprosy and AIDS continue to be an area of major concern in the health sector. With the decline in death rate and increase in life expectancy, epidemiological transition is underway, resulting in increase in non-communicable diseases like Cardio Vascular ailments, cancer, cataract, blindness, diabetes etc. The increasing population and abject poverty has created further complications. Government therefore, should strive to achieve better health care through a variety of measures including the implementation of several national programmes, upgradation and modernisation of the health infrastructure and augmentation of medical personnel particularly in rural and semi-urban areas.

(Para No. 2.25)

Reply of Department of Health

Keeping in view, the demographic and epidemiological changes underway, National Health Policy, 1983 is presently under revision. The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country with overriding importance being given to ensuring a more equitable access to health services across the social and geographical expose of the country. Specifically, schemes relating to supply of medicines to primary health and centres and augmentation of urban health infrastructure have been introduced as 'New Initiatives' during the Tenth Plan.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee find that there has been a steady increase of budget allocation from Rs. 897.34 crores in the Seventh Plan to Rs. 5118.19 crores in the Ninth Plan. Further, the Government also receives external assistance from various bilateral and multilateral agencies in implementing the National Programmes. The Committee agree that massive health investment is required for creating awareness and sensitising the masses to various health programmes as well as to the importance of the preventive aspect of health care. The Committee, therefore, recommend that the Planning Commission and Ministry of Finance step up the budget allocation for health services. The Government should also ensure that the existing infrastructure is fully operationalised so that it could be put to use. Close and constant cooperation of the State Governments, NGOs, Self Help Groups, Voluntary Organisations as well as Panchayati Raj Institutions would go a long way in achieving the optimum utilisation of the facilities.

(Para No. 2.26)

Reply of Department of Health

According to the Draft National Health Policy, 2002, emphasis would be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government. Against this backdrop, every effort is being made to ensure that adequate funds are made available not only at the Central level but also at the State level within the existing financial constraints. During the annual plan discussions, all the States are requested to ensure that they provide optimum outlays for health sector especially for primary health care. Efforts to ensure operationalisation of the existing infrastructure are continuously being made. Involvement of NGOs and Panchayati Raj Institutions is being encouraged. Assistance of NGOs/Voluntary Organisations working with women groups is being mobilized for implementing community intervention programmes especially in the case of HIV/AIDS, Blindness and Leprosy. Certain NGOs selected by State Governments are provided free drugs and also given grant-in-aid for operational expenses. The NGOs are expected to help identify affected persons and motivate and counsel them for early treatment and follow-up. Involvement of Panchayats for providing training, access to health care services is being explored. In Kerala, State Government has devolved 30 to 40% of its State budget to Panchayats. Under different programmes, training and sensitizing Panchayat leaders to

create awareness and increasingly involve their cooperation which is crucial for the success of any disease control programme, is being undertaken.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

It is a matter of deep concern that while the Government complains about the shortage of funds, the allocations for National Anti Malaria Programme and National TB Control Programme were not fully utilized in 1996-97, 1997-98, 1998-99 and 1999-2000. The Committee take a serious note of this lapse of the Department which only points to improper and faulty planning and implementation of the programmes.

(Para No. 2.29)

Reply of Department of Health

There has been some shortfall in plan expenditure during the initial years of the Ninth Plan for specific reasons. In the case of National Anti-Malaria Programme and the National TB Control Programme, the procurement could not be undertaken as envisaged because of various factors including non-finalisation of the procurement agencies as well as drug supply orders. In the early part of the plan period, the expenditure took sometime to build up as the modalities for implementation of new projects had to be finalised. However, with the passage of time the trend of expenditure has improved significantly.
[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee have noted that important issues related to women's empowerment include awareness about women's rights, proper education, legal literacy, adequacy of health facilities and services for them. Studies have shown that women and adolescent girls have a very limited knowledge of their own body and biological processes and needs. The Department should, therefore, make concerted efforts to involve both women and adolescent girls in various programmes and enhance their understanding and awareness towards various issues. The Committee should be apprised about the various initiatives taken/to be taken by the Department to address the problems of adolescent girls . The Department should also consider the feasibility of making Sex Education part of school curriculum as well as of the Adult Education programmes.

(Para No. 2.30)

Reply of Department of Health

Department of Health has developed a training guide for trainees/teachers, designed to equip them with the required technical knowledge on major areas of

adolescent health. Training programmes are also organised for teachers/trainers on issues related to adolescent health.

Further, the NACP-II and the Draft National AIDS, Policy recognised the need for women's empowerment, proper education and access to health facilities for women as an important aspect for the prevention and control of HIV/AIDS in the country. NACO has designed special IEC materials focusing towards adolescent girls and women in the reproductive age group. These materials are used for training of peer educators for the ICDS programme being implemented by D/o Women and Child Development. These concerns are also being integrated in the School Education Programme which is being taken up as an extracurricular activity to cover all schools in the country in a phased manner during the next five years.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee are of the opinion that proper implementation of various preventive programmes/schemes is of paramount importance if communicable and non-communicable diseases are to be effectively tackled and eradicated. The need for a surveillance mechanism in the country for detecting early signs of outbreaks of communicable diseases and the effective use of a rapid response system to arrest the spread of the same, cannot be overemphasised. Further, periodical evaluation is needed to ensure that there is an even progress of the programmes in different states and the Target States/Regions are dealt with accordingly. Special efforts also need to be made to work out and design interventions to help women get better access to the inputs being provided by the Government. The Committee are of the view that effective monitoring of all the activities with an element of random inspections/surveys is very essential for making the programmes a real success.

(Para No. 2.31)

Reply of Department of Health

All the major disease control programmes of Malaria, TB, Blindness, Leprosy and AIDS implemented by the Government have developed monitoring and evaluation tools to assess the progress in achieving the objectives. In addition to regular monitoring of the programme through Management Information System, there is also an inbuilt mechanism for evaluation of the programme by an independent agency. State level reviews and random visits to districts, is also carried out periodically as a part of monitoring activities. For early detection of disease, the disease surveillance programme is presently under operation in 80 Districts of the country. During Tenth Plan it is

proposed to extend the disease surveillance programme to the entire country. Data is being collected and analysed gender-wise to know the morbidity and mortality pattern due to epidemic prone communicable diseases.

Various policy recommendations contained in the Draft Health Policy-2002 with regard to the expansion of primary health sector infrastructure will also facilitate the increased access of women to basic health care.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The problem of Urinary Tract Infections, which is correlated to the health of women and which often go unnoticed and undetected, also needs to be looked into. UTI awareness Campaigns are necessary to make both men and women aware that the UTI infection could affect their child, spread to the sexual partner and make people vulnerable to Hepatitis B besides the STDs. It also predisposes cervix cancer. One important step that could be taken in this regard is to ensure the easy availability and affordability of condoms especially to the target couples.

(Para No. 2.33)

Reply of Department of Health

The Central Government hospitals are providing the tertiary level care to the patients presenting with UTI. The awareness and educational campaigns are carried out under the RCH programme. The prevalence of UTIs and STDs increases the risk of HIV infection. Keeping thisin mind NACO conducts the Family Health Awareness Campaign at least once a year to create greater awareness for proper care and treatment of STDs. The FHAC, which is conducted nationwide reaches out to the rural population through the Primary Health Care system. The response of women has been overwhelming through the FHAC.

Under the NACP, district level hospitals are provided drugs and consumables for management of RTI/STI. Easy availability and affordability of condoms is being promoted through free distribution and social marketing schemes of condoms by the Department of Family Welfare as well as National AIDS Control Organisation.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The increasing HIV prevalence amongst women has increased the risk of mother to child transmission of the HIV virus. The Committee find that government is considering to start feasibility study projects in some selected hospitals of the country where HIV infection in pregnant mothers is reported to be high viz Tamil Nadu, Maharashtra, Hyderabad, Bangalore and Manipur. The Committee would like to be informed as to whether such study projects have started and if so what the initial results of such projects are. The Committee would also like to reiterate that suitable facilities must be created/enhanced for HIV patients, by way of treatment and rehabilitation.

(Para No. 2.34)

Reply of Department of Health

Feasibility study project on PMTCT was started in 11 institutions in 5 high HIV prevalence States in the country, namely Tamil Nadu (3), Maharashtra (5), Karnataka (1), Andhra Pradesh (1) and Manipur (1). In this feasibility study HIV positive pregnant mothers were offerred Zidovudine (antiretroviral drug) from 36th week of gestation and during labour in the centres. The results of the study were quite promising. About 90% of mothers were counselled and out of that 60% accepted HIV est while 40-50% accepted AZT Tablets. The overall transmission efficacy at two months age of infant was about 10%.

Government provides treatment for opportunistic infections in HIV/AIDS patients in all public sector hospitals. Care and support for people living with HIV/AIDS has been undertaken in the National AIDS Control Programme. Community care centres have been established through NGOs to provide low cost and effective care at a community level to those who are infected and their families. In these projects emphasis is given to social and economic rehabilitation of HIV positive persons and their families.

Further Reply of Department

Pregnant mothers detected HIV positive during antenatal check-up under the prevention of mother to child transmission programme are counselled to come for follow-up of infants as well as themselves. However, it has been observed that most of the mothers drop out after making 1-2 visits.

At present, Government has made provisions for treatment of opportunistic infections free of cost in public sector hospitals to people living with HIV/AIDS including mothers who are HIV positive.

Besides provision of care facilities in public sector hospitals, community care centres have been established for care & support to people living with HIV/AIDS. These centres are managed by the NGOs. Drugs for opportunistic infection have been made available for management of HIV/AIDS patients in public sector hospitals.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee feel that the prevalent situation is largely due to the adoption of health development policies and establishment of curative centres, based on the models which are irrelevant to the real needs of our people and the socio-economic conditions prevalent in the country. This approach towards medical services has provided benefits essentially to those residing in the urban areas. The Committee are of the view that health schemes should be extended from district to the block level, like it has been done in some States.

(Para No. 2.35)

Reply of Department of Health

Substantial investment has been made in establishing a comprehensive network of rural health infrastructure for providing preventive, promotive and curative health care in rural areas and all efforts are being made to till the gaps, wherever present. Most of the disease control programmes like TB, Leprosy, Malaria are already being implemented through the primary health care infrastructure. From district level hospital to lowest level sub-centres, are involved in providing necessary medical services for control of such diseases. In the case of Malaria, community is also involved through durg distribution centres/fever treatment depots, particularlyl in difficult inaccessible and hardcore rural areas. In Blindness Control Programme, primary health centres are upgraded by posting an opthalmic Assistant, cataract surgery units are developed at sub-district level, eye camps are organised in rural areas and rural blind people are identified through the Village Blind Registry System. The design of AIDS Control Programme is also largely decentralised with greater emphasis to deliver all health services through the State AIDS Control Societies. While no separate infrastructure has been established for the HIV/AIDS Control Programme at the district level, the existing public health care system has been strengthened for improved delivery of services. This includes capacity building and regular training of health care providers at all levels.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

It is noticed that health melas are generally organised by the Government in urban areas and big cities where adequate medical facilities already exist. Since 80 per cent of our women reside in rural areas, the Committee feel that the Government should organise more of these melas in rural and semi-urban areas, so that maximum number of rural women could get the benefit of such melas.

(Para No. 2.36)

Reply of Department of Health

Health Melas has so far been held in 2001-02 at Sultan(UP), Gazipur (UP) and Najafgarh (Delhi). Some of the other places where such melas are likely to be held during the year are Tehsi-Baldev, District Mathura, Gonda, Meerut, Moradabad, Allahabad, Faizabad, Agra, Pilipheet, Deoria and Balia in UP, Sehore and Devas in Madhya Pradesh, Srinagar (Pauri Garhwal) in Uttranchal, Rajinnandgaon in Chattisgarh, Koraput and Bhadrak in Orissa, Rabongla and Gangtok (Sikkim), Imphal in Manipur, Uri, Leh, Tangdhar and Reasi (Udhanpur) in J&K, Indraprastha Nagar in Bhuj Tehsil of Kutch District in Gujarat, Chamba in Himachal Pradesh, Muzafarpur, Jehanabad and Katihar in Bihar and in Jhajjar district of Haryana which have predominantly rural population.

Further, Governments of all the States/UTs have been advised to consider holding of Parivar Kalyan Avam Swasthya Melas in the rural and semi urban areas keeping in view the above recommendations of the Committtee.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Department has admitted that various Disease Control Programmes are being implemented throughout the Country as National Programmes for the population as a whole, without any specific allocation for women. Certain areas of women's health may, however, require specific interventions especially those disabilities and morbidities which are very gender specific such as cervical and breast cancer. The main constraints are stated to be inadequate funding and

inadequate development of gender perspective in programme formulation. The Committee feel that apart from properly implementing the various health schemes taken up the Department of Health (of which the women will also be beneficiaries) a separate allocation for women in the annual plan would go a long way in launching specific interventions specially required for women.

(Para No. 2.37)

Reply of Department of Health

Separate allocation for women in National Disease Control Programmes implemented by Department of Health such as for control of Malaria, TB, Blindness, Leprosy and AIDs is not practical as all these diseases are gender neutral. The various Policy initiatives contained in the Draft Policy in regard to the expansion of primary health sector infrastructure will also facilitate the increased access of women to basic health care. In the case of cancer, women patients are equal beneficiaries at all centres having teletherapy facilities as well as Regional Cancer Centres. Modified District Cancer Control Programme has been initiated which is specifically targetted for women in 60 blocks in the four States. The target group for this programme is 20-65 years. The release of a postage stamps on 7th November, 2001 depicting a woman carrying out 'self breast examination' is an example of Government's sincerity regarding women related cancers.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee note that the Department of Health proposes to provide a special section on women's health needs in the National Health Policy which is under preparation. The Committee would like to be informed as to when the proposed policy paper on women's health would be ready and also about the steps taken/to be taken to implement the proposals contained therein.

