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COMMITTEE ON EMPOWERMENT OF WOMEN
(2008-2009)

(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

[Action Taken on Sixteenth Report of the Committee on Empowerment of Women (Fourteenth Lok Sabha)]

TWENTY FIRST REPORT

LOK SABHA SECRETARIAT
NEW DELHI

FEBRUARY, 2009/ MAGHA, 1930 (Saka)

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MINISTRY OF HEALTH AND FAMILY WELFARE

[Action Taken on Sixteenth Report of the Committee on Empowerment of Women (Fourteenth Lok Sabha)]

Presented to Lok Sabha on 17th February, 2009

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INTRODUCTION

I, the Chairperson of Committee on Empowerment of Women, present the Twenty First Report (Fourteenth Lok Sabha) on the Action Taken by the Government on the recommendations contained in the Sixteenth Report of the Committee on Empowerment of Women (Fourteenth Lok Sabha) on 'Medical Facilities for Women at All India Institute of Medical Sciences (AIIMS), Hospitals and Primary Health Centres'.

2. The Sixteenth Report (Fourteenth Lok Sabha) of the Committee on Empowerment of Women was presented to Lok Sabha and laid in Rajya Sabha on 29th April, 2008. The Action Taken Replies of the Government to all the Observations/Recommendations contained in the Report have been received.

3. The Draft Report was considered and adopted by the Committee on Empowerment of Women (2008-2009) at their sitting held on 12th February, 2009.

4. An Analysis of the Action Taken by the Government on the recommendations contained in the Sixteenth Report (Fourteenth Lok Sabha) of the Committee is given in Appendix II.

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

NEW DELHI
13th February, 2009
24 Magha, 1930 (Saka)

KRISHNA TIRATH
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

CHAPTER I

REPORT

This Report of the Committee deals with the action taken by the Government on the recommendations contained in the Sixteenth Report (Fourteenth Lok Sabha) of the Committee on Empowerment of Women on the subject 'Medical Facilities for Women in All India Institute of Medical Sciences (AIIMS), Hospitals and Primary Health Centres'.

2. The Sixteenth Report of the Committee was presented to Lok Sabha on 29th April, 2008. Replies of the Government in respect of all recommendations have been received and are categorized as under:-

i) Observations/Recommendations which have been accepted by the Government.
Para Nos:-
2,5,6,8,9,10,11,12,13,14,15,17,18,19,20,22,23,24,25,26,27,28,29, 30 and 32.

ii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government.
Para Nos:- Nil

iii) Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee.
Para Nos:- 1,3,7,16 and 31

iv) Observations/Recommendations in respect of which the Government have furnished interim replies.
Para Nos:- 4 and 21

3. The Committee desire that replies in respect of recommendations contained in Chapter 1 of this Report should be furnished by the Government expeditiously.

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

A. Low Public Expenditure on Health (Recommendation Para No. 1)

5. The Committee had noted that though our country had registered significant progress in health care over the years, a high proportion of population continued to suffer and die from preventable diseases and other health related complications. To combat the situation, National Health Policy had been designed in 2002. Its main objectives were to reduce the overall burden of diseases, promote health, encourage inter-sectoral coordination and improve service delivery. Moreover, the National Common Minimum Programme had committed to allocating 2 to 3% of the GDP as public expenditure on health, a target to be achieved by 2010. But the Committee had observed that in terms of percentage GDP, public expenditure on health was only in the vicinity of 1 %. They had further noted that public spending on health had declined from 1.16% in 2002 to 0.87% in 2004. In fact, less than 1% of GDP spent on health was far below what was needed to provide basic health care to the people. The Committee strongly felt that we were under-investing in health, whereas most of the developing countries were spending much more in health sector. The Committee, therefore, had desired that the public expenditure on health should at least be 3% of GDP.

6. The Ministry of Health and Family welfare has submitted the following reply in this regard:

> "Public spending on health is in the vicinity of 1% of GDP and all efforts are being made to enhance public spending on health. Health allocation per se will not necessarily bring about an improvement in health status.

Other determinants of health like nutrition, drinking water supply, sanitation etc., are critical. However, if a holistic view is taken of health alongwith these other determinants, public spending on health is 1.39% of GDP for the year 2007-08 (BE) according to the Economic Survey 2007-08.

The National Rural Health Mission (NRHM) launched in April, 2005 seeks to effect an architectural correction in the delivery of healthcare at primary and secondary levels. The mission, inter-alia, aims at providing accessible, affordable, accountable, effective and reliable primary health care facilities, especially to the poor and vulnerable section of the population, bridging the gap in rural health care services through creation of the cadre of Accredited Social Health Activist (ASHA), improving hospital care through strengthening of public health infrastructure, rationalization of manpower deployment, decentralization of programme to district level and effective utilization of resources. Community ownership, decentralized planning and flexibility in funding form the core tenets of NRHM. It also promotes a sector wide approach with focus on sanitation and hygiene, nutrition and safe drinking water.

The Eleventh Five Year Plan also aims to restructure policies to achieve a New Vision based on faster, broad – based and inclusive growth. Promotion of good health necessitates putting in place a comprehensive strategy encompassing individual health care, public health, sanitation, clean drinking water, access to food and better nutrition. The evolving strategy focusses on convergence and development of public health systems and services , reducing disparities in health across regions and communities, and focussed attention on communicable and non- communicable diseases. Public private partnership in healthcare delivery will be promoted. Good governance, transparency and accountability in the delivery of

health services will be ensured through involvement of Panchayati Raj Institutions (PRIs), Community and Civil Society Groups. Health as a right for all citizens will be the professed goal in the XI Plan.

Several new initiatives are being planned in the current plan – Health Care for the Elderly, Urban Health Mission, CVD, diabetes, programmes like Letospirosis Control Programme, Human Rabies, National Organ Transplant Programme, Oral Health, Prevention and Control of Fluorosis etc. Developing human resources is high on priority given our growing and varied requirements."

7. The Committee in their original report had observed that the public expenditure on health in our country was only about 1 % of G.D.P though the National Common Minimum Programme was committed to allocating 2% to 3% of the GDP to the health sector, a target to be achieved by 2010. They had further noted that when most of the developing countries were spending much more in health sector, the same in our country, had declined to just 0.87% of G.D.P in 2004. The Committee, while expressing their concern had desired that the public expenditure on health should at least be 3% of GDP. The Ministry of Health and Family Welfare in their reply has stated that all efforts are being made to enhance public spending on health beyond 1 %. They have further added that health allocation per se will not necessarily bring about an improvement in health status and the other determinants of health like nutrition, drinking water supply, sanitation etc., are more critical. Thus, it is stated that a holistic view of health alongwith these other determinants brings the public spending on health to 1.39% of GDP for the year 2007-08 (BE). The Committee, however, do not agree with such a projection of allocations and are unhappy to note that even the holistic approach does not bring the expenditure on health anywhere near the targetted 3% of our GDP. They, therefore, reiterate that concerted efforts should be made by the Government to achieve the target

by 2010 by suitably enhancing the allocations in favour of the health sector.

B. Monitoring of Health Care Institutions by Panchayati Raj Representatives

(Recommendation Para No.3)

8. The Committee had observed that NRHM had set up a platform for involving the Panchayati Raj Institutions (PRIs) and the community in the management of primary health programmes and infrastructures. Accordingly, the Village Health Committees were the link between the Gram Panchayat and the community and at the district level, the District Health Mission coordinated the NRHM functions under the Zila Pramukh. Since the strengthening of PRIs were critical to implementing various programmes under NRHM and achieving its goals, the Committee had recommended 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 had also desired that adequate representation of women members of PRIs be ensured in the District Health Committees and other equivalent bodies.

9. The Ministry of Health and Family welfare in their Action Taken note has explained the position as under:

> "NRHM envisages greater role and ownership of the Public Health System by the PRIs. Empowerment of the Community and Community Based institutions through continuous capacity building is an important component of NRHM. The Mission has created the institutions of Village Health & Sanitation Committees, Rogi Kalyan Samitis, District & State Health Missions which have representations of the PRIs. These institutions are empowerd under NRHM with dedicated and untied funding so that the local sensitivities and requirements are addressed without any bottlenecks. The representation of women members of the Panchayat is also ensured. The PRI representatives are kept apprised of the progress

of NRHM in their areas through participation in the various institutions of NRHM".

10. Since the strengthening of PRIs was critical for implementing various programmes under NRHM and in achieving its goals, the Committee had recommended 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 had also desired that adequate representation of women members of PRIs be ensured in the District Health Committees and other equivalent bodies. The Committee are happy to find from the reply of the Ministry that the PRI institutions are empowered under NRHM with dedicated/untied funding and adequate representation of women members of the Panchayat. However, the reply is silent about giving PRI institutions the power to monitor the facilities available at the public health care institutions. As proper monitoring by the representatives of the people will definitely improve the day to day functioning of these health care institutions, the committee reiterate their earlier recommendation to entrust the monitoring powers to PRI representatives.

C. Shortage of Health Care Personnel in the Government Sector (Recommendation Para No.4)

11. The Committee in their original Report had observed that in the last five decades, our country had built up a commendable health infrastructure and manpower at primary, secondary and tertiary care in Government, voluntary and private sectors. So far, we have had 262 Medical Colleges in the country. The Committee had also been informed that as on March, 2006, there were 144988 Sub Centres, 22669 Primary Health Centres(PHCs) and 3910 Community Health Centres (CHCs) in the country. But as per the population norms based on 2001 Census, the shortage was of 13804 Sub Centres, 3353 Primary Health Centres

and 2581 Community Health Centres. With respect to manpower, the Committee found that as against a requirement of 22669 Doctors in PHCs, only 22273 were in position, resulting in a shortfall of 1793 Doctors. Similarly, in CHCs, as against a requirement of 15640 Specialists, including one Surgeon, one Obstetrician & Gynecologist, one Physician and one Pediatrician for each CHC there were only 3979 Specialists in position as on March, 2006, resulting in a shortfall of 9413 Specialists. The case of ANMs, Male Health Workers, etc. was not different. The Committee found a wide gap between the demand and availability of trained health care personnel in the government sector. This gap was too alarming, i.e. 75%, in the case of Specialists. As infrastructure limitations were found to be a major bottleneck in effective health care delivery, the Committee had recommended that concerted and time-bound efforts should be made to overcome them, both physical and human. The Committee had also desired 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.

