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COMMITTEE ON EMPOWERMENT OF WOMEN (2007-2008)

(FOURTEENTH LOK SABHA)

‘MEDICAL FACILITIES FOR WOMEN AT ALL INDIA INSTITUTE OF MEDICAL SCIENCES (AIIMS), HOSPITALS AND PRIMARY HEALTH CENTRES’

MINISTRY OF HEALTH AND FAMILY WELFARE

SIXTEENTH REPORT

LOK SABHA SECRETARIAT
NEW DELHI

April, 2008/Vaisakha, 1930 (Saka)

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Presented to Lok Sabha on 29th April, 2008

Laid in Rajya Sabha on 29th April, 2008

LOK SABHA SECRETARIAT
NEW DELHI

April, 2008/ Vaisakha, 1930 (Saka)

E.W.C. No. 50

PRICE: Rs._____

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Published under ………………………………………

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COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2007-2008)

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** The vacancy occurred consequent upon the retirement of Smt. N.P. Durga, MP, Smt. Prema Cariappa, MP, Smt. Maya Singh, MP w.e.f. 9.4.2008.

INTRODUCTION

I, the Chairperson of the Committee on Empowerment of Women present the Sixteenth Report (Fourteenth Lok Sabha) of the Committee on the subject 'Medical Facilities for Women at All India Institute of Medical Sciences (AIIMS), Hospitals and Primary Health Centres'.

2. The Report is based on the inputs received from the Ministry of Health and Family Welfare and impressions gained during on the spot study visits to All India Institute of Medical Sciences (AIIMS), Lady Hardinge Medical College and Sucheta Kriplani Hospital for Women, Dr. Ram Manohar Lohia Hospital, and Primary Health Centres(PHCs).

3. The Committee on Empowerment of Women took oral evidence of the representatives of the Ministry of Health and Family Welfare, AIIMS and major hospitals in Delhi on 20th February, 2008.

4. The Draft Report was considered and adopted by the Committee on Empowerment of Women (2007-2008) at their sitting held on 25th April, 2008. The Minutes of the sitting form Part II of the Report.

5. The Committee wish to express their thanks to the Ministry of Health and Family Welfare, All India Institute of Medical Sciences (AIIMS), Lady Hardinge Medical College and Sucheta Kriplani Hospital for Women, Dr. Ram Manohar Lohia Hospital, Safdarjung Hospital etc. for placing before them material and information in connection with the examination of the subject and giving evidence before them.

6. The Committee also place on record their appreciation for the valuable assistance rendered to them by the officials of the Lok Sabha Secretariat attached to the Committee.

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

NEW DELHI;
25th April, 2008
5th Vaisakha, 1930 (Saka)

KRISHNA TIRATH
Chairperson
Committee on Empowerment of Women

CHAPTER I

HEALTH CARE SECTOR IN THE COUNTRY

Health and health care are key policy concerns in every matured society. Health is not mere absence of disease; it is freedom from illness and a sense of well being. Health care is not merely medical care but preventive care too.

1.2 Over the past few decades, our country has registered significant progress in some of the major indicators of health despite its huge population. However, even now a large number of people continue to suffer and die from preventable diseases, pregnancy and childbirth related complications, as well as malnutrition. In many States and regions, the rural public health care system is quite unsatisfactory. To combat the situation, the Tenth Plan added thrust to health sector in the country.

(a) National Health Policy (NHP), 2002

1.3 The basic paradigm for health sector reforms during the Tenth Plan was determined by the National Health Policy (NHP) which was designed in 2002 with an aim to reduce the overall burden of disease, promote health, encourage inter-sectoral coordination and improve the service delivery. This policy document enunciated certain targets for scaling-up health investments to control all communicable diseases and expanding and strengthening secondary and tertiary health care for the benefit of common man. The NHP, 2002 sought to decentralize the public health delivery system by establishing infrastructure in deficient areas.

1.4 The Committee have been informed that the National Health Policy focused on the following aspects to achieve its targets:-

- "Expanding and improving facilities in primary health services.
- Re-structuring Health care systems to facilitate more equitable access to healthcare.
- Area specific schemes to meet health needs of women, children, elderly, tribals and socio-economic vulnerable sections of society.
- Programmes for control of diseases like TB, Malaria, Blindness and HIV /AIDS.
- Disaster Management Plan to cope with natural and man-made calamities.
- Macroeconomic prescriptions for coordination between Government, Voluntary and Private sector, NGOs and other institutions of civil society."

1.5 Accordingly, the National Common Minimum Programme (NCMP), 2004 has accorded high priority for the health care sector and has committed to allocating 2-3% of the GDP as public expenditure on health, a target to be reached by 2010.

1.6 When the Committee desired to know the percentage of GDP, the Government spends on health care, it has been informed as under:-

> "In terms of percentage of GDP, public expenditure on health is in the vicinity of 1%. However, if expenditure incurred on other inter-dependent sectors like drinking water, nutrition etc. is taken, public expenditure on health as percentage of GDP during the last 3 years was 1.25% in 2004-05, 1.41% in 2005-06 and 1.39% in 2006-07 (Economic Survey 2006-07)."

1.7 Details of the expenditure on health sector in the country from 1995 to 2004, as a proportion of GDP, compiled from World Health Organization Reports for various years is given below:

Year	Total Expenditure on Health as% of Gross Domestic Product	General Government Expenditure on health as % of Total Expenditure on Health	Private expenditure on health as % of total expenditure on health
1995	5.0	0.81	4.19
1996	5.2	0.81	4.39
1997	5.3	0.83	4.47
1998	5.0	0.92	4.08
1999	5.2	0.93	4.27
2000	5.1	0.90	4.20
2001	5.1	0.91	4.19
2002	4.9	1.16	3.74
2003	4.8	1.19	3.61
2004	5.0	0.87	4.13

"

(b) National Rural Health Mission (NRHM), 2005

1.8 To effect an architectural correction in the health care delivery system, the National Rural Health Mission (NRHM) was launched in 2005. The Plan of Action of NRHM envisages increasing public expenditure on health, reducing regional imbalances in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets and providing public-private partnership. The goal of the mission is to improve the availability and access of quality health care to the people, especially for those residing in rural areas, the poor, women and children. The Mission has been trying to improve the health delivery system through comprehensive upgradation of infrastructure, augmentation of manpower and expansion of capacity for training various stakeholders.

1.9 While elaborating on the vision and targets of NRHM, the Ministry of Health and Family Welfare have, *inter-alia*, stated as below:-

"The Mission would help achieve goals set under the National Health Policy and Millennium Development Goals. The objectives of the Mission are:-

- Reduction in child and maternal mortality.
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

1.10 And, to achieve these goals NRHM will

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj Institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care."

1.11 During the course of evidence of the Ministry of Health and Family Welfare, the Committee desired to know more about the involvement of Panchayati Raj Institutions in the management of NRHM. In reply, the Secretary, Ministry of Health and Family Welfare stated as under:-

"As far as the involvement of the Panchayati Raj institutions in the National Rural Health Mission is concerned, we have tried to mainstream

> the Panchayati Raj institutions in our structures. At the village level, we have the Village Health and Sanitation Committees. Under the National Rural Health Mission we are giving Rs. 10,000/- to each Village Health and Sanitation Committee every year for local action."

1.12 The Committee also find that the NRHM seeks to strengthen the service delivery by ensuring community ownership of the health facilities. The sub-centres are envisaged to be under the management of the Local Panchayat. The Pradhan shall be operating the joint account with the ANM for utilization of Untied Funds. Similarly, the PHCs and CHCs are also proposed to be transferred to the local elected Panchayati Raj Institution for management.

(c) Health Infrastructure in the country

1.13 Over the last five decades, our country has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors.

1.14 The Committee have been informed that as on March, 2006 there are 262 Medical Colleges, 144988 Sub Centres, 22669 Primary Health Centres (PHCs) and 3910 Community Health Centres (CHCs) in the country. This is against a requirement of 158792 Sub Centres, 26022 PHCs and 6491 CHCs based on population norms using 2001 population (state-wise breakup is given in Annexure-I). At Sub Centres and PHCs, as compared to a requirement of 1,67,657 Female Health Workers/ANMs (one per each Sub Centre and PHC), there are 1,49,695 in position as on March, 2006 resulting in a shortfall of 18318, ignoring surplus in some States/UTs (Annexure-II). In case of Male Health Workers at Sub Centres, there is a requirement of 144988 against which only 65511 are in position resulting in a shortfall of 74721, ignoring surplus in some

States/UTs (Annexure III). At PHCs, there is a requirement of 22669 Doctors (one per each PHC) against which 22273 Doctors are in position resulting in a shortfall of 1793 Doctors, ignoring surplus in some States/UTs (Annexure IV). Similarly, at CHCs, there is a requirement of 15640 specialists (including one Surgeon, one Obstetrician & Gynaecologist, one Physician and one Paediatrician for each CHC) against which there are 3979 Specialist in position as on March, 2006, resulting in a shortfall of 9413 Specialists (Annexure V).

1.15 Delving into the problems being faced by the Government in evolving a better health delivery system, the Secretary, Ministry of Health and Family Welfare stated during evidence, as under:-

> "We have a grave shortage of trained manpower in the health sector and particularly gynaecologists. But despite these shortages we have managed, during the last year and a half, to engage over 11,000 staff nurses, over 2,200 specialist doctors, over 6,000 MBBS doctors, and over 4,000 AYUSH doctors who are being co-located in PHCs under the National Rural Health Mission on contract basis. So, this is an additional manpower that we have managed to make available. I think, we will be able to make up a little more which is available in the market at the moment but thereafter there is a grave shortage of human resources. It takes 18 months to train an ANM. It takes about six to six and a half years to train an MBBS doctor. So, it is not an easy solution. We are trying to put up more medical colleges. We are trying to address the human resources in the health sector, but it will take time."

1.16 As far as correcting the imbalance in availability of affordable/reliable tertiary level healthcare in the country in general and to augment facilities for quality medical education in the under-served States is concerned, the Committee have been informed that Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) which has been approved in March, 2006, envisages setting up 6 AIIMS like institutions one each in the States of Bihar, Madhya Pradesh, Orissa,

Rajasthan, Chhattisgarh and Uttaranchal. Each institution will have 850 bedded hospital intended to provide healthcare facilities in 39 Specialty/Super Specialty disciplines. The Medical Colleges will have 100 undergraduate intakes besides facilities for imparting PG/Doctoral courses in various disciplines. Under PMSSY, upgradation of 13 existing medical institutions has also been envisaged.

1.17 Through a post-evidence reply, the Committee have further been informed that at present there are 173 nursing schools and 336 ANM/HW(F) schools in the Government sector and a proposal for starting 137 nursing schools and 145 ANM/HW(F) schools in various states is under consideration .

(d) Role of Private Sector in Health Care

1.18 When the Committee desired to know the role of private sector in health care in the country, the Ministry of Health and Family Welfare has submitted as under:

> “Private sector is a major player in delivering healthcare services, despite the massive public health infrastructure in existence in the rural areas. The National Sample Survey 60th round has documented that access to public health facilities even if it exists, is not really being availed. The factors responsible for this situation include non-availability of medical personnel, diagnostic services, medicines etc. Through NRHM, the Central Government with the active support of State Governments aims to improve basic healthcare service delivery through Sub Centres, Primary Health Centres and Community Health Centres and to build up a vibrant service delivery system, so as to improve access to healthcare facilities. Over the years, the private sector has gained a dominant presence in providing health care services both diagnostic and curative. The 60th round of NSS, in its findings has indicated that:
>
> - The private sector is the main provider of inpatient healthcare both in the rural and urban areas.

- Near stagnation in the utilization of public facilities in health; outpatient care in public institutions are accessed by only 22% in the rural areas and 19% in the urban areas.

- There has been an increase by nearly 50% in health expenditures in urban and rural areas as compared to the last survey conducted in 1994-95;

In urban areas, corporate hospitals have built capabilities with State of Art technologies, which is increasingly catering to the well off sections and foreign tourists. R&D and a mix of the right talent and with a congenial environment have given them an edge in health care delivery in the urban areas. On the other side, Studies have shown that majority of private sector health institutions are single doctor dispensaries with very little infrastructure or without para-medical support. They provide symptomatic treatment for common ailments and because they are conveniently located and easily accessible, patients from even below poverty line utilize their services and pay for them."

1.19 The Committee have further been informed that the Government has introduced the 'Clinical Establishments (Registration and Regulation) Bill, 2007' in the Parliament, which is expected to provide for registration and regulation of all clinical establishments in the country. The provisions of the Bill are applicable to all clinical establishments including diagnostic centers under all recognized systems of Medicine, both in private and public sector.

1.20 During oral evidence, the Secretary, Ministry of Health and Family Welfare claimed that the National Rural Health Mission has brought the public back to the public health care institutions in the villages. Trying to substantiate the claim of the Secretary, the representative of the Ministry added as under:

"In a State like Tamil Nadu, out of the 1100 odd PHCs, about 900 have three nurses and the change it has brought about is that about 35,000 deliveries, which would have taken place in the private sector, have come back to the Government sector. The point that is coming out very clearly is that the poor people are coming to the public system wherever the

system starts working. For example, in Bihar, the average outpatient number per month for hospitals was 39 two years ago, but now on an average, every month 4,000 patients are coming to the public facility. The point which has come out very strongly in all the States is that wherever the public system has geared up to this demand – doctors are there, basic diagnostics are there and basic drugs are there – automatically the shift takes places to the public system."

(e) Public-Private Partnership in Health Care

1.21 With the growing demand for healthcare services, partnership with the private sector can bring about beneficial outcomes. Under the NRHM, partnering with NGO's constitutes an important component. This would help in tapping expertise available with the private sector and the experience gained by the NGOs in community health programmes.

1.22 Some of the projects being taken up by states under the Private-Public Partnership (PPP) mode as per the information furnished by the Ministry are as below:

- "Providing Land to major corporate care hospitals within the premises of State Medical colleges together with a grant to build and operate a cardiac specialty center at tertiary level, outsourcing laboratory and blood screening services to a private agency at secondary and tertiary level (Chhattisgarh).
- Establishment of life line drugs stores in Hospitals (Rajasthan).
- Contracting out the diagnostic services, CT scan/ MRI services to private agencies (Rajasthan, West Bengal).
- Mobile Hospitals and research Centers provide health care and diagnostic facility to poor in difficult hilly Terrains (Uttarakhand).
- Health insurance scheme for poor vulnerable sections of society (Karnataka and Andhra Pradesh)".

1.23 The Committee have also been informed that several States are replicating these models by customizing it to meet their requirements. These initiatives are to provide beneficiaries the choice of healthcare providers.