(Para No. 2.38)

Reply of Department of Health

The draft National Health Policy has been released by the Government for comments. The comments received are being examined and presently the draft policy is under finalisation. Thereafter, this Policy will be placed before the Cabinet for aplproval. Regarding women's health, the draft policy envisages the identification of specific programmes targeted at women's health. The policy notes that women, along with other under privileged groups are significantly handicapped due to a disproportionately low access to health care. The various policy recommendations of NHP-2002 commits the highest priority of the Central Government to the funding of the identified programmes relating to women's health.

Recommendation

In order to achieve a proper health profile of women, it is necessary to have their problems, deficiencies identified at the school going age. For this, regular health check ups of school going girls should be conducted and health cards maintained, with deficiencies if any, identified and treated at the initial stage.

(Para No. 2.39)

Reply of Department of Health

The Draft Health Policy envisages priority to school health programmes aiming at preventive health education, regular health check-ups and promotion of health seeking behaviour among children. School health programme in PHCs is being undertaken by the State Governments. Certain specific initiatives are also being taken in the implementation of various disease control programmes. School eye screening programme for detecting and correctiion of refractive errors is an important activitiy under the National Programme for Control of Blindness and is being continued by each District Blindness Control Society. Under NACO, School AIDS education programme is being implemented in a phased manner to cover all higher secondary schools in collaboration with NGOs and Department of Education. The main objective of such a programme is to provide scientific knowledge to school going girls about the various milestones in physical and mental development and reproductive health issues. Health check-up and maintenance of health cards in the school is done by State Governments. However, Central Health and Education Bureau, proposes to organise a training programme on health check-up and maintenance of health cards.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee note that the National Council for Applied Economic Research (NCAER) is currently analysing data available to identify common causes of morbidity in urban areas with special focus on low income groups including slum dwellers. This study will also cover an analysis of information on expenditures being incurred on women's health. The Committee would like to be informed as to whether NCAER has completed its study and, if so, what are its findings and what action government propose to take thereon.

(Para No. 2.40)

Reply of Department of Health

Findings of the NCAER survey conducted in the slums and resettlement colonies of Delhi and Chennai covering 1000 households in each city showed that morbidity rates for females were higher than for males. The percentage of illness episodes for which no treatment was sought worked out to be higher for females as compared to males. 'Illness not considered serious' turned out to be main reason for not seeking treatment for both males and females though compared to males financial constraint appeared to be more important for females. In nearly 48% of illness episodes treatment was sought from public health sources and survey did not reveal any sex differential in the source of treatment. Survey did not show any gender bias in the amount of expenditure incurred on treatment. Findings of the survey have been noted. Government is aware of the disproportionately low access to health care by women. Draft NHP-2002 also addresses this issue. During the tenth plan a scheme on urban health has been introduced for setting up an organised urban primary health care structure, especially, for the benefit of urban poor. IEC activities undertaken under different disease control programmes, are being intensified not only to increase awareness but also to change the behavioral style, especially in case of HIV/AIDS.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

Since the vast majority of women live in rural areas, where there are hardly any medical facilities available, women become victims of various diseases due to mal-nutrition, lack of clean and safe drinking water, unhygienic conditions etc. The Government ought to integrate various programmes and take a holistic approach to immunization, nutrition, health care, drinking water, cleanliness, health infrastructure, trained personnel etc. so as to improve the health of the rural women. As 33 per cent women are now in panchayats and other local bodies they can be utilized for improving the condition of women all over the country. The Committee desire that the Government should coordinate with various concerned Departments in this regard to draw up appropriate programmes and schemes along these lines.

(Para No. 2.41)

Reply of Department of Health

Government recognises the need for coordinated approach and the synergetic effect of different Departments such as Nutrition, Sanitation, Drinking Water, Immunization etc. Involvement of PRIs in health care is also well recognised and the various disease control programmes are making increasing efforts towards involving such institutions, especially in IEC activities, to improve health awareness. The draft National Health Policy, 2002 has also adequately addressed these issues

Further Reply of Department

The National Health Policy, 2002 (NHP-2002) envisages that the independently stated policies and programmes of the environment related sectors be smoothly interfaced with the policies and the programmes of the health sector. Implementation strategy of NHP-2002 is under preparation.

Under the Programme for Control of Blindness, Panchayat Raj Institutions and Community leaders are involved in organising eye care and services including conducting blind registry and organising eye camps.

Under National Leprosy Eradication Programme, for improving case finding in general and identifying female patients in particular, efforts are being made to involve women's groups, school students, suitable NGOs and other such agencies including PRIs. District Leprosy Officers have been directed to actively involve Anganwadi workers, mahila mandals, women self-groups, Girl guides, ANMs and Traditional Birth Attendants (Dais) who are in regular contact with the community for Leprosy.

National TB Control Programme is implemented by District TB Societies which have members from Panchayat Samities/Zila Parishads of the concerned districts.

Under National AIDS Control Programme, the members of Panchayat are involved in "Family Welfare awareness campaign" being organised under the Programme. State AIDS Control Societies are organising sensitisation workshops for the members of the Panchayati Raj Institutions in order to seek their support in advocacy social mobilisation and dissemination of correct information about HIV/AIDS.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee would like the Government to pay immediate attention to the vital aspect providing health services and take early action to open more Hospitals in rural and semi-urban areas, making it compulsory for all doctors to serve in rural areas for a specified period and ensuring that sufficient numbers of lady doctors posted there.

(Para No. 2.43)

Reply of Department of Health

The States/UTs are regularly being advised to fill up the existing gaps in primary health care infrastructure. Specific targets have been given to establish primary health centres, community health centres and sub-centres during the Ninth Five Year Plan. There is shortage of doctors in some of the primary and community centres in rural areas. The Central Council of Health and Family Welfare (CCH&FW) in its Sixth Congerence requested the States to consider reserving a minimum 25% of post-graduate seats for in-service medical officers who have put in minimum three yeas of rural service with a bond that they will serve Government for a minmum period of five years. The Ministry regularly reviews the position and urges the State Government to take all possible steps to fill up the vacnaies including those of lady doctors. A copy of the recommendations of this committee has been sent to all the States for taking appropriate action. Some State Governments like Maharashtra and Tamil Nadu have made rural service compulsory before admission to post graduate courses whereas in Gujarat rural/tribal area service is mandatory after PG course.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee in the aforesaid paragraph desire that issues relating to pre-menarchial period, during reproductive age group and issues relating to pre, peri and post menopausal period should be taken care of by the Government. Not only the problems relating to obstetric and gynecological aspects but other medical disorders pertaining to old age should also be addressed. The measures taken/proposed to be taken in this regard should be intimated to the Committee.

(Para No. 2.44)

Reply of Department of Health

Tertiary level care is available in the central Government hospitals for the problems related to pre-menarchial period, during reproductive age group and issues relating to pre, peri and post menopausal period. The RCH Programme also covers a number of these issues. Geriatric Programme (Old age health programme) is being contemplated in the 10th five year plan. Efforts are also being made to sensitise doctors about the problems and needs of the elderlyl in medical colleges, district hosptials, CHCs, PHCs etc.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The Committee note that women with depression and mental health problems have not been adequately targetted under the various health programmes of the Ministry of Health and Family Welfare, though the Department of Health has taken up a District Mental Health Programme consisting of training of mental health workers, public education in mental health, increased awareness to reduce stigma and provision of services both at OPD and indoor level for early detection and treatment. The Committee would like this programme to be suitably strengthened and to be informed as to how far this programme caters to the needs of women in need.

(Para No.2.45)

Reply of Department of Health

National Mental Health programme has been refocused/reoriented in the light of the experience gained and it is now proposed to extend it to 101 districts across the country. The District Mental Health Programme is designed to provide basic mental health services at the primary car level with special attention vbeing focused on the metal health care needs of vulnerable sections of the society, including women, children and the elderly. As such there is no separate or specific programme for women but they are equal beneficiaries from the existing programme. There is a proposal to substantiallly increase the financial outlay for this programme during the 10th plan. The Draft policy also envisages upgrading the physical infrastructure of institutions providing indoor treatment

to patients at Central Government expenses so as to secure the human rights of this vulnerable segment of the society.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

India remains a country of striking demographic diversity. There are substantial differences between States in the achievement of socio-demographic indices. It is significant that while nine States and Union Territories have achieved net replacement levels, twelve States and Union Territories have a total fertility rate of more than 2.1 but less than 3.0 and 11 States and Union Territories have a total fertility rate of over 3.0. The inter-state differences stem largely from poverty, illiteracy and inadequate access to health and family welfare services, which co-exist and reinforce each other. The Sample Registration Survey conducted by the Registrar General of India reveals that 8 states have higher percentage of girls marrying below 18 years of age, 5 states in which the pregnant women had not undertaken a minimum of 3 ante-natal check-ups and 6 States where safe deliveries are not being conducted.

(Para No. 3.43)

Reply of Department of Family Welfare

Observations are of a factual nature. No comments are needed.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee desire that the performance in the implementation of Family Welfare Programmes in the demographically weak States should be reviewed on a periodical basis with a view to taking remedial measures in consultation and coordination with the concerned State Governments. The Department of Family Welfare in consultation and coordination with the State Governments should immediately take necessary steps to remove the deficiencies in the programme.

(Para No. 3.44)

Reply of Department of Family Welfare

Initiatives undertaken after adoption of NPP 2000 in this regard gives focused attention to the demographic weaker states as may be seen from reply to para 1.25 above.

Recommendation

One of the major goals of the Department of Family Welfare is in the reduction of maternal mortality and morbidity. The maternal mortality rate of India is 408 per 1,00,000 live births, which was projected to be brought down to 200 per 1,00,000 in 2000. The trend in this regard has not changed significantly in the last five years. This is mainly due to the large number of deliveries being conducted at home and by untrained persons. In addition, lack of adequate referral facilities to provide emergency obstetric care for complicated cases also contributes to high maternal mortality and morbidity. Major causes of maternal death are ante and postpartum hemorrhage, anaemia, toxemia, abortions and sepsis. A large number of these causes are preventable through improved maternal care. Promoting safer institutional deliveries and ensuring appropriate treatment of complications can substantially reduce the fatality rate.

(Para No. 3.45)

Reply of Department of Family Welfare

Steps taken in this regard are incorporated in reply to para 1.21.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee is of the opinion that Maternal mortality is affected by a whole range of socio-economic determinants. Thus, besides improving the maternal health care services, it is necessary to improve the social status of women, including the literacy rate, to reduce the current level of MMR

(Para No. 3.46)

Recommendation

There are some problems of women like anemia, mal-nutrition and problems relating to menstrual cycle etc. which are prevalent in the reproductive age group including the adolescent girl. The women silently suffer these problems due to ignorance, the lack of medical facilities and attention by the concerned authorities. It is high time that the Department of Family Welfare takes note of these problems and takes suitable and remedial steps to identity these women and provide the necessary medical facilities in consultation and coordination with the State Governments and local NGOs.

(Para No. 3.47)

Reply of Department of Family Welfare

Nutrition Anaemia is one of the major public health problem in India. Although anaemia is widely spread in the country, it affects the reproductive age group and young children more. It is estimated that over 50% of pregnant women are anaemic. It is one of the commonest complications of pregnancy. Under the RCH programme efforts are being made to improve coverage, quality as well as the efficiency of the National Nutritional Anaemia Control Programme. The current RCH programme focuses on the provision of Iron and folate supplements in the form of tablets to high-risk group, for prevention as well as treatment of severe anaemia and also identification and treatment of severely anemic cases. Kit A which also contains 15,000 Iron and Folic Acid (large) tablets for pregnant women and 13,000 small Iron and folic acid tablets for children are being supplied twice a year to all the sub-centres during 2000 - 2001.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply,Dated 4th April, 2002]

Recommendation

It is pertinent to note that a vicious relationship exists between high birth rates and high infant mortality, contributing to the desire for more children. The highest priority must, therefore, be given to launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of society. The Committee were informed that the Department has initiated a number of measures to sustain and strengthen interventions started under the Child Survival and Safe Motherhood (CSSM) Programme. The Committee are of the opinion that such programmes need to be decentralized to the maximum possible extent, their delivery

being at the primary level, nearest to the doorsteps of the beneficiaries. While efforts should continue at providing refresher training and orientation to the traditional birth attendants, schemes and programmes should be launched to ensure that progressively, all deliveries are conducted by competently trained persons, so that complicated cases receive timely and expert attention. It is important to strengthen, energise and make accountable health infrastructure at the village, sub centre and primary health centre levels, to improve facilities for referral transportation and to encourage and strengthen local initiatives for ambulance services at village and block levels.

(Para No. 3.48)

Reply of Department of Family Welfare

The RCH Outreach Scheme is being implemented to improve the delivery of maternal and child health services in remote areas and urban slums. Improvement in quality and coverage under the Universal Immunization Programme is one of the major objectives of this Scheme. Selected districts have been provided additional support for mobility of staff improvement in quality of services and generation of demand for services. During 2000-2001, the Scheme has been operationalised in 50 districts. The scheme has been expanded to cover 101 additional districts in 2001-2002.