12. The Ministry of Health and Family welfare has submitted the following reply in this regard:

> "NRHM seeks to strengthen the Public Health delivery system at all levels. The Sub-centre and PHCs are envisaged to be revitalized through better human resource management, clear quality standards, better community support and an untied fund to enable local planning and action. The Indian Public Health Standards(IPHS) define structural, personnel, equipment and management standards and have been finalized for CHCs, PHCs and SCs. This will involve up-gradation of existing Community Health Centres and also up-gradation of Block PHCs to CHCs in all those blocks where no CHC exists at present. Based on the need for Community Health Centres in every block detailed facility surveys were mandated under the NRHM. All the states are undertaking facility surveys to identify the fund

requirements for upgrading the facilities and requirement of human resource. As per reports received under NRHM from State Governments, a total of 2870 Community Health Centres have so far been selected for up-gradation to IPHS. Out of these, facility surveys are reported to have been completed in 2569 CHCs. Physical up-gradation work had been identified in 2284 CHCs and started in 1493. 483 CHCs have reported completion of up-gradation work.

As on March 2007, there are 145272 SCs, 22370 PHCs & 4045 CHCs functioning in the country and a total of 5117 specialists are working in CHCs across the country as against the requirement of 16180. Under NRHM, State/UT Governments are being funded for contractual appointment of trained health personnel like doctors, ANM, Staff Nurse and other Para-Medics etc. States have taken several steps for ensuring availability of doctors. As regards recruitment of skilled health personnel, a total of 2282 Specialists, 6271 doctors, 12908 Staff Nurses and 4380 other category para-medical staff had been added under NRHM on contract, upto December 2007."

13. The Committee had found a wide gap between the demand and availability of trained health care personnel in the government sector including doctors, specialists, ANMs, Staff Nurse, Male Health Workers, etc. In the case of Specialists, the shortage was about 75%. Looking at this alarming situation which had become a bottleneck in effective health care delivery, the Committee had recommended that concerted and time-bound efforts should be made to overcome the physical and human constraints in the system. It is observed from Government's reply that there has been a marginal increase in the number of Sub- Centres and as on March 2007 and there are 145272 SCs, 22370 PHCs & 4045 CHCs functioning in the country. In the case of specialists, the shortage has narrowed down to 71.6%. It has further been submitted that under NRHM contractual

appointments of trained health personnel like doctors, ANMs, Staff Nurse and other Para-Medicos etc. are being encouraged to fill the gaps in the system. Accordingly, a total of 2282 Specialists, 6271 doctors, 12908 Staff Nurses and 4380 other category para-medical staff has been added under NRHM on contract, up to December 2007. The Committee desire to be apprised of the steps taken by the Government to bring down further the shortage of Specialists and to extend contractual appointments of trained health personnel beyond 2007. They would also 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.

D. Public –Private Partnership in Health Sector
(Recommendation Para No.7)

14. The Committee had found that under NRHM, Public-Private Partnerships (PPP) mode was being encouraged to harness the large pool of private sector resources and draw them into the process of nation building like improving efficiency, effectiveness and quality in public health care sector. Initiatives like 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. were fine examples of such an interface. The Committee, while appreciating such initiatives had desired that the States should formulate clear guidelines regarding PPP partnership and Memorandum of Understanding should be signed in each case to prevent any abuse. The Committee had also urged the Government to make an assessment of all Private-Public Partnership Programmes that were underway in each States with a view to overcoming procedural pitfalls.

15. The Ministry of Health and Family Welfare replied as below:

"Noted for action".

16. The Committee, while appreciating Public-Private Partnership initiatives as efforts to tap expertise available with the private sector, had desired that there should be clear guidelines and MoUs in this regard to prevent any abuse. They had also urged the Government to make an assessment of all Private-Public Partnership Programmes that were underway in each State with a view to overcoming procedural pitfalls. The Committee regret to observe that the Government has not responded to the specific recommendations of the Committee and have simply stated that the recommendation has been noted for action. They, therefore, reiterate their earlier recommendation that the Government should formulate guidelines and MoUs regarding PPP programmes and assess all the ongoing programmes within three months under intimation to the Committee.

E. Remuneration to Accredited Social Activists (ASHAs) (Recommendation Para No.16)

17. The Committee had observed that the 'ASHA' or Accredited Social Health Activist was the backbone of the Janani Suraksha Yojana, the safe motherhood programme under National Rural Health Mission. Selected from the village itself, the ASHA was trained to work as an interface between the community and the public health system. Under the scheme, cash benefit was 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 had to work, the Committee failed to understand the rationale behind compensating her only on the basis of performing certain specific tasks. If ASHA was the 'Amritdhara' of the whole programme, adequate remuneration, which was delinked from specific activities, should be assured to her, with a performance linked component, if necessary. Uncertain and very limited compensation under the existing scheme of things might not keep her motivated. The Committee had

also desired that ASHA should be paid promptly and with dignity and should not be made to run from pillar to post to get her payments.

18. The Ministry of Health and Family Welfare has submitted as under:

> "The protocols for payment of Incentives to ASHAs are being strengthened in the states at all levels".

19. The Committee felt that 'ASHA' or Accredited Social Health Activist being the backbone of the Janani Suraksha Yojana - the safe motherhood programme under National Rural Health Mission- deserves to be paid adequately and promptly and hence had recommended the same. The Committee are dismayed over the vague reply from the government that the protocols for payment of incentives to ASHAs are being strengthened. In view of the tough working conditions and the commendable service of ASHAs the Committee reiterate their earlier recommendation that the question of payment of adequate remuneration be delinked from specific activities and the ASHAs should be assured of adequately higher remuneration with an additional performance linked component.

F. Functioning of Sub- Centres
(Recommendation Para No.21)

20. The Committee had been informed that the Health and Family Welfare Programme in the country was being implemented though Primary Health Care System. Sub-Centre was the first peripheral contact point between primary health care system and the community. One Female Auxiliary Nurse Midwife (ANM) and one Male Health Worker were manning each Sub-Centre. It was informed that under NRHM one extra contractual ANM was also provided to Sub-Centres. These centres were assigned tasks relating to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases. However, the Committee had their own doubts as to how many of

these Sub-Centres were actually functioning. Out of about 145000 Sub-Centres on record, only 50% function from a government building. Even in High Performing States like Kerala some of the Sub-Centres were functioning only on paper. In view of the above, the Committee had recommended that the 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.

21. The Ministry of Health and Family welfare has submitted the following reply in this regard:

> "Monitoring and Evaluation division under Union Ministry of health and Family Welfare are already collecting state-wise data pertaining to all indicators on NRHM, so that assessment could be done on regular basis. Needless to say, the Monitoring & Evaluation strategy for the NRHM is a multi-faceted approach taking into consideration various elements like MIS, Quality Assurance, Evaluation Surveys, Programme Management and Community Monitoring as per the NRHM framework for implementation. For the MIS, several initiatives have been taken for expediting the flow of information from the States/UTs. The Ministry is in the process of developing a web enabled MIS system, which will capture both the physical and financial data of various interventions being launched under NRHM from the district level upwards. The web- based MIS will capture data from the Districts on the integrated MIES format which captures the physical performance on various NRHM interventions.
>
> Yes, there is a huge gap of requirement and availability of Sub centres, being the first peripheral contact point between primary health care system and the community. Under NRHM, there is a provision of civil construction up to 33% in special focus States and 25% in other States. Construction of Sub Centres have been taken up from NRHM

funds as well as Finance Commission funds released to States. Efforts to improve the construction of sub-centres would be made further on. At present, barely 50% Sub Centres have then own building with the thrust on Sub Centre buildings under NRHM, the situation is likely to change".

22. The Committee in their original recommendation had expressed their apprehension as to how many Sub- Centres under Primary Health Care System were actually functioning. They had observed that even in High Performing States like Kerala, some of the Sub-Centres were functioning only on paper. They, therefore, had desired the government to collect state-wise data pertaining to the actual functioning of Sub-Centres. The Ministry, in their reply has explained the nuances of the Monitoring & Evaluation strategy for NRHM and the efforts taken to construct buildings for such Sub-Centres. However, they have failed to collect the state-wise data regarding the number of Sub-Centres actually functioning and those only on paper. Since the basic requirement in any evaluation process is the data pertaining to functional units of the programme, the Committee once again urge upon the Government to collect state-wise data and apprise the Committee of the same within three months.

G. Reconstruction of Safdarjung Hospital (Recommendation Para No.31)

23 The Committee had found that Safdarjung Hospital, the largest Central Government Hospital in Delhi had been catering to about 6300 patients in its OPD and about 800 in casualty every day. They also observed that this hospital had some of the best facilities in the country in the public sector like its Burns Ward. However, the hospital had only 1531 authorized beds including bassinets to provide medical care to the citizen of Delhi and neighbouring states. Out of this, 38.5% of beds had been earmarked to female patients. However, the Committee had observed that this hospital's mission to provide quality medical

care to patients had become a casualty in the mismatch between the high influx of patients from all over the country and the limited facilities available. The Committee, therefore, had desired that the Government should give high priority to the reconstruction plan of Safdarjung Hospital which would increase its bed strength from the present 1531 to 4000. They also had looked forward to enhanced facilities to women in their various departments.