1.24 During evidence, the Secretary, Ministry of Health and Family Welfare added:

> "As far as public-private partnership is concerned, in fact a lot of flexibility has been given to the States under the National Rural Health Mission to develop such partnerships. In a number of States very successful partnerships have been developed. Some of the examples I can give you are that in the State of Andhra Pradesh, the entire emergency in medical relief system, ambulances are being provided by the Satyam Computers. The Satyam Computers have instituted a scheme by which they run all the ambulances all over the State and a single telephone number has been provided for that. Now within 15 minutes of a call, an ambulance reaches the place where it is required. All the ambulances come under the National Rural Health Mission plus all the ambulances with the State Government have been pooled to do this. Similar systems are being adopted in other States like Gujarat. There are other schemes like Chiranjeevi Scheme where for the deliveries of the BPL category, they are giving Rs. 1,80,000 to provide private gynaecologist services for 100 deliveries regardless of normal delivery or caesarean delivery."

(f) Health Indicators in the Country

1.25 Though our country has made rapid strides in health sector since independence, especially in terms of indicators viz. life expectancy, infant mortality rate, etc. a large number of people still continue to die of infectious diseases and millions do not have access to the most basic health care.

i) Life expectancy

1.26 Life expectancy at birth and infant mortality are two important indicators of health. As per data furnished by the Ministry of Health & Family Welfare, expectancy of life at birth in our country is as follows:-

“Census Year	Male	Female	Combined”
1901-10	22.6	23.3	22.9
1911-20	19.4	20.9	20.0
1921-30	26.9	26.6	26.8
1931-40	32.1	31.4	31.8
1941-50	32.4	31.7	32.1
1951-60	41.9	40.6	41.3
1961-70	46.4	44.7	45.6
1970-75	50.5	49.0	49.7
1976-80	52.5	52.1	52.3
1981-85	55.4	55.7	55.4
1986-90	57.7	58.1	57.7
1991-96	60.6	61.7	61.2
1996-01	62.3	65.3	NA
2001-05	63.8	66.1	NA
2006-10	65.8	68.1	NA
2011-15	67.3	69.6	NA
2016-20	68.8	71.1	NA
2021-25	69.8	72.3	NA”

Source:

(a) **Office of the Registrar General, India.**

(b) **Occasional Paper SRS No. 3 of 1995.**

(c) **Report of the Technical Group on Population Projections, 1996-2016 (RG-India)**

(d) **Report of the Technical Group on Population Projections, 2001-2026 (RG – In dia)**

ii) *Infant Mortality Ratio (IMR)*

1.27 As per the information provided to the Committee, Infant mortality is currently at 57 per 1000 live births (2007). In fact, over the past 15 years infant mortality has declined substantially, i.e. by 35%. Manipur has the lowest IMR (11 /1000 live births) and Madhya Pradesh is the highest at 74 per 1000 live births.

Infant mortality rates have declined in both urban (39/1000 live births) and rural areas (62/1000 live births). Higher rates of antenatal, delivery and post-natal care are usually associated with lower infant mortality. Such an inverse relationship is observed with higher education status of mothers and a higher standard of living index.

1.28 The rate of decline of infant mortality ratio was rapid in the eighties but has slowed down in the nineties to only two points per year. The pace of decline of Infant Mortality Rate needs to be accelerated for the country to be able to achieve the Millennium Development Goal of 30 per thousand live births by 2015. Low birth weight (30%), birth injury, acute respiratory infections, sepsis and diarrhoeal diseases are considered to be the principal causes of infant mortality in India. Malnutrition among children is another major factor, which adds to IMR in the country.

1.29 The IMR for boys (56 deaths per 1000 live births) is lower than for girls (61 deaths per 1000 live births). The child mortality rate is also considerably higher (37 deaths per 1000 live births) for girls than for boys (25 deaths per 1000 live births). This sex differential in mortality reflects the negative impact of social, cultural and health conditions related to low status of women in India.

1.30 When the Committee desired to know the respective health indicators in other countries in the world, it has been furnished as under:-

"Sl. No.	Country	Population (Millions) 2006	Average Annual Growth Rate (percentage)	Total Fertility Rate	Infant Mortality Rate (per 1000 Live Births)	Life Expectancy at Birth (Years)	
						Males	Females
1.	China	1393.6	0.6	1.72	32	70.6	74.2
2.	Democratic People's Republic of Korea	22.6	0.4	1.95	43	61.1	66.9
3.	Japan	128.2	0.1	1.35	3	78.9	86.1
4.	Republic of Korea	48	0.3	1.19	3	74.2	81.5
5.	Indonesia	225.5	1.1	2.25	36	66.2	69.9
6.	Malaysia	25.8	1.7	2.71	9	71.6	76.2
7.	Myanmar	51	0.9	2.17	69	58.4	64.2
8.	Philippines	84.5	1.6	2.94	25	69.1	73.4
9.	Singapore	4.4	1.2	1.30	3	77.3	81.1
10.	Thailand	64.8	0.8	1.89	18	67.7	74.6
11.	Vietnam	85.3	1.3	2.19	27	69.5	73.4
12.	Afghanistan	31.1	3.5	7.18	144	46.9	47.3
13.	Bangladesh	144.4	1.8	3.04	52	63.3	65.1"
14.	India	1119.5	1.4	2.85	62	62.7	66.1
15.	Iran	70.3	1.3	2.04	29	69.7	73.0
16.	Nepal	27.7	1.9	3.40	58	62.4	63.4
17.	Pakistan	161.2	2.1	3.87	73	64.0	64.3
18.	Sri Lanka	20.9	0.8	1.89	15	72.2	77.5
18.	Australia	19.5	1.0	1.75	5	78.3	83.3
19.	More developed Rgn	1214.5	0.2	1.58	7	72.4	79.7
20.	Less developed Rgn.	5325.8	1.3	2.79	59	62.5	66.0
21.	World	6540.3	1.1	2.58	54	63.9	68.4"

Source: The State of World Population, 2006 (UNFPA Publication)

iii) Maternal Mortality Ratio(MMR)

1.31 High maternal mortality is a major public health concern in India. Thousands of women die every year due to causes related to pregnancy and childbirth. During 2001-03, MMR was highest in UP including Uttaranchal (517) and lowest in Kerala (110). 2 out of 3 maternal deaths were from 8 EAG

States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal) and Assam. RGI-SRS report on MMR (2001-03) when compared with the previous one i.e. 1999-01 indicates that the MMR has declined in all the States except Assam where it has shown an increase from 398 to 490 per 1, 00,000 live births. This could be attributed to the low capacity of the State in operationalizing their health facilities and fulfilling the gaps in skilled human resources leading to a low institutional delivery rate.

1.32 When the Committee desired to know the maternal mortality ratio of select countries in the world the following data has been furnished :

"(MMR per 1,00,000 live births)

Name of the Country	Year 2007
India	540
Afghanistan	1900
Bangladesh	380
Nepal	740
Pakistan	500
Sri Lanka	92
China	56
Myanmar	360
Thailand	44
Singapore	92
UK	13
US	17"

Source: State of World Population, 2007

CHAPTER II

HEALTH CARE FOR WOMEN IN INDIA

Development of Women has been receiving attention of the Government ever since the inception of planning in the country. It was only in Sixth Plan, a multi disciplinary approach for development of women was designed with a special thrust on the three areas: health, education and employment. In the Seventh Plan, the development programme continued with a major objective of enhancing economic and social status of women and bringing them in to the mainstream of national development. The Eighth Plan, which focused on human development, played a vital role in the development of women with promise to ensure that the benefits of the development from different development sectors do not by-pass women.

2.1 During the Ninth Plan, there were two main policy shifts towards planning for women. The first one recognized 'Empowerment of Women' as one of the nine primary objectives of the Plan. The approach was to create an enabling environment, where women could freely access their right as equal partners along with men. The second policy shift envisaged a Women's Component Plan (WCP) through which not less than 30% of the funds flow towards women from all general development sectors.

2.2 Acting upon the recommendations of Programme of Action (POA), formulated at International Conference on Population and Development at

Cairo,1994, several new initiatives were taken in the Ninth Plan as part of Reproductive and Child Health programme. During this period, the focus shifted from individualist vertical interventions to a more holistic integrated life cycle approach with more intensive reproductive health care. This included access to essential obstetric care during the entire period of pregnancy, provision of emergency obstetric care as close to the community as possible, improving safe abortion services and provisions for treatment of Reproductive Tract Infections (RTI) and Sexually transmitted diseases at the sub district level, provision of reproductive health education and services for adolescent boys and girls, screening of women for cervical and uterine cancer and treatment wherever required.

2.3 The National Health Policy 2002 recognized the need to ensure increased access of women to basic health care and committed higher priority to funding of identified programmes related to women's health. It called for further strengthening of the decentralized mode of implementation to facilitate the process of service delivery.

2.4 The Tenth Five Year Plan had set out certain monitorable indicators for women, which included reduction of maternal mortality rates to 2 per 1000 live births by 2007 and 1 per 1000 live births by 2010. However, the results of National Family Health Survey (NFHS-III) indicate that institutional births accounted for only 40.7 per cent and Mothers who received antenatal and post-natal care constituted 50.7 percent and 36.4 percent respectively.

2.5 Delving into the factors which act as barriers to health care for women, the Committee have been informed, *inter-alia,* as under:-

> "The low social and economic status of girls and women restrict their access to education and appropriate nutrition as well as health and family planning services. Sons are perceived to have economic, social and religious utility; daughters are felt to be an economic liability. Mal- nutrition, many a times, begins at the stage of infancy, especially in the not so well to do families and sets in motion a life long cycle of poor health. The general discrimination in health care access becomes more obvious when women are illiterate, unemployed or dependent. The combination of the perceived ill health and lack of support mechanism contributes to poor quality of health.
>
> Various studies have shown that significant disparities exist in health care utilization and health status between women and men. Poor women compared to poor men consume fewer resources and suffer worse health. A large and increasing share of health expenditure by the poor is outside the public sector. The girl child faces discrimination at every stage of life to name of few, low age at marriage, unsafe and unplanned deliveries, limited access to family planning methods etc.
>
> The Census 2001 showed that sex ratio of the population of the age - group 0-6 years declined to 927 from 945 in 1991. A strong preference for son, combined with the increasing evidence of wide spread sex selection prior to conception is distorting the already adverse sex ratio. Accordingly, the Pre-Natal Diagnostic Techniques Act 1994, was amended in 2003 to bring under its purview all actions relating to sex selection of imaging and ultrasound machine only to clinics registered under the Act and to strengthen enforcement with stringent penalties for violation."

2.6 To overcome these hurdles and to achieve high standards in the health care of women, the Government has envisaged a lot of programmes under various schemes, viz. the National Rural Health Mission (NRHM), the Reproductive and Child Health Care (RCH) programme, etc. Moreover, the Department of Health & Family Welfare in the Ministry of Health & Family Welfare has been implementing various Women Specific programmes (100% benefit for women) and Pro-Women (at least 30% benefit for women) schemes,

viz. nursing colleges, contraceptive programmes, rural family welfare services, reproductive and child health projects, etc. A separate gender budgeting exercise is also undertaken in the Department to assess the flow of resources for the benefit of women. The Committee have been told that the Ministry expects 29% of the total budget of the department during 2007-08 to be spent on Women-Specific Schemes as compared to 11% during 2006-07 (RE).

(a) Women specific programmes under NRHM and RCH

2.7 Under the NRHM (2005-2012) and the RCH Programme Phase-II (2005-10), the Government has been actively pursuing the goals of reduction in Maternal Mortality Rate by focussing on major strategies like essential obstetric and new born care for all, skilled attendance at every birth, emergency obstetric care for those having complications and referral services. Moreover as 8% of the maternal deaths are due to unsafe abortions, safe abortion services under RCH Programme have also been expanded and strengthened. Another major intervention is done through the amending of the MTP Act and Rules in 2002-03 thereby delegating the powers to recognize MTP centres to the districts.

2.8 Some of the women specific programmes under NHRM and RCH are as under:-

i) Essential obstetric care

2.9 This includes quality ante-natal care including prevention and treatment of anemia, institutional / safe delivery services and post natal care. Quality ANC includes minimum of at least 3 ANCs, 2 doses of T.T, immunization and consumption of IFA tablets for 100 days. To ensure quality anti-natal care, a

programme for prophylaxis and treatment of anemia has been under implementation throughout the country since 1997-98. Under this programme, all pregnant and lactating women are provided with one tablet (containing 100 mg of elemental iron and 0.5 mg of Folic Acid) daily for 100 days. Those who have severe anemia are provided with double dose of these tablets.

2.10 However, the Committee have been informed that as per National Family Health Survey III (2005-06), 56.1% of ever-married women aged 15-49 years are anaemic. The problem is more severe during pregnancy, with 57.8% of pregnant women (15-49 years) being anemic.

2.11 To provide essential obstetric care services, the Government has envisaged operationalizing 24X7 services at PHCs and also training the SNs/LHVs/ANMs in skilled attendance at birth. Under RCH – II, all the CHCs and 50% of the PHCs are being operationalized for providing round the clock delivery services by placing at least 3–5 Staff Nurses and one Medical Officer in these facilities. However, the Committee have been informed that as per the reports from the States, till now only 8755 PHCs have been operationalized as 24 X 7 PHCs and the performance of States other than Andhra Pradesh, Arunachal Pradesh, Bihar, Gujarat, Himachal Pradesh, J & K, Madhya Pradesh, Mizoram, Nagaland, Punjab, Tamil Nadu, Kerala, West Bengal and Puducherry are not that satisfactory.

2.12 Ensuring post natal care within first 24 hours of delivery and subsequent home visits on day 3 and 7 are the important components for identification and

management of emergencies occurring during post natal period. The ANMs, LHVs and staff nurses are being made aware of and also oriented for tackling emergencies identified during these visits. Organizing of Village Health & Nutrition Day (VHNDs) at Anganwadi center at least once every month to provide ante natal/ post partum care for pregnant women, also promote institutional delivery and health education. As reported by the States 28, 88,313 VHNDs were held in year 2006-07.

ii) Skilled Attendance at Birth

2.13 The Committee have been told that the Government has committed itself to providing skilled attendance at every birth, both at community and institutional level. To manage and handle some common obstetric emergencies at the time of birth, the Government of India has taken a policy decision to permit Staff Nurses (SNs) and ANMs to give certain injections and also perform certain interventions under specific emergency situations to save the life of the mother. Their training strategy involves a 2-3 week training of SNs and 3-6 week training of ANMs/LHVs in Skilled Attendance at Birth. For this, specific curriculum and technical guidelines have been developed and have been disseminated to the States.

2.14 It has further been informed that the training are being imparted in about 25 States and UTs involving about 336 districts, with about 1957 trainers trained. 4005 ANMs/SNs have already been trained.

iii) Provision of Emergency Obstetric and Neo natal Care at First Referral Units (FRUs)

2.15 The Committee have been told that the provision for emergency obstetric and neo- natal care have been ensured by operationalising 1594 FRUs in the country and the achievements in the States of Andhra Pradesh, Arunachal Pradesh, Gujarat, Himachal Pradesh, Jammu & Kashmir, Madhya Pradesh, Kerala, Nagaland, Punjab, Tamil Nadu and Pondicherry ,in this regard, are satisfactory.