Scheme for Strengthening of Newborn Care

Department of Family Welfare has initiated a project in collaboration with the National Neonatalogy Form (NNF) for operationalisation of newborn care facilities at the primary level. NNF will train medical and para medical personnel at the district and sub-district level health facilities where equipment for essential newborn care is being provided under the RCH Programme. In the current year this scheme has been initiated in 60 districts. It is proposed to expand the scheme over the next two to three years to cover all the weak districts.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

Child survival interventions i.e. universal immunisation, control of childhood diarrhoea with oral rehydration therapies, management of acute respiratory infections, and

massive doses of Vitamin A and food supplements should be provided to reduce infant and child mortality and morbidity and disabilities. With intensified efforts, the eradication of polio is within reach. However, the decline in standards, outreach and quality of routine immunisation is a matter of concern. Significant improvements need to be made in the quality and coverage of the routine immunisation programme. It is necessary to launch an organised, nation-wide immunisation programme, aimed at 100 per cent coverage of targeted population groups with vaccines against preventable and communicable diseases. Such an approach would not only prevent and reduce disease and disability, but also bring down the existing high infant and child mortality rate.

(Para No. 3.49)

Reply of Department of Family Welfare

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[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, Dated 4th April, 2002]

Recommendation

Time and again it has been emphasised that breast-feeding is vital to the health of the infants. Women need to be properly educated and made aware of the importance of breast-feeding through large-scale campaigns. Since a number of women now work in both the organised and unorganized sectors the government should ensure that

maternity leave which has been recently extended, is made uniform in all the States so that the benefits of the extended leave is given to all the women

(Para No. 3.50)

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

Despite five decades of concerted efforts by the Government under the Contraception Programme, desired results have not been achieved in lowering the fertility level in the country. About 44% of the eligible couples in the reproductive age group (15-44 years) are currently protected against conception by one or the other approved family planning methods as of 31st March, 1999. This falls far short of the target laid down in

the National Health Policy, which targets 60% of effective couple protection by the year 2000.

(Para No. 3.51)

Reply of Department of Family Welfare

As regards efforts towards women empowerment, following aspects of Supply and Social Marketing also lead to this objective as discussed below:-

- The Social Marketing Projects taken up in certain States namely Madhya Pradesh (five districts), Bihar, Orissa and Jharkhand (four districts each) and also in whole of Andhra Pradesh is another step forward towards this objective. Through this area specific endeavor, sale of condom, oral contraceptive pills, sanitary napkins and Oral Dehydration Salt is made in the rural areas. In Andhra Pradesh, even IUD has been included in the programme and the services are being provided through VINITA Clinics.
- The choice of selecting contraceptive has also been widened by adding Copper-T 380A as the same is being already undertaken by Social Marketing Organisations and also by including emergency contraceptives in the basket of contraception choices
- Another step taken in this direction is re-strengthening of social marketing endeavour so as to reach rural and semi-urban areas through public-private partnership which includes nearly 14 organisations comprising manufacturers, producers, industry and voluntary organizations. This is in fact to meet the requirement of those areas where Government system could not reach effectively. In addition, it takes care of those segment of society who want to pay for services as their social status is comparatively better

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

Abortion has been a matter of public health concern particularly because of sepses and other complications which lead to high maternal morbidity and mortality. The Committee note that the MTP Act, 1971 which came into force in 1972 enables women to opt out of an unwanted pregnancy, by an authorization from a registered Medical

Practitioner only in Government Hospitals and in places approved by the Government. Despite this, illegal abortions continue to be conducted by unqualified persons and in unauthorised places. The Committee would like to emphasise that the aim of the MTP Act was to reduce maternal mortality due to illegal and unsafe abortions. The Government should therefore expand and improve the MTP facilities and their utilisation under the RCH Programme so as to make safe abortion facilities accessible to all women in the country. Necessary assistance from the Government of India should be provided in the form of training, supply of adequate MTP equipment, and provision for engaging doctors trained in MTP to visit Primary Health Centres.

(Para No.3.55)

Reply of Department of Family Welfare

Under the RCH Programme the GOI is expanding and improving the MTP facilities and their utilization so as to make safe abortion facilities accessible to all women in the country. The assistance from the GOI is in the form of training, supply of MTP equipment and provision for engaging doctors trained in MTP to visit PHCs. Skilled based training in MTP technique has been imparted to 2281 doctors under the RCH Programme as on 9.10.2001. 180 sets of MTP equipment have been supplied to the Medical Store Depots in Mumbai, Calcutta, Hederabad, Chennai, Guwahati and Karnal for supply to the First Referral Units (FRUs) in the respective states as per requirement of the FRUs. Rs. 800 is being paid to the Safe Motherhood consultants per day visit for performing MTP and providing other maternal health services in the identified PHCs in 19 States.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, Dated 4th April, 2002]

Recommendation

The Committee has been informed that the MTP Act has been reviewed by the Ministry in consultation with the experts and three amendments are proposed to be made. One of these amendments proposed is that the decision to seek abortion should be available to a minor if she is married. The Committee are of the view that if a minor is married, that itself is against the law. Medical Termination of Pregnancy, especially in the present context, is more of an issue related to women's health rather than a social

issue. The Committee therefore insist that irrespective of whether a woman, in this case a 'minor', is married or not, she should have the right to a safe abortion. The Committee expects the Government to make the necessary amendments to the MTP Act keeping this in view.

(Para No. 3.56)
Reply of Department of Family Welfare

The current proposal for amendment in the MTP Act, 1971 does not include the issue of 'minor' either married or unmarried.

Further Reply of Department

The proposed amendments in the MTP Act, 1971 are as under:

i) No pregnancy can be terminated in a woman who has not attained the age of 18 years or is a lunatic except with the consent of her guardian. For this purpose lunatic has meaning assigned to it in Section 3 of Indian Lunacy Act, 1912. This Act has been replaced by the Mental Health Act, 1987. Therefore, the expression **lunatic** in the present Act is sought to be changed with the words **mentally ill person** as provided under the Mental Health Act, 1987. It means a person who is in need of treatment by reason of a mental disorder other than mental retardation.

The proposed amendment to Section 4 (a) & (b) seeks to delegate the powers for approval of places as MTP Centres from the States to the District level through a Committee headed by Chief Medical Officer/District Health Officer and comprising three to five members which will include the District Gynaecologist/Surgeon and other members drawn from the medical profession non-governmental organisation and Panchayati Raj institutions.

ii) One of the weaknesses of the MTP Act, 1971 has been that it does not prescribe specific punishment for abortions conducted illegally by untrained persons and in hospitals and clinics not approved by the Government. The 1971 Act only

reiterates that all the offences under the Act are punishable under the appropriate provisions of IPC. The proposed amendment prescribes specific punishment, which shall not be less than 2 years but which may extend to 7 years in the following cases.

a) **Clinics** which are not authorised to conduct abortions. The owners of these clinics have been brought under the ambit of the amended Act. However, the owner would mean any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or a place which is not approved.

b) **A trained Registered Medical Practitioner** who conducts an MTP at a place which is not approved; and

c) **An untrained Registered Medical Practitioner** who conducts an MTP even if MTP is conducted at a placed, which is approved.

Over the years, need was felt to simplify the procedures of recognition of medical institutions for performance of MTP and also for imposing penalty for unauthorised actions in connection with MTP. An Expert Group under the Chairmanship of Secretary (FW) was constituted in 1997 to review and update MTP Act. National Commission for Women, Ministry of Law, the State Governments and Union Territory Administrations have also been consulted while finalising the amendments. The Medical Termination of Pregnancy Act Amended Bill, 2002 has been approved by Rajya Sabha. It is now pending with the Lok Sabha for discussion and approval.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee note that despite having passed a law to check female foeticide, the girl child is being denied birth by using modern scientific devices, and female foeticide still continues unabated. In spite of the existence of appropriate authorities and advisory committees set up for monitoring the progress of implementation of the Act, very few cases

of female foeticide have been reported. The Committee strongly feel that innovative strategies and programmes for awareness and for advocacy are needed to stop this practice. The Government should also examine the loopholes in the existing rules to enforce strict compliance of the provisions of the Act.

(Para No. 3.57)

Reply of Department of Family Welfare

With a view to containing the menace of female foeticide the Government has brought into force the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PNDT Act) with effect from 1.1.1996. Under the PNDT Act, Central Supervisory Board has been constituted under the Chairmanship of Minister for Health & Family Welfare. The Board has met six times. The last meeting was held on 18.10.2001. Appropriate Authorities and Advisory Committees have been constituted in all States and UTs for implementing the PNDT Act.

Supreme Court of India is monitoring implementation of the PNDT Act almost every month.

The CSB has constituted two sub-committees viz. (i) Technical Sub-Committee for considering amendments to the PNDT Act keeping in view the emerging technologies and difficulties experienced in the implementation of the Act and (ii) Sub-Committee on Implementation Strategy for implementing the Act for curbing female foeticide. Both the Committees have already met three times.

In the last meeting of the CSB certain amendments to the PNDT Act/Rules have been finalized after taking into account the views of various organizations, members of the Sub-Committees, experts and States/UTs.

Draft Cabinet Note for carrying out the amendments to the PNDT Act has been circulated to various Ministries/Departments of the Central Government, such as Legislative Department, Department of Legal Affairs, Department of Women & Child Development, Ministry of Social Justice & Empowerment, Ministry of Home Affairs, Ministry of Finance. On receipt of their comments the same will be placed before the Cabinet for bringing an amending Bill.

The CSB has also constituted two subgroups viz. (i) for considering the proposals for research studies on sex ratio and female foeticide and (ii) for considering the proposals for creating video films, TV spots etc. Some Projects have been approved for funding for

creation of awareness about the provisions of PNDT Act to contain female foeticide and improve sex ratio.

A meeting of the religious leaders was organized in July 2001 against the practice of female foeticide. In this Meet the practice of female foeticide was widely condemned and a pledge was taken to stop it. Akal Takhat in Punjab has issued a Hukumnama to Sikh community to stop the practice of female foeticide.

National Inspection and Monitoring Committee has been set up to keep a constant watch on all States and UTs for implementation of the PNDT Act and compliance of the directions of the Supreme Court of India.

Various stations of AIR are broadcasting spots, group discussions, talks and panel discussions on PNDT Act in various languages. Two spots are being telecast once a week on National Network and a film 'NIRANKUSH' is being telecast on Punjabi Channel on PNDT Act. NFDC has been asked to produce a small film on female foeticide. A film "ATMAJA" produced by Plan International India on female foeticide is also being telecast on National Channel of Doordarshan.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

Studies have shown that a large section of eligible couples are knowledgeable and about 60% hold a favorable attitude towards family Welfare. But the percentage of couples using contraception is much smaller (44% CPR). This gap between knowledge and attitude on the one hand and practice on the other requires to be bridged. One reason for this gap is the non-availability of contraceptive services at convenient points. Other reasons for this gap therefore, require to be identified and tackled effectively. Although in theory the reach of print and electronic media is quite large but it is still not reaching certain groups, particularly the disadvantaged one because of illiteracy and non-availability of radio-TV sets at the household or even at the village level. Alternate approaches closer to the cultural affinity of target groups have to be adopted for this segment of the population who are mostly residents of rural and tribal areas. Social and behavioral scientists, media specialists and providers of family welfare services, must closely interact to design new and meaningful approaches for information dissemination and community motivation.

(Para No. 3.58)

Reply of Department of Family Welfare

As per National Family Health Survey - II, the Couple Protection Rate is 48.6. The immediate objective of NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. Further, the NPP 2000 says that information, education and communication (IEC) of family welfare messages must be clear, focussed and disseminated everywhere, including the remote corners of the country, and in local dialects. The action taken in this regard is mentioned in reply to para 1.26.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee would like to point out that the age group of 6-16 years is particularly critical and vulnerable as far as women are concerned. The Ministry has admitted in this connection, that there has not been much progress in the area of adolescent reproductive health reach. It is essential to make this group aware and knowledgeable as to how the birth of the child could be avoided. This aspect is not being given any attention and girls in this age group generally get pregnant at an early age which causes many health and social problems. It is, therefore, important that an environment is created in which the younger generation particularly the girls in schools, are brought within some kind of programme of awareness about responsiveness and responsibility.

(Para No. 3.59)

Reply of Department of Family Welfare

A beginning has been made in the field of Adolescent Health Clinics are being established in Safdarjung Hospital, New Delhi and Medical College Hospitals in Ahmedabad, Chandigarh, Thiruvananthapuram and Kolkata. A similar clinic has been sanctioned for the Family Planning Association of India, Panchkula Branch.

In addition, two innovative projects have been sanctioned. NIMHANS Bangalore will launch a project for introduction of Life Skills Education through the school curriculum.

MAMTA-Health Institute for Mother and Child will initiate a project for adolescent health and development in Bawal Block in Haryana.

With the interventions for adolescents, seven projects under the head "Support to Gender Issues Project" have been sanctioned.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Committee are informed that to make PHCs and CHCs functional the Government of India on its part is taking various steps which include supply of drugs and equipment kits, essential obstetric care, emergency obstetric care, 24 hour delivery services, referral transport to indigent families through panchayats, blood supply to FRUs/PHCs, essential newborn care inputs, medical termination of pregnancy etc.

(Para No. 3.60)

Reply of Department of Family Welfare

No comments required.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee would also like to point out that during interaction with the beneficiaries at various Primary Health Centres/Community Health Centres, it came to their notice that there is acute shortage of doctors and para-medical staff and at times hardly any doctor is available. In this regard, the Committee were informed by the officials that they faced difficulty as doctors are reluctant to work in such centres which are mostly situated in rural areas. In this connection, the Committee would suggest that for the medical students it should be made obligatory to serve the last six months of their internship in rural health centres. The concerned State Government authorities should be impressed upon to coordinate with the medical colleges in their respective States regarding this suggestion of the Committee.