24. The Ministry of Health and Family welfare in their Action Taken note has explained the position as under:

> "Seven Counters in OPD are exclusively for Women which are operated by Female Computer Clerk and one Women Security Guard is posted there for helping the Women patients.
> The Women staff Nurses are posted in OPD for presence while Women patients are examined by male Doctors.
> There are also separate ladies toilets and announcement system is also available for Women who get separated from the relatives due to crowd.
>
> In the Department of Obstetrics & Gynaecology. The following facilities are available:-
>
> - Antenatal, Post natal case
> - Family Welfare Services to all
> - Adolescent Clinic.
> - Gynae Cases.
> - Menopausal Clinic
> - Infertility Clinic
> - Colpescopy Clinic
> - OPD, Indoor & emergency services are available"

25. The Committee had observed that Safdarjung Hospital in Delhi had been facing problems in delivering quality heath care to the large number of people turning up at the hospital from all over the country due to limited facilities available. They had hence recommended that the Government should give high priority to the reconstruction plan of Safdarjung Hospital.

From the reply it has been observed that a lot of steps have been taken to improve the services being offered to women. However the Government have not taken due cognizance of recommendation of the Committee that high priority should be accorded to the reconstruction plan of Safdarjung Hospital which would increase its bed strength from the present 1531 to 4000. The Committee once again urge upon the Government to do the same.

CHAPTER II
RECOMMENDATIONS / OBSERVATIONS WHICH HAVE BEEN ACCEPTED BY THE GOVERNMENT

Recommendation (Para No. 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.

Reply of the Government

Concurrent evaluation and Community Based monitoring of Health System are built into the NRHM as Core strategies and the same have been operationalised.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Government of India has approved the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) in March, 2006 with the objective of correcting regional imbalance in the availability of affordable/reliable tertiary healthcare services and also to augment facilities for quality medical education in the country. Under the PMSSY, it has been decided to set up 6 AIIMS-like institutions, one each in the States of Bihar (Patna), Chattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneshwar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh) at an estimated cost of Rs 332 Crores per institution.

Each institution will have a 960 bedded hospital with speciality/super-speciality disciplines and medical college having an annual intake of 100 undergraduates and PG/Doctoral courses in various disciplines.

There is also a proposal to establish 6 Nursing Colleges @ Rs. 15.00 crores each in the proposed six AIIMS like institutions. Planning Commission has accorded 'in principle approval for setting up of Nursing colleges at the AIIMS-like institutions. Detailed Project Reports for setting up of AIIMS-like institutions are under preparation, which will include the construction of Nursing Colleges.

With the setting up of Nursing Colleges in the AIIMS-like institutions, the facilities for quality nursing education in the underserved States of the country would get a boost, in addition to meeting the considerable shortage of nurses. As the proposed AIIMS-like institutions are in the hinterland, availability of trained paramedics/nurses is a critical requirement.

Progress made in setting up of AIIMS-like institutions.

State Governments have provided 100 acres or more land. Boundary wall constructed and pre-construction survey and EIA study conducted. Design DPR Consultants were selected for preparation of designs and DPR for Medical College & Hospital Complex at each institution. Layout/master plans for all the six sites approved. Preliminary architectural designs for the sites at Bhopal, Jodhpur and Rishikesh have been approved and that of the other three sites are likely to be approved by the Project Management Committee (PMC) in its meeting scheduled for 28.5.2008. The detailed project reports (DPR) would be

ready by August-September, 2008. Thereafter, tenders would be invited for selection of contractor for civil construction work.

Concept plans for housing complexes at all the sites approved. Bids invited for selection of contractors for Bhubaneswar and Raipur sites by HSCC has turned unsuccessful due to exorbitant price quoted by bidders and re-tendering process has been initiated. HLL has invited tenders for Rishikesh and Patna sites. Tender for Bhopal site is likely to be issued in July, 2008. Project Consultants were also selected for all the sites. It is expected that the civil construction work is likely to be completed by 2009-10 (for housing) and by 2010-11 (for hospital/medical college).

Under the upgradation project of PMSSY, Nursing Colleges/Schools are being set up in Bangalore Medical College and B.J. Medical College, Ahmedabad. These Nursing Colleges would be ready by the end of 2009.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Ministry

The Committee has observed that despite the massive public health infrastructure in the country, private sector is the major player. Private Health Sector is not the privilege of rich but at times the only option of poor . However the majority of private which is used by poor have single doctor dispensaries with little infrastructure or without paramedical support. The committee has therefore desired to revamp public health services ensuring quality facilities, adequate supplies and required manpower.

The rural primary health delivery system :

The health and family welfare programme in the country is being implemented through primary health care system. In rural areas, primary health care services are provided through a network of 145272 Sub-centres, 22370 Primary Health Centres and 4045 Community Health Centres as on March 2007 based on the following population norms:

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

Besides population norms, now the SC, PHCs and CHCs are opened on the basis of workload and distance.

Sub-Centre

Sub-centre is the first peripheral contact point between Primary Health Care system and the community. It is manned by one Female (ANM) and one Male Health Worker and one LHV for six such Sub-Centres. Sub-centres are assigned task relating to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes and provided with basic drugs for minor ailments needed for taking care for essential health need for women and children. Under NRHM, an additional ANM has been provided in a Sub-centre on contractual basis.

Govt. of India bears the salary of ANM and LHV besides rent liability and contingency whereas, the salary of the Male Health Worker is borne by the State Governments.

Primary Health Centre (PHC)

PHC is the first contact point between village community and the Medical Officer. It is manned by a Medical Officer and 14 other staff. 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. Under NRHM, the PHCs are strengthened by provision of 3 Staff Nurses and an AYUSH practitioner.

Community Health Centre (CHC)

CHC is established and maintained by the State Governments under MNP/BMS Programmes and manned by Four Medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, and Labour room and Laboratory facilities and serves as a referral centre for 4 PHCs. It provides facilities for emergency obstaetrics care and specialist consultations. Indian Public Health standards upgrades the CHC to be manned by 6 Medical Specialists including Anaesthetics and an eye surgeon (for 5 CHCs) supported by 24 paramedical and other staff with inclusion of two nurse midwives in the present system of seven nurse midwives.

National Rural Health Mission-Strengthening of primary health care services

NRHM has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.

The launch of NRHM has provided the Central and State Governments with a unique opportunity for carrying out necessary reforms in the Health Sector. The reforms are necessary for restructuring the health delivery system as well as for developing better health financing mechanisms. The strengthening and effectiveness of health institutions like SC\PHC\CHC\Distt. Hospital have positive consequences for all health programmes.

NRHM has three cardinal approaches i.e. decentralization, setting standards and architectural correction. The Mission provides additional resources to the States to enable them to meet the diverse health needs of citizens. Necessary flexibility is provided to States to take care of the local needs and socio-cultural variations. The states are urged to take innovative schemes to deal with local issues.

The mission also sets down minimum set to service guarantees and minimum infrastructure requirements that would define access to services. The Indian Public Health Standards sets those guaranteed standards of infrastructure for SC/PHC/CHC/Sub-Div/District Hospitals as per their bed strength.

Besides, the Architectural Corrections calls for health sector reform to make it functional through communitisation and flexible financing.

Strengthening of SC/PHC/CHC/Sub-Div/District Hospitals under NRHM

NRHM seeks to strengthen Sub-centres by provision of untied funds of Rs. 10,000/- per year which would be operated by the ANM and the Sarpanch, supply of allopathic and indigenous medicines in addition to an ANM on contract basis. Annual maintenance grant of Rs.10,000/- is also made available to every Sub-centre for undertaking construction and maintenance of the facility as per the request received from the States. It also seeks to sanction new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises.

The 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 and round the clock services in all PHCs across the country, in addition to upgrading single doctor PHC to 2 doctors PHC by posting AYUSH practitioners at PHC level and providing standard treatment protocols and training medical officers and para-medical workers in their use. In addition, Untied Grant for local health action and annual maintenance grant for PHCs through PHC level Panchayat Committee/Rogi Kalyan Samiti to undertake and supervise improvement and maintenance of physical infrastructure has been provided.

One of the key strategies of the NRHM is to support upgradation of all Community Health Centres to function as First Referral Units as per the Indian Public Health Standards (IPHS). State/UTs are carrying out the facility survey of all CHCs so as to gauge the exact requirement of funds in terms of upgradation of the facility as far as manpower, building, equipments etc. is concerned. Initial funds @ Rs.20 lakhs per CHC has already been provided under initiative during 2005-06. Based on the facility survey, required funds would be released to the States as per the request made by them in their Programme Implementation Plan (PIP).

Indian Public Health Standards (IPHS)

Indian Public Health Standards (IPHS), which detail the specifications of standards to which these institutions would have to be raised to so that the citizen is confident of getting public health services in the hospital that can be measured to be of acceptable standards. Indian Public Health Standards (IPHS) for Community Health Centres, Primary Health Centres, and Sub-centres, have been prepared which lay down Standards not only for personnel and physical infrastructure, but also for delivery of services, and management. The same has been circulated to all State/UTs for carrying out facility survey of all institutions. A system of performance bench marks would be introduced to concurrently assess the adherence of public hospitals to IPHS, in a transparent manner. Each hospital would, as part of IPHS, be required to set up a Patients Welfare Committee/Rogi Kalyan Samittee (RKS), which would bring in community control into the management of public hospitals. Guidelines for setting up of Rogi Kalyan Samiti have been circulated to all State/UTs. Based on the registration details of RKSs set up by various States/UTs, the funds have been released for setting up of RKSs to these States/UTs.

Mobile Medical Units/Health Camps

With the objective to take health care to the door step of the public in the rural areas, especially in under-served areas, Mobile Medical Units (MMUs), have been provided, one per district under NRHM. The States are however, expected to address the diversity and ensure the adoption of more suitable and sustainable model for the MMU to suit their local requirements. They are also required to plan for long-term sustainability of the intervention.

Two kinds of MMUs, one with diagnostic facility for the States other than North-East States, Himachal Pradesh and J&K and for the North- Eastern States, Himachal Pradesh and J&K, specialized facilities and services such as X-ray, ECG and ultrasound are provided in MMUs due to their difficult hilly terrain, non-approachability by public transport, long distances to be covered etc.

