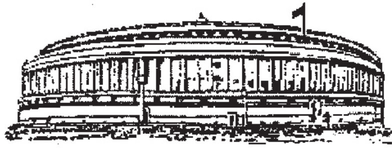

11

PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN

(2017-2018)

(SIXTEENTH LOK SABHA)

ORIGINAL REPORT

'WOMEN'S HEALTHCARE: POLICY OPTIONS'

LOK SABHA SECRETARIAT
NEW DELHI

January, 2017/Pausa, 1938 (Saka)

COMMITTEE ON EMPOWERMENT OF WOMEN

(2017-2018)

(SIXTEENTH LOK SABHA)

'WOMEN'S HEALTHCARE: POLICY OPTIONS'

Presented to Lok Sabha on 3.1.2018

Laid in Rajya Sabha on 3.1.2018

LOK SABHA SECRETARIAT
NEW DELHI

January, 2017/Pausa, 1938 (Saka)

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<u>**CONTENTS**</u>

Page Nos.

Composition of the Committee on Empowerment of Women (2015-2016)... (iii)

Composition of the Committee on Empowerment of Women (2016-2017)... (iv)

Composition of the Committee on Empowerment of Women (2017-2018)...

Introduction... (vi)

REPORT

PART I

NARRATION ANALYSIS

I. Introductory………………………………………………………………..... ..

II. Women Healthcare responsibilities: Centre and States ....

III. Janani Suraksha Yojana, Maternal Health and institutional deliveries..... ..

IV. Insurance coverage of pregnant women and cash incentives under MBP ..

V. Role played by Accredited Social Health Activists (ASHAs), their trainings and wages...…………………………………………………………….... ..

VI. Anemia in mothers and children.......………………………………... ..

VII. Prevalence and Control of Malnutrition............................ ..

VIII. Obstetric Care and Women Health................................ ..

IX. Contraception and Women's Health... ..

X. Women's health & Non-communicable diseases ……… ..

XI. Mental Health & Women …….……………………….... ..

PART II

Observations/Recommendations of the Committee…………………….................. 20

ANNEXURE

I. Institutional Delivery & MMR…………………………… ….

II. Institutional Delivery …………………………………………… …

III. State-wise prevalence of anaemia in women of reproductive age group (15-49)………………………………………………………………..…… ...

IV. Percentage of Women having below normal body mass Index (BMI) ……………. …..

V. Ante-Natal Care service Status ……………………..…………………… ….

VI. Post-Natal care services …………………………..……………………… …..

APPENDICES

I. Minutes of the 4th sitting held on 18.11.2015…….....................… ..

II. Minutes of the 9th sitting held on 11.05.2016...…………………... ..

III. Minutes of the 3rd sitting held on 11.11.2016.......................……. ..

IV. Minutes of the 10th sitting held on 02.06.2017.............................. ..

V. Minutes of the 4th sitting held on 21.12.2017……………………….. ...

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2015-2016)

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Members

Lok Sabha

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3. Shrimati Renuka Butta
4. Km. Sushmita Dev
5. Shrimati Rama Devi
6. Shrimati Jyoti Dhurve
7. Shrimati Bhavana Gawali
8. Shrimati Raksha Khadse
9. Shrimati Poonamben Hematbhai Maadam

10.$ vacant

11.# vacant

12. Shrimati Jayshreeben Patel
13. Shrimati Riti Pathak
14. Shrimati Satabdi Roy (Banerjee)
15. Shrimati Mala Rajya Laxmi Shah
16. Shrimati Supriya Sule
17. Shrimati Rita Tarai
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19. Shrimati Savitri Thakur
20. Shrimati R. Vanaroja

Rajya Sabha

21*. Shri Prabhat Jha

22. Shrimati Vandana Chavan
23. Shrimati Kanimozhi

24.% Vacant

25. Shri Anubhav Mohanty
26. Shrimati Kahkashan Perween

27. @ Vacant

28*. Ms. Dola Sen

29. Shri A.V. Swamy
30. Shrimati Wansuk Syiem

* Nominated to the Committee w.e.f. 20.06.2016

$ Smt. Mehbooba Mufti, MP (LS) resigned w.e.f. 04.07.2016.

Smt. Anupriya Patel appointed as Minister w.e.f. 05.07.2016

@ Smt. Kanak Lata Singh, retired w.e.f. 04.07.2016

% Smt. Mohsina Kidwai retired w.e.f. 29.06.2016

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2016-2017)

Shrimati Bijoya Chakravarty - Chairperson

Members
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2. Shrimati Anju Bala
3. Shrimati Renuka Butta
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5. Shrimati Rama Devi
6. Shrimati Jyoti Dhurve
7. Shrimati Bhavana Gawali
8. Shrimati Darshanaben Jardosh
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25. Shrimati Rajani Patil
26. Shrimati Kahkashan Perween
27. Ms. Dola Sen
28. Shri A.V. Swamy
29. Shrimati Wansuk Syiem

30*. Shrimati Jharna Das Baidya

* Shrimati Jharna Das Baidya has been nominated to the Committee with effect from 16th December, 2016.