(Para NO. 3.62)

Reply of Department of Family Welfare

Government has previously also been contemplating the idea of making some rural service obligatory for doctors. The matter was also taken up with MCI and some states have come forward with regulations in this regard. The Committee's suggestion will now be taken up with State Governments, which may coordinate with the Medical College Authority, in the connection.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

The Committee have been informed that the total outlay of the Central Government both under plan and non-plan for all the three Departments of the Ministry of Health and Family Welfare is Rs. 7,400 crores for the year 2000-2001. Out of this, an expenditure of Rs. 2,250 crores is exclusively earmarked for diseases related to women. These are stated to be generally related to mother and child care and family welfare related activities. In this connection the Committee feel that all the studies and surveys made, should be gender specific, so that the Government is able to find the number of women suffering from various diseases, the number of them being provided medical facilities, and the amount being spent on the women related diseases/issues and the additional funds which need to be spent for them. This would help the government to formulate and implement the necessary policies/schemes accordingly.

(Para No. 3. 65)

Reply of Department of Family Welfare

As far as Gender specific studies are concerned, necessary actions have been initiated. Gender specific information on Immunisation, vaccination, breast feeding, age specific death rates and selected demographic indicators is being collected through both the National Family Health Survey (NFHS) and the Rapid Household Survey (RHS). Besides these, gender specific information is also being collected under Community Needs Assessment Approach (CNAA) on a monthly basis. In addition, there are eighteen Population Research Centres (PRCs) located in seventeen major states, engaged in carrying out research on various topics pertaining to Socio-Demographic aspects

including Gender specific studies. These survey results are used by Department of Family Welfare to decide upon and adopt necessary interventions, whenever and wherever called for, with a view to ensuring the reproductive health of the population by adopting a life cycle approach.

[D/o Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

It has been noted that more than 50 % of the budgetary outlay is towards recurring expenditure. The Committee would like the Department to ensure that available funds are properly and prudently utilised through well laid out plans, schemes and constant vigilance and monitoring. Caring must be taken to avoid overlapping of schemes and wastage of resources. At the same time, available infrastructure and facilities should be put to optimum use. However, in view of the critical importance of the projects and schemes, the Committee would urge upon the Government to further enhance the annual budgets for Family Welfare Programmes. Prevention and promotion services such as antenatal, post-natal care for women, immunisation of children, availability of contraceptives etc., should be given priority in allocation of funds.

(Para No. 3.66)

Reply of Department of Family Welfare

The suggestion has been noted.

[D/o Family WelfareO.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

National Population Policy, 2000 has pointed out huge inadequacies in trained personnel for the Family Welfare Programme. The Committee are of the view that without adequate trained health personnel, it would be difficult for the Government to achieve the objective of population stabilization even with the increased infrastructure and facilities. There is an urgent need for capacity building of the existing staff. The Planning Commission and the Ministry of Finance should also consider the need for a special grant in this connection so as to enable the Department of Family Welfare to recruit and train health personnel.

(Para No. 3.67)

Reply of Department of Family Welfare

National Institute of Health & Family Welfare was appointed as the National Nodal Agency by the Government of India in December, 1997 to coordinate various in-service training activities under the RCH programme all over the country. Since then, the Institute pursued its responsibilities of coordinating and monitoring the training activities with the help of 18 Collaborating Training Institutions (CTIs) in various parts of the country. Training has been operationalized now in all the components of RCH programme. Besides, 6 Management Institutions and 19 Communication Institutes are imparting Specialized Management Training and Training in Communication respectively.

Various categories of health functionaries are being trained through the following kind of training.

1. Awareness Generation Training.
2. Integrated Skill Training.
3. Specialized Skill Training
4. Specialized Management Training.
5. Training in Communication.

Awareness Generation Training, however, has been discontinued from 31.12.2000.

Training modules/guidelines/facilitators guide for various types of trainings have been prepared and are in use.

For effective monitoring of the training programmes 18 Consultants have been provided to NIHFW as input besides the supervisory support provided by the CTIs. Comprehensive Training Plans (CTPs) duly approved by respective State Authorities have been submitted to NIHFW and based on these NIHFW is releasing funds annually. An amount of Rs. 40 Crores has been earmarked for this purpose during 2001-2002. Till 20th December 2001 the number of persons trained were as follows-

Master Trainers –131, Trainers- TOT trained – 4003, Awareness Generation Training – 400741, Integrated Skill Training – 38321, Specialised Skill Training – 6587, Management

Training (State level) –153, Management Training (Distt level) – 852, Management Training (WHO funded) Distt level – 187, Spl Communication Training (DEMIOs) – 471, and Spl Communication Training (BEE) – 1369.

[D/o Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Committee have been given to understand that as per targets laid down by the Government, 80 per cent of the births will be institutionalized by the year 2010. The Committee, however, find this target too ambitious and are of the opinion that it will take considerable time to achieve this target. The Committee feel that there should be a practical approach in this regard. It should be the effort of the government to make a team of panchayat members, anganwadi workers, Self Help Groups, trained dais and the rural health care women in each village so as to deliver maternal care and services to women. To give basic health care to women and children, it would be better if the existing grassroots functionaries are motivated so that they become instruments of a better health delivery system. The Government should give serious thought to this approach and take proper measures in consultation with State Governments.

(Para No. 3.68)

Reply of Department of Family Welfare

A new scheme for training of Dais has been initiated during the year 2001. The scheme is being implemented in 142 districts in 15 States of the country. The districts have been selected on the basis of the safe delivery rates being less than 30%.

RCH Camps: In order to provide the RCH services to people living in remote areas where the existing services at PHC level are under utilized, a scheme for holding camps has been initiated during this year. The scheme will be implemented in the 10 weak States and also in 7 North Eastern States. Initially 102 districts have been selected in these States and more districts would be added next year. It is proposed to expand the scheme to all category C districts in the country.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

In order to improve the efficiency and effectiveness of the family planning programme, and to achieve better health for both the mother and the child, the Committee insist that 100% ante-natal registration should be made mandatory. This should form the basis of identifying high risk pregnancies and the eligible couples for permanent sterilisation. The Committee would also like to recommend that pilot studies be undertaken in a few districts in each State to generate a district level data base for programme planning, monitoring and evaluation. National level institutions, viz. Indian Council of Medical Research, National Institute of Health and Family Welfare and selected Medical Colleges may be entrusted the responsibility of concurrent evaluation and monitoring of the programme. The Planning Commission should also monitor the activities of the Family Welfare Programme vis-à-vis other related issues such as literacy, rural development, employment, women and child welfare, nutrition, environment, etc. The Committee would like to be apprised of the precise measures taken in this regard.

(Para No. 3.69)

Reply of Department of Family Welfare

Rapid Household Survey is being conducted since 1998 in order to make critical assessment of the Health & Family Welfare services provided by the Governments at the district level under Reproductive and Child Health (RCH) programme. These surveys help in producing/generating district level key process and impact indicators, which would facilitate appropriate programme planning, and concurrent monitoring in the Family Welfare Sector.

The PRCs are involved inter-alia in pursuing Area. Specific Research Studies in the concerned states and it is an on going process. Besides these, PRCs are also engaged in doing concurrent evaluation of various Family Welfare activities and would help the state government to identify the areas for action. Also, coordination between PRC and concerned state is being done through the mechanism of Research Coordination Committee (RCC). The proposal to get the Post Partum Programme evaluated by NIHFW, for taking a definite view on improvement of the scheme in Tenth plan, is under

process. The concurrent evaluation of the Sterilisation Bed Scheme is being carried out by Population Research Centres located in the States.

Further Reply of Department

As a matter of policy the Department of Family Welfare aims to achieve 100% ante-natal registration. This forms of component of the essential obstetric care which is sought to be provided to all pregnant women.

The Department have further stated that the objective of Essential Obstetric Care is to provide the basic material health care services to all pregnant women through:

- early registration of pregnancy (12-16 weeks)
- minimum three ante-natal check up
- identification of high risk pregnancy and referral whenever required
- universal coverage of all pregnant women with TT immunisation
- prophylasix and treatment of anaemia by providing recommended doses of iron and folic acid (IFA tablet)
- advice on food, nutrition and rest
- promotion of institutional delivery
- safe deliveries by trained personnel
- counselling for birth spacing
- post natal check up

According to the Department, the utilisation of ante natal care services differs greatly by State. National Family Health Survey-II (1998-99) reveals that in Goa, Kerala and Tamil Nadu 99% received at least one ante natal care, which shows 99% registration of ante natal cases. However, the States of Uttar Pradesh, Bihar and Rajasthan have 34.6, 36.3 and 47.5 that received at least one ante natal check up respectively, showing very low percentage of ante natal registration.

The RCH Programme aims at providing at least three ante natal check up during which weight and blood pressure check, abdominal examination, immunisation against TT, iron and folic acid prophylaxis as well as anaemia management are provided to the pregnant women. Various schemes for improving access to RCH services and implementation of essential obstetric care services including 100% ante natal registraiton. These have been taken up.

Provision of additional ANMs in all 'C' category districts of 18 States of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Haryana, Assam, Nagaland, Rajasthan and other North Eastern States. In addition, Delhi is eligible for appointing 140 ANMs for extending services through slum areas. Public Health/Staff Nurses are also provided to 25% in PHCs in 'C' category districts and 50% PHCs in 'B' category districts.

In order to provide the RCH services including ante natal care to people living in remote areas where the existing services at PHC level are under utilised, a scheme for holding RCH camps has been initiated. The scheme is being implemented in the 10 weak States and also in seven North Eastern States. Initially102 districts have been selected in these States. It is proposed to extend the scheme to all districts in the Empowered Action Group States in the country. Efforts are made to improve ante natal registration through IEC.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

Malnutrition, improper/inadequate health care facilities provided/available to women during pregnancy leads to children being born with physical and mental deficiencies. This aspect needs special attention. Women ought to be made aware of the importance of proper nutrition for pregnant women especially in rural/semi-urban areas. The Committee also desire that the Department of Family Welfare take suitable steps to ensure proper treatment of children born with deficiencies in coordination with State Governments and other concerned authorities.

(Para No. 3.70)

Reply of Department of Family Welfare

Home based Neonatal Care: The Department of Family Welfare has conveyed its "in principle" approval to two proposals for introducing home based neonatal care. The first, is based on the Gadchiroli model and entails development of training materials, pilot testing and launching of the initiative in selected blocks mainly through NGOs. The ultimate objective is to evolve a National Programme for provision of neonatal care at the grassroots level. The second is a proposal from ICMR, which is in the nature of an operations research project to implement home based neonatal care through various models viz. private practitioners, ANMs, NGOs etc. These projects are expected to the finalised and approved within the next couple of months.

Border District Cluster Strategy (BDCS): Under this initiative 49 districts spread over 17 States have been selected for providing focused interventions for reducing the infant mortality and maternal mortality rates by at least 50% over the next two to three years. States and districts have been allowed sufficient flexibility to introduce innovations to achieve the objectives. Districts are being supported for development and training of Health and Nutrition Teams, physical up-gradation of sub-centres and primary health centres, additional supply of equipment and drugs, organization of outreach sessions, support for mobility of staff, development of local IEC for social mobilization. In addition, training of medical officers, up-gradation of First Referral Units and filling of vacant posts through contractual appointments has been allowed depending on the needs of the districts.

Further Reply of Department

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4.4.2002]

Recommendation

In order to create alternate resources for augmenting the availability of medicinal plants for medicines, the Committee find that the Deptt. of ISM&H had initiated a Central Scheme for Development and Cultivation of Medicine Plants in 1990-91 and another Central Scheme for Development of Agro Techniques and Cultivation of Medicinal Plants used in Ayurveda, Siddha, Unani and Homoeopathy in 1997-98. The Committee would like the Govt. to conduct a study to find out as to how far these schemes have helped in enhancing the availability of quality raw materials for the manufacture of drugs. The Committee would like to be informed of results of such a study and the action taken in pursuance thereof.

(Para No.4.15)

Reply of Department of Indian Systems of Medicine and Homeopathy

The schemes for cultivation of medicinal plants was also made to serve as demonstration garden for teaching of PG students in the colleges, to meet the requirement of the pharmacy college . Agro-techniques has to be developed so that cultivation of the plants qualities available in forest are encouraged ex-situ. 116 plants were allotted to 32 institutions. About 40 agro-techniques are almost ready. The scheme for cultivation of medicinal plants has been modified to increase its out-reach . A Medicinal Plants Board has been set up to coordinate all activities relating to consumption , cultivation, propagation etc.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

In the opinion of the Committee, there is also need to create greater awareness amongst the rural/tribal women about the medicinal and economic value of the herbs and plants needed for ISM&H medicines. They should be encouraged and directly engaged in cultivation of such plants. Proper incentives due support should be given for developmental programmes in social forestry for producing plants and herbs particularly those which are becoming extinct.