The States are needed to involve District Health Society/Rogi Kalyan Samiti/NGOs in deciding the appropriate modality for operationalization of the

MMUs. The provision of staff will be considered only for the States who will run the vehicles with support of NGOs/RKSs and in case of States out-sourcing the vehicles. States are needed to work out numbers of mobile dispensaries/health camps as a means of mobilizing local communities for health action and for creating demand.

Release of Funds to Various States/UTs under Mission Flexipool for year 2006-06 to 2008-09:

Under NRHM funds are released to State Governments for strengthening of their Rural Health Infrastructure. The State Governments are however required to reflect their requirement under NRHM Programme Implementation Plan which is examined in this Ministry and funds are released to State/UT Governments as per the recommendations of the National Programme Coordination Committee [NPCC].

Ensuring Availability of Doctors/Paramedics at Rural Health Centres :

The Government is also seized of the problem of lack of doctors in rural areas. Human resource engagement is a major thrust area under NRHM and is a priority being pursued with the States. Various initiatives which have been taken by various state/UT Govenrments for this purpose include contractual engagement of health staff based on local residence criteria, multi-skilling of doctors and para medics, provisions of incentives etc.. A Task Group constituted under the National Rural Health Mission under the chairmanship of Director General of Health Services has recommended the following measures to ensure the services of doctors in rural areas :

- Increase in the age of retirement of doctors to 65 years preferably with posting near hometown;
- Decentralization of recruitment at district level;
- Walk-in-interview and contractual appointment of doctors;
- Enhancing the salary for posting in rural areas by one-third;
- Increasing the admission capacity in medical colleges for Anesthesia;
- Reviving the Diploma Course in Anesthesia;
- To start one year Certificate Course in Anesthesia for Medical Officers working in the system at present to be given by National Board of Examination.

- Recognition of five hundred bedded Hospitals to provide the facility for conducting the above course;
- Hiring of private practitioners on case-to-case basis.

The above recommendations were communicated to all State/UT Governments and the following initiatives have been taken by State/UT governments to ensure availability of Doctors at rural health centres :

- Compulsory rural/difficult area posting for admission to post-graduate courses and as a pre-requisite for promotion, foreign assignment or training abroad ;
- Compulsory rotation of doctors on completion of prescribed tenure as per classification of locations;
- Contractual appointment of doctors;
- Option to forgo non practicing allowance and undertake practice without compromising on assigned duties, as per the service rules; offering incentive in form of allowance etc.
- Manning of PHCs by NGOs/ Non Government Statkeholders
- Involvement of Medical colleges.

Trend in Rural Health Infrastructure

There is a significant trend in augmentation of rural Health infrastructure. There is an increase of 2617 Sub Centres from 142655 reported in 2004 to 145272 in 2007. There is also a significant increase of 823 CHCs from 3222 in 2004 to 4045 in 2007. There is reduction in number of PHCs from 23109 in 2004 to 22370 in 2007 mainly due to upgradation of many PHCs at the Block level into CHCs.

Trends in Manpower from 2004 to 2007.

There is a significant increase in number of ANMs at Su Centres and PHCs from 138906 in 2004 to 147439 in 2007.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The Infant Mortality Rate for India was 80 per thousand live births in the year 1990 and has been brought down to 57 per thousand live births in 2006(Latest available Sample Registration System, SRS, data released by the office of the Registrar General of India) .

Yet as per the State of the World's Children 2008 Report of UNICEF the Infant Mortality Rate for India compares unfavorably with countries like Sri Lanka

(IMR 11 per thousand live births), Vietnam (IMR 15 per thousand live births) and Thailand (IMR 7 per thousand live births).

There is also a sex differential in IMR i.e the Mortality Rate for females is 59 per thousand live births as compared to 56 per thousand live births (SRS, 2006) for males. The Government is implementing the pre-natal diagnostic at PNDT Act , creating awareness about the issue to the Mass Media and promoting behavioural change communication throughout the country to fight the issue.

The Government is aware of the need to accelerate the pace of neonatal, infant and child mortality for the country to be able to achieve the national as well as the MDG goals

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

As per the latest survey report of Registrar General of India (RGI-SRS 2001-03) published in the year 2006, the Maternal Mortality Ratio (MMR) for India is 301 per 100,000 live births which translates into about 77,000 maternal deaths per year. The same report states that 2/3rd of maternal deaths occur in 8 EAG States and Assam. To bring out the reduction in Maternal Mortality in the EAG and other States with weak public health infrastructure, various interventions are being implemented under the National Rural Health Mission (NRHM) and the Reproductive and Child Health Progrmme Phase II to improve the availability of and access to quality health care including services for Immunization and safe Motherhood especially in rural areas.

Village Health Nutrition Day are being organized in the States once a month in every village to provide a package of quality primary health care including RCH services, platform for inter-sectoral convergence and also to raise awareness of community groups especially on health promotion, prevention of common disease and importance of timely care seeking behavior. Issues on which awareness is being generated in the Community are on Danger signs during pregnancy, Importance of institutional delivery and where to go for delivery, Importance of seeking post-natal care, Counselling on Essential New Born Care, Registration for the JSY, Counselling for better nutrition, Exclusive Breastfeeding, Weaning and complementary feeding, Care during diarrhoea and home management, Café during acute respiratory infections, Prevention of malaria, TB, and other communicable diseases, Prevention of HIV/AIDS, Prevention of STIs, Importance of safe drinking water, Personal hygiene, Household sanitation, Education of children, Dangers of sex selection, Age at marriage, Information on RTIs, STIs, HIV and AIDS, Disease outbreak, Disaster management etc.

In various interactions with the States during workshops and as per the information given by the State's in the State Project Implementation Plan (SPIP), for the year 2008-09 about 13 States will be implementing Maternal Death Audit either at facility or community level on pilot basis. These States are Assam, J & K, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Nagaland, Punjab, Rajasthan,Tamil Nadu, Tripura and West Bengal.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The Department of Health & Family Welfare is regularly carrying out the Gender Budget Exercise to assess the flow of budgetary resources towards benefit of women. Specific gender disaggregated Data is being collected under all major schemes. Guidelines of different programmes/schemes are continuously reviewed to facilitate increased access of women under the different schemes. There are four major Women Specific programmes namely RCH Flexible Pool, Rural Family Welfare Centres, reproductive & Child health project and Training institutions under States which falls under 100% benefit for women and 22 schemes/programmes/ institutions that fall under pro-Women (at least 30% benefit for women) schemes.

As programmes are gender neutral, in health and family welfare schemes, physical targets are not gender specific (except in case of 100% specific women schemes) as the delivery mechanism does not permit utilization of funds separately for women. Moreover, target free approach is followed in family welfare schemes, including family planning programmes, as the approach is voluntary in nature. Rural and urban segments of female population are factored in these schemes. Assistance is provided to beneficiaries, belonging to below poverty line in some specific schemes.

Selection and placement of ASHAs (Accredited Social Health Activist) is an important milestone to promote further gender equality through better awareness of health needs, facilities and in general health seeking behavior. With the launching of National Rural Health Mission in 2005, ASHAs have been selected in States, so as to work as a link among beneficiaries at village level, Anganwadi Worker and ANM and the health facilities. She is to assist and guide women to assess the health facilities for ante-natal care, Institutional delivery, post-natal care and counseling on nutrition and Family Planning Services.

The recommendation regarding gender audit and gender outcome assessment has been noted and efforts will be made to undertake this during the course of the year.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

As per the RCH NPIP(National PIP) and also NRHM Mission Document 50% of PHCs and all CHCs have to be operationalized for 24 X 7 services. Till now 8755 PHCs have been operationalized as 24 X 7 centres. The essential criteria for considering PHCs functional for 24 X 7 services are 24- hour delivery services; both normal and assisted, Essential new born care and Referal for emergencies. To facilitate the operationalization of these 24 X 7 facilities, skilled

based training like Skilled Birth Attendant training for SNs/LHVs/ANMs is being scaled up. To facilitate the operationalization of 24 X 7 PHCs a rapid assessment of targeted Health Facilities in 8 EAG States and Assam has been done and States have been provided with the assessment report for fulfilling the gaps identified at such facilities. Along with this, in different interaction with the States during workshops, Review Mission, meetings etc. States have been requested for a holistic planning of these facilities by facilities by matching of skilled based trainings with availability of logistics

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Funds are being provided through JSY, RKS, United Grants and under Referral transport for providing referral facilities both at the community and at facility level. States have adopted various models for making referral transport

available at place like centralized EMRI Model in Andhra Pradesh, Chhattisgarh, Delhi, Gujarat or under PPP as in Arunachal Pradesh, Manipur or through Voucher Schemes as in Uttar Pradesh and Uttarakhand.

As per the RCH NPIP(National PIP) and also NRHM Mission Document 50% of PHCs and all CHCs have to be operationalized for 24 X 7 services. Till now 8755 PHCs have been operationalized as 24 X 7 centres. The essential criteria for considering PHCs functional for 24 X 7 services are 24- hour delivery services; both normal and assisted, Essential new born care and Referal for emergencies. To facilitate the operationalization of these 24 X 7 facilities, skilled based training like Skilled Birth Attendant training for SNs/LHVs/ANMs is being scaled up. To facilitate the operationalization of 24 X 7 PHCs a rapid assessment of targeted Health Facilities in 8 EAG States and Assam has been done and States have been provided with the assessment report for fulfilling the gaps identified at such facilities. Along with this, in different interaction with the States during workshops, Review Mission, meetings etc. States have been requested for a holistic planning of these facilities by facilities by matching of skilled based trainings with availability of logistics

GOIs SBA training involves a 2-3 week and 3-6 week intensive skilled based training for SNs and ANMs respectively. Training guidelines and curriculum have already been developed and disseminated to the States. It is a residential training with emphasis on hands on practice and skill acquisition especially in certain obstetric procedures. To ensure quality in the training norms of certification have been defined and certificate is only given after trainees perform certain recommended number of client practice as per the requisite standards.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources. The Mission seeks to bring the CHCs on a par with the IPHS to provide round the clock hospital-like services. As far as manpower is concerned, it would be achieved through provision of seven Specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH set up would be provided in each CHC/PHC. Contractual appointment of AYUSH doctors are being provided for this purpose. This would be reflected in the State Plans as per their needs. Accordingly this ministry would be providing financial assistance for hiring trained health professionals/ specialist and updating the health care infrastructure, as per need based.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The age bar and restriction of two live births for becoming eligible for JSY benefits have already been removed in respect of Low Performing States i.e. Assam, Bihar, Jharkhand, Chattisgarh, J&K, Madhya Pradesh, Orissa, U.P., Rajasthan and Uttarakhand.