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN

(2017-2018)

Shrimati Bijoya Chakravarty - Chairperson

Members
Lok Sabha

2. Shrimati Anju Bala
3. Shrimati Renuka Butta
4. Km. Sushmita Dev
5. Shrimati Rama Devi
6. Shrimati Jyoti Dhurve
7. Ms. Bhavana Gawali (Patil)
8. Shrimati Darshanaben Jardosh
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30. Shrimati Wansuk Syiem

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4.	Shri Rajesh Mohan	-	Executive Officer
5.	Shri Aritra Das	-	Sr. Executive Assistant

INTRODUCTION

I, the Chairperson, Committee on Empowerment of Women, having been authorised by the Committee to submit the Report on their behalf, present this Tenth Report on 'Women's Health Care: Policy Options'.

2. Realizing the importance of various challenges faced by women and the various healthcare policy options in terms of better accessibility, affordability and availability and their overall impact on health indicators of women in the country, the Committee on Empowerment of Women (2014-15) selected this subject for detailed examination and Report to Parliament during the year 2015-16, the subject was further reselected during 2015-16 and 2016-17 for detailed examination. In order to gain firsthand knowledge on the subject, the Committee interacted with various jail authorities during the study visits. The Committee also took oral evidence of the Ministry on 20.06.2017.

3. The Committee wish to express their thanks to the representatives of the Ministry of Health and Family Welfare for appearing before the Committee for evidence and furnishing the information desired by the Committee in connection with the issues relating to the subject.

4. The Report was considered and adopted by the Committee at their sitting held on ....

5. For facility of reference and convenience, the observations and recommendations of the Committee have been printed in bold letters in Part II of the Report.

NEW DELHI
<u>03 January, 2018</u>
<u>13 Pausa, 1938 (Saka)</u>

BIJOYA CHAKRAVARTY,
Chairperson,
Committee on Empowerment of Women.

REPORT

PART I

I. Introductory

We are all aware that women's healthcare in this country was once in shambles, resulting in various depressing consequences for women and child health particularly and country's overall health scenario as a whole for long. Prevalence of chronic anemia, malnourishment, spread of communicable diseases, complications during or after pregnancy, inadequate antenatal, intranatal and postnatal care etc. all contributed to the wastage of precious human resources and stifled the country's progress even in the times not so distant back .

1.2 The situation, off-late, have undergone changes for better. Today women healthcare has been attracting due attention and importance it long deserved in our country. These changes are manifest not only in increased resources allocated to it, but, in the diversity of policy options undertaken for them and directed, particularly, to the special needs of marginalized women and children across the length and breadth of this vast country. However, the Committee believe that it is only a humble beginning and a long and winding road is yet to be covered before a comprehensive, equitable and accessible healthcare system is made available to them.

1.3 With the objective to reviewing the status of women's healthcare in the country and finding ways and means to empower them in terms of access, availability and affordability to healthcare facilities, the Committee on Empowerment of Women selected the subject ' Women's Healthcare: Policy Options' for detailed examination and presentation of report. During the course of examination of the subject, the Committee had studied in-depth the prevailing conditions of various healthcare schemes, approaches adopted by Government, both at the Centre and the States/UTs, the outcome generated by flagship programmes, innovative healthcare programmes at regional and local levels,status of mental health etc.

1.4 The Committee are also given to understand that the Ministry of Health and Family Welfare is the nodal Ministry for the framing of overall policy, planning and coordination of programmes for the development of women's healthcare, where States receive continuous financial support from the Union Government. The Ministry have acknowledged that few critical gaps that plague healthcare policy options in India need closer look. They include variable capacities between States regarding governance and implementation capacitates to manage healthcare, growing burden of lifestyle diseases, huge paucity of human resources in health sector as well as continuing high pocket expenditure and low government spending on healthcare options to hinder access of women to healthcare services.

1.5 During evidence, the representatives of the Ministry deposed before the Committee as under:-

".....First and foremost, what the Ministry has done to ensure better health for women and children in this country, particularly, women is that 40% our resources under National Health Mission are today spent on the health and of women and children. Our women's health has shown improvement in recent time but the road is long and we have to do lot more work".

II Women Healthcare responsibilities: Centre and States

1.6 The Committee are aware that Health is a part of the State List as per the schedule 7 of the Constitution of India. Owing to its federal structure the policy making function is performed by Union as well as State governments in the country. Union government largely performs the stewardship function vis-à-vis policy formulation keeping in view the National priorities- such as disease elimination/eradication, control of pandemics, and meeting global commitments on levels of morbidity and mortality etc., formulating programs to meet emerging demands (e.g National Urban Health Mission). On the other hand, States formulate policies that are predominantly a mix of their respective priorities and also address national concerns along-with local implementation bottlenecks. For instance, although the Union does not have a public

health cadre, many states have formulated policies regarding public health cadres (e.g. Tamil Nadu, Maharashtra).

1.7 The Committee have also been informed during the course of examination of subject that discussion of National Health Policies with States is also an important aspect of policy formulation and Central Council of Health and Family Welfare acts as an important platform for this. Further, the union also proposes Model Acts that States modify as per their needs. Concurrence from States is always sought for most legislative and policy initiatives (pertaining to health) that come within the purview of 7th schedule of Constitution of India. The Ministry have also stated that in terms of implementation, the responsibility is largely borne by the States, except for the National Health Mission, where the States and Centre have committed towards common agenda, receive continuous policy as well as financial support from the Union. This ensures that the burden of implementation (and outcomes) is shared by Union as well as the State(s). An important aspect in implementation is support from Union in case of health contingencies that are faced by States owing to disasters – natural or manmade. In most of these instances Union supports the States with deployment of human resources too (in addition to financial and infrastructural support).