(Para No. 4.16)

Reply of Department of Indian Systems of Medicine and Homeopathy

Medicinal Plants Board has been set up. The schemes and programmes to be funded by it will cover such awareness programmes and cultivational schemes.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee in the aforesaid paragraph of their earlier report have felt that the following measures should be taken by the Deptt. Of ISM&H to popularise and effectively use this traditional medical system to its full potential : -

(i) There should be an ISM&H component in the public health delivery systems set up by the Govt. of India/ State level public health institutions;

(ii) There should be a strong component of the ISM&H in the National Health & Family Welfare Programme;

(iii) Awareness about the efficacy and effectiveness of the system to be generated through print and electronic media;

(iv) Proper utilisation of grassroot level functionaries like village Health Guides, Mahila Mandals, Anganwadi workers, Gram Panchayat Members, NGOs, etc., should be made in spreading awareness regarding benefits of ISM&H in rural areas;

(v) Regular refresher and reorientation programmes should be organized for the ISM&H practitioners to upgrade their skills and to motivate them to take up responsibilities for better health care;

(vi) Greater emphasis on the research activities should be laid by the four Research Councils, to ensure meaningful research and their findings disseminated for the benefits of educationists, research physicians, manufacturers and common users;

(vii) Physical exercise and yoga should be made compulsory in the schools;

(viii) Specialised clinics in Ayurveda, Unani and Homoeopathy should be set up in the OPD of all the major Govt. Hospitals to enable the patients to take advantage of these systems of medicine;

(Para No. 4.17)

Reply of Department of Indian Systems of Medicine and Homeopathy

The Deptt. Has been implementing IEC scheme to popularize and propagate ISM&H. Th Deptt. Is participating in Health Melas, arranging Ayogya exhibitions etc. NGOs are being provided grant-in-aid for creating awareness. Re-orientation training programme is already under implementation. It has recently been re-oriented expand its out-reach. The Research Council are focussing on the areas they have strength in. They have been asked to publish and dissemination their findings. Scientific Advisory Committees have been re-oriented to provide guidance in research areas and approach. M/o HRD has been approved to introduce Yoga in schools. Specialized clinics are already working in SJH and Dr. R.M.L. Hospital. State Governments would be assisted for creating ISM&H wing in District Hospital. Modern Hospitals will also be asserted for starting specialty clinics including Panchkarma and Kishan Sutra Clinics.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee hope that while formulating and implementing the schemes, the Govt. would ensure tht more women are covered as beneficiaries. The Department should expand its financial support to institutes which seek assistance for construction of hostels for women/girls students under grant-in-aid scheme for strengthening of undergraduate and post graduate ISM&H institutes.

(Para No. 4.18)

Reply of Department of Indian Systems of Medicine and Homeopathy

Department is providing grant-in-aid to UG Colleges of ISM&H in Govt. Sector aided colleges for creating infrastructure including construction of hostel for women/gents.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee note that the Department has now prepared a capsule containing basic concepts and fundamentals of ISM&H for incorporation in MBBS curricula which has been forwarded to the Medical Council of India for appropriate action. The Committee feel that this should have been done long ago as the National Health Policy had envisaged as early as in 1983 integration of ISM&H with the modern system of medicine. The Committee urge the Department to pursue with the Medical Council of India early action in this regard.

(Para No. 4.19)

Reply of Department of Indian Systems of Medicine and Homeopathy

The matter has been referred by the MCI to stakeholders for comments . The purpose is to sensitise students of modern medicines almost the strength of ISM&H.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee feel that it is important for the Department to institute studies to ascertain the success of its various programmes especially with reference to women and children. The Department should also conduct studies to investigate the medical need of women and children so that the Department can gear itself to cater to their needs.

(Para No. 4.20)

Reply of Department of Indian Systems of Medicine and Homeopathy

Department of Family Welfare is primarily taking care of all reproductive health needs of the women of the Country and is implementing various programmes. However, the suggestion has been noted.

Recommendation

The Committee has noted that contraceptives for women such as "pipliyadi yog" are available under the Indian system of medicine. But in spite of this the department has not taken adequate steps to popularize this contraceptive. The Committee observes that the department has failed in its IEC programme as far as ISM&H is concerned. The Committee urges the department to take steps to promote the contraceptives under this system.

(Para No. 4. 21)

Reply of Department of Indian Systems of Medicine and Homeopathy

For introduction of this drug in RCH Programmes, II Phase trials are going on in PGI Chandigar, AIIMS, Delhi, JIPMER Pondicherry and KEM Hospital Bombay.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee have been informed that the research councils under ISM&H Department have conducted research projects in economically poor, rural and tribal areas, where free medical treatment and free cost of medicine is provided. The Committee would like to know which are the areas where such programmes especially with regard to women and children, have been held in the last two years and how successful have these programmes been. Even though the Committee have been informed that such programmes are very popular, the Committee are of the opinion that such camps have not been popularized in the form of a national campaign, thus, leaving a lot to be desired.

All these programmes need to have a separate component for women. It is in this regard that the Committee would like the Department to initiate necessary measures, but ensuring that women and children do not become victims of such experiments.

(Para No. 4.22)

Reply of Department of Indian Systems of Medicine and Homeopathy

The 4 councils of ISM&H have conducted and still are carrying research and medication activities in remote, rural and tribal areas viz; Car Nicobar, Imphal, Leh, Ziro (Arunachal Pradesh), Dhule (Maharashtra) Palamau, Jhabua (Nagpur), Thirupathur (TN) Bhadrak (Orissa), Karimganj (Assam), Barhanpur (MP), Edathla (Kerala), Ranchi, Gonda, Shillong, Silliguri, Aizawal, Leh, Bharuch, Agartala, Gangtok, Durgapur, Banswara, Sirohi, Barmer, Jaisalmer etc. NIN Pune organised 2 special programmes on Women Development through Naturopathy at Wangbal and Kangaba Kshetri Leikai of Distt. Thoubal in Manipur. The programmes have been very popular. The medication, therapies and methods used therein are quite safe.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee have been given to understand that there is general skepticism and misconception prevailing in the minds of the people about the efficacy and effectiveness of this system. In light of the above, the Committee would like to know what steps are being taken by the Department to remove the skepticism and misconception prevailing in the minds of the people. The Committee feel that it is important for the Department to set up standards with respect to ISM&H education, quality of drugs, test facilities, manufacturing units and also the laboratories and pharmacies. These standards have to be set to ensure that ISM&H is a success.

(Para No. 4. 23)

Reply of Department of Indian Systems of Medicine and Homeopathy

ISM&H have been practised for centuries. These are acceptable to the people as these are safe efficacious and affordable . Awareness is being created about the strength of these systems. ISM&H institutions are being assisted to create and augment infrastructure and improve quality of teaching and research. Educational regulations are

in force two statutory councils are regulating education and practice in ISM&H. Efforts have been made for ensuring supply of raw material which are genuine and have essential quality by establishing Medicinal Plants Board , Good manufacturing practices have been notified . State pharmacies and laboratories have been provided financial assistance. Private drugs testing laboratories would be recognized to expand facilities for testing ISM&H products. Central govt. laboratories, PLIM and HPL are being strengthened.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

Recommendation

The Committee strongly feel that the Department in its endeavor to provide good health services has to involve women and children who constitute the majority of the citizens. No programmes can be successful without investments for women and children. The Committee, therefore, hope that Government will take all necessary steps in this regard.

(Para No. 4.24)

Reply of Department of Indian Systems of Medicine and Homeopathy

While preparing schemes and programmes the recommendation of the Committee would be duly kept in view.

[Department of ISM&H O.M. No.Z 28015/62/2000-P&C, dated 28.3.2002]

CHAPTER III

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

Recommendation

The Committee note that several steps have been initiated by the Department at the national level to combat various communicable and non-communicable diseases. There is at last a growing recognition that women suffer from other gender specific disabilities and morbidities, and therefore, there is need to examine the adequacy of our strategies in ensuring that the interests of women are properly covered.

(Para No.2.27)

Reply of Department of Health

Disease control programmes presently being implemented by Government are gender neutral. Women are seen to be more stigmatized to diseases like TB and Leprosy. Special efforts are being made by involving women groups to increase awareness among the women regarding problems of TB, etc. and encourage them to report for treatment. Anganwadi Workers are also involved in providing treatment to TB patients. Family Health Awareness Campaign is an innovative strategy initiated to sensitise women in rural and slum areas about Reproductive Tract Infection/Sexually Transmitted Infection and facilitate prompt diagnosis and treatment through health care system. Special targeted intervention projects have also been initiated for commercial sex workers to increase their awareness about HIV/AIDS. The focus of the "prevention of mother to child transmission of HIV infection" programme is also to empower women, with the knowledge about prevention of HIV infection.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

It is generally seen that women when out of the reproductive age group, are not provided any kind of medical attention. The women in this age group usually suffer from menopausal and hormonal problems. The Committee note that a number of programmes/schemes have been drawn up by the Government of India but this group is not covered under these schemes. It is high time that this age group is also attended to, and suitable steps taken to identify and tackle their problems.

(Para No. 2.28)

Reply of Department of Health

2.28 The Draft Health Policy, 2002 envisages the identification of specific programmes targeted at women's health. However, menopausal and hormonal problems of the women are taken care of by the Obst. & Gynae. Departments of the Central Government hospitals. Tertiary level care is provided to the patients who suffer from these problems.

[Department of Health O.M. No. H.11019/13/2001- BP dated 14.3.2002]

Recommendation

The general norms prescribed for setting up health and family welfare service centres elsewhere in the country should not be applied to the tribal areas because tribal habitats are scattered in rough and difficult topographic areas. The yardstick for the tribal areas should be distance instead of population. Till this is achieved, provision for more outreach camps and mobile clinics should be made to improve the health and family welfare services in tribal, remote and inaccessible areas.

(Para No. 3.64)

Reply of Department of Family Welfare

The norms for establishment of sub centres, PHCs and CHCs are already relaxed in respect of tribal areas. Efforts are being made to increase the outreach of health care services in these areas, through Swasthya Melas and RCH camps etc.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply dated 4.4.2002]

Recommendation

The Committee have been given to understand that there is general skepticism and misconception prevailing in the minds of the people about the efficacy and effectiveness of this system. In light of the above, the Committee would like to know what steps are being taken by the Department to remove the skepticism and misconception prevailing in the minds of the people. The Committee feel that it is important for the Department to set up standards with respect to ISM&H education, quality of drugs, test facilities, manufacturing units and also the laboratories and pharmacies. These standards have to be set to ensure that ISM&H is a success.

(Para No. 4.23)

Reply of Department of Indian Systems of Medicine and Homeopathy

ISM&H have been preached for centuries. These are acceptable to the people as these are safe efficacious and affordable . Awareness is being created about the strength of these systems. ISM&H institutions are being assisted to create and augment infrastructure and improve quality of teaching and research. Educational regulations are in force two statutory councils are regulating education and practice in ISM&H. Efforts have been made for ensuring supply of raw material which are genuine and have essential quality by establishing Medicinal Plants Board , Good manufacturing practices have been notified . State pharmacies and laboratories have been provided financial assistance. Private drugs testing laboratories would be recognized to expand facilities for testing ISM&H products. Central govt. laboratories, PLIM and HPL are being strengthened.

[Department of ISM&H O.M. No. Z.28015/62/2000- P&C dated 28.3.2002]

CHAPTER IV

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

Recommendation

The Committee are concerned over the alarming increase in the number of HIV positive cases in the Country. The Committee feel that identification of target population, providing proper and timely counselling, increasing public awareness and community support, improving blood safety and controlling Sexually Transmitted Diseases are some of the measures, which if implemented, can result in arresting the increasing spread of AIDS.

(Para No.2.32)

Reply of Department of Health

The NACP Phase-II is a comprehensive programme for the prevention and control of HIV/AIDS in the country. The programme has five components which include priority interventions among marginalised and vulnerable population, provision of STD services, comprehensive awareness programme, establishing voluntary counselling and testing centres, modernisation of blood banks to ensure blood safety, care and support through free drugs for opportunistic infectious, establishing community care centres through NGOs and developing a multi-sectoral response by working partner Ministries such as Railways, Defence, Labour etc.

[Department of Health O.M. No. H.11019/13/2001-BP, dated 14th March, 2002]

Recommendation

The demand and supply of health facilities is highly skewed. There is urgent need to improve the conditions of the Government hospitals by making available doctors, para-medical staff, requisite medicines and necessary medical equipments. Not only is

there need for more doctors and nurses but the norms for doctor patient ratio and nurse patient ratio needs to be reviewed and appropriate steps taken to provide medical staff as per those norms. It is known fact that the emergency wards of Government hospitals in major cites are managed by junior doctors while the senior doctors have to be called, if need arises. The Government should take appropriate steps to ensure the presence of senior doctors round the clock in each discipline in the emergency wards of major Hospitals.

(Para No. 2.42)

Reply of Department of Health

Gap in demand and supply of health facilities in terms of manpower, equipment and medicines is well recognised. Schemes such as establishment of Medical Grants Commission for providing grants to medical colleges, scheme for providing essential drugs to primary health centres and scheme of urban health for setting up an organised urban primary health care structure have been initiated during the 10th plan to bridge this gap to the extent feasible. Nurse-patient ratio has already been fixed by Indian Nursing Council. Review of this ratio is not considered necessary at this stage. State Governments have been advised to implement the nurse – patient ratio. There are no Internationality recognised norms for doctor-patient ratio. There are no Internationally recognised norms for doctor-patient ratio. Manning of emergecy services in Government hospitals differs from hospital to hospital depneding upon the requirement. Senior residents who are well qualified are available round the clock for emergency duties in Government hospitals. Senior faculty members who have been provided residence in the hospital vicinity are available on call duty. In addition, one specialist each from medicine and surgery along with those of Orthopaedics, Paediatrics, Neurology etc. are also available round the clock in emergency in certain Government hospitals.

[Department of Health O.M. No. H.11019/13/2001-BP, dated 14th March, 2002]

Recommendation

The Committee is of the view that rather than implementing the same strategy or following the same policies, newer intervention strategies need to be planned and vigorously implemented, so as to see a rapid decline in fertility rate in the immediate

future. The Committee recommends that sterilisation facilities be made available in each of the PHSCs, PHCs, Community Health Centres, etc. The outreach of the Family Planning Services should be increased by involvement of NGOs, Health volunteers and through community based distribution of contraceptives. Lastly, there should be proper emphasis on programmes for training and skill development of both the Medical Officers and Health workers of both Government and voluntary agencies involved in the delivery of family welfare services, with respect to special procedures such as IUD insertions, sterilisation and also administering of oral contraceptives.