The classification of States was primarily made with a view to identity the States where the rate of institutional deliveries was low and it was necessary to have accelerated growth in the rate of institutional delivery in those States.

The question of removing these restrictions in high performing States shas, however, been engaging the attention of the Ministry for sometime. The restrictions on age and parity was not removed in these States as because Janani Suraksha Yojana is a demand generation Scheme and these States were already having high rate of institutional deliveries even without the assistance of

the Scheme and there was no need to incentivise institutional deliveries in these States. It was thought that the limited resources should be utilized to encourage institutional deliveries as a whole and in bringing the level of institutional deliveries of the low performing states, where the rate is abysmally low, to the level of high performing states. On achieving parity between these two categories of States, the question of removing the restrictions in case of JSY beneficiaries in High performing states, will be considered.

Further, Hon'ble Supreme Court has also directed the Ministry to reexamine the issue of removing the restriction of age and parity in respect of JSY beneficiaries. In view of this it would be difficult to remove these restrictions for JSY beneficiaries of high performing states, at this given point of time.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The Ministry has advised all the States/UT governments to introduce a two-tier monitoring system to monitor the process of implementation of the

scheme in the states/UTs and process of disbursement of cash and record keeping of financial transactions. This has been done with a view to reduce possibilities of situation as has been mentioned in the Committee's report. Further, with a view to eliminate any chance of slippage in the payment system, the State Governments have been advised to ensure that the disbursement of cash assistance to the beneficiaries and ASHA(s) should be made through cheques, preferably by account payee ones. Further, guidelines on grievances redressal mechanism have also been sent to the States/UT Governments for necessary action.

In addition, Joint Review Missions (JRM) comprising representatives of this Ministry and the Development Partners undertake visits of 5 to 6 States each twice a year. In each State, the JRMs make detailed study of the functioning of the various interventions under NRHM, including JSY by inspecting facilities ranging from sub-centers to District hospitals, in 2 to 3 districts.

The Committee's observations have been noted. The Principal Secretaries (HFW) of the States/UTs are being advised to tighten their monitoring and grievance redressal mechanisms to eliminate chances of corruption in the system

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

At the instance of this Ministry Health & Family Welfare, M/s. Hindustan Latex Limited (HLL) through its subsidiary Hindustan Latex Family Planning Promotion Trust (HLFPPT), took up the publicity of the kit in February, 2008 by using media mix, the communication needs in strategic areas, focus on inter-personal communication and branding. For this purpose, Ministry has placed funds at the disposal of M/s. HLL as per the flowing details:

Phase	Amount Sanctioned (Rs.)	Amount released (Rs.)
I	6,80,21,355.00	6,80,21,355.00
II& III	3,15,00,000.00	1,26,00,000.00

IEC and advocacy activities taken up by HLFPPT include local promotion, ASHA training at block level, communication material for outreach communication, production of mass media creative and training films etc.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

1. Vasectomy was the most popular and common mode of sterilization in the sixties and the seventies. Its number dropped sharply after the 1975 debacle and never picked up after that especially subsequent to the introduction of laparoscopic female sterilization around the same time.

2. Increasing male participation in RCH is one of the major components of NPP,2000

3. Promotion of Vasectomy as a Family Planning measure is one of the most important & visible component of increasing male participation in RCH with the twin objectives of:-

   i) achieving population stabilization in a short period

   ii) shifting the responsibility of Family Planning from the female to the male and hence addressing gender equity concerns

4. The main reasons for poor performance in NSV has been

   i) poor dissemination of the method

   ii) lack of counseling services

   iii) lack of trained providers (manpower)

   iv) lack of assured service delivery points

   v) less thrust at the state as well as the GOI level

5. With a view to address this issue the Government of India had developed and provided guidelines on “Camp approach in NSV through Advocacy and Community Mobilization” along with funds through RCH II flexi pool and this was utilized by the states to promote NSV.

6. Development of manpower for service provision is also not uniform in all the states. The well performing states have stepped up their NSV training of service providers which is not seen in the other states.

7. The Government of India is therefore promoting male participation by increasing the access to, acceptance of, awareness on and availability of NSV services.

Systematic plan for Training of surgical faculty of medical colleges at 7 centres across the country, who can then train the undergraduates and post graduates in the technique and thereby developing manpower for the same

Training of district trainers with a view to have at least 1 district trainer for each district in the country and responsible for developing an action plan for training and service delivery for the whole district..

8. The Government has enhanced the compensation package substantially for acceptors, motivators and providers of vasectomy services as compared to tubectomy to give a boost to the vasectomy programme

9. The Government has developed Advocacy kit and decision making tools on vasectomy for adoption by the States in coordination with the IEC division

10. The Government has introduced the National family Planning Insurance scheme in cases of deaths, complications and failures in sterilization

11. Percentage of male sterilization out of the total sterilization in the country had increased from 2.5% in 2004-05 to 3.5% in 2005-06 due to special thrust from the Government of India level. The continued thrust has further resulted in the increase to 4.5% in the year 2007-08. Moreover in terms of number it has almost increased by 93% from 1,14,055 in 2006-07 to 2,19,776 in 2007-08. This is a remarkable achievement under the circumstances and the momentum needs to be carried on in the current year (2008-09)

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The Clinical trials are conducted both on male and female patient 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 (GCP) Guideline and Ethical Guideline.

Why Clinical Trial?

Studies involving human subjects are an essential component of drug discovery research. In order to generate adequate evidence to establish safety and efficacy of any substance for any specific indication, it is necessary that over and above all in vitro, in vivo, and ex vivo experimentations, the product is also administered to healthy volunteers and patients, and clinically studied under a

well-defined protocol, to establish the safety and efficacy of a new drug. This is a highly knowledge intensive activity, generally carried out in international programmes.

Over the years, the norms for such clinical trails have become very demanding in order to ensure of human subjects and the quality of data generated.

Are there adequate legal provisions for conducting Clinical trials for new drugs in India?

Adequate provisions have been made under the Drugs and Cosmetics Rules to ensure that no unauthorized clinical trials are conducted and that trials are conducted in a manner, which protects the interests of the study subject and are performed in compliance to the prescribed norms of Good Clinical Practices(GCP).

Drugs & Cosmetics Rule 122-DA to E, which was amended in 2001 and Schedule Y, which been revised in January 2005, prescribe all the relevant norms. Revised Schedule Y prescribes elaborate procedures for enrolling subjects for clinical trials. The stipulations have been made to ensure that the patients/volunteers participate in studies only after proper understanding of the study. Elaborate informed consent process has been prescribed in the amended Schedule Y. The responsibilities of Institutional Ethics Committee, Clinical Investigators, Sponsors and Monitors etc have been clearly defined. The revised Schedule Y has also made it mandatory that trials have to be conducted as per GCP norms published by the Government.

Each unexpected serious adverse event (SAE) is required to be reported to respective ethics committee within 7 days and to the regulatory authority within 14 days. The trial can be stopped by either the ethics committee or by regulators, if it is deemed to be unsafe to continue further. The National Pharmacovigilance Advisory Committee, constituted by the Ministry of Health and Family Welfare, has been mandated to oversee the safety of drugs used in the country.

Protection of Interests of Human Subjects: Sponsors of clinical trials are required to provide an undertaking that adequate provisions have been made to provide compensation to the study subjects who may suffer any unforeseen harm. Insurance for clinical trial study subjects is provide in the country by General Insurance companies. Regulatory provisions in this regard are well in line with the globally accepted norms and practices.

The revised Schedule Y is in line with ICH-GCP requirements, which are considered gold standard for conducting clinical trials all over the world. In fact some stake holders perceive ethics requirements in the new Indian regulations to be stricter than global norms. For example, India is the only country which has prescribed:-

- Compositions of ethics committee which accord ethics clearance to clinical trial protocols.
- An elaborate format for obtaining informed consent of study participants.
- A format for conveying ethics committee's review procedure and decision.
- India is the first country outside the ICH regions to have a systematic, elaborate and extensive clinical trials inspections programme.

Whether there is adequate provision for compensation if something goes wrong during the trial?

In India, every clinical trial has to be conducted as per the norms prescribed under Schedule Y, which mandates conformance to India GCP guidelines. The Para 2.4.7 of GCP guidelines requires compensation for accidental injury and the obligation of the sponsor to pay compensation. This is an in built mechanism, which is checked by regulatory authorities as well as by the ethics committee, at the protocol approval stage itself.

Ethics committees are directly responsible to safeguard the rights, safety and well being of study subjects. It is mandatory for them to make ongoing review of clinical trails being conducted with their approval.

Regulatory Inspection of Clinical Trial:

In India , the clinical trial pertaining to totally new molecules has been very miniscule. However, this trend is now changing and also, there would be increasing numbers of multicentric global clinical trials. CDSCO has, therefore evolved a strategy to start inspections of clinical trial centers. Number of workshops have already been held in coordination with Department of Pharmacology, BYL Nair Hospital, Mumbai along with centers namely at AIIMS, Pondicherry, Kolkata, Hyderabad to develop necessary Standard Operating Procedures (SOPs), protocols etc. A training programme for the prospective inspectors of clinical trials was conducted in New Delhi to develop competence and capacity to undertake inspections/audits.