1.8 While dwelling on the major critical gaps that plague the healthcare policy options in India, the Ministry divulged as under:-

a) India is a vast and diverse country, where the policies are framed at the National level, with the National and Global goals and commitments to adhere to. However, governance & implementation capacities to manage large health care programmes vary across States.

b) Growing burden of lifestyle diseases- Double burden of diseases, increasing burden of Non-Communicable Diseases (NCDs) even when communicable disease burden exists on account of communicable diseases and Maternal and Child Health care (MCH).

c) Huge paucity of human resources for health including allied health professionals compounded further by large inter-state and rural–urban variations is a continuous and complex challenge.

d) Continuing High out of Pocket Expenditure and low government spending on healthcare continue to hinder access of women to healthcare services.

1.9 The Ministry have submitted that Under the National Health Mission, initiatives such as free drugs and free diagnostics services, focus on grievance redressal services, focus on non-communicable diseases, provision for recruitment of contractual manpower etc have been introduced and similarly a host of measures have been introduced by the M/o Health & Family Welfare to address the shortage of human resources across the country. The Committee have also, inter- alia, taken note of the Maternity Benefit (Amendment) Act, 2017, notified by the Gazette of India, Extraordinary, Part-II, Section 1, dated 28th March, 2017. The Amendment has increased paid maternity leave available for women employees from the existing 12 weeks to 26 weeks with the provisioning of maternity leave for adoptive and commissioning mothers as well. The concerned amendment has also spelt out certain provisions like 'Work from home', 'Crèche' and 'Employee awareness' for women employees.

III Janani Suraksha Yojana, Maternal Health and institutional deliveries

1.10 Janani Suraksha Yojana was launched in 2005 with the objective to reduce maternal and infant mortality by providing cash assistance to pregnant women especially poor women and women form weaker sections of the society to deliver in health facilities. Janani Suraksha Yojana (JSY) provides special focus on Empowered Action Group (EAG) States as these States together account for 69% of infant deaths and 87% of maternal mortality.

1.11 Regarding the objective of reducing the Maternal Mortality Rates, the Ministry have put forth that it is one of the central tenets of international (Millennium Development Goals) and national (National Health Mission) goals. It has also been told that States such as Assam, Bihar, Jharkhand, MP, Chhattisgarh, Orissa, Rajasthan,

Uttar Pradesh and Uttaranchal would be considered as laggard States as all of them have an MMR above 200/ lakh live births. Such States are classified as high focus States under the National Health Mission and higher allocation is provided to high focus states and high priority districts to bring them at par with better performing States/ UTs. High focus states can be provided upto 33% of their total resource envelope for infrastructure up-gradation whereas other States can be provided up to 25% resource envelope for the same. Moreover, under NHM, flexibility is provided to States/ UTs including laggard States/ UTs to plan as per their local needs and priorities to address their gaps/ challenges. The annual Plans submitted by the State Governments are appraised by the National Programme Coordination Committee (NPCC) in light of the national as well as State priorities, detailed discussions with representatives from State/ UTs Governments during the NPCC meetings, NHM norms and availability of resources. Following these discussions, State specific annual plans are approved under NHM by the Secretary, M/o Health & FW (Chairman of Empowered Programme Committee).

1.12 The Ministry have also emphasized on the criticality of First Referral Units (FRUs), under JSY, to improve access to comprehensive emergency obstetrics care, reduce maternal mortality and address healthcare issues of women. Under NHM, the Committee have been informed, flexibility has been provided to the States for operationalization of FRUs. These are as under:

a) In order to address the shortage of specialists at FRUs, under JSY, States are allowed to hire services of private specialists on the basis of market situation prevalent in the State/ certain districts (duly approved in the State plans)

b) State have also been asked to explore the possibility of adopting campus recruitments in medical colleges, providing hard area and performance linked incentives to specialists, in sourcing of specialists (part time) and empanelling not for profit institutions.

c) A D.O. letter by Secretary (H&FW) on detailed steps for operationalization of FRUs has been shared with States/ UTs to encourage them to undertake comprehensive planned and take appropriate action for this step.

1.13 The Ministry have further elaborated that financial assistance under JSY is available to all pregnant women in those States that have low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu & Kashmir which are categorized as Low Performing States (LPS). However, in remaining States where the levels of institutional delivery are satisfactory, pregnant women from BPL/SC/ST households only are entitled for JSY benefits. These states are categorized as High Performing States (HPS) under JSY.

1.14 The Committee have been informed that delay in responding to the onset of labor and other complications has been shown to be one of the major barriers to reducing mortality and morbidity surrounding childbirth. The Ministry have also stated that JSY has been one of the major contributing factors in increased utilization of public health facilities for delivery care services by the pregnant women.

1.15 During evidence, the representatives of the Ministry deposed before the Committee as under:-

"....One of the most disturbing factors in women health in this country used to be maternal mortality which has come down to 167 live births as on 2013. One critical element I want to put forward in one of the issues which has helped us get where we are is a dramatic increase in institutional delivery in India. Now the institutional delivery is 80% in the country. To incentivize, we run a scheme called Janani Suraksha Yojana whereby we give financial incentives to the women to come to the institutions to deliver. We have also ensured that referral transport in National Health Mission alone in this country has added 23,000 referral transports which is one of the reasons of change that we see".