(Para No.3.52)

Reply of Department of Family Welfare

Various categories of health functionaries are being trained through the following kind of training:

Awareness Generation Training.

Integrated Skill Training.

Specialized Skill Training

Specialized Management Training.

Training in Communication.

Awareness Generation Training, however, has been discontinued from 31.12.2000.

Training modules /guidelines/ facilitators guide for various types of trainings have been prepared and are in use.

For effective monitoring of the training programmes 18 Consultants have been provided to NIHFW as input besides the supervisory support provided by the CTIs. Comprehensive Training Plans (CTPs) duly approved by respective State Authorities have been submitted to NIHFW and based on these NIHFW is releasing funds annually. An amount of Rs. 40 Crores has been earmarked for this purpose during 2001-2002. Till 20th December 2001 the number of persons trained were as follows-

Master Trainers –131, Trainers- TOT trained – 4003, Awareness Generation Training – 400741, Integrated Skill Training – 38321, Specialised Skill Training – 6587,

Management Training (State level) –153, Management Training (Distt level) – 852, Management Training (WHO funded) Distt level – 187, Spl Communication Training (DEMIOs) – 471, and Spl Communication Training (BEE) – 1369.

Recommendation

The Committee also note that the proportion of tubectomy acceptors to total sterilization have been approximately 98% compared to only 2% of vasectomy acceptors which shows that till now the entire burden of sterilization has fallen on the women, even though, studies have shown that sterilization on men is less complicated. The Committee therefore urge upon the Department of Family Welfare and the Government to initiate necessary changes in policy formulation and strategy implementation so as to involve more males in the family planning exercise. The counselling of couples in this regard would go a long way in encouraging male sterilisation. In this regard, the type and quantum of incentives given for male sterilization should be enhanced in order to encourage more men to opt for sterilization.

(Para No. 3.53)

Reply of Department

The first amendments proposed is in the definition of "lunatic" to bring it in conformity with Mental Health Act, 1987. The second amendment proposed is to delegate the power of approving places for medical termination of pregnancy to the District level Committee headed by the Chief Medical Officer/District Health Officer constituted by the Government for the purpose. The third proposal is to strengthen the punitive measures for unregistered clinics and untrained persons performing abortions.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The prime reasons cited by the Department for such low rate of male sterilization viz. fear of weakness (66%), fear of operation (13%) and method failure (6%), could have been easily tackled through an effective Information, Education and Communication (IEC) strategy. The fact that such misconception has been allowed to prevail for so long

without any counter strategy on the part of the Government and the Department, exposes their gender bias and callous and casual approach to the matter.

(Para No. 3.54)

Reply of Department of Family Welfare

Since the launch of No Scalpel Vasectomy Project to promote male participation in the Family Welfare programme by the Department in January 1998, the number of male sterilisation have gradually increased from 1.7% in 1997 to 2.3% in 2000. The % rise has been double. It is hoped that this doubling effect will continue.

The project till date has been implemented in 20 States. So far 273 NSV Training Courses have been held covering 252 districts of the country. Till date 1041 doctors have been trained in NSV technique.

Out of these 1041 doctors trained, 980 doctors have been certified as NSV service providers (this trained manpower available at the peripheries will increase the male participation in FW programme), 44 doctors certified as State NSV Trainers and 17 doctors certified as district NSV trainers.

These NSV trainers are to train other doctors in the State in NSV to make the State self sufficient in its NSV manpower needs.
This will help to decentralize the NSV training.

Set up NSV training centres in the States. These training centres would be manned by the State trainer who will help develop the required trained man power in the technique of NSV for the State. 8 NSV training centres have been identified in the first phase and funds are being released for setting up these Centres. The centres are in Andhra Pradesh, Madhya Pradesh, Karnataka, Tamil Nadu, Manipur, Sikkim etc.
Developing district trainers to make each district in the State, self sufficient in its NSV man power requirement. It is felt with this trained manpower available at the peripheries (districts) the male participation in Family Welfare would go up.

An approach paper has been moved for establishing male Reproductive Health centres in the tenth five year plan. Till date there are no centres where men can go to get

their problems on impotency, infertility, family planning or any other sexual disorder addressed. These centres will help to promote men to come forward and to accept Family planning by addressing their problems.

With regards to dispelling fears on male sterilisation the NSV project has developed new IEC materials on NSV. These are mainly a) NSV training b) advocacy video c) NSV audio and d) NSV print materials. These IEC materials have been developed after research by Ms Thomson Social with the help of UNFPA and are to be distributed to the States for NSV publicity to dispel fear on male sterilisation. Sample of the print material developed is enclosed. It is hoped that with NSV IEC material in place the fear and misconception on male sterilisation will be dispelled.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Committee are, however, constrained to point out that despite these steps taken by the Government, the state of Primary Health Centres is dismal. Obviously, the steps contemplated by Government have not resulted in actual improvement of PHCs. The Committee during its Study tours to some States have observed the condition of the Primary Health Centres and their poor maintenance. Some of these are set up in dilapidated buildings with no infrastructure, like electricity, beds, furniture and telephone facilities. They lack the necessary hygiene. At some centres there is no separate ward for female patients and only one doctor is posted on rotation basis to attend to all the patients. Also there is acute shortage of essential drugs and other material. The result is that these Centres are unable to meet the basic health service needs of the community. It is, therefore, necessary that the PHSC, PHC and Community Health Centres should be fully operationalised by providing necessary facilities including buildings and residential quarters, filling-up of all vacant posts and ensuring supply of essential drugs, dressings and other consumables.

(Para No. 3.61)

Reply of Department of Family Welfare

The Government is aware of the gaps in primary health care infrastructure in states. Government endeavors to improve the situation through a number of programme under the State Health Systems Projects, Community Health Centres and District Hospitals are being upgraded and better equipped. Under the Pradhan Mantri Gramodaya Yojana (PMGY) specific funds have been provided to the states for repair and renovation of health care institution, purchase of drugs (including ISM&H drugs) and for essential consumable & contingencies. One of the main activities of Area Projects, being implemented in various states, includes construction of buildings for sub centres, primary health centres and community health centres. Under Reproductive and Child Health (RCH) Programme (Major Civil Works) efforts are being made to strengthen the primary health care institution through provision of equipments, medicines and vaccines; repair / construction of OT / labour rooms and upgradation of water and electric supply. It also makes provision for contractual appointments of essential staff.

[Department of Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

To improve the outreach and quality of the family welfare services, the Committee recommends that a time bound programme should be launched by the Department to remove the backlog of establishment of sub-centres and primary health centres. Special area projects, community donations and adoption of cheaper and appropriate technology for construction should be used for removing the backlog in physical facilities.

(Para No.3.63)

Reply of the Government

As a matter of fact, the non achievement of targets, in establishment of sub centres and primary health centres, by the states is due to financial constraints and also that recently the stress has been on strengthening of existing infrastructure.

[D/o Family Welfare O.M. No. H.11011/3/2000-Ply, dated 4th April, 2002]

Recommendation

The Department of Indian Systems of Medicine and Homoeopathy have admitted that there has been very little progress towards integration of ISM&H with the modern systems of medicine as envisaged under the National Health Policy of 1983. Although some State Govts. like Maharashtra and Gujarat do post Ayurvedic doctors in the primary health centres, this has not been done by all the States in a systematic manner. The Committee are of the view that the Department can not escape its responsibility in this regard by saying that huge investment is necessary for developing the necessary infrastructure for integration of these systems with modern medicine.

(Para No. 4.14)

Reply of the Department of Indian Systems of Medicine and Homeopathy

In addition to Mahrastra and Gujarat , Rajasthan has recruited a good number of Ayurveda Physicians . Himachal has posted a number of Ayurveda physicians to PHCs. The States have been advised to post to ISM physicians, stock medicines included in essential drug list; enhance budget for the purchase of medicines and also use PMGY funds for procurement of ISM &H drugs.

Further reply of the Department

The Department of ISM&H has repeatedly been advising the State Governments, to integrate ISM&H in health care delivery systems. Some States have taken concrete steps, like Maharashtra, Gujarat, Himachal Pradesh and Rajasthan as already intimated to the Committee. However, there is no positive response from other States. This Department is preparing Central Scheme to assist State Governments to create ISM&H wing in their District Hospitals and other allopathic hospitals. It is expected that the said scheme will be implemented during current financial year. The Department will again write to States and impress upon them to further integrate ISM&H keeping in view the recommendations of the Committee.

[D/o ISM&H O.M. No. Z.28015/62/2000-P&C dated 28-03-2002]

CHAPTER V

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

- Nil –

NEW DELHI;
March 25, 2002
Chaitra 4 , 1925 (Saka)

MARGARET ALVA
CHAIRPERSON,
COMMITTEE ON EMPOWERMENT OF WOMEN.

APPENDIX I

OBSERVATIONS/RECOMMENDATIONS

SL NO.	Para No.	Ministry/ Department	Observations/Recommendations
1.	1.10	Ministry of Health and Family Welfare i) Department of Health ii) Department of Family Welfare iii) Department of ISM&H	In their Original Report, the Committee had opined that measures for improving the health and nutritional status of women and children should be the priority of the Government in the immediate future. It was pointed out that anaemia, urinary tract infections, malnutrition, repeated child births, adolescent marriages and overwork took the toll of women's lives while their health and nutritional needs received little focus. All Health Care Programmes for Women were tailored for pregnant and nursing mothers or for achieving population stabilisation. The Committee therefore, felt that this approach needed to be changed and women's holistic health care emphasised.
2.	1.11.	-do-	The Department of Family Welfare in their Action Taken reply have stated that the Reproductive and Child Health Scheme (RCH) is being implemented by the Department to improve the delivery of maternal and child health services in remote areas and urban slums. The services provided under the programme include early registration of pregnancies and referral services for women with complications of pregnancies, complete immunisation for infants upto one year and counselling of women of 15-45 age group on the family welfare services. The Committee find that in the services provided under the RCH Programme, the focus continues to be on the reproductive age group. The general or holistic health care of women especially health needs of adolescent girls and peri and post-menopausal women are not given priority under the existing health programmes. The Committee feel that apart from addressing the health needs of women in the reproductive age group, adequate emphasis should be given for improving the health care of adolescent girls and aged women. While reiterating the earlier Recommendation, the Committee urge the Government to take a fresh look at the existing Schemes/Programmes for health care for women in order to adequately focus on promoting not only the reproductive health of women but also of their general health from birth through old-age with particular emphasis on some common health problems faced by women such as malnutrition, aneamia, urinary tract infection, depression etc.
3.	1.12	-do-	The Committee also note that several schemes are underway to disseminate information to improve mass awareness on family planning programmes and on reproductive and child health care schemes through electronic and print media. The Committee feel that unless the IEC messages enable behavioural change, they are unlikely to have any impact. The Committee, therefore

			desire that measures should be taken by the Department to review and assess the impact of schemes being implemented for improving awareness of women regarding their health and family welfare schemes. The study should also assess how far these schemes are able to bring attitudinal and behavioural change in women especially in the rural areas.
4.	**1.16**	**-do-**	The Committee in their Original Report had observed that massive health investment was required for creating awareness and sensitising the masses to various health programmes as well as to the importance of the preventive aspect of health care. The Committee had, therefore, recommended that the Planning Commission and Ministry of Finance should step up the budget allocation for health services. In their Action Taken reply the Department of Health have stated that the draft National Health Policy, 2000, emphasises on increasing the aggregate public health investment through a substantially increased contribution by the Central Government. The Department have also stated that efforts are being made to ensure that adequate funds are made available not only at the Central level but also at the State level within the existing financial constraints. Further, during the annual plan discussion, all the States are stated to be requested to provide optimum outlays for the health sector, especially for primary health.
5.	**1.17**	**-do-**	The Outlay for the Department of Health is stated to have been enhanced from Rs. 5118 crore during the Ninth Plan period to Rs. 9253 crore during the Tenth Plan period registering an increase of 81%. Further, the Committee have been informed that every effort is made to provide a progressive increase in outlays by the Planning Commission for the three Departments and also as Additional Central Assistance (ACA). Although the budget allocation for the Tenth Plan for health services has been increased, the Committee feel that it is not adequate to improve the health delivery system and bridge the gaps from the grass-root level to the district level. Funds are not only required for treatment of diseases but also for creating awareness and sensitising the masses to various health programmes and determinants as well as to the preventive aspects of health care. The Committee are of the view that for this purpose the Central Government should continue to impress upon the States the need to allocate a fixed percentage of their outlay for the health sector.
	1.18	**-do-**	The Committee also desire that the Department of Health should develop a proper mechanism in co-ordination with the Planning Commission to ensure proper utilisation of the financial assistance released to the States and ensure that there is no slippage/diversion of the funds in the States. It must also be ensured that investments that are being made for upgradation of health facilities are actually improving the access to and quality of health services and infrastructural facilities in the States.