These measures will significantly enhance standards of clinical trials and will address to the prevailing perception about exploitation of India study subjects, especially the poor and illiterate as well as women.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Ministry

The NRHM covers sector wide health sector reform agenda. It addresses health, not merely as Reproductive & Child Health (RCH). It addresses entire gamut of health requirements of the beneficiaries. The collateral determinants of health are also addressed in the Mission. The Integrated District Plans and the sector wide State Programme Implementation Plans (PIPs) are intended to

improve all aspects of the health delivery system and not restrict to the RCH activities.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Up-gradation to IPHS involves simultaneous efforts for improvement of physical infrastructure, equipment, human resources and clearly articulated service guarantees. Efforts to up-grade block PHCs into CHCs have also been made under NRHM and from grants received from the Finance Commission. As regards recruitment of human resource, a total of 2300 Specialists doctors, 6271 doctors, 12908 Staff Nurses and 4380 other category para-medical staff had been added under NRHM on contract, upto December 2007.

As per the IPHS, one MBBS doctor and one AYUSH doctor has to be provided at the PHC. So far 6271 MBBS doctors and 3882 AYUSH doctors have been appointed on contract under the NRHM. As per RHS 2007, number of

doctors at PHCs has increased from 22273 in 2006 to 26608 in 2007. The number of PHCs without a doctor has reduced from 1314 in 2006 to 807 in 2007 with the addition of MBBS doctors and AYUSH doctors in large number under NRHM, the position would definitely have further improved.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Yes, it is rightly said that every women in the village should be made aware of the facilities available at health institutions through poster campaigns, media advocacy, sensitization of health care providers at lower levels etc. There is provision of community health worker called Accredited Social Health Activist (ASHA), who would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. She will also help the villagers promote preventive health by converging activities of nutrition, education, drinking water, sanitation etc. In order that ASHAs work in close coordination with the AWW,

she would be fully anchored in the Anganwadi system. ASHAs would also provide immediate and easy access for the rural population to essential health supplies like ORS, contraceptives, a set of ten basic drugs and she would have a health communication kit and other IEC materials developed for villages. At present Health Day's are organized every month at the Anganwadi level in each village in which immunization, ante / post natal check ups and services related to mother and child health care including nutrition are being provided. During 2006-07, more than 31 lakh monthly health day organized which significantly increased more than 40 lakh during 2007-08.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Enough provision has been made for referral transport facilities for patients, telephone and other necessary requirements at the health institutions level for smooth and better health care facility. State may specify their requirements in their PIP and enough provision has been made for such activities. In fact, several states has asked financial assistance for referral and transport facilities, telephone and other necessary requirements. Furthermore, Rogi Kalyan Samiti/Hospital Development Committee at PHC/CHC/Sub-district

and District level have been authorized to incur day to day necessary requirements as per need based for their institutions.

(Ministry of Health & Family welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

Due emphasis has given on women's health research. A list of ongoing research projects are as under:-

2007-2008

Ongoing Research Projects

Title : Prevention of Parents to Child Transmission of HIV

Chief Investigator : Dr. Suneeta Mittal

Funding Agency : Delhi State AIDS Control Society

Duration : Ongoing long project

Total funding : Rs. 50,000/-

Title : Phase I Clinical trial of once weekly administration of 50 mg Mifepristone as oral contraceptive.

Chief Investigator : Dr. Suneeta Mittal
Funding Agency : ICMR
Duration : Ongoing long project
Total funding : HRRC funds

Title : Phase III Multicentre Clinical trial with subdermal single Rod contraceptive Implant – Implanon
Chief Investigator : Dr. Suneeta Mittal
Funding Agency : ICMR
Duration : Two years
Total funding : HRRC funds

Title : Monthly statistics on Eclampsia
Chief Investigator : Dr. Suneeta Mittal
Funding Agency : ICMR
Duration : 1/2/2006 to 31/1/2007
Total funding : HRRC

Title : Comparison of Diane 35 plus Finasteride combination with Diane 35 plus spironolactone in the treatment of hirsutism.
Chief Investigator : Prof. Alka Kriplani
Funding Agency :
Duration : January, 2005–
Total funding : Rs.

Title : Diagnosis of genital tuberculosis in infertile women and the effect of antitubercular therapy
Chief Investigator : Prof. Alka Kriplani
Funding Agency : Indian Council of Medical Research
Duration : January, 2006 – December 2008
Total funding : Rs. 4,79465/-

Title : Evaluation of curcumin in the management of cancer cervix
Chief Investigator : Dr. Sunesh Kumar
Funding Agency : DBT.
Duration : 3 years
Total funding : Rs. 27,27,000/-

Title: Seroprevalence of Cytomegalovirus (CMV) Infection in pregnant women and prenatal diagnosis of Fetal CMV Infection.
Chief Investigator : Dr. D. Deka
Funding Agency : ICMR
Duration of Project: 2yrs. (2007-2009)
Total funding:

Title: Development of HPV candidate vaccine/s: preparation of clinical trial site/cohort for vaccine testing.
Chief Investigator : Dr. Neerja Bhatla
Funding Agency :DBT
Duration: March 2005 to July 2008
Total funding : Rs.84,98,000/-

Title: A phase III, double-blind, ramdomized, controlled study to evaluate the immunogenicity and safety of GlaxiSmithKline Biologicals' HPV-16/18 VLP/AS04 vaccine administered intramuscularly according to a 0, 1, 6 months schedule in healthy Indian female subjects aged 18-35 years.

Chief Investigator : Dr. Neerja Bhatla
Funding Agency :GSK
During : June 2006 to May 2008
Total funding : Rs.6,88,930/-

Title: Parallel performance trial of Fast HPV versus HC2 for Cervical Cancer Screening.
Chief Investigator: Dr. Neerja Bhatla
Funding Agency:Digene
Duration: March 2007 to May 2008
Total funding : Rs.13,50,000/-

Title: CORONIS- International study of caesarean section surgincal techniques – a randomized factorial trial
Chief Investigator : Dr. J.B. Sharma
Funding Agency : University of Oxford, UK.
During : March 2007 to March 2011
Total Funding : Rs.68, 27, 272/-

B. Ongoing Departmental Research

1. Detection and quantification of fetomaternal hemorrhage (FMH) following deliveries in Rh-ve non immunized pregnancy by KBT, flow cytometry.
2. Comparison of harmonic scalpel with bipolar cautery in laparoscopic assisted vaginal hysterectomy.
3. A comparative study of VIA, cyto diagnosis, HPC testing and colposcopy as tools for cervical cancer screening.
4. Screening with cytology, visual inspection, acetic acid and Lugol's iodine for early detection of cervical neoplasia and comparative evaluation of single-versus double freeze cryotherapy technique in the treatment of cervical intraepithelial neoplasia.
5. Conscious pain mapping : a new technique of laparoscopy for evaluation of chronic pelvic pain.
6. Doppler Assessment in various fetal vessels and fetal weight estimation using antenatal soft tissue thickness in intra uterine growth restriction with normal pregnancies.

7. Prevention of uterine atony during cesarean section: Randomized comparison of sublingual misoprostol versus syntocinon.
8. Value of routine antenatal screening ultrasonography at 24-28 weeks of gestation.
9. effect of intraperitoneal bupivacaine in reducing postoperative pain after laparoscopic gynaecological surgery.
10. Endometrial changes and overian function in women with early breast cancer.
11. A randomized study to compare two surgical technique of laparoscopic stripping of overian endometrioma.
12. Feasibility of virtposy : minimally invasive autopsy using ultrasonographic imaging and percutaneous organ biopsies as an alternative to open body autopsy in fetal abnormality.
13. Role of Middle Cerebral Atery- Peak Systolic Velocity in Predicting fetal anemia in Rh Isoimmunisation after previous Intrauterine Transfusions.
14. Use of Letrozole Versus Climphene Citrate combined with Gonadotrophine in Superovulation and IUI Cycles.
15. Hyperhomocystenemia : in unexplained recurrent pregnancy loss and therapeutic response to vitamin B6, B12, and folic acid.
16. Prophylactic administration of micronized progesterone in prevension of preterm labour in women at increased risk.
17. Prospective randomized comparative study of total laparoscopic hysterectomy, laparoscopically assisted viginal hysterectomy and non descent vaginal hysterectomy for treatment of benign diseases of the uterus.
18. Evaluation of benefit of FDG-PET in staging and management of ovarian malignancies.
19. Correlation of stage and imaging of endometriosis with fertility outcome.
20. Role of messenger RNA PCR in the diagnosis of genital tuberculosis in infertile women.

21. Comparison of uterine and radial artery flow changes detected by pulse Doppler in women undergoing stimulated intrauterine insemination for unexplained infertility.
22. To compare 3 different time regimen of vaginal misoprostol after oral Miferpristone for medical abortion.
23. Transvaginal ultrasound markers for ovarian reserve and periovarian adhesions after laparoscopic ovarian drilling in patients with clomiphene citrate resistant polycystic ovarian syndrome.
24. Comparison of the effectiveness of single versus double intrauterine insemination in infertile couples.
25. Role of PET in staging of overian malignancies
26. Persistence of HPV DNA and its correlation with residual diseases in treated cases of CIN.
27. Feasibility of Virtopsy : Minimally Invasive Autopsy using Ultrasonographic Imaging and percutaneous organ biopsies as an alternative to open body autopsy in Fetal Abnormality.
28. Value of routine antenatal USG screening Ultrasonography at 24-28wjs of gestation.
29. To compare BPP with Doppler in pregnant patients with IUGR in normal pregnancies.
30. Role of Anastrozole for treatment of symptomatic leiomyoma in premenopausal women.
31. Ovarian function and endometrial changes in case of carcinoma breast.
32. Comparative study between MRI and Ultrasound in prenatal diagnosis using autopsy or postpartum imaging as a standard of reference.
33. Role of Pulse Doppler in detecting Uterine and Radial artery flow change in predicting Pregnancy outcome in Unexplained Infertility.
34. A randomized controlled Trial to Compare 3 time regimens of Misopostol after Oral Mifepristone in Medical Aboration.