1.16 On being asked about the performance of JSY in EAG states, Jammu & Kashmir and North-East states of the country, the Ministry have submitted that JSY has been

quite successful in EAG states, J&K and Assam. Institutional deliveries in these states have improved considerably resulting in decline in MMR as depicted in ***Annexure-I.*** In addition, the Committee have also been informed by the Ministry that institutional delivery in the country as a whole has increased by more than 100 percentage points from 38.7% in 2005-6 (NFHS-3) to 78.7% (RCOS, 2013-14) with states which had low institutional delivery rates i.e. EAG states and Assam performed fairly well and reported more than 100% achievement. A chart showing successes achieved by states between NFHS(2005-06) and RSOC(2013-14) has been shown as per **Annexure-II.**

1.17 The Ministry have stated before that the Committee that certain districts such as Janjgir-Champa and Kawardha in Chattisgarh have shown more than 70% of home deliveries; where studies have shown that lack of geographical and financial access as important barriers to accessing institutional delivery services. It has also been stated by the Ministry that cultural beliefs and practices are other common reasons identified for high home deliveries and low literacy is also associated with high number of home births in certain areas.

1.18 The Ministry's note also refers to the referral transport for pregnant women, sick neonates and sick infants that is provided by the States as per their local needs, using different models which include a network of emergency response vehicles through toll free numbers, Government ambulances, available transport under public private partnership etc. with a total over 18000 ambulances now operational across states.

1.19 The Committee desired to know during evidence as to why the drivers are not employed for ambulances in rural and remote areas, without whom the ambulances stand idle and pregnant women are deprived of the services while they need them most. The Ministry informed the Committee that the responsibility to recruit the ambulance drivers rests with the state governments.

1.20 The Committee have been also informed that Public health facilities such as the District Hospital (DH)/Sub-district Hospital(SDH)/Community Health Centre (CHC)/Primary Health Centre (PHC)/Sub- district Health Centre (SHC) are categorized depending on the levels (1, 2 and 3) of maternal and child health care and service

delivery. Among these levels, some have been categorized as delivery points based on their performance and case load. The Ministry have also stated that as per the guidelines released to States/ UTs, they have been asked to focus on making delivery points functional on priority for provision of comprehensive Reproductive, Maternal, Neo-natal, Child Health+ Adolescent services including adolescent health and family planning services such as post partum IUCD services and safe abortion services. While approving annual State programme implementation plans under NHM, priority is accorded to proposals for strengthening of delivery points in terms of infrastructure up-gradation, additional human resources, procurement of equipments and capacity building of available human resources. Further to strengthen these facilities funds are provided for strengthening of labor rooms, Obstetric Intensive Care Unit (ICU) and High Dependency Unit (HDU) as per the proposal received from states.

IV Insurance coverage of pregnant women and cash incentives under Maternity Benefit Programme (MBP)

1.21 As regards the insurance coverage of pregnant women, the Committee have been informed by the Ministry as under:

a) The beneficiary under RSBY is any person belonging to Below Poverty Line (BPL) family, whose information is included in the district BPL list prepared by the State government. The other categories covered are auto Rickshaw & taxi Drivers, beedi workers, building and other construction workers, domestic workers, mine workers, MNREGA workers, rag pickers, rickshaw pullers, sanitation workers, street vendors, railway porters.

b) Rashtriya Swasthya Bima Yojana provides cover for hospitalization expenses upto Rs. 30,000/- for a family of five on a floater basis per year. Transportation charges are also covered upto a maximum of Rs. 1,000/- with Rs. 100/- per visit, per year.

c) The maternity benefits are covered under RSBY Scheme. Both normal and caesarean deliveries are covered under RSBY.

d). Treatment in respect of any complications requiring hospitalization prior/during/post-delivery is taken care of as per the listed medical packages under RSBY.

e) All expenses related to the delivery of the baby in the hospital are covered and hospital cost will be reimbursed by the insurer.

f) A new-born covered under the RSBY since birth is automatically covered for the remaining period of the health insurance policy. Further, there are neonatal packages included in the RSBY Scheme for treating neonates.

g) Even if the new-born is sixth member (as maximum allowed members covered under RSBY are five per family), he/she will be covered.

h) The new-born will be covered for the remaining RSBY policy period. However at the time of renewal of the policy, the household will have to take a decision whether to include the new born for the following year.

1.22 Besides, the Committee have been told that Ministry of Women and Child Development launched a Centrally Sponsored Conditional cash transfer scheme, Indira Gandhi Matritya Sahajog Yojana (IGMSY), for pregnant women and lactating mothers in October, 2010. The scheme has now been rechristened as Maternity Benefit Programme (MBP). The scheme creates better enabling environment by providing cash incentives for improved health and nutrition to pregnant and lactating mothers. The scheme is being implemented using the platform of ICDS and the focal point of implementation of the scheme is Anganwadi Centre (AWC) at the village. The scheme covers pregnant women of 19 years of age and above for first two live births (benefit for still births would be as per the guidelines of scheme) and all the government employees are excluded from the scheme. Each pregnant and lactating mother are being given a total cash incentive of Rs. 4000/- (First Rs 1500 at the end of second trimester, Second Rs 1500 at 3 months after delivery and Third Rs 1000 at 6 months after delivery) between the second trimester till the child attains the age of 6 months.