2.16 To operationalize all FRUs, States are concentrating their efforts on the critical components such as manpower, blood storage units and referral linkages etc. An initiative of training of MBBS Doctors (an 18 weeks programme) in life saving anesthetic skills for Emergency Obstetric Care at FRUs is being conducted in about 91 Medical Colleges of 21 states. Under this training, so far 295 MBBS doctors have been trained in Assam, Haryana, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Jammu & Kashmir, Andhra Pradesh, Karnataka, Manipur and West-Bengal.

2.17 Government of India has also introduced training of MBBS doctors in Obstetric Management Skills in collaboration with Federation of Obstetric and Gynecological Society of India. A 16 weeks training programme in obstetric management skills including Caesarian Section operation is being implemented in 14 Medical Colleges of 13 states. Till now 97 Master Trainers and 95 MBBS doctors have been trained in Orissa, Bihar, Madhya Pradesh and West Bengal.

(b) Janani Suraksha Yojana:

2.18 Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM). The Yojana has been launched on 12th April, 2005, it has the dual objectives of reducing maternal and infant mortality by promoting institutional delivery among the poor women. Under the Yojana, community level link workers called Accredited Social Health Activists (ASHAs) are working as link among beneficiary at village level, Anganwadi Worker and ANM. She helps and guide women to access the health facilities for anti-natal care, institutional delivery, post-natal care and counselling on nutrition and Family Planning Services.

2.19 Under Janani Suraksha Yojana, cash benefits are provided to the poor pregnant women for institutional delivery and also the village link worker/ASHA for bringing the women to the institutions for delivery. Even the cost of transportation is borne by the Government. But, these benefits are graded in nature and vary from high performing States to low performing States and also from rural to urban areas. The eligibility criteria is as under:

LPS States	All pregnant women delivering in Government health centres like Sub-centres, PHC/CHC/FRU/or in the general wards of District and state Hospitals or accredited private institutions.
HPS States and North-Eastern States	All BPL pregnant women, aged 19 years and above.
LPS & HPS	All SC and ST women delivering in Government health centre like Sub-centres, PHC/CHC/FRU/ or in the general wards of District and state Hospitals or accredited private institutions.

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Cash Assistance for Institutional Delivery under the scheme is as below:

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	ASHA's Package		Mother's Package	ASHA's Package	
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

2.20 However, cash assistance for institutional delivery in High Performing States is limited up to 2 live Births. When the Committee expressed their concern over restricting the financial assistance under the mother's package to BPL women aged 19 years and above in High Performing States and North-East, the Secretary, M/o Health and Family Welfare responded as under:

> "It is illegal in this country to be married at an age less than 18. I grant you that in the rural areas 53 per cent are getting married less than that age. But, it is basically for our society, our representatives of the society to really build that awareness and change the social attitude"

2.21 However, the Committee felt that child marriage as a social evil needs to be addressed in a different platform and a mother who is below 19 years, should not be punished for a mistake not of hers, by excluding her from the financial benefits of the scheme.

2.22 About ASHAs, the Committee have further been informed as under:-

> "Operationalization of the ASHA initiative is an important strategic intervention under NRHM. ASHA is a trained female health activist provided in each village in the ratio of one per 1000 population. For

tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload.

ASHA must be primarily a woman resident of the village with formal education upto Class VIII and preferably in the age group 25-45. She would be selected by the Gram Sabha following an intense community mobilization process. She will counsel and provide services to the families as per her defined role and responsibility. She would be fully accountable to Panchayat. ASHA would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable disease, nutrition and sanitation. In order to work in close coordination with AWC and AWW, she would be fully anchored in the Anganwadi system.

ASHA will have to undergo series of training episodes. The cost of training and drug kits would be supported by the centre in the 18 High Focus States. Though she would not be paid any honorarium, she would be entitled for performance based compensation. She will have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day on about 4 days per week, except during some mobilization events and training programmes."

2.23 However, the Committee expressed their concern over the remuneration that an ASHA is offered. As per the Committee, it would be extremely difficult for an ASHA worker to meet the minimum standards expected of her in tribal, hilly and remote areas, and at times the maximum she could earn would be Rs. 800/- per month, which, obviously, is too paltry a remuneration.

2.24 Responding to this the Secretary, Ministry of Health and Family Welfare during oral evidence stated as under:-

"ASHA has become some sort of a *Amritdhara* at the village level and we expect them to do everything. About remuneration, ASHA gets remuneration according to the amount for the work that she does. For each service, we are fixing amounts which they will be getting. Under each programme, where we are expecting them to do some work, they are going to be given some remuneration for each one of them. It is going to

take time for the whole system to stabilize. It is true that in the very beginning, they may not be getting sufficient."

(c) Easy -to-use Pregnancy Kit

2.25 During the course of evidence, while talking about other pertinent issues concerning the facilities available to women, the Secretary, Ministry of Health and Family Welfare *suo-motu* stated as under:

> "One thing I would like to mention specially is that in none of our health facilities in the Government sector, there is a facility to do a simple thing like pregnancy test till recently and as a result, there was very late detection of pregnancy. Now, we have asked our Ministry's PSU, the Hindustan Latex Limited, to make an easy-to-use pregnancy test kit available which we could then give to our whole system. I am happy to report that Hindustan Latex, on the 29th of November, 2007 inaugurated their factory, and they have now started producing these kits. These are very simple and easy-to-use kits."

(d) Contraception Programmes

2.26 As far as contraception programmes by the Government are concerned, the Committee have been informed that the National Family Welfare Programme provides the following contraceptive services:

- "Sterilization as a terminal method.
- Intra-Uterine Devices (IUDs) for spacing births.
- Daily/weekly Oral Contraceptive Pills (OCPS) for spacing births and Emergency Contraceptive Pills (ECPs) for preventing conception due to unplanned/unprotected sex.
- Condoms for spacing births and prevention from STI/RTI/HIV/AIDS."

2.27 During the course of evidence the Committee have been informed that the Government is promoting terminal methods like tubectomy and vasectomy, both female and male condoms and IUDs. However, from the data furnished to

the Committee in regard to vasectomy and tubectomy conducted in the country (state-wise) during the last 5 years (Annexure-VI), yet to be appended it has been observed that the per centage of tubectomy to total sterilizations has been 97.5% in 2002-03, 97.7% in 2003-04, 97.2% in 2004-05, 96.5% in 2005-06 and 97.5% in 2006-07.

2.28 Since the above figures showed a clear preference for female sterilization, the Committee desired to know the hurdles in achieving higher rates of male sterilization. To this, it has been replied as below:

> "Following are the factors that come in the way of achieving high rate of male sterilization:-
>
> - Although a large number of NSV training programme were organised to train the doctors in No-Scalpel Vasecotomy (NSV) technique all over the country, only few qualified service providers are available in comparison to the required number.
> - There are inadequate service centres due to less number of service providers as well as other required facilities.
> - So many times, it is observed that due to lack of administrative support, programme gets affected.
> - Poor IEC regarding the programme is also a major reason for low rate of male participation.
> - There is lack of advocacy.
>
> There are some social reasons too that come in the way of achieving higher rate of male sterilization, like
>
> - There is a very common misconception that males will lose their sexual power, although it is not the case.
> - Another misconception is that, they will lose their physical power and that too is not the case.
> - There are so many myths and fears too. Some, religious bodies discourage sterilization.

2.29 When the Committee desired to know about the latest status of male contraceptive pill they have been informed that no such research is being done on the male contraceptive pill under the Family Planning Division.

(e) Clinical trials concerning women

2.30 Various clinical trials involving women have been another major concern of the Committee. In this regard, it has been informed that the clinical trials are conducted both on male and female patients to study the drug effects, which is a scientifically established procedure to rule out gender bias. However, clinical trials of some drugs, which are specifically indicated for women, are conducted only in women patients.

2.31 As per rule 122 DA of Drugs and Cosmetics Rules, no clinical trial for any New Drug can be conducted by any institution without permission from DCG(I). The clinical trial is required to be conducted in the country as per Schedule Y of Drugs and Cosmetics Rules, Good Clinical Practice Guidelines (GCP), and Ethical Guidelines. The concern regarding involvement of women in clinical trials has been specifically addressed in Para 2.4.6.1 of Indian GCP Guidelines. Sponsors, investigators and ethics Committees monitor the clinical trials.

2.32 During oral evidence, the Secretary, Ministry of Health and Family Welfare added:

> "As far as clinical trials and the Drug Controller organizations are concerned, our industry has actually outgrown our regulatory mechanism and we are in the process of completely upgrading the Drug Controller Organisations. So far it was the CDSCO under the Drug Controller General of India which was regulating the clinical trials, vaccines as well as licensing of drugs. You may be aware that we have introduced a Bill in

Parliament in the last Session to amend the Drugs and Cosmetics Act to set up the Central Drug Authority".

CHAPTER III

MEDICAL FACILITIES FOR WOMEN IN PRIMARY HEALTH CENTRES

(a) Primary Health Care System

The Health and Family Welfare Programme in the country is being implemented through primary health care system. In rural areas, primary health care is provided through a network of Sub-Centres, Primary Health Centres and Community Health Centres based on the following population norms:

Centre	Population Norms	
	Plain Area	Hilly/Tribal areas
Sub-Centre	5000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

3.2 Sub-Centre is the first peripheral contact point between Primary Health Care System and the community. It is manned by one female Auxilliary Nurse Midwife (ANM) and one Male Health Worker and one LHV for six such Sub-Centres. Sub-centres are assigned tasks relating to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes and provided with basic drugs for minor ailments needed for taking care for essential health needs for women and children.

3.3 While replying to a query regarding the facilities being offered at the Sub-Centre level, the Secretary, M/o Health and Family welfare stated during oral evidence as below:

> "At the Sub –Centre, which is the lowest level of facility that we have, we earlier used to have one ANM. Under NRHM we have given one extra contractual ANM to the Sub-Centre. There is no doctor at the sub-Centre. The doctor comes in the Primary Health Centre.
>
> At the Sub-Centre level, we are giving untied grant, we are giving some maintenance money, and we are giving them money for drugs also. So, that is done at the lowest level. There are about 1,45,000 Sub-Centres in this country, of which about 70,000 are in government buildings and the rest are in rented buildings. So, now, under the Mission we are also giving money to the States to construct new Sub-Centres to fill up this gap."

3.4 PHC is the first contact point between village community and the Medical Officer. A Medical Officer and 14 other staff man it. It acts as a referral unit for 6 Sub-Centres and has 4-6 beds for patients. It performs curative, preventive, promotive and Family Welfare services.

3.5 Community Health Centres (CHCs) are 30 bedded higher order public hospitals at sub-district level. It is manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist and Pediatrician supported by 21 para-medical and other staff. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

3.6 The Committee have further been informed that under NRHM, PHCs are being strengthened to provide a package of essential public health programmes and support for outreach services to ensure regular supplies of essential drugs and equipment, round the clock services in all the PHCs across the country, upgrading single doctor PHC to 2 doctors PHCs by posting of AYUSH

practitioner at PHC level and providing standard treatment protocols and training medical officers and para-medical workers in their use. Indian Public Health Standards (IPHS) have proposed upgradation of PHCs in terms of physical infrastructure, manpower etc. The PHCs have been given Untied Funds for local health needs, annual maintenance grant for improvement and maintenance of physical infrastructure,etc. Under NRHM, an annual grant of Rs. One lakh is also given to Rogi Kalyan Samities at PHCs.

(b) Facilities available for women at PHCs

3.7 When the Committee desired to know the facilities available for women at PHCs, it has been submitted as under :

> "Assured services covering all the essential elements of preventive, promotive, curative and rehabilitative primary health care services provided at the PHCs include:-
>
> *(i) Medical care:*
>
> - OPD services: 4 hours in the morning and 2 hours in the afternoon/evening (Time schedule varies from State to State).
> - First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions.
> - Referral services
> - In-patient services (6 beds)
>
> *(ii) Antenatal care*
>
> - Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes late in her pregnancy for registration she should be registered and care given to her according to gestational age.
> - Minimum 3 antenatal checkups and provision of complete package of services. First visit as soon as pregnancy is suspected/between 4th and 6th month (before 26 weeks), second visit at 8th month (around 32 weeks) and third visit at 9th month (around 36 weeks). Associated services like

providing iron and folic acid tablets, injection Tetanus Toxoid etc. (as per the guidelines for ante-natal care and skilled attendance at birth by ANMs and LHVs)

- Minimum laboratory investigations like haemoglobin, urine albumin and sugar, RPR test for syphilis
- Nutrition and health counseling
- Identification of high-risk pregnancies/appropriate management
- Chemoprophylaxis for Malaria in high malaria endemic areas as per NVBDCP guidelines.
- Referral to First Referral Units (FRUs)/other Hospitals of high risk pregnancy beyond the capability of Medical Officer, PHC to manage.

(iii) Intra-natal care (24-hour delivery services in certain designated PHCs)

- Promotion of institutional deliveries.
- Conducting of normal deliveries.
- Assisted vaginal deliveries including forceps/vacuum delivery whenever required.
- Manual removal of placenta
- Appropriate and prompt referral for cases needing specialist care.
- Management of Pregnancy Induced hypertension including referral.
- Pre-referral management (Obstetric first-aid) in Obstetric emergencies that need expert assistance.

(iv) Postnatal Care

- Initiation of early breast-feeding within half-hour of birth.
- Education on nutrition, hygiene, contraception, essential new born care.
- (As per Guidelines of GOI on Essential New –born Care)
- Others: Provision of facilities under Janani Suraksha Yojana (JSY).

(v) New Born care

(vi) Care of the Child:

- Care of routine childhood illness.
- Promotion of exclusive breast-feeding for 6 months.
- Full immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI.
- Vitamin A prophylaxis to the children as per guidelines.
- Prevention and control of childhood diseases, infections, etc.

(vii) Family Planning

- Education, Motivation and counselling to adopt appropriate Family planning methods.
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions.
- Permanent methods like Tubal ligation and vasectomy/ NSV (Referral Camps).
- Follow up services to the eligible couples adopting permanent methods (Tubectomy/Vasectomy).
- Counselling and appropriate referral for safe abortion services (MTP) for those in need.
- Counselling and appropriate referral for couples having infertility."

3.8 As a part of detailed examination of the subject, the Committee have visited some of the Primary Health Centres in various states. During their visits, they are given to understand that though the PHCs are supposed to refer complicated cases to higher health facilities, even a telephone is not available in many PHCs. Replying to a question , the Committee have been informed that except in the States like Kerala (45%), Mizoram (11%), Orissa (5%), Tamil Nadu (31%), Tripura (33%) and Uttaranchal (17%) all other States/UTs have 50% or more PHCs with Telephone facilities.