35. Prospective randomized study for comparson of LAVH, TLH and NDVH for treatment of berign disease of uterus.
36. Application of PET scan in preoperative evaluation of carcinoma endometrium.
37. Effect of oral contraceptive containing ethinyl estradiol combined with drospirenone vs desogestril on clinical and biochemical parameters in patients of PCOS.
38. Correlation of HPV DNA testing with residual decrease in treated cases of CIN.
39. Sentinel Lymph node biopsy in cancer cervix.
40. The Comparison between laparoscopic assisted vaginal hysterectomy with non descent vaginal hysterectomy for large large uteri – a randomized clinical trial.

C. Ongoing Collaborative Research

21. **Title :** Development of Human Papillomavirus vaccine prototype/s Molecular Epidemiology of HPV types prevalent in India and Identification of HPV- 16 L1 & E 6 variants
    Department : Department of Biochemistry, AIIMS

22. **Title :** Apoptosis in placental membranes in pre-eclampsia : An immunohistochemical study
    Department : Department of Anatomy, AIIMS

23. **Title :** PEARL study (post menopausal evaluation and risk reducation with lasofoxifene). Global research and development, Pfizer Ltd., **Pfizedr Ltd.**
    Department : Department of Endocrinology, AIIMS

24. **Title :** The Generation trial. Effects of Arzoxifene on vertebral fracture incidence and on invasive breast cancer incidence in postmenopausal

women with osteoporosis or with low bone density.
Department : Department of Endocrinology, AIIMS

25. **Title :** Chromosome Anenploidy and Mosaicism in preimplantation Embryo.
Department : Department of Anatomy

26. **Title :** Sequence based identification of myocobacterium species isolated from extra – pulmonary tuberculosis cases.
Department : Lab, Medicine, AIIMS

27. **Title :** Establishment & characterization of human fetal liver hematopoitetic stem cell line
Department : Medical Oncology, IRCH, AIIMS

28. **Title:** To study the subset of Antiphospholipid syndrome defined by anti b2 glyocoprotein 1 anti body.
Department : Lab Medicine, AIIMS

29. **Title :** Role of centchroman in benign brease disease
Department : Department of Surgery, AIIMS

30. **Title :** Epidural analgesia in labour
Department : Department of Anaesthesiology

31. **Title :** Chromosome Aneuploidy and Mosaicism in preimplantation Embryo
Department : Department of Anatomy, AIIMS

32. **Tital :** Prenatal development and maturation of the human inferior colliculus
    Department : Department of Anatomy, AIIMS

33. **Title :** Evaluation of ovarian function in female patients with multi-bacillary leprosy
    Department : Department of Dermatology & Venereology, AIIMS

34. **Title:** Biostatistical Aspects in Case control Studies on Unintended Pregnanies
    Department : Department of Biostatistics, AIIMS

35. **Tital :** A study of molecular basis of endometrial receptivity for blastocyst implantation in primates
    Department : Department of Physiology, AIIMS

36. **Title :** Prevention of parent to child transmission of HIV
    Department : Department of Paediatrics & Microbiology, AIIMS

37. **Title :** Diabetis mellitus and vulvo vaginal candidiasis : prevalence and its rational management
    Department : Department of Endocrinology, AIIMS

38. **Title :** Prevalence of bacterial vagionosis and other reproductive tract infections among symptomatic women (study in tertiary centre)
    Department : Department of Microbiology, AIIMS

39. **Title :** To study the effect of human chorionic gondotrophin (hCG) on vascular endothelial growth factor (VEGF) expression by human amid-secretary endometrial cells grown on rat-tail collagen matrix
    Department : Department of Physiology, AIIMS

40. **Title :** Effect of progesterone on hsp 27 expression in human, mid-secretary stage endometrial cells grown on collagen matrix in vitro.
    Department : Department of Physiology, AIIMS

41. **Title :** To study the prevalence of vitamin D deficiency in pregnant women at first and third trimester during the routine case
    Department : Department of Endocrinology, AIIMS

42. **Title :** Correlation between first trimester glucose screening & serum insulin levels with development of gestational diabetes mellitus in pregnancy
    Department : Department of Endocinology

    Title : An in vitro model study of hyperlipoproteinemia on the degree of LDL receptor expression in placental trophoblast cells correlation with oral steroid contraceptive induced hyperlipoproteinemia (ICMR Project)

43. **Title :** Comparative evaluation of neo adjuvant chemotherapy vs primary debulking surgery in the management of advanced eqithelial ovarian cancer.
    Department : IRCH, AIIMS

44. **Title :** p161NK 4a and E-cadherin expression profile in pre-cancerous lesions of cervix and cervical carcinomas
    Department : Pathology, AIIMS

45. **Title :** Role of circulating angiogenetic factors in the pathogenesis of Preeclampsia
    Department : Anatomy, AIIMS

46. **Title :** Validation of Strategies for Rapid Prenatal Detection of Aneuploides
    Department : Genetics, AIIMS

47. **Title :** Evaluation of the diagnostic potential of fetal DNA in maternal plasma as possible tool for Non-invasive prenatal diagnosis of common single disorders
    Department : Genetics, AIIMS

48. **Title :** Non invasive prenatal diagnosis of Beta Thalassemia and fetal RhD status
    Department : Department of Peadiatrics, AIIMS

49. **Title :** Establishment & characterization of human fetal liver humatopoietic line
    Department : Medical Oncology, IRCH, AIIMS

50. **Title :** Endotheliel progenital cells as biomarker of disease activity in multiple mylemo
    Department : Department of Oncology, AIIMS

51. **Title :** Use of Hb A estimation by HPLC for prenatal diagnosis of B-thalassemia in fetal blood samples during second trimester pregnancies.
    Department : Haematology, AIIMS

(Ministry of Health & Family welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

AIIMS has prepared a proposal for Construction of a Hospital for 'Mother and Child'. The work of consultancy and construction of the said Centre has been entrusted to CPWD and it is expected that the work would be started next year and shall be competed by end of 2010.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

A proposal in the form of EFC memo had been prepared by AIIMS for Construction of Doctors and Nurses Hostel at Masjid moth Campus at AIIMS. The said EFC proposal is under examination in the Ministry in consultation with the Integrated Finance Division. AIIMS has also been asked on 2.7.2008 to take the approval of Institute Body/ General Body of AIIMS. Meanwhile AIIMS has entrusted the work of preparation of revised Master Plan of Ansari Nagar and Masjid Moth Campuses to CPWD. Also the work detailed consultancy and construction for the construction of hostels has also been entrusted to CPWD. It is expected that the construction of the said hostels would start in the next year and shall be completed by end of 2010

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

This Institution has already in process enhancing the capacity and infrastructure for patient care under this two OPD blocks, Accident Emergency Block and Radiotherapy Block will be added. Beside these, there is a provision for adding super specialties Departments and OTs etc. in this Institution.

The services of M/s Sulabh International Social Services Organization has been hired for cleaning some of the critical area of this institution to improve the hygienic conditions of the Institution. A proposal for additional sanction for engagement of additional workers of above Organisation for Hospital was forwarded to CMO (NFSG), Dte. G.H.S. and approval for the same is awaited.

As regards to the safety provisions, this Institution has handed over the security to Director General of Home guards & Civil Defiance.

Action for filling up of the vacant posts of faculty has been initiated and the total 18 vacant posts will be filled up within two month on contract basis. The

vacant posts of Nursing Personnel, Para-medical staff & non-technical posts which are cleared by the screening committee, M/o Health % FW have already been advertised and will be filled in near future.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

More number of beds to be set apart for women: A proposal for 30 beds for General Maternity Cases has been submitted to the Ministry of Helth & FW who has asked for a checklist for creation of posts as per norms for consideration of the proposal.

A digital Mammography Machine and a Bone Densitometry Unit are in the process of being procured for the Department of Radiology.

The Hospital has none CTG Machine and one more is also being procured for which tenders have been invited.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

The Up gradation of School of Nursing to College of Nursing in the hospital is an approved plan activity of XIth Five Year Plan. It has been decided by the Ministry /DGHS to start B.Sc Degree Course in Nursing in place of existing Diploma in General nursing & Midwifery being provided by the School of Nursing with 50 annual intake capacity in the Central Govt. Hospital including Dr. R. M. L Hospital from the Academic Session 2008-09. It has been decided in the meeting taken by DGHS on 24.04.08, the hospital has approached the GGSIP University for affiliation of B.Sc Degree Course in Nursing from the current academic session 2008-09. The “In-Principle” approval of the Indian Nursing Council (INC) has been received on 27.04.08 to upgrade the School of Nursing to College of Nursing from the academic year 2008-09 with 50 students intake. NDMC has been approached on 06.05.08 for the issue of Health Certificate for the building where the proposed construction of College of Nursing is going on by the HSCC. The renovation work is likely to be completed within one month.

The inspection team of GGSIP University for grant of affiliation is expected to visit the campus on 27.05.08.

(Ministry of Health & Family welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Recommendation (Para No. 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.

Reply of the Government

A committee was constituted under the chairmanship of Shri Javed A. Chowdhury to look into measures for improvement in the service conditions of CHS. The committee had submitted many recommendations to improve the service conditions and to satisfy the personal aspirations of the doctors. The Committee made many recommendations for improving the service conditions of CHS doctors. The Committee also suggested to take measures to stop unplanned departure of doctors from the service. One such recommendation was that the doctors going on foreign assignments should be asked to give an unconditional and irrevocable Bank Guarantee for an amount equal to three times the gross annual emoluments (Basic Pay + DA+NPA) in the post he holds in government. The terms of the guarantee should be such that government may encase it at its discretion, if it finds that the doctor has violated any condition on which he was permitted to proceed on foreign assignment.

The recommendation was considered and it was decided to implement the recommendation in consultation with DOP&T/Deptt. Of Expenditure, with slight modification that the Bank Guarantee be taken for an amount equal to two times the gross annual emoluments (Basic Pay+DA + NPA). DOP&T has been requested to include the same in the consolidated Instructions on Foreign assignment of Indian Experts.