1.23 The Annual Report (2016-17) of the Ministry of Women and Child Development states as under:-

"... The scheme has an Annual Budget Estimates (BE) of Rs.400 crores. MBP has promoted financial inclusion, among 6 lakh women annually, thereby promoting economic empowerment process. From 2015-16, the scheme has cost sharing of 60:40 between Centre and General Category States including UTs with legislature, 90:10 between Centre and Special Category States (8 North-Eastern States and 3 Himalayan States) and 100% financial support for UTs without legislature".

1.24 The aforementioned Report also states that the proposal for continuation and expansion of MBP from 53 pilot districts to all the districts of the country as per the provisions of the National Food Security Act, 2013 is under consideration in the Ministry. The scheme will be expanded to cover all the districts of the country after obtaining approval of Competent Authority. It further adds that the budget estimate for 2017-18 is Rs. 200 crore as per Central Government share for implementing the scheme in accordance with the provisions of the National Food Security Act, 2013.

V Role played by Accredited Social Health Activists (ASHAs), their trainings and wages

1.25 The Ministry, in their replies to the Committee, have stated that About 9.42 lakh ASHAs have been selected under National Health Mission. Currently the ASHA programme has been rolled out in all states and UTs except Goa. Over last decade all States have selected over 90% ASHAs against the target proposed except in six states of Rajasthan (80% selection), Himachal Pradesh (83%), Karnataka (83%), Kerala (84%), Maharashtra (89%) and West Bengal (77%). With regards to problems related to ASHA selection, it has been stated by the Ministry that low literacy levels in remote areas and failure to relax education norms for ASHA selection in such areas at local/ State levels as well as better income generating opportunities especially in the peri-urban areas pose a challenge in ASHA selection.

1.26 The Ministry, while responding to queries of the Committee as to the roles played by ASHA workers, have submitted that they work as an effective link between the

pregnant women and government health facilities to promote institutional delivery. ASHA workers provide support in tracking the pregnant women, facilitate timely ANCs and assist the pregnant women in availing benefits such as JSY incentive and entitlements under JSSK. ASHA workers also play a key role in guiding the pregnant women to enroll for Aadhaar and open bank/post office accounts to get government subsidies. The Committee have also been informed that that findings of the evaluation of JSY conducted in 2010-11 across eight high focus states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttrakhand) showed that – ASHAs accompanied the pregnant women for institutional delivery in 67% cases and ASHAs were also the prime source of information for ANC in 64% of the cases.

1.27 The Ministry have also stated that training on maternal and reproductive health is a key component of ASHA training. So far, eight training modules have been developed, which enable the ASHA to become skilled in a set of competencies**.** For ASHAs, The topic of maternal and reproductive health is covered in the following modules:-

1. Module 2- Maternal and child Health
2. Module 3- Family planning
3. Module 6- Maternal and child health
4. Module 7 -Women's reproductive health – family planning, safe abortion and RTI/ STI
5. Induction Module (consolidated version of Module 1-5) – Maternal and Newborn Health, Family Planning, Women's Reproductive Health

1.28 The Ministry have further stated that in 2010, Modules 6 and 7, which emphasized skills and competencies were developed. The revised national guidelines stipulate that all ASHAs must receive 28 days of training in the first year- 8 days training on Induction module (formerly for 23 days spread into five modules) and 20 days training in four rounds of five days each for module 6&7.

1.29 The Ministry have also informed the Committee that ASHA programme also comprises a set of support structures at sub block, block, district and state level. Over last few years substantial progress has been made by states in setting up support structures for ASHAs. ASHA facilitators visit ASHAs every month to provide on-the-job mentoring and supervision. The monthly PHC review meetings of ASHAs are a forum for review and refresher training. This facilitates mentor ASHAs to improve their performance and skill in all areas including Maternal and new- born health. In addition MoHFW has taken several steps to support ASHAs, such as – streamlining of payments by linking with Public Finance Management System (PFMS), introduction of new incentives and revision of incentives, roll out of ASHA Certification process, setting up of Grievance Redressal mechanism and introduction of social recognition initiatives like ASHA awards and sammellan. These measures also contribute towards improving the performance of ASHAs.

1.30 As far as major problems faced by ASHAs are concerned, the Ministry have cited the following:-

i. Training of ASHAs across most states is affected by the lack of permanent training mechanisms such as availability of trainers, infrastructure and equipment. The recently launched initiative of certification of ASHAs would accredit all components of ASHA training – trainers, curriculum, sites and ASHAs. This would give an opportunity to states to standardize the availability of basic training infrastructure and ensure quality of training.

ii. Out of stock drugs and Home Based New-born Care equipment is an unresolved issue across all states. In 2013, MoHFW has suggested that the replenishment of ASHA drug kits should be done at the SHC/ PHC level to facilitate easy replenishment process for ASHAs. Replenishment of Home Based Newborn Care (NBHC) kits is supported by the NHM.

iii. Delay in payments of incentives especially for incentives for activities related to Revised National T.B. Control Programme (RNTCP) , National Vector Borne Disease Control Programme (NVBDCP). To address these delays, MoHFW has taken a policy

decision to include ASHA payments under PFMS . At present most states are in the process of transition of linking ASHA payments with PFMS for the online transfers.