3.9 In the context of out-reach of the PHCs and facilities for referring complicated cases to higher health facilities, the Committee have further observed that the availability of a vehicle in running condition also is a critical input in PHCs. As per facility survey Phase – II, 2004, only less than 50% of PHCs in the States/UTs have any vehicle with the exception of Gujarat (86.5%), Maharashtra (55.8%), Mizoram (59.3%) and Tripura (72.7%).

CHAPTER IV

MEDICAL FACILITITES FOR WOMEN AT ALL INDIA INSTITUTE OF MEDICAL SCIENCES (AIIMS)

(a) An overview of AIIMS

All India Institute of Medical Sciences (AIIMS), an institution of national importance, was established in 1956 by an Act of Parliament. AIIMS was conceived to be a centre of excellence in modern medicine with comprehensive training facility. The Institute has been entrusted to develop patterns of teaching in undergraduate and postgraduate medical education in all its branches so as to demonstrate a high standard of medical education to all medical colleges and other allied institutions in India, to bring together at one place educational facilities of the highest order for the training of personnel in all important branches of health activity and to attain self-sufficiency in postgraduate medical education.

4.2 In the field of medical research, AIIMS is the leader, having more than 1200 research publications by its faculty and researchers in a year. In fact many research projects are being carried out in AIIMS on topics which are of national importance. The AIIMS faculty members have been generating research funds to the tune of Rs. 32 crores approximately per year from various governmental and international funding agencies like CSIR, ICMR, WHO etc. In addition there are many grants from bilateral collaboration programmes such as Indo-US, Indo-French & Indo-German. All these funding agencies give research grants on a competitive basis based on the project.

4.3 The Committee have also been informed that the research at AIIMS can be gauged by its impact on National Health Programme & Policy. Elaborating further it has been submitted in a written note as under:-

> "The National Goitre Control Programme and its resultant Iodine Deficiency Disorders programme stem entirely from the seminal work conducted by several generations of research workers at AIIMS. The National Policy on Idonization of Salt was largely guided by data generated by AIIMS research. The technical support provided to the Integrated Child Development Schemes (ICDS) also relates to epidemiological and programmatic research done at AIIMS. The concept of the use of Oral Rehydration Solution for diarrhoea, also resulted from the pioneering work done on childhood diarrheas at AIIMS. The governmental policy on Prevention of Blindness has been guided significantly by the epidemiological research done at AIIMS as has been the Control of Flourosis under the Technology Mission on Safe Drinking Water. All these are examples of how clinical and applied research at AIIMS in diseases relevant to our population have resulted in National policy generation, modification and implementation."

4.4 The AIIMS also provides the best possible medical care treatment to all patients attending the hospital. The hospital has a bed strength of 2332 and on an average 1,00,000 patients are admitted indoor per year.

4.5 In reply to a question, the Committee have been told that the average number of doctors present in the OPD's per day is approximately 1:32. As a part of the detailed examination of the subject, the Committee have visited AIIMS on 19th May 2007 to gain first hand knowledge of the facilities at the institution. During the visit, they have been informed that the hospital has the required number of doctors, nurses and other staff to provide the best patient care services as far as possible. They have also been told that keeping in view the increasing number of patients, all efforts are being made from time to time to increase the infrastructure facilities for better patient care.

(b) Medical Facilities for Women at AIIMS

4.6 All India Institute of Medical Sciences is a Super Specialty hospital. It provides state-of-art medical care to all the patients irrespective of their socio-economic status or sex. Due weightage is always given to admission and investigation of patients depending on the severity of their sickness. However, there are no separate indoor facilities earmarked for the female patients other than in the Department of Obstetrics & Gynaecology. There are 85 beds available in the Department & Obstetrics & Gynaecology at AIIMS. On an average, 40% patients admitted in the private wards are females. The same holds true for the total indoor hospital clientele.

4.7 The Committee have been informed in a reply that the following medical care facilities or clinical services are provided to the women in AIIMS:

- "The registration counters in the OPD provide for separate queues for females.
- Separate counters for registration of female patients are available in the specialty and super specialty clinics as well as at the diagnostic counters.
- A group of female Medical Social Guides is posted in the OPD exclusively for assisting the female and other needy patients for their registration, guidance as well as arranging consultations with the concerned doctors.
- As a standard procedure, the woman patients are examined only in the presence of another female, either a relative or a staff nurse.
- In case of casualty patients, an earmarked room for examination of female victims of alleged sexual assault etc. has been kept.
- Toilets for women are available on each floor of the OPD/ward.
- Besides separate OPD for Obstetric & Gynaecology patients, two special clinics are also held for Gynaecology malignancies and for breast cancer patients.

- All precautions are taken to ensure segregation of female patients in cubicles wherever possible when they are admitted in the general wards rather than keeping them with the male patients. However, there are difficulties in areas like the Intensive Care Units (ICU) and High Dependency Units (HDU) where very limited beds are available.

- All invasive examinations and procedures are preferably done by a lady doctor or in the presence of a female attendant where female caregivers are not available."

4.8 However, during their informal visit to AIIMS, the Committee had felt that there was an acute shortage of space in the Paediatrics and Gynaecology wards of the Hospital. Space constraints had even resulted in the breach of privacy of the patients. Moreover, there was no proper arrangement for the attendants of patients to wait.

4.9 During informal interaction, the Committee were informed that in the last 40 years, there had been no increase in the space provided for the Paediatric General Ward and for the last six years a proposal had been pending for a separate gynaecology wing with additional beds.

4.10 During oral evidence, Director, AIIMS added:

> "As regards space we have made a proposal for a separate Mother and Child Hospital. We have projected it in the XI Five Year Plan, which is under the consideration of the Ministry. Moreover, recently we have allocated additional space to the Department of Gynaecology in the Old Nurses Hostel. Nearly 30 rooms have been allotted to them and it is under renovation."

4.11 It has also been informed that there is a proposal for a Redevelopment Plan for future expansion of AIIMS. This plan envisages development of Super Specialty blocks at the vacant land of Masjid Moth Campus. Twelve number of super specialty facilities viz. School of Public Health, Advanced Facility for Child Health, Advanced Facility for Mother Care & Reproductive Health, Advanced Facility for Geriatrics, Advanced Facility for Gastroenterology, Advanced Facility for G.I. Surgery, Advanced Facility for Urology, Advanced Facility for Nephrology, Advanced Facility for Chest Diseases, Advanced Facility for Molecular Biology –

Genomics, Stem Cell, Nano-Technology, Advanced Facility for Endocrinology & Metabolism Disorders and Advanced diagnostic Facility are proposed.

4.12 Regarding staff quarters and hostels, especially for ladies, Director, AIIMS submitted during oral evidence that the proposal for building hostels and residential facilities has almost been cleared by the Ministry.

(c) Working Conditions of Female Staff

4.13 When the Committee wanted to know the percentage of female employees in the hospital, it has been stated that 30% of the faculty in AIIMS are female. i.e. out of 450 doctors in the faculty, 135 are female.

4.14 A statement showing the staff position in AIIMS is as under:-

	Male	Female
Group 'A'	129	65
Group 'B'	384	212
Group 'C'	1924	2467
Group 'D'	1405	122

4.15 The Committee have further been informed that all the privileges due to a lady worker have been ensured to the women employees, starting from crèches for the children of the workers to separate toilets and bath room facilities. Separate rest and dining rooms are also provided to women workers and rules for availing maternity, study leave etc. are being followed. There is a grievance redressal committee comprising of senior lady officers/faculty to address the

grievances of female workers/cases of sexual harassment and to ensure corrective measures.

4.16 The Committee also desired to know the details of the facilities available for Resident Doctors as well as the security arrangements made for the safety of patients /residents in the campus. In this regard, it has been stated that the Hostel, Mess and Shopping Complex are all located on the campus itself. There is an 'AIIMS Jimkhana Club' for recreation of the Doctors. For safety of the patients in the campus, adequate security arrangements have been made in the hospital, campus and residential areas. Mostly, the Security Officers/Guards are retired defence personnel.

4.17 As regards transport facilities, the Committee have been apprised that a separate transport facility is available for the female nursing workforce. Female patients availing medical facilities from the Employees Health Scheme have separate rooms earmarked for them for admission. The female workers also have privileged access to the recreational amenities club. In case of in service death of any employee, preference is given to the female's next of kin for compensatory employment.

CHAPTER –V

MEDICAL FACILITIES FOR WOMEN AT OTHER MAJOR HOSPITALS IN DELHI

(a) LADY HARDINGE MEDICAL COLLEGE/SUCHETA KRIPLANI HOSPITAL FOR WOMEN

The Lady Hardinge Medical College and Smt. Sucheta Kriplani Hospital for women was founded in 1914 to commemorate the visit of Her Majesty Queen Mary. Lady Hardinge – the wife of the then Viceroy was the first to take initiative for starting a medical college for women and made it possible for Indian women to study medicine. But she died later in the same year and on the suggestion of Queen Mary, the college and the hospital was named after Lady Hardinge to perpetuate the memory of its founder. Lord Hardinge formally opened the college and hospital in February, 1916.

5.2 Dr. Kate Platt was the first Principal of the college. The duration of course was 7 years including 2 years of pre-medical intermediate science course of Punjab University. The students had to travel all the way to Lahore for their examination and to compete with the students of the King Edward Medical College, Lahore. The pre-medical science departments were closed in 1935, thus reducing the course in the college from 7 years to 5 years. In 1960, rotating internship was introduced for 6 months. The MBBS course was reduced from 5 years to 4-1/2 years in 1964 with compulsory internship of one year.

5.3 Since 1950, the college has been affiliated to University of Delhi. In view of considerable demand for postgraduate students, postgraduate courses were

started in 1954 in affiliation with Punjab University and later on with the University of Delhi in 1956. To start with, only female postgraduate students were admitted, but since 1970, both male and female students are being enrolled for various postgraduate courses.

5.4 Started in 1916 with only 80 beds for the Departments of Medicine, Obstetrics and Gynaecology, the Lady Hardinge Medical College now has bed strength of 877 in Smt. S.K. Hospital and 350 beds in Kalawati Saran Childrens Hospital. A separate outpatient block was started in 1958 to cater to the needs of ever increasing population of Delhi.

5.5 Kalawati Saran Children Hospital was established on 17th March, 1956 as a centre of excellence for comprehensive Paediatric care and research. At the outset, it had only 50 beds gradually by 1994 the bed strength increased to 370 beds. It has the largest neo-natal wing in Delhi with 84 beds. The opening of Indo-Japan new block has created facilities for 150 additional beds. The hospital is now poised to play a pivotal role in the health care of the future generation of our country.

5.6 LHMC and SSKH are mainly female institutes/hospitals. Out of total number 877 beds available, 705 beds are for female patients including 348 beds earmarked for Obstetric & Gynaecology Department which is the biggest department in this Institution. Approx. 70% to 75% of total budget is being utilized on female patients and female medical students.

5.7 The percentage of female doctors in this institution is 47%. The Committee have been informed in a written note that the following facilities are provided in the hospital in the Specialty of Gynaecology and Obstetrics:

"The out-patient services
1. General Gynaecological OPD
2. Family Welfare OPD
3. Clinics – Antenatal Clinic
   Postnatal Clinic
   Colposcopy Clinic
4. Infertility Clinic
5. Prevention of parent to Child transmission or HIV (PPTCT Clinic)
6. Post menopausal clinic including urodynamic clinic

The In-patient services
1. 24 hrs. emergency obstetric & Gynaecologic care
2. Intensive/critical obstetrics care.
3. All major and minor gynaecologic & obstetric operation
4. Endoscopic surgery
5. Microsurgery
6. Gynaecological onco surgery
7. Reproductive health care in Family Welfare procedure of medical termination of pregnancy and all types of tubal sterilization."

5.8 The Committee have also been informed that the Department of Community Medicine is associated with the health care delivery through 2 Primary Health Centres (Palam & Mehrauli) and one Urban Health Centre. The faculty, Residents, Interns and other paramedical workers posted in the above Health Centre provide comprehensive Health Care at the clinics, Anganwadi Centres and Schools in those areas. In addition, they organize extension services to the sub centres through Mobile clinics at least once a week from the above centres. Various National Health Programmes on Malaria, Pulse Polio, Tuberculosis, RCH are provided through extension of services by Mobile clinics.

5.9 The department of Community Medicine organizes 'Health Melas' in the rural areas and urban resettlement colonies in relation to the prevention and control of HIV/AIDS, Polio, Blindness, Family Planning and nutrition education among children and women in the reproductive age group.

5.10 During an informal visit to the Sucheta Kriplani Hospital on 23.03.2006, the Committee observed that there was severe shortage of space and more than one patient was sharing a bed. In some cases there were 3-4 patients on one bed. The Committee felt that this not only breached the privacy of the patients but also hampered proper treatment of patients.

5.11 The Committee also felt that the standards of hygiene and cleanliness were not up to the mark in various sections of the Hospital. When the Members enquired about the reason, the hospital authorities informed that there was severe shortage of staff and some of the services were being availed on contractual basis. Responding to a query whether the Hospital authorities had taken any steps to address the issue, it was stated that they had approached the Ministry of Finance for creation of new posts and also for filling up vacant posts. The management further stated that many posts of Nurses are still lying vacant and there is a similar shortage of para-medical and faculty staff.

5.12 Another major concern highlighted during the visit was the dilapidated state of Hospital building. It was stated that even CPWD had declared that these buildings had already outlived their lives. In this context, the Committee desired to know what efforts had been made to construct new buildings. In reply to the query, the Committee were told that the matter had been taken-up with Ministry

of Urban Development and the Ministry had directed them to prepare a comprehensive re-development plan to restructure the whole premises. But most of the plans had not been cleared and, therefore, construction of new building in the premises had not been made possible as yet.

5.13 It is also felt that the capacity of the hospital should be expanded as there is heavy influx of patients from different parts of the country due to its proximity to New Delhi Railway Station.

5.14 When the Committee desired to know about the facilities provided to female employees, it has been informed that most of the female workers are provided residential accommodation in the campus, and there is a separate rest room and dining space for female employees. Creche facility is also available at the Hospital.

5.15 The Committee have further been informed that a Grievances Redressal Committee is functioning in this institution to look into grievances of female employees. Complaints received are redressed by grievance Redressal Committee of LHMC & Smt. S.K. Hospital from time to time and the institution takes necessary corrective measures as recommended.

(b) DR. RAM MANOHAR LOHIA HOSPITAL

5.16 Dr. Ram Manohar Lohia Hospital was originally known as Willingdon Hospital and Nursing Home. The hospital was established during 1933-35 out of donations from His Excellency Marchioner of Willingdon. Later, its administrative control was transferred to the New Delhi Municipal Committee and

in 1954 this hospital was taken over by the Central Government. In the recent past, the old building portion of the hospital has been declared as a Heritage Building.