On the other hand, the recommendations of the Committee, for improving the service conditions of CHS doctors has been examined in consultation with

concerned Authorities. Accordingly, the age of superannuation of Specialists of Teaching, Non-Teaching and Public health has been enhanced from 60 years to 62 years. Further, financial assistance in individual cases for attending International Conference/Symposia has been raised to Rs. 1.00 lakh or the actual expenditure whichever is less, subject to availability of funds.

Further the Cabinet has taken the following decisions for improving the service conditions of

CHS officers

(i) the Dynamic Assured Career Progression Scheme has been extended upto the posts of SAG level.

(ii) Special formula for fixation of pay of CHS officers including NPA, has been devised.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

CHAPTER III

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

- NIL -

CHAPTER IV

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

Recommendation (Para No. 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.

Reply of the Government

Public spending on health is in the vicinity of 1% of GDP and all efforts are being made to enhance public spending on health. Health allocation per se will not necessarily bring about an improvement in health status. Other determinants

of health like nutrition, drinking water supply, sanitation etc., are critical. However if a holistic view is taken of health alongwith these other determinants, public spending on health is 1.39% of GDP for the year 2007-08 (BE) according to the Economic Survey 2007-08.

The National Rural Health Mission (NRHM) launched in April, 2005 seeks to effect an architectural correction in the delivery of healthcare at primary and secondary levels. The mission inter-alia aims at providing accessible, affordable, accountable, effective and reliable primary health care facilities, especially to poor and vulnerable section of the population, bridging the gap in rural health care services through creation of cadre of Accredited Social Health Activist (ASHA), improving hospital care through strengthening of public health infrastructure, rationalization of manpower deployment, decentralization of programme to district level and effective utilization of resources. Community ownership, decentralized planning and flexibility in funding form the core tenets of NRHM. It also promotes a sector wide approach with focus on sanitation and hygiene, nutrition and safe drinking water.

The Eleventh Five Year Plan also aims to restructure policies to achieve a New Vision based on faster, broad – based and inclusive growth. Promotion of good health necessitates putting in place a comprehensive strategy encompassing individual health care, public health, sanitation, clean drinking water, access to food and better nutrition. The evolving strategy focuses on convergence and development of public health systems and services , reducing disparities in health across regions and communities, and focused attention on communicable and non- communicable diseases. Public private partnership in healthcare delivery will be promoted. Good governance, transparency and accountability in the delivery of health services will be ensured through involvement of Panchayati Raj Institutions (PRIs), Community and Civil Society Groups. Health as a right for all citizens will be the professed goal in the XI Plan.

Several new initiatives are being planned in the current plan – Health Care Elderly, Urban Health Mission, CVD, diabetes, programmes like Letospirosis Control Programme, Human Rabies, National Organ Transplant Programme, Oral Health, Prevention and Control of Fluorosis etc. Developing human resources is high on priority given our growing and varied requirements.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 7 of Chapter I of the Report)

Recommendation (Para No. 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.

Reply of the Government

NRHM envisages greater role and ownership of the Public Health System by the PRIs. Empowerment of the Community and Community Based institutions through continuous capacity building is an important component of NRHM. The Mission has created the institutions of Village Health & Sanitation Committees, Rogi Kalyan Samitis, District & State Health Missions which have representations of the PRIs. These institutions are empowerd under NRHM with dedicated and untied funding so that the local sensitivities and requirements are addressed without any bottlenecks. The representation of women members of the Panchayat is also ensured. The PRI representatives are kept apprised of the progress of NRHM in their areas through participation in the various institutions of NRHM.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 10 of Chapter I of the Report)

Recommendation (Para No. 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.

Reply of the Government

Noted for action

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 16 of Chapter I of the Report)

Recommendation (Para No. 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.

Reply of the Government

The protocols for payment of Incentives to ASHAs are being strengthened in the states at all levels.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 19 of Chapter I of the Report)

Recommendation (Para No. 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.

Reply of the Government

- Seven Counters in OPD are exclusively for Women which are operated by Female Computer Clerk and one Women Security Guard is posted there for helping the Women patients.
- The Women staff Nurses are posted in OPD for presence while Women patients are examined by male Doctors.

- There are also separate ladies toilets and announcement system is also available for Women who get separated from the relatives due to crowd.

  In the Department of Obst. & Gynae. The following facilities are available:-

  - Antenatal, Post natal case
  - Family Welfare Services to all
  - Adolscent Clinic.
  - Gynae Cases.
  - Manepausal Clinic
  - Infertility Clinic
  - Colpescopy Clinic

  (OPD, Indoor & emergency services are available)

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 25 of Chapter I of the Report)

CHAPTER V

RECOMMENDATIONS/OBSERVATIONS IN RESPECT OF WHICH FINAL REPLIES OF THE GOVERNMENT ARE STILL AWAITED

Recommendation (Para No. 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.

Replies of the Ministry of Health & Family welfare

NRHM seeks to strengthen the Public Health delivery system at all levels. The Sub-centre and PHCs are envisaged to be revitalized through better human resource management, clear quality standards, better community support and an untied fund to enable local planning and action. The Indian Public Health Standards(IPHS) define structural, personnel, equipment and management standards and have been finalized for CHCs, PHCs and SCs. This will involve up-gradation of existing Community Health Centres and also up-gradation of Block PHCs to CHCs in all those blocks where no CHC exist at present. Based on the need for Community Health Centres in every block detailed facility surveys were mandated under the NRHM. All the states are undertaking facility surveys to identify the fund requirements for upgrading the facilities and requirement of human resource. As per reports received under NRHM from State Governments, a total of 2870 Community Health Centres have so far been selected for up-gradation to IPHS. Out of these, facility surveys are reported to have been completed in 2569 CHCs. Physical up-gradation work had been identified in 2284 CHCs and started in 1493. 483 CHCs have reported completion of up-gradation work.

As on March 2007, there are 145272 SCs, 22370 PHCs & 4045 CHCs functioning in the country and a total of 5117 specialists are working in CHCs across the country as against the requirement of 16180. Under NRHM, State/UT Governments are being funded for contractual appointment of trained health

personnel like doctors, ANM, Staff Nurse and other Para-Medics etc. States have taken several steps for ensuring availability of doctors. As regards recruitment of skilled health personnel, a total of 2282 Specialists, 6271 doctors, 12908 Staff Nurses and 4380 other category para-medical staff had been added under NRHM on contract, upto December 2007.

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 13 of Chapter I of the Report)

Recommendation (Para No. 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.

Replies of the Ministry of Health & Family welfare

Monitoring and Evaluation division under Union Ministry of health and Family Welfare are already collecting state-wise data pertaining to all indicators on NRHM, so that assessment could be done on regular basis. Needless to say, the Monitoring & Evaluation strategy for the NRHM is a multi-faceted approach taking into consideration various elements like MIS, Quality Assurance, Evaluation Surveys, Programme Management and Community Monitoring as per the NRHM framework for implementation. For the MIS, several initiatives have been taken for expediting the flow of information from the States/UTs. The Ministry is in the process of developing a web enabled MIS system, which will capture both the physical and financial data of various interventions being launched under NRHM from the district level upwards. The web- based MIS will capture data from the Districts on the integrated MIES format which captures the physical performance on various NRHM interventions.

Yes, there is a huge gap of requirement and availability of Sub centres, being the first peripheral contact point between primary health care system and the community. Under NRHM, there is a provision of civil construction up to 33% in special focus States and 25% in other States. Construction of Sub Centres have been taken up from NRHM funds as well as Finance Commission funds released to States. Efforts to improve the construction of sub-centres would be made further on. At present, barely 50% Sub Centres have then own building with the thrust on Sub Centre buildings under NRHM, the situation is likely to change

(Ministry of Health & Family Welfare O.M. No.H. 11013/01/08-Coordn-I dated 27.01.2009)

Comments of the Committee

(Please see para 22 of Chapter I of the Report)

NEW DELHI
13th FEBRUARY, 2009
24 Magha, 1930 (Saka)

KRISHNA TIRATH
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

APPENDIX - I

MINUTES
COMMITTEE ON EMPOWERMENT OF WOMEN (2008-2009)

Seventh Sitting
(13.02.2009)

The Committee sat on Friday, the 13th February, 2009 from 1500 hrs. to 1600 hrs. in the Chamber of Hon'ble Chairperson, EWC (Room No.130), First Floor, Parliament House Annexe, New Delhi.

PRESENT

Smt. Krishna Tirath - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Preneet Kaur
3. Shri Tek Lal Mahato
4. Shri Rajesh Kumar Manjhi
5. Smt. K. Rani
6. Smt. Minati Sen
7. Smt. Karuna Shukla
8. Smt. C.S. Sujatha
9. Shri Kinjarapu Yerrannaidu
10. Shri Kiren Rijiju

RAJYA SABHA

11. Shri Jabir Hussain
12. Shri Ambeth Rajan

SECRETARIAT

1.	Shri S. Bal Shekar	Joint Secretary
2.	Smt. Mamta Kemwal	Deputy Secretary-II
3.	Smt. Reena Gopalakrishnan	Under Secretary

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

3. The Committee then took up for consideration the X X X X draft Action Taken 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 the Parliament.

The Committee then adjourned.

X – matters not pertaining to the Report

APPENDIX II

(Vide Para 4 of the Introduction)

ANALYSIS OF ACTION TAKEN BY GOVERNMENT ON THE SIXTEENTH REPORT OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (14TH LOK SABHA)

(i)	Total No. of Recommendations	32
(ii)	Recommendations/Observations which have been accepted by the Government: Para Nos. 2, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 32 Percentage to Total	25 78%
(iii)	Recommendations/Observations which the Committee do not desire to pursue in view of the replies of the Government: Para No. Nil Percentage to Total	Nil Nil
(iv)	Recommendations/Observations in respect of which replies of the Government have not been accepted by the Committee: Para Nos. 1, 3, 7, 16 and 31 Percentage to Total	05 16 %
(v)	Recommendations/Observations in respect of which the Government have furnished interim replies: Para Nos. 4 and 21	02 6%