1.31 On being enquired by the Committee as to how the ASHAs are remunerated and their performances monitored, the Ministry have stated that ASHA workers are entitled for Performance Based Incentives (PBI) under the JSY for facilitating Ante-Natal Care and institutional delivery of pregnant women. ASHA workers get their PBI directly into their bank accounts through DBT mode i.e. through Aadhaar linked bank account or through Core Banking Solution (CBS) in case Aadhaar number is not available/ linked to the bank account of ASHA. Payments to ASHAs in cash are not allowed across the country as a rule. The Committee have further been told that ASHAs are eligible for JSY incentive in case of BPL/SC-ST beneficiaries in on-high-focus States and for all categories of beneficiaries in case of high-focus States. The incentive package for ASHAs under JSY is as follows:-

a) Rs. 600 per delivery for Rural Areas : Rs. 300 for antenatal component and Rs. 300 for facilitating institutional delivery.

b) Rs. 400 delivery for Urban Areas: Rs. 200 for antenatal component and Rs. 200 for facilitating institutional delivery.

1.32 Regarding the monitoring of performance of ASHA workers, the Ministry have stated that it is reviewed by district/State Health authorities on the basis of number of institutional deliveries facilitated by them.

VI Anemia in mothers and children

1.33 In reply to the concerns of the Committee on alarmingly high cases of anemia among women and children, the Ministry have informed that as per National Family Health Survey (NFHS) - III (2005-06), prevalence of anemia in women is 56.2% with higher in rural areas (58.2%) than in urban areas (51.5%). Information regarding prevalence of anemia in pregnant women is not available separately for rural and urban areas. Overall, 57.9% of pregnant women in the country are anemic as per the survey.

The Committee have also been told that NFHS 4 data is available only for 18 States as given in the **Annexure-III.**

1.34 Under the NHM, the Ministry have mentioned, the steps are taken to address anemia among pregnant women and adolescent girls in all States and UTs. These are:-

a) Universal screening of pregnant women for anemia is a part of ante-natal care and all pregnant women are provided iron and folic acid tablets during their ante-natal visits through the existing network of sub-centers and primary health centers and other health facilities as well as through outreach activities at Village Health & Nutrition Days (VHNDs).

b) Every pregnant woman is given 100 tablets of iron and folic acid (IFA), after the first trimester, to be taken 1 tablet daily and same is continued during the post natal period. Pregnant women, who are found to be clinically anemic, are given additional 100 tablets for taking two tablets daily. This has been now expanded to 6 month during ANC and 6 month during PNC.

c) Government of India have given directions to the States for identification and tracking of severely anemic cases at all the sub centres and PHCs for their timely management.

d) Health and nutrition education through Information Education Communication (IEC) & Behavior Change Communication (BCC) to promote dietary diversification, inclusion of iron folate rich food as well as food items that promotes iron absorption.

e) To tackle the problem of anemia due to malaria particularly in pregnant women and children, Long Lasting Insecticide Nets (LLINs) and Insecticide Treated Bed Nets (ITBNs) are being distributed in endemic areas.

f) Both the Health management information system & Mother Child tracking system are reporting the cases of anemic and severely anemic pregnant women.

g) 184 High Priority Districts (HPDs) have been identified and prioritized for Reproductive Maternal Newborn Child Health+ Adolescent (RMNCH+A) interventions for achieving improved maternal and child health outcomes.

h) Safe Motherhood Booklet is being distributed to the pregnant women for educating them on dietary diversification and promotion of consumption of IFA.

1.35 To address the iron deficiency and anemia problem in adolescents, the Ministry have initiated the Weekly Iron Folic Acid Supplementation (WIFS) component of National Iron+ Initiative (NIPI), under which blue-colored tablets are provided to both school and out-of-school adolescents on weekly basis. Ministry of Women and Child Development, the Committee have been informed, is implementing Rajiv Gandhi Scheme for empowerment of adolescent girls – 'Sabla', introduced on a pilot basis in the year 2010. The scheme, operational in 205 selected districts from all the States/UTs across the country, aims at all-round development of adolescent girls of 11-18 years (with a focus on all out-of-school AGs). One of the objectives under the scheme is IFA Supplementation. For which State Government /UT concerned establish convergence with health department to ensure the supply of tablets of IFA for each beneficiary of 'Sabla'. Policy guidelines regarding IFA supplementation, issued, inter alia, by the NRHM, are adhered to. Distribution of IFA tablets is recorded. The funds for procurement of these IFA supplements are provided to State Governments and UT administrations under the Annual Programme Implementation Plan. The State/UTs procure these supplements as per the technical specifications provided by MoHFW and distribute it to schools and AWCs. The adolescents going to school are provided supplements at the school, while those who are out-of-school are provided these supplements at AWCs. ANM/AWW give information to AGs on food fortification, dietary diversification, advantages of IFA tablets supplementation and its consumption with food for combating IFA deficiency.

1.36 The Ministry, on being enquired as to what executing mechanism are followed in NIPI, have clarified as under:

a) The State Government determine the number of target beneficiaries and fix a denominator for a year.

b) On the basis of target beneficiaries, State Government proposes the budget for IFA supplements in the Annual Programme Implementation Plan. The funds are provided by the Ministry of Health and Family Welfare to States/ UTs for procurement of IFA supplements, carrying out orientation work-shops, printing of necessary formats.

c) Execution of NIPI 6-59 month component:

€ The IFA syrup is either provided to mothers or is kept with ASHAs/AWW for biweekly IFA supplementation.