5.17 Starting with 54 beds in 1954, the hospital expanded to meet the ever-increasing demand on its services and now there is a 1000 bedded hospital, spread over an area of 30 acres of land. The hospital caters to the needs of CGHS beneficiaries and Hon'ble MPs, Ex-MPs, Ministers, Judges and other VVIP dignitaries besides other general patients. Nursing Home facilities are available to entitled CGHS beneficiaries.

5.18 During the examination of the subject, the Committee have been informed that the following medical facilities are available at the Hospital for the women beneficiaries:

- "OPD services for all women on all six days of week.
- ANC clinics for pregnant women thrice in a week.
- Post Natal Clinic.
- Urogynae clinic once in a week.
- Adolescent clinic for young girls once in a week.
- Free family planning services
- Emergency contraceptive
- MTPs
- Laparoscopic sterilization
- Vasectomy
- Free facilities for cancer cervix and cancer endometrium detection by PAPs smear.
- Facilities for minor operation procedure like EB, Cervical Biopsy, hydrotubation etc.
- Indoor facilities include admission for women in gynaec ward. In addition to routine treatment there are facilities for detection of cancer of female genital tract, laparocscopic surgery and hysteroscopy.
- A Maternity Nursing Home facility for CGHS beneficiaries with 20 beds is available."

5.19 The Committee have further been informed that the following number of beds have been allocated for females in different wards:

"(a)	Old Block Building		
	Surgery	-	31 Beds
	Gynae	-	25 Beds
	Orthopaedic	-	09 Beds
	Sick Room for female employees	-	06 Beds(including 2 beds in Maternity Nursing Home)
	Neurology	-	12 Beds
(b)	New Building Block		
	Medicine (Ward No-11)	-	32 Beds
	Medicine (Ward No-12)	-	32 Beds
	ENT & Dermatology Ward	-	31 Beds
	MTP Cases Ward	-	06 Beds
(c)	Emergency Department		
	Medical (Ward – 19)	-	06 Beds
	Surgical & Orthopedics (Ward –19)	-	08 Beds
	C2F (Medical)(Ward-21)	-	07 Beds
	ICS (Ward-20) for surgery And Neuro surgery	-	20 Beds
	C3F (Ward 22) Ortho	-	06 Beds"

5.20 The Committee have been informed that on an average 1016 female out patients are being attended to in the various departments of this hospital. However, during their informal visit to Dr. Ram Manohar Lohia Hospital on 19.05.2007 the Committee had observed that there was no availability of a general maternity facility. Though all pregnant women are registered and the CGHS entitled cases are booked for delivery in the Maternity Nursing Home, other maternity cases of general patients are referred for delivery to other Government Hospitals.

5.21 The Committee further observed during their visit that there was just one Cardio Tocography Machine (CTG) machine in the labour room. They also

observed that the Hospital did not have a Mammography Machine which helps in detecting breast cancer.

5.22 The Committee have been informed that this Hospital is a centre for Post-graduate training to M.D./M.S./DNB students of Delhi University & National Board of Examination in various specialties like Medicine, Ortho, Surgery, Anaesthesia, Radiology, Skin, Eye & Paediatrics. Recently DNB courses have started in the Department of Neurosurgery, Psychiatry & Cardio Thoracic & Vascular Surgery. The Under-graduate students of LHMC come to this hospital for training. A School of Nursing is also run by hospital, which awards 3 years diploma in Nursing. 25 students are enrolled for the Diploma course. However, the School of Nursing is in the process of being upgraded as a College of Nursing, which will award B.Sc. (Nursing) Degree. During the informal visit, the Committee have been told that about 57 posts of Staff Nurses have been lying vacant.

5.23 On being asked about the availability of female Doctors in the hospital, the Committee have been informed that 26.59% Specialists & GDMO Cadre, 21.05% Sr. Residents and 26.06% Jr. Residents are female. In Group B, 45% are women and in Group C and D it is 30% and 18.5 % respectively. Among staff nurses 95% are women.

(c) SAFDARJUNG HOSPITAL

5.24 Safdarjung Hospital, New Delhi is the largest of the three Central Government Hospitals in Delhi which functions under the administrative control of Director General of Health Services/Ministry of Health and Family Welfare. Until the inception of All India Institute of Medical Sciences in 1956, Safdarjung

Hospital was the only tertiary care hospital in South Delhi. The hospital provides medical care to lakhs of citizens not only of Delhi but also from the neighbouring States/countries. Based on the needs and developments in medical care, the hospital has been regularly upgrading its facilities from diagnostic and therapeutic angles in all the specialties.

5.25 At present, Safdarjung Hospital is having a bed strength of 1531 including basinets. It provides Medicare services as per the commitment of the Government to all the citizens. The hospital's mission is to provide quality medical care to OPD, indoor and emergency patients in various disciplines of Medicare. Average daily attendance of the hospital's OPDs is approx. 6300, and at Casualty it is approx. 800. Average 300 patients are admitted per day. There is a 24-hour laboratory facility besides round the clock ECG, Ultrasound, X-ray & CT scan services. The Department of Obstetric & Gynaecology and the burns ward have separate independent casualties. Adequate number of computerized registration counters are functioning with Ante Natal Clinics running its own registration counters.

5.26 During oral evidence, Secretary, M/o Health and Family Welfare added:

> "We also have a plan for a complete rebuilding of the Safdarjung Hospital. We plan to have a reconstruction of the hospital, which will bring it to over 4000 beds"

5.27 Regarding the medical facilities for women in Safdarjung Hospital, the Committee have been informed as under:-

"Facilities for women in Gynae & Obst. :

- There are 11 wards in the department of Obst. & Gynae. with 293 beds. -Ten more beds have been added due to overcrowding.
- Patient care service is provided in the Gynaec, Casualty (GRR), Ante Natal OPD, Gynaec OPD, Special Clinics, Family Planning

Unit, Labour Rooms, Operation Theatre for major and minor surgeries including indoor patients.

- Three Special Clinics run every week. These are Infertility Clinic, Menopause Clinic and Dysplasia Clinic.
- Yearly Colposcopy Workshop and Training Programme is being held under the aegis of AOGD and FOGSI in this department.
- There is a separate Family Planning Unit where MTPs , Laparascopic Sterilization, Mini Lap. Cu-T(380-A) insertion, distribution of Contraception is being done on regular basis.
- The Operation Theatres in the Obstetric. & Gynaecology are exclusively used for female patients and the same has been recently renovated.
- An ICMR research project is going on Teenage pregnancy. Adolescent reproductive sexual health education. 'Prevention of parents to child transmission of HIV' research project is being carried out by Delhi State AIDS control society.

Facilities for women in other Departments are given below:

- Besides Obstetric & Gynaecology, there are three other wards, which are exclusively for women. These wards are having bed strength of 113. In addition, 166 beds in different wards are being used for female patients.
- It is ensured that examination of female patients is conducted in the presence of female nursing staff/attendant.
- There are two separate OPD Registration counters for female Gynae patients in New OPD Central Registration Counters.

5.28 The Committee have further been informed that there are separate female wards and beds for the female patients in all the departments. The details are given as under:

" Female Bed strength

Name of Department/Block	No. of Beds
H-Block	
- Medicine	48
- ENT, Eye	24
- CTVS, Neuro Surgery, Neurology	22
- Cancer Surgery	09
- Tetanus	05
- Cardiology	05
Maternity Block	
- Surgery Female Ward	41
- Radiotherapy Female Ward	42

-	Obst. Gynae Ward	293

Burns Plastic & Maxillofacial Surgery Department

-	Plastic Surgery	30
-	Burns Ward (Every patient has separate cubicle)	45

Central Institute of Orthopedics and Others

-	Ortho Female Ward	48
-	Skin	08
-	Urology	04
-	Spinal	06
-	Respiratory	05
	Total	590”

OBSERVATIONS/RECOMMENDATIONS

1. Health care embraces all goods and services designed to promote health; including preventive, curative and palliative interventions directed to individuals or populations. Though our country has registered significant progress in health care over the years, a high proportion of population continues to suffer and die from preventable diseases and other health related complications. To combat the situation, National Health Policy has been designed in 2002. Its main objectives are to reduce the overall burden of diseases, promote health, encourage inter-sectoral coordination and improve service delivery. Moreover, the National Common Minimum Programme has committed to allocating 2 to 3% of the GDP as public expenditure on health, a target to be achieved by 2010. But the Committee have observed that in terms of percentage GDP, public expenditure on health is now only in the vicinity of 1%. They have further noted that public spending on health has declined from 1.16% in 2002 to 0.87% in 2004. In fact, less than 1% of GDP spending on health is far below what is needed to provide basic health care to the people. The Committee strongly feel that we are under-investing in health, whereas most of the developing countries are spending much more in health sector. The Committee would also like to remind the Government that the Bhore Committee recommendation was for 15% committed revenue expenditure on health. However, the Committee desire that the public expenditure on health should at least be 3% of GDP keeping in mind its long term benefits and the emphasis should be on preventive health care.

2. The Committee find that the National Rural Health Mission (NRHM) was launched in 2005 to effect an architectural correction in the health care delivery system. The goal of the mission is to improve the availability and accessibility of quality health care to the people, especially to those residing in rural areas, the poor, women and children. The Mission has been trying to improve the health delivery system through comprehensive upgradation of infrastructure, augmentation of manpower and expansion of capacity for training various stakeholders. The Committee hail this mission as a mission with a vision and hope that it could help correct the gross neglect of the healthcare needs of the rural people. Though they know for sure that the Government has come up with plans with the best of intentions, they are apprehensive of the results, until the administrative issues are addressed. The Committee, therefore, recommend that a study should be conducted to identify the issues related to the governance of NRHM and bring in clarity on aspects like chain of command, functions and responsibilities of various stakeholders at various levels etc. Moreover, a system of concurrent evaluation of the Mission activities needs to be developed and data should be generated for undertaking immediate corrective action wherever required.

3. The Committee understand that in order to address health from holistic, preventive, promotive and curative angles, NRHM has set up a platform for involving the Panchayati Raj Institutions (PRIs) and community in the management of primary health programmes and

infrastructure. Accordingly, the village Health Committees forms the link between the Gram Panchayat and the community; a Block Coordination Committee at the block level monitor effective functioning and convergence; and at the district level, the District Health Mission coordinate NRHM functions under the Zila Pramukh. Since, strengthening of PRIs are critical to implementing various programmes under NRHM and achieving its goals, the Committee recommend that the PRI institutions should be given the power to monitor the facilities available at the public health care institutions as per the Indian Public Health Standards check list. They also desire that adequate representation of women members of PRIs be ensured in the District Health Committees and other equivalent bodies. Moreover, the people's representatives should be apprised thoroughly so that the people living around the CHCs, PHCs etc. could put demand side pressure on these public health care institutions for betterment of services.

4. Over the last five decades, our country has built up a commendable health infrastructure and manpower at primary, secondary and tertiary care in Government, voluntary and private sectors. So far, we have 262 Medical Colleges in the country. The Committee have also been informed that as on March, 2006, there are 144988 Sub Centres, 22669 Primary Health Centres (PHCs) and 3910 Community Health Centres (CHCs) in the country. But, based on population norms using 2001 Census, this falls short of 13804 Sub Centres, 3353 Primary Health Centres and 2581 Community

Health Centres. As far as manpower is concerned, the Committee find that as against a requirement of 22669 Doctors in PHCs, only 22273 are in position, resulting in a shortfall of 1793 Doctors. Similarly, in CHCs, as against a requirement of 15640 Specialists, including one Surgeon, one Obstetrician & Gynaecologist, one Physician and one Paediatrician for each CHC there are only 3979 Specialists in position as on March, 2006, resulting in a shortfall of 9413 Specialists. The case of ANMs, Male Health Workers, etc. is not different. The Committee find a wide gap between the demand and availability of trained health care personnel in the government sector. This gap is too alarming in case of Specialists i.e. 75%. As infrastructure limitation is found to be a major bottleneck in effective health care delivery, the Committee recommend that concerted and time-bound efforts be taken to overcome basic infrastructure constraints, both physical and human. Besides, the Committee would like to be apprised of the mechanism evolved to ensure punctuality and attendance of Doctors and the staff working in PHCs/Community Health Centres in different parts of the country. The Committee also desire to be apprised of the steps initiated by the Government in filling up the gaps in the systems.

5. The Committee have further been informed that the Government envisages setting up 6 AIIMS like institutions and upgrading 13 Medical Colleges under Pradhan Mantri Swasthya Suraksha Yojana and proposals are under consideration for starting 137 Nursing Schools and 145 ANM/HW(F) Training Centres in various States during Eleventh Plan period.

The Committee desire that these proposals translate into reality within a stipulated time so that the human resource crunch in the health sector is addressed properly.

6. The Committee find that despite the massive public health infrastructure in the country, private sector is a major player in delivering healthcare services. The 60th round of National Sample Survey on health care, conducted in 2004, has observed a near stagnation in the utilization of public health facilities i.e. out-patient care in public institutions are accessed by only 22% in the rural areas and 19% in the urban areas. As per the study, nearly 50% increase has been registered in health expenditure since 1994-95. The Committee note with concern that private health care services is not a privilege of the rich but at times the only option of the poor as well. In urban areas, corporate hospitals run by big business houses create demand and attract the critically vulnerable at increasing costs with their state-of-art technology. But the majority of the private sector health institutions from where the rural poor seek medical care are single Doctor dispensaries with very little infrastructure or without para-medical support. Despite the optimism of the Health Ministry that NRHM has brought the public back to health care institutions in villages, the fact remains that the efforts are being sabotaged by poor quality of services in public health institutions. The Committee, therefore, desire that the public health service be revamped ensuring quality facilities, adequate supplies and required manpower. They also urge upon the Government to

pass the Clinical Establishments (Registration and Regulation), 2007 Bill at the earliest to standardise health care services of private clinical establishments and ward of medical malpractices/ growth of fake clinical establishments.

7. Public-Private Partnerships (PPP) in health care sector aim to harness the large pool of private sector resources and draw them into the process of nation building. The Committee find that under NRHM, PPP mode is being encouraged to bring about beneficial outcomes like improving efficiency, effectiveness and quality. Accordingly, several States have initiated steps to tap expertise available with private sector and experience gained by the NGOs in community health programmes. Chiranjeevi Scheme in Gujarat, life line drug stores in Hospitals in Rajasthan , health insurance scheme for the poor in Karnataka & Andhra Pradesh, ambulance service in Andhra Pradesh, etc. are fine examples of such an interface. The Committee, while appreciating such initiatives desire that it should be made mandatory for the States to formulate clear guidelines and sign Memorandum of Understanding in each PPP programme to prevent any abuse. The Committee also urge upon the Government to make an assessment of all Private-Public Partnership programmes that are underway in each States with a view to overcoming procedural pitfalls.