	1.19	**-do-**	The Committee are, concerned to note that the level of community involvement in infrastructure in the Country is low. In this regard, the Committee have been informed that in Kerala, the devolution of 30% to 40% of the State Budget to panchayats has enabled improved quality of services through better physical infrastructure. The Committee, therefore, desire that the Department of Health should impress upon the other States/UT Administration, the need to devolve fiscal powers to the Panchayats for supervision and maintenance of primary health infrastructure. Further, NGOs should also be involved and encouraged to participate in the working groups for planning health services including infrastructure improvements at district and block level.
6	**1.22**	**-do-**	The Committee note that the National AIDS Control Programme –Phase II is being implemented by the Department for prevention and control of AIDS/HIV in the country. The Committee are, however, of the opinion that the implementation of the components of NACP Programme by the Department such as provision of STD services, awareness programmes, voluntary counselling and testing centres are not adequate in view of the alarming increase of HIV/AIDS cases in the country. The Department should consider urgent intervention strategies by integrating prevention, care and support which should extend from giving people access to diagnostic tests and condoms, to stepping up the treatment and prevention of other sexually transferred diseases. Adequate attention should also be given by the Department to improve access to proven HIV prevention interventions among the 'mobile' and vulnerable sections of the population.
7.	**1.23**	**-do-**	The Committee find that despite the public awareness programmes and other preventive measures being undertaken by the Department, ignorance, social ostracisation and inadequate medical care still remain major concerns. One of the biggest challenges is the stigma and discrimination towards People living with HIV/AIDS by the community and medical practitioners. The Committee feel that immediate steps should be taken by the Department to remove the stigma and discrimination associated with this disease which in the view of the Committee lead to major violations of human rights. The Committee suggest that Health care providers must be oriented to universal precautions, exposed to training programs for attitudinal change regarding HIV/AIDS so that they are able to address this menace even at the grass-root level and in remote villages.
8.	**1.26**	**-do-**	**The Committee are not convinced by the reply of the Department that separate allocation for women in National Disease Control Programmes implemented by them such as for control of Malaria, TB, Blindness, Leprosy and AIDs is not practical as all these diseases are gender neutral.** **The Committee feel that the impact of all communicable and non-communicable diseases is not**

			gender neutral. Besides the disabilities and morbidities such as cervical and breast cancer which are gender specific, other diseases/disabilities such as Urinary Tract Infection, Anaemia, malnutrition etc. also impact women's health. Thus, developing gender specific strategies in combating health problems is an essential pre-requisite. The Committee, therefore, reiterate that a separate allocation for women in the annual plan is necessary which would go a long way in launching interventions specially required for women.
9.	**1.27**	**-do-**	**The Committee also desire that steps should be taken for gender sensitization of health workers, managers and grass-root workers which is critical for management and implementation of health programmes for women. The Committee also desire that obtaining gender disaggregated data and clear analysis should be made mandatory for any review or assessment or research study on these programmes.**
10	**1.31**	**-do-**	**The Committee in their Original Report had observed that there was urgent need to improve the conditions of the Government hospitals by making available doctors, para-medical staff, requisite medicines and necessary medical equipments. Not only was there need for more doctors and nurses but the norms for doctor patient ratio and nurse patient ratio needed to be reviewed and appropriate steps taken to provide medical staff as per those norms. In their Action Taken reply the Department have conceded the fact that there is a gap in demand and supply of health facilities in terms of personnel, equipment and medicines. Schemes such as establishment of Medical Grants Commission for providing grants to medical colleges, scheme for providing essential drugs to primary health centres and scheme of urban health for setting up an organised urban primary health care structure have been initiated during the 10th Plan to bridge this gap to the extent feasible. The Committee fail to understand why such schemes have been initiated so late (in the Tenth Plan) when the urban primary health care infrastructure including Government Hospitals have remained plagued by shortage of medicines, doctors and equipments for years.**
11.	**1.32**	**-do-**	**The Committee had earlier pointed out that the emergency wards of Government hospitals in major cites were managed by junior doctors and the senior doctors had to be called, if need arose. The Committee had, therefore, desired that the Government should take appropriate steps to ensure the presence of senior doctors round the clock in each discipline in the Emergency Wards of major Hospitals. In this connection, the Department have stated that staffing of emergency services in Government hospitals differs from hospital to hospital depending upon the requirement. Senior resident doctors who are well qualified are available round the clock for emergency duties in Government hospitals. Further, senior resident doctors and one**

			specialist each from medicine and surgery are also available round the clock in Emergency Wards in certain Government hospitals. However, despite these claims of the Department, it is generally seen that Emergency Wards are always managed by Junior doctors and Senior Resident/Specialists are either not bothered or arrive considerably late. This usually compels the relatives of patients to rush to private hospitals for prompt treatment. It is, therefore, of paramount importance that there ought to be a system to ensure availability of Senior doctors regularly in Emergency Wards. This can only be possible if the Senior Doctors/Specialists in each discipline are present round the clock so that best possible medical treatment is made available to patients who are rushed to emergency wards in serious/critical conditions.
12	**1.33**	**-do-**	**1.33 The Committee also desire that measures need to be taken to ensure accountability among Doctors and other Para-Medics to enable them to be responsive to the patients admitted. The Committee also feel that the public at large should be made aware of the availability of the health care facilities at Government Institutions and their rights as patients seeking treatment which will serve as a deterrent to irresponsible and errant Doctors. The Committee would like to be apprised of the precise steps taken in this regard.**
13.	**1.39**	**-do-**	The Committee had earlier observed that instead of implementing the same strategy/policies, newer intervention strategies needed to be planned and vigorously implemented, so as to see a rapid decline in fertility rate in the immediate future. However, the Department of Family Welfare in their Action Taken reply has remained silent on this issue. This show the lack of seriousness on the part of the Department in dealing with this important recommendations of the Committee. The Committee would have appreciated if the Department of Family Welfare had spelt out clearly whether they are considering new intervention strategies to achieve immediate reduction in the fertility rate. The Committee while reiterating their earlier recommendation desire that the Department of Family Welfare should undertake a mid term appraisal or review of all the programmes for population stabilisation being implemented by them and should impress upon all States/Union Territories to submit a report to the Department on the performance of each Scheme/Programme for population stabilisation in their respective States and the achievement of physical and financial targets etc. The Department should also conduct first-hand/field visits of its senior officials to States/Union Territories to assess the extent to which the programmes are achieving the desired objectives.
14.	**1.40**	**-do-**	The Committee had also recommended that sterilisation facilities should be made available in each of the PHSCs, PHCs, CHCs etc. The Committee had further desired that the outreach of the Family Planning services should be increased by involvement of NGOs, Health Volunteers and through

			community based distribution of contraceptives. The Department have replied that all States are being provided Rs. 10 lakhs for civil works under RCH to upgrade sterilisation facilities in Primary Health Centres besides also providing additional ANMs, drugs, equipment supplies etc. However, the Committee are constrained to note that despite claims of the Department, availability of basic facilities for sterilisation are not available in most of PHCs in many States. It is learned from a news item that in Uttar Pradesh for instance health centres use crude methods such as bicycle pumps for laproscopy in place of the high-precision equipments required for the purpose. The Committee were anguished to note that besides the cycle pump being used as a standard substitute for the medical pump, the same syringe and gloves were being used for 50 patients in these camps in almost all the Primary Health Centres in Western Uttar Pradesh. The Committee feel that this flouts all the guidelines issued by the Union Health Ministry in October, 1999 prescribing standards for sterilisaton. The Committee therefore, desire that the Department of Family Welfare should seek reports from other States/UTs on whether such practices are being followed there and also urge upon them to take necessary remedial action to punish those responsible for this inhuman act. In addition, the Department should impress upon all the States/UTs to implement the guidelines issued by the Union Health Ministry in October, 1999 for conduct of sterilization in the primary health centres.
15.	**1.41**	**-do-**	The Committee also note that various programmes are being implemented by the Department for training of health personnel with focus on skill upgradation. The Department have however stated that Awareness Generation Traning has been discontinued from 31.12.2000 without furnishing any reasons as to why this has been discontinued. The Committee would like to know the reason as to why this Training programme has been discontinued. The Committee also desire that while various training programmes have been initiated by the Department, the Department should also take steps to assess the impact and efficiency of the training programmes to see whether the programmes are able to address the various facets of training required to improve women's health such as technical competence, behavioral change techniques, attitudinal change etc.
16.	**1.49**	**-do-**	The Committee in their Original Report had noted that proportion of tubectomy acceptors to total sterilisation have been approximately 98% compared to only 2% of vasectomy acceptors. The Committee had, therefore urged upon the Department of Family Welfare to initiate necessary changes in the policy formulation and strategy implementation so as to involve more male in the family planning exercise. The Committee are informed that a number of measures have been taken by the Department of Family Welfare so far for involving of males in the family planning exercise. The Committee are, however, constrained to note that the percentage of male sterilisation has increased from 1.8% in 1997 to only 2.46% in

2002. The Committee feel that the pace of increase in the percentage of male sterilisation is abysmally low and that at this rate it will take years to achieve a substantial increase in male participation in the family planning exercise.

17.	**1.50**	**-do**	The Committee note that a new initiative on promotion of Male Participation under men in Planned Parenthood has been launched by the Department in the Tenth Five Year Plan. The goal of this new initiative is to promote gender equity and equality and enable men to take responsibility for their sexual reproductive behaviour and their social and family roles. The Department have also informed that another initiative undertaken by the Department is the promotion of 'No-Scalpel Vasectomy Project' to promote male participation. The project is being funded by UNFPA with the Government of India contributing in kind such as providing centres for training and making available necessary infrastructure at the training sites. The Committee feel that while such initiatives are laudable, it is not enough for involvement of males in the family planning exercise. What is of utmost importance is timely and proper implementation of such initiatives. The Committee also desire that more interpersonal communication should also be undertaken and the focus should be on making men aware of their responsibility and to project NSV as one of the components of male responsibility to ensure better women's health.
18.	**1.51**	**-do-**	The Committee note that the training sessions under the No-Scalpel Vasectomy Programme are organised upon the request of the States. Once a request is received from the States, funds are released to the States for each training session . The Committee feel that the Department should impress all the States/UTs, especially, the backward States with high growth rate of population, to compulsorily send proposals for organisation of training programmes on No-Scalpel Vasectomy in their respective States/UTs. The Committee are disappointed to note that till date only 299 NSV training sessions have been held under the project in the country since the introduction of the Programme in 1998. The Committee are of the opinion that as training in new NSV technique is integral to the spread and reach of the programme which in turn will enhance the rate of male sterilisation, the Department should impress upon the States/UTs to take steps to organise greater number of training sessions, especially in the remote villages and districts and at the grassroot level. Being the nodal Department, senior level officials of the Department of Family Welfare should also undertake monitoring visits to the NSV training centres in the States and Districts thereof to assess the facilities and quality of training.
19.	**1.52**	**-do-**	The Committee had observed that the counselling of couples would go a long way in encouraging male sterilization. The Committee had also suggested that the type and quantum of incentives given for male sterilization should be enhanced in order to encourage more men to opt for sterilization. The Committee are at a loss to understand as to why the Department have not furnished any comments to the important

			recommendation made by the Committee which only goes to prove the casual approach of the Department in dealing with this recommendation. The Committee would like to be apprised of the specific steps taken by the Department to increase the availability of counselling facilities. The Committee while reiterating their earlier recommendation also desire the Department to seriously examine the issue of increasing incentives for male sterilization to achieve substantial increase in the rate of male participation in the family planning exercise.
20.	**1.57**	**-do-**	**The Committee observe that the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 was brought into force to regulate the misuse of pre-natal diagnostic techniques for determination of sex of the foetus. However, despite the existence of the Act, this technology is being misused on a large scale for sex determination leading to female foeticide and precipitating a severe imbalance in the sex ratio (females per 1000 males) as reflected in Census 2001 for some States/UTs viz. Punjab (874), Haryana (861), Delhi (821), Uttar Pradesh (898), Madhya Pradesh (920), Gujarat (921) and Maharashtra (922).**
21.	**1.58**	**-do-**	Consequently to plug the loopholes and shortcoming in the PNDT Act, 1994, it became necessary to enact and implement a legislation that will ban the use of both sex selection techniques prior to conception as well as the misuse of pre-natal diagnostic techniques for sex-selection abortions, which need to be regulated. With this view, the Government introduced the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Bill, 2002 after detailed deliberations in various meetings of the Technical Sub-Committee constituted for this purpose and later by the Central Supervisory Board, the apex body constituted at the Central level. The Committee on Empowerment of Women had also taken up for consideration the provisions of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Bill, 2002 and interacted with a number of NGOs, Women Activists, Doctors and finalised their suggestions on the said Bill in the light of the amendments/objections expressed by these agencies and forwarded a copy of their suggestions to the Minister for Health and Family Welfare for consideration and necessary action.
22	**1.59**	**-do-**	Now that the Amendment Bill has been passed by both the Houses of Parliament, the Committee hope that the Government would take immediate and effective steps to implement the provisions of the PNDT Amendment Bill, 2002 in letter and spirit throughout the country and especially in the 7 States (Punjab, Haryana, Delhi, Uttar Pradesh, Madhya Pradesh, Gujarat, Maharashtra) where there is a steady decline in the sex ratio. The Committee also desire that proper mechanism should be put in place by the Department to ensure that the punishments prescribed under the Bill are implemented strictly which will minimise violations and also serve as a deterrent to unethical doctors against carrying out such

practices in the larger interests of the society.