€ ASHA has to ensure the compliance of the minimum eight doses during the month and monthly reporting.

d) Execution of NIPI 5-10 years component:

€ The IFA tablets (WIFS junior) is provided to the primary school by the district health department.

€ A day in a week is fixed for administration of the IFA tablet. On that fixed day of the week, all children from class 1st to 5th are provided one tablet after their mid-day meal.

€ Report on compliance and stock is shared by the school nodal teacher to the ANM on a monthly basis.

1.37 The Ministry have further stated that apart from IFA supplementation, the community members are counseled on anemia and consumption of iron rich diet during the Village Health and Nutrition Days (VHNDs). The severely anemic children are screened by the Rashtriya Baal Swasthya Karyakram and referred to health facilities for treatment.

1.38 As regards control of anemia in tribal dominated areas, the Ministry in their written replies have stated that in order to address the prevalence of Hemoglobinopathies which significantly contribute to anemia in tribal areas, funds are provided to States/ UTs under NHM in their annual programme implementation plans, based on the proposal from State governments. Accordingly, funds have been provided to the States of Andhra Pradesh, Chhattisgarh, Gujarat, Maharashtra, Odisha, Jharkhand, Madhya Pradesh, Tripura, Telangana, Nagaland, Arunachal Pradesh.

VII Prevalence and Control of Malnutrition

1.39 The Ministry have stated that as per the NFHS-III (2005-06), the percentage of women aged 15-49 whose Body Mass Index(BMI) is below normal (BMI<18.5 kg/m2) is 35.6%.The NFHS-IV data is not available. Data which have been received from 18 states are given in **Annexure-IV**.

1.40 To tackle malnutrition, the Ministry have stated, there is Integrated Child Development Services (ICDS) Scheme which is a centrally sponsored flagship scheme of the Government of India implemented by the State Governments/UT Administrations with the objectives: i) to improve the nutritional and health status of pre-school children in the age-group of 0-6 years; ii) to lay the foundation of proper psychological development of the child iii) to reduce the incidence of mortality, morbidity, malnutrition and school drop-out iv) to achieve effective coordination of policy and implementation amongst the various departments to promote child development and (v) to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education. These objectives are sought to be achieved through a package of six services comprising (i) Supplementary Nutrition (ii) Immunization (iii) Health Check-up (iv) Referral Services (v) Pre-school Non-formal Education and (vi) Nutrition and Health Education. Three of the six services viz. Immunization, Health Check-up and referral services are provided by Auxiliary Nurse Mid-Wife (ANM)/Medical Officer (MO) of NRHM & Public Health Infrastructure. These services are supplemented with non- formal education for women with stress upon applied nutrition activities like local production and consumption of nutritious food. Nutrition and health education is given to all women in the age group of 15-45 years;

priority is given to nursing and expectant mothers. A special follow up is made to mothers whose children suffer from malnutrition or from frequent illness.

1.41 The Ministry have also informed that the provision of supplementary nutrition under ICDS Scheme prescribed for various categories of beneficiaries in Anganwadi Centres is as follows:

Serial No	Categories	Types of Food
1	Children (6-36 months)	Take Home Ration in the form that is palatable to the child. It could be given in the form of micro- nutrient fortified food and/or energy dense food.
2	Severely malnourished children (6-36 months)	Same type of food as above with food supplement of 800 calories of energy and 20-25 grams of protein.
3	Children (3-6 years)	Morning snack in the form of milk/ banana/ seasonal fruits etc. and Hot cooked Meal.
4	Severely malnourished children (3-6 years)	Additional 300 calories of energy and 8-10 grams of protein in the form of micro-nutrient fortified food and/or energy dense food.
5	Pregnant women and Nursing mothers	Take Home Ration in the form of micro-nutrient fortified food and/or energy dense food to ensure exclusive breastfeeding for first 6 months of life of the child.

1.42 The Committee have been also informed that supplementary Nutrition to pregnant women & lactating mothers and children below six years is now a legal entitlement under the National Food Security Act. In Schedule II of the said Act, nutritional norms to the above beneficiaries have been prescribed, considering the Indian conditions and food habits. These are as under:

Serial No	Category	Revised Norms (Per beneficiary per day)	
		Calories (Kcal)	Protein(g)
1	Children (6-72 months)	500	12-15
2	Severely malnourished children (6-72 months)	800	20-25
3	Pregnant women and Nursing mothers	600	18-20

1.43 The Ministry, elaborating further the linkages between 'Sabla' scheme and its effect on reduction on malnutrition among adolescent girls, have put forth that the nutrition component of the scheme aims at improving the nutritional and health status of young adolescent girls. The out of school AGs in the age group of 11-14 years attending Anganwadi Centres (AWCs) and all girls in the age group of 14-18 years are provided Supplementary Nutrition containing 600Kcal, 18-20 grams of protein and micronutrients, per day for 300 days in a year. The Nutrition is given in the form of Take Home Ration (THR) or Hot Cooked Meals. The nutrition component aims at improving the health & nutrition status of the adolescent girls. Further, the adolescent girls are provided other services including IFA supplementation, health check-up & referral services, nutrition & health education, Adolescent Reproductive Sexual Health (ARSH) counseling/guidance on family welfare, life skill education, guidance on accessing public services and vocational training (only 16-18 year old adolescent girls). The scheme is being implemented in 28 districts in north eastern region of the country.