8. Our country is a bewildering contradiction as far as health status of people in different states is concerned. We have states like Kerala where health indicators are comparable to those of developed countries as well as places where abysmal conditions exist. However, since independence we have made remarkable strides in improving some of the health indicators. The Committee observe that the average life expectancy which was 32.1 in 1941-50 has touched 64.9 by 2001-05. Infant Mortality Ratio (IMR) has almost been halved and currently is at 57 per 1000 live births. Yet, we lag far behind countries like even Sri Lanka, Vietnam, Thailand, Iran, etc. The Committee also notice a sex differential in IMR, i.e. the mortality rate of girls is considerably higher than boys, a pointer to the plight of women in our society. To achieve the Millennium Development Goal of IMR of 30 per 1000 live births by 2015, we need to further accelerate the present pace of decline of infant mortality through targeted programmes addressing the root cause of the problem viz. low birth weight, sepsis, diarrhoea, malnutrition, etc. The Committee also strongly believe that antenatal care and paediatric care in infancy and early childhood are the most effective measures to improve health over the entire life circle. They, therefore, recommend that efforts should be made towards acquisition of 'womb to tomb' data on health and ill health by encouraging health research.

9. Higher Maternal Mortality Rate (MMR) is another major public health concern in India. Maternal mortality is generally defined as the death of a

woman during pregnancy or delivery, or within 42 days of the end of pregnancy, from pregnancy-related problems. The MMR data of 2007 shows that in India, 540 mothers die per 100000 live births, which is about 40 times than that of U.K and 30 times than that of U.S. Even our neighbouring developing countries like Sri Lanka, China and Bangladesh fair much better than us in this regard. It is also to be remembered that a large number of maternal deaths in our country go officially unrecorded. The Committee also note that 2 out of every 3 maternal deaths are from Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal and Assam. To tackle the problem and achieve the targeted reduction of MMR to 100 per 100000 live births by 2010, the Committee recommend a focused approach giving additional emphasis on educating women and their husbands about how to reduce the risk of maternal and infant deaths. This should include education about the balance diet during pregnancy, spacing births and not having babies until the woman reaches maturity, etc. The Committee also recommend that the Central Government should urge upon the states to initiate 'Maternal Audits', a detailed maternal death enquiry system.

10. The Committee find that since inception of Planning in the country, development of women has been receiving attention of the Government. The Ninth Plan recognized 'Empowerment of Women' as one of its primary objectives and accordingly, reproductive and child health programmes were given emphasis. The National Health Policy 2002 recognised the need

to ensure increased access of women to basic health care and committed higher priority funding to women's health programmes. The Tenth Plan set out certain monitorable indicators for women, which included the reduction of Maternal Mortality Ratio. However, despite such efforts, significant disparities exist in health care utilisation between men and women. The Committee note that poor women compared to poor men consume fewer resources and suffer worse health. Widespread sex selection of the foetus continues to distort the already adverse sex ratio. To overcome these hurdles and to achieve high standards in the health care of women, the government has envisaged various programmes, viz. National Rural Health Mission (NRHM), the Reproductive and Child Health Care (RCH) programme, etc. In addition, the Department of Health & Family Welfare in the Ministry of Health & Family Welfare is implementing various women specific activities. The Committee also find that a separate gender budgeting exercise is undertaken by the Department to assess the flow of resources for the benefit of women. Though the concept of Gender Budgeting is unique and great, the mandatory 30 percent allocation for women is far from being implemented. Mostly, misleading computations exaggerate the amount being actually spent on women. The Committee, therefore, desire that the Gender Budget Cell of the Ministry of Health and Family Welfare should go in for a realistic calculation of the amount that was actually spent on women in percentage terms during the year 2007-08 and apprise the Committee of the same. They also desire that the ambit of

gender budgeting should include gender audit and gender outcome assessment in all ministries/ departments at the central and state levels.

11. The Committee find that under NRHM and RCH Programmes the Government has been actively pursuing major agendas like essential obstetric and new born care for all, skilled attendance at every birth, emergency obstetric care for those having complications and referral services. To provide essential obstetric care to all pregnant women, 24X7 service at 50% PHCs and all CHCs has been envisaged. However, the Committee observe that only 8755 PHCs, i.e 37.6 % have so far been operationalised into round the clock PHCs. The Committee, therefore, recommend that requisite number of PHCs may immediately be operationalised in to 24x7 facility.

12. The Committee have been told that the Government has committed itself to providing skilled attendance at every birth, both at community and institution level. To manage and handle some of the common obstetric emergencies, the Government of India has taken a policy decision to permit Staff Nurses (SNs) and ANMs to give certain injections and also perform certain interventions under specific emergency situations to save the life of the mother. For this they need comprehensive training. In this regard, the Committee have been informed that 4005 ANMs/SNs have already been trained. Since the presence of a skilled birth attendant at delivery can avert maternal and neonatal mortality, such training should provide for competency and pursuit of quality. But in most cases, even such training

will not equip them to save women's lives as they are unable to treat complications due to lack of proper facilities or to refer. The Committee, therefore, recommend that the minimum competency level necessary to meet the definition of skilled birth attendant be defined and their skills be updated continuously through refresher courses. Further, the Government should ensure logistic and policy support to them.

13. NRHM has also envisaged 24-hours specialist care in Medicine, Obstetric and Gynecology and Surgery and Pediatrics at First Referral Units (FRUs). It is the Community Health Centre (CHC), which actually serves as a referral centre for 4 PHCs and provides for obstetric care and specialist consultations. The Committee have been informed that about 1594 out of 3910 CHCs in the country have so far been operationalised as FRUs in the country. This means that the backlog is almost 60%. The Committee find that specialized manpower, blood storage units and referral linkages are the critical components in operationalising FRUs. Though the training given to MBBS doctors in Obstetric Management Skills can make them competent in giving emergency obstetric care, the scarcity of specialists will continue to be a major hurdle in the success of NRHM. The Committee, therefore, urge upon the Government to invest heavily in hiring trained health professionals /specialists and updating the public health care infrastructure. Without these fundamentals, women will resist seeking medical treatment from public health facilities and those who do will find these facilities unable to deliver adequate care.

14. Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) with the objective of reducing maternal and neonatal mortality through the promotion of institutional deliveries. The programme targets BPL women, with special focus on low performing states. The Committee find that JSY provides cash assistance to poor pregnant women to enable them to deliver in health care institutions. Under the Yojana, community level link workers called Accredited Social Health Activists (ASHAs) will help and guide women in accessing health facilities for ante-natal care, institutional delivery, post-natal care and counseling on nutrition and Family Planning Services. The Committee further note that in order to promote delaying of first child birth and to dissuade large families, the JSY uses a 'minimum age' criteria and a 'two child' cut-off norm in High Performing States. However, the Committee are of the strong opinion that the women do not have full control over their age of marriage or child birth and delivery risks are higher at a younger age. The Committee, hence, view this minimum age cut-off as patently discriminatory towards young women. Similarly, women do not usually have the right to decide the number of children they will have. Moreover, in high performing states this restriction may lead to sex pre-selection. Since the ultimate aim is to bring down MMR and IMR, the Committee strongly feel that the issue of child marriage, two children norm, etc. are to be addressed from a different platform. They, therefore, recommend that the minimum age criteria and the two children norm may be lifted forthwith for providing maternity benefits under JSY.

15. The Committee find that the cash assistance benefits under JSY is linked to availing of antenatal check ups by the pregnant women and getting the delivery conducted in health care centres. Cash assistance is graded in nature and accordingly the mothers package in Low Performing States is Rs.1400 (rural areas)/ Rs.1000 (urban areas) and in High Performing States it is Rs. 700 in rural areas and Rs.600 in urban areas. Though the scheme is a great step towards assisting poor pregnant women who are generally short of cash, the Committee are apprehensive whether the money is actually reaching them and that too on time. They desire that the Government should ensure that the payment to mothers are not denied or delayed and the correct amount is reaching them. Moreover, the Committee wish that some mechanism may be evolved to ensure that women who are getting financial support under JSY are not forced to bribe the local health staff. They also recommend that the financial transactions under JSY be monitored for corruption and those responsible should be punished.

16. The Committee observe that the 'ASHA' or Accredited Social Health Activist is the backbone of the JSY. Selected from the village itself, the ASHA is trained to work as an interface between the community and the public health system. Under the scheme, cash benefit is also given to ASHA/ village link worker, i.e. Rs. 600 per institutional delivery in rural areas and Rs. 200 in urban areas. In view of the difficult circumstances in

which an ASHA has to work, the Committee are unable to understand the rationale behind compensating her only on the basis of performing certain specific tasks. If ASHA is the *'Amritdhara'* of the whole programme, adequate remuneration, which is delinked from specific activities, should be assured to her, with a performance linked component, if necessary. Uncertain and very limited compensation under the present scheme of things may not keep her motivated. The Committee also desire that ASHA should be paid promptly and with dignity and should not be made to run from pillar to post to get her payments.

17. The Committee have been informed that the Hindustan Latex Ltd., a 'miniratna' under the Ministry of Health and Family Welfare has recently developed an 'easy to use pregnancy kit' which, the Government plan to make available to the public. In fact, non-availability of such a simple kit is a major reason for late detection of pregnancy among poor women. Since early detection of pregnancy can ward off many of the complications in later stage, the Committee appreciate the efforts of the Government in this regard. At the same time, they desire that these kits should be made available to all potential beneficiaries through ASHAs, Sub Centres, Primary Health Centres, etc. Easy availability of the kit even in small shops in the villages at reasonable rates should be ensured. The Committee also desire that wide publicity should be given to the said kit.

18. As far as contraception programmes are concerned, the Government has been promoting methods like Tubectomy, Vasectomy, both male and female condoms and IUDs. But from the data that are available before them, the Committee find that over a period of time the entire contraception programme of the Government has become women-centric and male sterilization has been put to the back burner. Of all the couples who opted for a permanent method of contraception in 2006-07, as many as 4402139 chose tubectomy or female sterilization whereas only 114125 chose vasectomy, i.e. a whopping 97.5% of all sterilizations are tubectomies. Though the fact remains that the easy, non-scalpel vasectomy is not being preferred by men due to various myths and misconceptions viz. fear of loss of libido, strength, method failure, etc., and our male dominated society increasingly puts pressure on women to take care of issues like contraception and birth control on their own, the Committee strongly feel that the situation can also be attributed to the excesses committed when target drives mindlessly pushed vasectomies. They, therefore, recommend that the male sterilization services may be made easily accessible and attractive through incentives like free insurance, etc. There is also a need to strengthen communication support to such initiatives through mass media campaigns to remove fears about vasectomy from the minds of men. The Committee also desire that research on male contraceptive pill be initiated on priority basis under the Family Planning Division.

19. Various clinical trials involving women has been a major concern of the Committee. They have been informed that the clinical trials are conducted both on male and female patients to study the drug effects. However, clinical trials of some drugs, which are specifically indicated for women are conducted only in women patients and these trials are required to be conducted in the country as per Schedule Y of Drugs and Cosmetics Rules, Good Clinical Practice Guidelines (GCP) and Ethical Guidelines. Though the concerns regarding involvement of women in clinical trials have specifically been addressed in Indian GCP Guidelines, the Committee are doubtful whether the guidelines are being followed in letter and spirit. Since, most of the scandals about clinical trials revolve round issues like whether the patient knew about being part of the trial, whether informed consent to participate was taken or not, whether the patient was told about the possible side-effects, risks, etc., the Committee desire that the Government should make the conditions more stringent for clinical trials including compensation, insurance, etc. The Government should also consider an amendment to schedule 'Y' making the trials easier.

20. It is observed that various measures and programmes have been initiated by the Government to address the health concerns of women. However, almost all these programmes focus on the reproductive health of women. The Committee are of the strong opinion that a holistic perspective on women's health beyond reproductive age should be evolved beginning from a very young age and extending up to old age. Such a perspective

should incorporate aspects like communicable diseases, mental illness, complications related to menopause, old age, etc.

21. The Health and Family Welfare Programme in the country is being implemented through primary health care system. Sub-Centre is the first peripheral contact point between Primary Health Care system and the community. The Committee have been informed that each Sub–Centre is being manned by one Female Auxiliary Nurse Midwife (ANM) and one Male Health Worker. It is said that under NRHM one extra contractual ANM is also provided to Sub- Centres. These centres are assigned tasks relating to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases. However, the

Committee doubt whether many of these Sub -Centres are actually functioning or not. Out of about 145000 Sub–Centres on record, only 50% function from a government building. Many of them are without even an ANM. Even in High Performing States like Kerala some of the Sub- Centres are functioning only on paper. In view of the above, the Committee recommend that a monitoring cell under NRHM may collect state-wise data pertaining to the actual functioning of Sub- Centres and apprise the Committee of the same within three months.

22. Primary Health Centre (PHC) is the first contact point between village community and the Medical Officer. In addition to the Medical Officer, each PHC is supposed to be manned by 14 other staff. It acts as a referral Unit

for 6 Sub-Centres and has 4-6 beds for patients. Though PHCs are the cornerstones of the rural health care system, the Committee note with dismay that in terms of availability as per population norms, adequacy of facilities, presence of Doctors and trained para medical staff, etc. the shortfall is too alarming. They are of the view that the funds infused in to our public health care system will go waste if the PHCs are not strengthened, plugging the loopholes in the system. In fact a large number of vacancies of medical officers, nurses, paramedics, etc. are either lying vacant or those who are posted to rural areas choose to stay away using various means like arranging deputation, falsifying attendance records, etc. They, therefore, desire that these tendencies be addressed and postings in difficult areas be linked with necessary incentives.

23. The Committee find that a wide range of facilities covering all the essential elements of preventive, promotive, curative and rehabilitative primary care services are available for women at PHCs. This varies from OPD services in the morning and afternoon, first aid, antenatal check ups, intra-natal care, postnatal care, laboratory investigations, counseling to new born care and family planning services. But, lack of proper awareness about the availability of all these services, distance from PHCs and poor public dealing of health delivery staff come in the way of availing the facilities provided at the PHCs. For better utilization of public health services, we need to create awareness through rights based approach and therefore, the Committee recommend that every women in the village

should be made aware of the facilities available at these centres through poster campaigns. Moreover the attitude of health care providers should undergo a radical change so as to inculcate the feeling that the client is important and needs to be treated with respect.