23.	**1.65**	**-do-**	The Committee in their earlier Report had pointed out that despite the steps taken by the Government, the state of Primary Health Centres was dismal. During their study tours the Committee had observed the poor maintenance of the Centres. The Committee had noted that some of these were set up in dilapidated buildings with no infrastructure, like electricity, beds, furniture and telephone facilities and lacked necessary hygiene. The Committee had noted that these Centres were unable to meet the basic health service needs of the community. The Committee had therefore desired that the PHSC, PHC and Community Health Centres should be fully operationalised by providing necessary facilities including buildings and residential quarters, filling-up of all vacant posts and ensuring supply of essential drugs, dressings and other consumables.
24.	**1.66**	**-do-**	The Department have conceded that they are aware of the gaps in primary health care infrastructure in the States. In their Action Taken reply the Department have stated that Government endeavors to improve the situation through a number of programmes under the State Health Systems Projects. The Department have stated that Community Health Centres and District Hospitals are being upgraded and better equipped. Under the Pradhan Mantri Gramodaya Yojana (PMGY) specific funds have been provided to the States for repair and renovation of health care institution, purchase of drugs (including ISM&H drugs) and for essential consumable & contingencies. However, despite these steps having been taken by the Department, the condition of Primary Health Centres does not appear to have improved much. The contention of the Department of Health and the Department of Family Welfare that recently the stress has been on strengthening of existing infrastructure is unacceptable as the Committee found pathetic conditions of facilities in Primary Health Centres visited by them in various States before and after the presentation of the Committee's Original Report.
25.	**1.67**	**-do-**	The Committee during their recent tour to Udaipur found lack of infrastructure facilities, trained manpower, drugs, medicines, supplies and appropriate equipment in these Centres. In the Centres visited by the Committee, it was pointed out that there was only one Lady Doctor who was handling all the general cases as well as cases of deliveries and abortions. In her absence, nurse and ANMs looked after emergency cases. The Committee were informed that there was no regular female staff nurse. Though there were posts of 2 nurses, only one male nurse was working who also was appointed on contract basis. It was also pointed out that there was acute water problems in the Centre. Further, there was no X-Ray machine in the room allocated for the purpose. The Committee feel that as Primary Health Centres and Sub-Centres constitute the core of the primary health care system in the country, prompt and immediate improvement in the facilities in the condition of Primary Health Centres is absolutely essential for achieving the task of taking primary health care to the door steps of the people.

26.	**1.68**	**-do-**	The Committee had desired that to improve the outreach and quality of the family welfare services, a time bound programme should be launched by the Department to remove the backlog of establishment of sub-centres and primary health centres. The Committee are however not inclined to accept the reply of the Department that the non achievement of targets, in establishment of sub centres and primary health centres by the States is due to financial constraints. The Committee are of the opinion that the Department have not seriously examined the alternatives suggested by the Committee for improving the outreach and quality of the Family Welfare services such as special area projects, community donations and adoption of cheaper and appropriate technology for construction which would have helped the Department to a great extent to overcome the financial constraints. The Committee note that as informed by the Department elsewhere, the budgetary provision for the Annual Plans for the Department have been increasing every year. The Committee expect that the enhanced allocation will be utilised by the Department to meet the requirements to a large extent for improvement of the primary health care infrastructure.
27.	**1.72**	**-do-**	The Committee in their Original Report were concerned to note that there had been very little progress towards integration of ISM&H with the modern systems of medicine as envisaged under the National Health Policy of 1983. Although some State Govts did post Ayurvedic doctors in the primary health centres, this has not been done by all the States in a systematic manner. The Committee were of the view that the Department could not escape its responsibility in this regard by saying that huge investment is necessary for developing the necessary infrastructure for integration of these systems with modern medicine. The Committee regret to note that even after nearly one and half years of presentation of the Committee's Report to the Parliament, only four States viz. Maharashtra, Gujarat, Rajasthan and Himachal Pradesh have recruited and posted Ayurveda Physicians to Primary Health Centres. The Committee had expected that the Department, on being pointed out about the little progress made in this regard would have taken concrete steps to impress upon the remaining States/UTs to ensure the incorporation of ISM&H component in the public health delivery in their respective States. The Committee also note that as stated by the Department, there is no positive response from the remaining States in this regard. The Committee feel that the Ministry should have tried to ascertain the reasons as to why the remaining States have still not taken adequate and effective steps for inclusion of Indian Systems of Medicine and Homeopathy in the health institutions in their States.
28.	**1.73**	**-do-**	The Committee while reiterating their earlier recommendation desire that the Department should take immediate and prompt steps to take up the matter with the concerned States at an appropriate level and ensure that there is an ISM&H component in the State level public health institutions as will as the public

			health delivery systems set up by the Government of India. The Committee also desire to be apprised about the specific steps taken by the Department in this regard.
29.	**1.74**	**-do-**	**The Committee desire the Government to consider the following suggestions also in consultation and coordination with the State Governments for improvement in the health care facilities for women.** **11. Greater clarity is needed on the specific measures to be taken to ensure that women's health concerns and their poor access to health care are taken into consideration. Mechanisms should be instituted so that providers are aware of such specific concerns and women are aware of such policies to ensure proper health care for them.** **12. Measures ought to be taken to ensure that there are no delays in procurement of drugs, supplies, equipments etc which have been quoted by the Department of Health as being responsible for non-utilisation of funds for major National Programmes.** **13. Steps should be taken to ensure availability of lady doctors in rural areas to ensure women's access to health care. Field reality is that there are very few lady doctors at district level and below, and the situation is worse in the socio-economically backward states. These States need to be impressed upon to pay adequate attention to this aspect.** **14. One of the biggest hurdles in reducing maternal mortality ratio is the lack of specialists (anesthetists and obstetricians) particularly in rural and semi-urban areas for conducting caesarian sections/ vacuum or forceps for obstetric emergencies which needs to be addressed.** **15. To combat Iron Deficiency Anemia, compliance with consumption of Iron Folic Acid tablets should be ensured among women. The role of nutrition education to overcome Iron Deficiency Anemia should be popularized. Constraints in the supply of IFA Tablet should be removed.** **16. Adolescent health clinics should be set up and health providers should be trained in the specifics of adolescent health.** **17. Ministry of Health and Family Welfare should collaborate with the Ministry of Human Resource Development to ensure that the programmes of the HRD Ministry recognise the gravity of maternal mortality and tailor their programmes to address issues of empowering women which could affect some of the determinants of maternal mortality.**

18. **Regarding mother to child transmission (MTCT) of HIV/AIDS virus, measures should be taken to establish care and support centres in the community, particularly in the high prevalence areas.**

19. **Regarding the Mental Health Programme, outreach mechanism should be put in place so that men and women are aware that such programmes exist. Health workers should be provided with sensitization and training so that they are alive to the issue of mental disorders.**

MINUTES OF THE FIRST SITTING OF THE ACTION TAKEN SUB-COMMITTEE OF COMMITTEE ON EMPOWERMENT OF WOMEN (2002-2003) ON 'HEALTH AND FAMILY WELFARE PROGRAMMES FOR WOMEN'.

The Sub-Committee sat on Wednesday, 7th August, 2002 from 1600 hours to 1745 hours in Room No. 115, Parliament House Annexe, New Delhi.

PRESENT

IN CHAIR

Dr. (Smt.) V. Saroja - Convenor

MEMBERS

LOK SABHA

2. Smt. Renuka Chowdhury

RAJYA SABHA

3. Smt. Jayaben B. Thakkar

4. Smt. Gurcharan Kaur

SECRETARIAT

1. Smt. Veena Sharma - Under Secretary

At the outset, the Convenor welcomed the Members to the first sitting of the Action Taken Sub-Committee on 'Health and Family Welfare Programmes for Women'. The Sub-Committee then took up for consideration, the action taken replies received from the Ministry of Health and Family Welfare (Department of Health, Department of Family Welfare and Department of Indian Systems of Medicine and Homeopathy) on the action taken by them on the recommendations contained in the Fourth Report of the Committee on Empowerment of Women (2001-2002) on the subject 'Health and Family Welfare Programmes for Women'.

2. The Convenor then explained to the Members of the Sub-Committee the procedure being followed after the receipt of the action taken replies from the concerned Ministry/Department on the original reports.

3. After some deliberations, the Sub-Committee decided that a comprehensive list of points arising out of the action taken replies received from the Ministry of Health and Family Welfare (Department Health, Department of Family Welfare and Department of Indian Systems of Medicine and Homeopathy) seeking further clarifications be prepared and sent to the concerned Ministry for eliciting requisite information.

The Sub-Committee then adjourned.

MINUTES OF THE EIGTHTEENTH SITTING OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2002-2003

The Committee sat on 27th March, 2003 from 1500 hours to 1530 hours in Committee Room 'E', Parliament House Annexe, New Delhi.

PRESENT

IN CHAIR

Smt. Margaret Alva - Chairperson

MEMBERS

LOK SABHA

1. Dr. (Smt.) Anita Arya
2. Smt. Santosh Chowdhary
3. Dr. (Smt.) Beatrix D'Souza
4. Adv. Suresh Ramrao Jadhav
5. Smt. Abha Mahto
6. Dr. Ashok Patel
7. Shri E. Ponnuswamy,
8. Smt. Sushila Saroj
9. Dr. (Smt.) V. Saroja
10. Smt. Minati Sen
11. Smt. Shyama Singh
12. Shri Prakash Mani Tripathi
13. Dr. (Smt.) Vukkala Rajeswaramma

14. RAJYA SABHA

14. Smt. Shabana Azmi
15. Dr. (Ms) P. Selvie Das
16. Smt Vanga Geetha
17. Smt. S.G. Indira
18. Smt. Gurcharan Kaur
19. Smt. Chandra Kala Pandey
20. Smt. Bimba Raikar
21. Miss Mabel Rebello

SECRETARIAT

1. Shri P.D.T Achary - Additional Secretary
2. Shri Ashok Sarin - Director
3. Smt. Veena Sharma - Under Secretary

At the outset, the Chairperson welcomed the Members to the sitting of the Committee on Empowerment of Women. The Committee then took up for consideration the draft Action Taken Report on the subject 'Health and Family Welfare Programmes for Women'. After some deliberations, the Committee adopted the draft Report and authorised the Chairperson to finalise and present the same to the Parliament.

The Committee then took note of the fact that as decided by them during their sitting held on 13th March, 2003, a copy of the letter sent by Shri Bishnu Pada Ray, MP regarding an incident of barbarous gang rape and molestation of women and dacoity that occurred in the night of 5th February, 2003 in the marriage barat party buses in District Nadia in West Bengal was sent to the National Commission for Women for necessary action. The Committee decided that the National Commission for Women might be asked to furnish a copy of the Report of their findings of the incident to the Committee.

The Committee then adjourned.

MINUTES OF THE SIXTH SITTING OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2002-2003)

The Committee sat on the 5th September, 2002 from 1100 hours to 1500 hours in Committee Room 'D', Parliament House Annexe, New Delhi.

PRESENT

IN CHAIR

Smt.Margaret Alva - Chairperson

MEMBERS

LOK SABHA

2. Smt.Jayashree Banerjee
3. Smt. Renuka Chowdhury
4. Dr.(Smt.)Beatrix D'Souza
5. Adv. Suresh Ramrao Jadhav
6. Smt. Abha Mahto
7. Dr.Ashok Patel
8. Smt. Sushila Saroj
9. Dr.(Smt.) V.Saroja
10. Smt. Minati Sen

RAJYA SABHA

11. Smt.Saroj Dubey
12. Smt.Vanga Geetha
13. Smt. S.G. Indira
14. Smt. Gurcharan Kaur
15. Smt. Chandrakala Pandey
16. Smt. Bimba Raikar
17. Ms. Mabel Rebello

INVITEES

Doctors:

1. Dr. Rajiv Bhatia

2. Dr. Geeta Shroff,
3. Dr. (Col.) C.S.Pant
4. Dr. Joe Varghese,
5. Dr. Mira Shiva
6. Dr. S. S. Dodha,

Lawyers

1	Ms. Indira Jaisingh,	Director, Lawyers Collective, Women's Rights Initiative
2.	Ms. Swati Mehta,	Lawyers Collective,
3.	Ms. Asmita Basu,	Lawyers Collective,

NGOs

1.	Mrs. Bulusareen	Coordinator, Forum for Creche and Child Care Services
2.	Ms. Vani	[SAHELI]
3.	Mr. Sabu George,	CEHAT
4.	Mr. James Valliyat	Public Relation Officer (Incharge of Delhi Office) Catholic Health Association of India
5.	Mr. E. Antony	Catholic Health Association of India
6.	Prof. Mohan Rao,	Secretary, Delhi Science Forum,
7.	Smt. Madhu Kishwar	Centre for the Study of Developing Societies,

SECRETARIAT

1. **Shri Ashok Sarin - Deputy Secretary**
2. Smt. Veena Sharma - Under Secretary

At the outset, the Chairperson, Committee on Empowerment of Women, welcomed the Members to the sitting of the Committee and apprised them that the Pre Natal Diagnostic Techniques (Regulation and Prevention of Misuse)

Amendment Bill, 2002 which contained certain amendments to the Pre Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 was likely to come up for discussion in the Parliament in the Winter Session. She also informed that a number of suggestions were given by the various Women MPs of both the houses when they were earlier invited to tender their views on the Bill. She had also received representations from certain NGOs, doctors and lawyers who wanted to present their views on the Bill before the Committee. The Committee had, therefore, invited them in this meeting.

2. The Chairperson thereafter, welcomed the doctors, lawyers and representatives of some NGOs to the sitting of the Committee. They were then asked to express their views independently regarding the various clauses contained in the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Bill,2002.The doctors, lawyers and the NGOs put forth their views, objections and suggestions in respect of the Bill. They also replied to the queries of the Members of the Committee regarding the Bill.

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

4. The Committee then decided to hear the views of the Secretary and other officials of the Ministry of Health and Family Welfare (Department of Family Welfare), Indian Medical Association, Central Supervisory Board and Appropriate Authority in Delhi in the light of suggestions received from various quarters before finalising their views on the Bill. The Committee also decided to undertake one day local visit to Faridabad to see some of the recognised Ultra Sound Centres and hold informal discussion with the local health authorities in connection with extensive sex determination tests taking place in the region.

The Committee then adjourned.