24. The Committee also note that most of the PHCs do not have even a telephone connection. In Orissa, the facility is available only in 5% of PHCs. The status in Mizoram, Uttaranchal and Tripura is also very poor with only 11%, 17% and 33% connectivity respectively. Even in High Performing States like Tamil Nadu and Kerala only less than 50% PHCs have telephone connectivity. The Committee further note with dismay that even a vehicle in running condition is a scarce resource in PHCs. Since PHCs are supposed to refer and transport patients in critical condition to referral hospitals, telephone connectivity and transport facilities are critical inputs. The Committee, therefore, urge upon the Government to look into the matter and ensure 100% telephone connectivity and transport facility for PHCs at the earliest.

25. All India Institute of Medical Sciences (AIIMS) is an institution of excellence in medical education, research and health care and is rightly regarded as a valuable national asset. The prime concern of the Institute is to develop patterns of teaching in undergraduate and postgraduate medical education. In the field of medical research, AIIMS is the leader, having more than 1200 research publications

by its faculty and researchers every year. The Committee find that many research projects which are being carried out in AIIMS are on topics of national importance. AIIMS also attracts sizeable grants from national and international agencies. The Committee while appreciating the value of the research being undertaken in AIIMS desire that there should be an emphasis on women's health research.

26. All India Institute of Medical Sciences is a Super Specialty hospital. It provides state-of-art medical care to all the patients irrespective of their socio-economic status or sex. The Committee have been informed that due weightage is always given to admission and investigation of patients depending on the severity of their sickness. However, there are no separate indoor facilities earmarked for the female patients other than in the Department of Obstetrics & Gynaecology. In the Department of Obstetrics & Gynaecology, 85 beds are available. The Committee, however, observed during an informal visit that there was an acute shortage of space in the gynaecology and paediatrics ward of the hospital. Though 36 additional rooms have been provided to the Department of Gynaecology in the old Nurses Hostel as a temporary arrangement to tide over the crisis, the situation is still grim. The Committee find it depressing that in an institution of national importance like AIIMS there has been no increase in space provided for the Paediatric and Gynaecology wards during the last 40 years or so. In view of the serious space constraints, which have led to the breach of privacy of the patients, the Committee urge upon the

Government to make the 'Mother and Child Hospital' in AIIMS a reality without any further delay and the Committee may be apprised about the schedule of completion of the project.

27. The Committee have further been informed that being an employer, a large number of female workers like doctors, nurses, paramedical staff, etc. are engaged in the hospital. All the privileges due to a lady worker have been ensured to them, starting from crèches for the children to separate toilets, rest rooms, dining rooms, etc. They also find that a grievance redressal committee comprising of senior lady officers/faculty to address the grievances of female workers/cases of sexual harassment has also been formed. The Committee are happy to note that the transport and security needs of the staff are also well taken care of. However, they are concerned about the shortage of accommodation facilities for the staff especially the nurses. They, therefore desire that the existing proposal for the construction of a new Nurses Hostel be expedited.

28. The Lady Hardinge Medical College & Smt. Sucheta Kripalani Hospital was established in the year 1916 to facilitate medical education and focussed medical attention to women. The Kalawati Saran Children's Hospital was established in 1956 for providing medical care services exclusively for paediatric patients. Out of the total 877 beds available in S.K. Hospital, 705 beds are for female patients including 348 beds earmarked for Obstetric & Gynaecology Department which is the biggest department in this Institution. Approximately 70% to 75% of the total

budget is being utilized on female patients and female medical students. The Committee are happy to observe that 24 hours expert service, extending to all aspects of women's health care, is being offered in this institution. But severe space crunch, poor hygienic standards and acute shortage of staff are the major constraints in offering the best possible service to women patients. The Committee , therefore desire that the Government should accord high priority to sanctioning/executing developmental projects in this hospital. The heavy influx of patients from different parts of the country due to its proximity to New Delhi Railway Station also validates the need to enhance the capacity of the hospital. The Committee also desire that a special recruitment drive to fill up all vacant posts of doctors, nurses and para-medical staff should be undertaken. Cleanliness and hygiene should be given utmost importance.

29. Dr. Ram Manohar Lohia Hospital has been providing comprehensive patient care including specialized treatment to VIPs, CGHS beneficiaries and General Public. Over the years the hospital has expanded to meet the ever-increasing demand of its services and now is a 1000 bedded hospital. The Committee have been informed that on an average 1016 female out patients are being attended to in the various departments of this hospital. However, they are disheartened to find that only 122 beds have been earmarked for women in the various departments. Considering the fact that there are 100% utilization of these beds and large number of women seek medical care from this centrally placed hospital, the Committee

recommend that more number of beds be set apart for women. They also desire that equipments like Mammography Machines to detect breast cancer and Cardio Tocography Machines (CTG) for foetal assessment during labour , if not available already, may be acquired at the earliest and the Committee may be apprised of the same.

30. The Committee find that a School of Nursing is also being run by Dr. R.M.L Hospital, which awards 3 years diploma in Nursing. 25 students are enrolled for the Diploma course. However, the School of Nursing is in the process of being upgraded as a College of Nursing, which will award B.Sc. (Nursing) Degree. Considering the huge demand and large number of vacancies of nursing staff in the government sector, the Committee recommend that the upgradation of School of Nursing to College of Nursing be done without any further delay. They also desire that the number of seats for the diploma course be doubled.

31. The Committee find that the Safdarjung Hospital is the largest Central Government Hospital in Delhi catering to about 6300 patients in its OPD and about 800 in casualty every day. They also understand that this hospital has some of the best facilities in the country in the public sector like its Burns Ward. However, the hospital has only 1531 authorised beds including bassinets to provide medical care to the citizen of Delhi and neighbouring states. Out of this, 38.5% of beds have been earmarked for female patients. While appreciating this, the Committee could not help

observing that this hospital's mission to provide quality medical care to patients has become a casualty in the mismatch between the high influx of patients from all over the country and the available facilities. The Committee, therefore, desire that the Government should give high priority to the reconstruction plan of Safdarjung Hospital which will increase its bed strength from the present 1531 to 4000. They also look forward to enhanced facilities to women in its various departments.

32. Last but not the least, the Committee are concerned about the tendency of doctors honing their skills in Government hospitals and setting up private practice. They are of the opinion that the pathetic health standards in Government sector can to a great extent be attributed to such tendencies. The Committee strongly desire that such hypocritical practices should be dealt with strictly. At the same time, the Government should ensure that the remuneration, perquisites, facilities, etc. given to Government doctors should be extremely descent and attractive.

NEW DELHI:	**KRISHNA TIRATH,**
25TH April, 2008	***Chairperson,***
5 Vaisakha, 1930 (Saka)	***Committee on Empowerment of Women.***

Annexure I

STATE-WISE BREAK-UP OF CHCs, PHCs, etc.

Sl. No.	State	Sub-Centre		PHCs		CHCs	
		Available	Required	Available	Required	Available	Required
	HIGH FOCUS STATES OTHER THAN NORTH EAST						
1.	Bihar	8858	14959	1641	2489	70	622
2.	Chhattisgarh	4692	4164	518	659	118	164
3.	Himachal Pradesh	2069	1128	439	186	66	46
4.	Jammu & Kashmir	1888	1666	374	271	80	67
5.	Jharkhand	3958	5057	330	806	194	201
6.	Madhya Pradesh	8874	10402	1192	1670	229	417
7.	Orissa	5927	7283	1279	1171	231	292
8.	Rajasthan	10512	9554	1713	1555	325	388
9.	Uttarakhand	1631	1294	222	214	49	53
10.	Uttar Pradesh	20521	26344	3660	4390	386	1097
	HIGH FOCUS STATES OF NORTH EAST						
1.	Sikkim	147	109	24	17	4	4
2.	Mizoram	366	146	57	22	9	5
3.	Nagaland	397	535	84	80	21	20
4.	Manipur	420	412	72	64	16	16
5.	Arunachal Pradesh	379	254	85	39	31	09
6.	Tripura	539	659	73	104	10	26
7.	Meghalaya	401	597	90	196	25	22
8.	Assam	5109	5063	610	826	100	206
	OTHER THAN HIGH FOCUS STATES LARGE						
1.	Andhra Pradesh	12522	11699	1570	1924	31	09
2.	Gujarat	7274	7263	1072	1172	273	293
3.	Maharashtra	10453	12153	1800	1984	407	496
4.	Kerala	5094	4761	909	791	107	197
5.	Karnataka	8143	7369	1679	1211	254	302
6.	Tamil Nadu	8683	7057	1252	1173	165	293
7.	Punjab	2858	3219	484	536	126	134
8.	Haryana	2433	3055	408	500	82	125
9.	Goa	172	135	19	22	05	05
10.	West Bengal	10356	12101	922	1993	346	498
	OTHER THAN HIGH FOCUS STATES SMALL & UTs						
1.	Chandigarh	13	18	00	03	01	00
2.	Dadar &Nagar Haveli	38	50	06	07	01	01
3.	Daman& Diu	21	21	03	03	01	00
4.	Puducherry	77	65	39	10	04	02
5.	Delhi	41	188	08	31	00	07
6.	Andaman & Nicobar	108	51	20	08	04	02
7.	Lakshdweep	14	11	04	01	03	00
	Total	**144988**	**158792**	**22669**	**26022**	**3910**	**6491**

ANNEXURE II

AVAILABILITY OF MULTIPURPOSE WORKER (FEMALE)/ANM AT SUB CENTRES & PHCs IN THE COUNTRY (As on March, 2006)

Sl. No.	State/UT	Health Worker (Female)/ANM				
		Required[1] (R)	Sanctioned (S)	In Position (P)	Vacant (S-P)	Shortfall (R-P)
1.	Andhra Pradesh	14092	14077	13740	337	352
2.	Arunachal Pradesh	464	454	454	0	0
3.	Assam	5719	5719	5719	0	0
4.	Bihar	10499	10499	8904	1595	1595
5.	Chhattisgarh	5210	4335	3667	668	1543
6.	Goa	191	196	179	17	12
7.	Gujarat	8346	7274	6508	766	1838
8.	Haryana	2841	2841	2860	*	*
9.	Himachal Pradesh	2508	2210	1790	420	718
10.	Jammu & Kashmir	2262	1964	1588	376	674
11.	Jharkhand	4288	5543	4392	1151	*
12.	Karnataka	9822	8756	8544	212	1278
13.	Kerala	6003	5587	5572	15	431
14.	Madhya Pradesh	10066	10027	9345	682	721
15.	Maharashtra	12253	12253	9598	2655	2655
16.	Manipur	492	485	515	*	*
17.	Meghalaya	502	667	608	59	*
18.	Mizoram	423	442	423	19	0
19.	Nagaland	481	342	342	0	139
20.	Orissa	7206	7121	6768	353	438
21.	Punjab	3342	3182	2515	667	827
22.	Rajasthan	12225	11425	11425	0	800
23.	Sikkim	171	267	260	7	*
24.	Tamil Nadu	9935	10367	9550	817	385
25.	Tripura	612	603	593	10	19
26.	Uttaranchal	1853	1715	1636	79	217
27.	Uttar Pradesh	24181	23656	21900	1756	2281
28.	West Bengal	11278	10356	9900	456	1378
29.	A&N Islands	128	127	127	0	1
30.	Chandigarh	13	22	22	0	*
31.	D &N Haveli	44	38	38	0	6
32.	Daman & Diu	24	24	24	0	0
33.	Delhi	49	60	51	9	*
34.	Lakshadweep	18	22	22	0	*
35.	Pondicherry	116	116	116	0	0
	All India[2]	**167657**	**162772**	**149695**	**13126**	**18318**

Notes
NA: Not Available
** Surplus*
1 One per each existing Sub Centre and Primary Health Centre
2 For calculating the overall percentages of vacancy and shortfall, the States/UTs for which manpower position is not available, should be excluded.

ANNEXURE -III

AVAILABILITY OF HEALTH WORKER (MALE)/MPW [M]AT SUB CENTRES (As on March, 2006)

Sl. No.	State/UT	Health Worker (male)				
		Required[1] (R)	Sanctioned (S)	In Position (P)	Vacant (S-P)	Shortfall (R-P)
1.	Andhra Pradesh	12522	7340	6327	1013	6195
2.	Arunachal Pradesh	379	23	23	0	356
3.	Assam	5109	NA	NA	NA	NA
4.	Bihar	8858	2135	1035	1100	7823
5.	Chhattisgarh	4692	3818	2852	966	1840
6.	Goa	172	150	125	25	47
7.	Gujarat	7274	5092	2773	2319	4501
8.	Haryana	2433	2132	1744	388	689
9.	Himachal Pradesh	2069	2005	1786	219	283
10.	Jammu & Kashmir	1888	381	377	4	1511
11.	Jharkhand	3958	5438	4311	1127	*
12.	Karnataka	8143	5853	4576	1277	3567
13.	Kerala	5094	4366	4166	200	928
14.	Madhya Pradesh	8874	7715	7298	417	1576
15.	Maharashtra	10453	10453	6097	4356	4356
16.	Manipur	420	400	371	29	49
17.	Meghalaya	401	273	273	0	128
18.	Mizoram	366	366	303	63	63
19.	Nagaland	397	276	300	*	97
20.	Orissa	5927	4911	3392	1519	2535
21.	Punjab	2858	2858	1375	1483	1483
22.	Rajasthan	10512	3968	2528	1400	7984
23.	Sikkim	147	147	147	0	0
24.	Tamil Nadu	8683	4790	1503	3287	7180
25.	Tripura	539	449	268	181	271
26.	Uttaranchal	1631	771	616	155	1015
27.	Uttar Pradesh	20521	9080	5732	3348	14789
28.	West Bengal	10356	9660	5178	4482	5178
29.	A&N Islands	108	26	0	26	108
30.	Chandigarh	13	8	8	0	5
31.	D &N Haveli	38	9	9	0	29
32.	Daman & Diu	21	17	17	0	4
33.	Delhi	41	0	0	0	41
34.	Lakshadweep	14	14	1	13	13
35.	Pondicherry	77	0	0	0	77
	All India[2]	**144988**	**94924**	**65511**	**29437**	**74721**

Notes
NA: Not Available
* *Surplus*
1 One per each Sub Centre
2 For calculating the overall percentages of vacancy and shortfall, the States/UTs for which manpower position is not available, should be excluded

ANNEXURE - IV

AVAILABILITY OF DOCTORS AT PRIMARY HEALTH CENTRES(As on March, 2006)

Sl. No.	State/UT	Required[1] (R)	Sanctioned (S)	In Position (P)	Vacant (S-P)	Shortfall (R-P)
1.	Andhra Pradesh	1570	2497	2202	295	*
2.	Arunachal Pradesh	85	78	78	0	7
3.	Assam	610	NA	NA	NA	NA
4.	Bihar	1641	2078	1606	472	35
5.	Chhattisgarh	518	1542	1154	388	*
6.	Goa	19	56	53	3	*
7.	Gujarat	1072	1070	907	163	165
8.	Haryana	408	570	433	137	*
9.	Himachal Pradesh	439	354	467	*	*
10.	Jammu & Kashmir	374	668	643	25	*
11.	Jharkhand	330	3906	2332	1574	*
12.	Karnataka	1679	2237	2041	196	*
13.	Kerala	909	1345	1151	194	*
14.	Madhya Pradesh	1192	1278	839	439	353
15.	Maharashtra	1800	1800	1191	609	609
16.	Manipur	72	62	96	*	*
17.	Meghalaya	101	127	106	21	*
18.	Mizoram	57	57	35	22	22
19.	Nagaland	84	53	53	0	31
20.	Orissa	1279	1353	1353	0	*
21.	Punjab	484	634	350	284	134
22.	Rajasthan	1713	1525	1316	209	397
23.	Sikkim	24	48	48	0	*
24.	Tamil Nadu	1252	3089	2537	552	*
25.	Tripura	73	161	152	9	*
26.	Uttaranchal	222	272	182	90	40
27.	Uttar Pradesh	3660	NA	NA	NA	NA
28.	West Bengal	922	922	811	111	*
29.	A&N Islands	20	36	36	0	*
30.	Chandigarh	0	0	0	0	0
31.	D &N Haveli	6	6	6	0	0
32.	Daman & Diu	3	5	5	0	*
33.	Delhi	8	31	23	8	*
34.	Lakshadweep	4	4	4	0	0
35.	Pondicherry	39	63	63	0	*
	All India[2]	**22669**	**27927**	**22273**	**5801**	**1793**

Notes
NA: Not Available
** Surplus*
1 One per each existing Primary Health Centre
2 For calculating the overall percentages of vacancy and shortfall, the States/UTs for which manpower position is not available, should be excluded.

ANNEXURE - V

AVAILABILITY OF SPECIALISTS AT CHCs (As on March, 2006)

Total Specialists [Surgeons, OB&GY, Physicians & Paediatricians]

Sl. No.	State/UT	Required[1] (R)	Sanctioned (S)	In Position (P)	Vacant (S-P)	Shortfall (R-P)
1.	Andhra Pradesh	668	406	224	182	444
2.	Arunachal Pradesh	124	4	0	4	124
3.	Assam	400	NA	NA	NA	NA
4.	Bihar	280	280	88	192	192
5.	Chhattisgarh	472	700	49	651	423
6.	Goa	.20	14	7	7	13
7.	Gujarat	1092	322	84	238	1008
8.	Haryana	328	112	37	75	291
9.	Himachal Pradesh	264	NA	NA	NA*	NA
10.	Jammu & Kashmir	320	276	142	134	178
11.	Jharkhand	776	63	146	*	630
12.	Karnataka	1016	843	691	152	325
13.	Kerala	428	424	115	309	313
14.	Madhya Pradesh	916	253	49	204	867
15.	Maharashtra	1628	1628	448	1180	1180
16.	Manipur	64	30	3	27	61
17.	Meghalaya	100	2	1	1	99
18.	Mizoram	36	0	0	0	36
19.	Nagaland	84	0	0	0	84
20.	Orissa	924	496	NA	NA	NA
21.	Punjab	504	343	177	166	327
22.	Rajasthan	1300	870	592	278	708
23.	Sikkim	16	16	4	12	12
24.	Tamil Nadu	660	NA	NA	NA	NA
25.	Tripura	40	2	2	0	38
26.	Uttaranchal	196	163	71	92	125
27.	Uttar Pradesh	1544	1110	413	697	1131
28.	West Bengal	1384	692	624	68	760
29.	A&N Islands	16	12	0	12	16
30.	Chandigarh	4	4	4	0	0
31.	D &N Haveli	4	2	2	0	2
32.	Daman & Diu	4	0	0	0	4
33.	Delhi	0	0	0	0	0
34.	Lakshadweep	12	0	0	0	12
35.	Pondicherry	16	4	6	*	10
	All India[2]	**15640**	**9071**	**3979**	**4681**	**9413**

Notes
NA: Not Available
* *Surplus*
1 *One per each Community Health Centre*
2 *For calculating the overall percentages of vacancy and shortfall, the States/UTs for which manpower position is not available, should be excluded.*

ANNEXURE VI

STATE-WISE VASECTECTOMIES, TUBECTOMIES AND SHARE OF TUBECTOMY IN TOTAL STERILISATIONS

Sl. No.	State/UT/Agency	2002-03			2003-04			2004-05			2005-06			2006-07*		
		Vasec-tomy	Tubectomy	%of tubec-tomy to total sterili-sations	Vasec-tomy	Tubectomy	%of tubec-tomy to total sterilisa-tions	Vasec-tomy	Tubec-tomy	%of tubec-tomy to total sterilisa-tions	Vasec-tomy	Tubec-tomy	%of tubec-tomy to total sterilisa-tions	Vasectomy	Tubectomy	%of tubectomy to total sterilisations
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
I	**Major States (Population> 20million)**															
1.	Andhra Pradesh	45,772	788,767	94.5	31,804	799,008	96.2	28,808	707,609	96.1	26,683	717,588	96.4	26,266	741,327	96.6
2.	Assam	142	33,962	99.6	406	44,728	99.1	366	39,189	99.1	84	24,117	99.7	110	17,172	99.4
3.	Bihar	599	111,325	99.5	478	120,421	99.6	916	87,210	99.0	555	95,786	99.4	1,134	118,843	99.1
4.	Chattisgarh	2,862	112,436	97.5	3,242	112,606	97.2	3,788	120,690	97.0	6,699	117,800	94.6	6,322	126,772	95.2
5.	Gujarat	1,831	270,170	99.3	1,677	261,219	99.4	1,587	276,546	99.4	1,446	278,888	99.5	1,032	266,517	99.6
6.	Haryana	1,414	89,970	98.5	1,712	89,093	98.1	1,990	87,903	97.8	12,779	80,171	86.3	10,986	74,783	87.2
7.	Jharkhand	521	57,264	99.1	326	48,634	99.3	577	41,044	98.6	2,669	81,994	96.8	6,461	94,836	93.6
8.	Karnataka	1,110	394,035	99.7	780	377,001	99.8	681	376,279	99.8	995	375,313	99.7	766	374,537	99.8
9.	Kerala	1,532	152,484	99.0	1,626	148,484	98.9	1,583	149,488	99.0	1,458	131,544	98.9	976	126,725	99.2
10.	Madhya Pradesh	6,082	366,935	98.4	7,052	346.594	98.0	15,091	353,948	95.9	30,625	336,305	91.7	10,972	355,870	97.0
11.	Maharashtra	38,160	643,697	94.4	42,028	647,042	93.9	41,341	648,406	94.0	29,795	629,762	95.5	21,425	574,303	96.4
12.	Orissa	1,168	72,814	98.4	1,232	89,491	98.6	1,498	99,819	98.5	951	82,098	98.9	790	92,949	99.2
13.	Punjab	1,200	100,538	98.8	1,638	95,960	98.3	4,012	98,456	96.1	15,762	91,829	85.4	5,615	88,143	94.0
14.	Rajasthan	1,737	284,122	99.4	1,769	298,369	99.4	8,761	325,210	97.4	18,048	299,259	94.3	6,366	281,723	97.8
15.	Tamil Nadu	467	417,550	99.9	956	429,356	99.8	676	416,351	99.8	629	379,399	99.8	734	356,202	99.8
16.	Uttar Pradesh	1,771	468,243	99.6	5,276	477,865	98.9	10,003	493,599	98.0	4,568	445,863	99.0	2,669	426,772	99.4
17.	West Bengal	1,873	243385	99.2	1,126	252,754	99.6	1,519	287,432	99.5	827	194,166	99.6	1,828	134,929	98.7
II	**Smaller States**															
1.	Arunachal Pradesh	2	1,427	99.9	3	1,629	99.8	1	2,100	100.0	3	1,414	99.8	12	1,934	99.4
2.	Delhi	2,011	37,089	94.9	1,712	37,557	95.6	2,060	37,581	94.8	1,616	32,552	95.3	1,320	27,562	95.4
3.	Goa	26	5,224	99.5	13	5,077	99.7	25	5,171	99.5	20	5,331	99.6	39	5,286	99.3
4.	Himachal Pradesh	3,054	30,857	91.0	3,160	29,177	90.2	2,956	30,575	91.2	2,880	25,503	89.9	3,144	23,301	88.1
5.	Jammu & Kashmir	538	20,311	97.4	418	20,354	98.0	482	21,115	97.8	322	21,144	98.5	455	18,826	97.6
6.	Manipur	360	1,352	79.0	144	1,330	90.2	23	495	95.6	133	1,610	92.4	4	402	99.0
7.	Meghalaya	40	2,443	98.4	9	2,633	99.7	16	2,189	99.3	5	2,259	99.8	45	2,488	98.2
8.	Mizoram	1	4,969	100.0	2	3,934	99.9	0	2,140	100.0	7	2,313	99.7	-	2,342	100.0
9.	Nagaland	56	1,096	95.1	28	1,126	97.6	19	735	97.5	12	1,183	99.0	11	961	98.9
10.	Sikkim	359	210	36.9	180	1,175	86.7	167	1,006	85.8	372	1,146	75.5	-	1,471	100.0
11.	Tripura	31	3,396	99.1	2	3,119	99.9	24	2,250	98.9	18	3,960	99.5	13	3,290	99.6
12.	Uttaranchal	3,254	28,020	89.6	1,900	29,300	93.9	1,718	83,081	95.1	217	34,763	99.4	1,417	31,350	95.7
III	**Union Territories**															
1.	A&N Islands	15	1,830	99.2	11	1,293	99.2	3	1,415	99.8	11	1,100	99.0	9	979	99.1
2.	Chandigarh	60	2,729	97.8	63	2,845	97.8	53	2,340	97.8	30	2,172	98.6	41	2,344	98.3
3.	D&N Haveli	33	702	95.5	26	759	96.7	11	932	98.8	3	927	99.7	1	977	99.9
4.	Daman & Diu	4	619	99.4	5	555	99.1	3	576	99.5	5	464	98.9	6	494	98.8
5.	Lakshdweep	-	21	100.0	0	17	100.0	0	22	100.0	3	20	87.0	-	40	100.0
6.	Pondicherry	16	12,273	99.9	21	12,524	99.8	17	11,915	99.9	19	10,194	99.8	24	10,459	99.8
VI	**Other Agencies**															
1.	M/o Defence	2,758	11,715	80.9	2,748	10,847	79.8	5,082	12,587	71.2	4,587	11,617	71.7	2,705	10,754	79.9
2.	M/o Railways	835	7,714	90.2	722	6,653	90.2	588	6,295	91.5	508	5,186	91.1	445	4,476	91.0
	All India	**121,694**	**4,781,694**	**97.5**	**114,295**	**4,810,529**	**97.7**	**136,445**	**4,783,699**	**97.2**	**165,342**	**4,526,690**	**96.5**	**114,125**	**4,402,139**	**97.5**

*Figures are provisional

- Nil

ANNEXURE VII

Minutes
Committee on Empowerment of Women (2007-2008)

Fourth Sitting
(20.02.2008)

The Committee sat on Wednesday, the 20th February, 2008 from 1130 hours to 1330 hours in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Smt. Krishna Tirath - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Neeta Pateriya
3. Smt. Minati Sen
4. Smt. Jayaben Thakkar
5. Shri P.C. Thomas
6. Shri M.P. Veerendra Kumar

RAJYA SABHA

7. Smt. Prema Cariappa
8. Kumari Nirmala Deshpande
9 Smt. Brinda Karat
10. Smt. Maya Singh
11. Smt. Syeda Anwara Taimur

WITNESSES
REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE

1.	Shri Naresh Dayal	Secretary
2.	Dr. R. N. Salhan	Additional Director General, Health Services
3.	Shri K. Ramamurthy	Joint Secretary
4.	Shri Vineet Chawdhry	Joint Secretary
5.	Shri Amarjeet Sinha	Joint Secretary

REPRESENTATIVES OF AIIMS AND OTHER HOSPITALS IN DELHI

1.	Dr. T.T. Dogra	Director, AIIMS
2.	Dr. G.K. Sharma	Principal and Medical Superintendent Lady Harding Medical College
3.	Dr. Jagdish Prasad	Medical Superintendent Safdarjung Hospital
4.	Dr. N.K. Chaturvedi	Medical Superintendent Dr. Ram Manohar Lohia Hospital

SECRETARIAT

1.	Shri S.K. Sharma	Additional Secretary
2.	Shri C. S. Joon	Director
3.	Smt. Veena Sharma	Deputy Secretary

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

3. Thereafter, the Secretary, Ministry of Health and Family Welfare, gave a brief account of the programmes and initiatives of the Government to strengthen the public health delivery system with special reference to women's health in the country.

4. Then, the Committee took oral evidence on the subject 'Medical Facilities for Women at All India Institute of Medical Sciences (AIIMS), Hospitals and Primary Health Centres'. During the course of evidence, various issues/aspects pertaining to the subject viz. health infrastructure in the country, thrust areas of National Rural Health Mission (NRHM), shortage of manpower in health sector, programmes like Janani Suraksha Yojana, functioning of Sub-Centres/Primary Health Centres, facilities available for women at AIIMS/other Hospitals in Delhi, role and working conditions of Accredited Social Health Activists (ASHAs), status of nursing schools in the country, upgradation projects of the various hospitals/health institutes in the country, public-private partnership in health sector, etc. were discussed.

5. Members sought clarifications on different points most of which were replied to by the representatives. The Ministry was also asked to furnish written replies to the queries, which could not be resolved during the sitting.

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

The Committee then adjourned.

ANNEXURE VIII

MINUTES
COMMITTEE ON EMPOWERMENT OF WOMEN (2007-2008)

Sixth Sitting
(25.4.2008)

The Committee sat on Friday, the 25th April, 2008 from 1000 hrs. to 1030 hrs. in Room No. 139, Parliament House Annexe, New Delhi.

PRESENT

Smt. Krishna Tirath - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Priya Dutt
3. Smt. Sushila Kerketta
4. Smt. Manorama Madhvaraj
5. Shri Rajesh Kumar Manjhi
6. Smt. Minati Sen
7. Smt. Karuna Shukla
8. Smt. C. S. Sujatha
9. Shri P.C. Thomas

RAJYA SABHA

10. Kumari Nirmala Deshpande
11. Smt. Brinda Karat
12. Smt. Syeda Anwara Taimur

SECRETARIAT

1. Shri A.K. Singh — Joint Secretary
2. Shri C.S. Joon — Director
3. Smt. Mamta Kemwal — Deputy Secretary-II

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

3. The Committee then took up for consideration the draft Report on the subject **'Medical Facilities for Women at All India Institute of Medical Sciences (AIIMS), Hospitals and Primary Health Centres'.** After some deliberations, the Committee adopted the draft Report without changes and authorised the Chairperson to finalise the Report and present the same to Parliament.

The Committee then adjourned.