1.44 The Ministry also hold hopes that the services under the scheme, *'Sabla'*, will make AGs self reliant by facilitating access to learning, health and nutrition through various interventions under the scheme. This will contribute to bring down the high levels of anaemia, improve maternal mortality rate, reduce child marriages, break the inter-generational cycle of malnutrition, mainstreaming out of school girls to school system, skill up gradation and enhance the self esteem of AGs. While giving factual details to the Committee, the Ministry have informed the Committee that nearly one crore beneficiaries are covered annually under nutrition component of the scheme while under the non-nutrition component, 56.19 lakh beneficiaries are provided IFA supplementation, 38.92 lakh were given nutrition and health education, 31.41 lakh

beneficiaries received guidance regarding ARSH/childcare practices, 24.77 lakh beneficiaries received life skill education,17.47 lakh adolescent girls were covered for exposure visits, 0.53 lakh girls have been mainstreamed to school system while 1.09 lakh adolescent girls received vocational education in the year 2015-16.

1.45 Addressing the issue of Nutrition and Health Education (NHE), it has been stated by the Ministry that NHE is being given to all AGs at the AWC jointly by the ICDS and health functionaries and resource persons/ field trainers from NGOs/Community Based Organizations (CBOs). These include encouraging healthy traditional practices and dispelling harmful myths, healthy cooking and eating habits, use of safe drinking water and sanitation, personal hygiene, including management of menarche etc. The adolescent girls are also informed about balanced diet, nutrient deficiency disorders and their prevention, identification of locally available nutritious food, nutrition during pregnancy and for infants. They are also imparted information about common ailments, personal hygiene, exercise/ yoga and holistic health practices. Sustained information on nutrition & health issues result in a better health status of the girls, leading to an overall improvement in the family health and also help in breaking the vicious intergenerational cycle of malnutrition.

1.46 While discussing the issue of malnutrition during the course of evidence, the Committee were of view that monitoring of the schemes to fight-off malnourishment should be strengthened. Also the Committee underlined the issue of quality of food given to children. During the discussion, the Committee observed as under:-

"......Like all these schemes, namely, malnutrition which we are discussing, Aanganwadi, mid-day meal and even scheme for adolescent and pregnant ladies, all these are inter departmental linked schemes. We would like to understand who is actually monitoring the malnutrition and who is taking the responsibility of informing the other departments. For example, in mid-day meal scheme, the quality of food is really bad. When the Government of India is sponsoring 60 per cent of the funding, why cannot we take up the responsibility of monitoring and asking all the States to standardize that this kind of quality has to be given regarding food and all, where we can give instructions to the State Governments to follow certain norms. That

mechanism has to set in. Auditing system and checking of the schools should be done timely. The Government of India can take up such type of responsibility".

1.47 Responding to the concerns raised by the Committee, the representatives of the Ministry deposed before the Committee as under:

".....There are eight States which are under the ISSNIP (ICDS Systems Strengthening and Nutrition Improvement Project) programme which have the highest burden of malnutrition. In those districts , initially, we are beginning as a pilot but this will be spread to the rest of the country under the National Nutrition Mission which is underway. It has not yet been approved by the Cabinet, but it has been cleared by the Planning Commission. As of now an Anganwadi worker has got some 11 registers to maintain which she finds it very difficult to do because about seven hours are required to do that work. What we are doing is, we are substituting this with the touch phone in which the software is preloaded. We are giving the CDPOs at the supervisory officers, a tablet. So, there are two things to it. One, it makes her work very easy. Second, we are able to take a snapshot of who is there in the Anganwadi at what time. So, the time as well as what she is feeding is going to be evident to the State Government as well as to us in Delhi. Similarly, it will be very easy for her to do a complete house survey, know who is pregnant, know what is the date of pregnancy, when is the immunization to be done. It is all going to be auto generated. Suppose there is an immunization schedule for the next day, she will know through a SMS which will be generated to all those who need to be immunized on that day. If somebody misses out, there is going to be a SMS generated asking as to why they have not come. Plus, she has a list of the people who did not come and she knows she has to go and meet them, take a photograph with them during his hose visit, she has to talk with them, the child might have been not available in the place, she may be ill, whatever it is. All that will be getting updated as and when she does the act. So, the problem of her giving a false number, giving a false account of what she has done, will be taken care of."

VIII Obstetric Care and Women Health

1.48 On being asked as to what measures have so far been taken by the Government to address the direct causes of maternal deaths, such as, excessive bleeding, infections, pregnancy induced hypertension, obstructed labour and unsafe abortions etc, the Committee have been informed as under:-

a) Under NHM, operationalization of First Referral Units (FRUs) is a priority and funds are provided for strengthening FRUs for quality emergency obstetric care services. This includes funds for infrastructure, equipments etc, funds for engagement of specialists, funds for operationalizing blood banks/ blood storage units etc. More than 2100 FRUs have been operationalized across the country for emergency obstetric care.

b) Apart from providing emergency care, programmes have been introduced for improving institutional delivery in view of the fact that any pregnancy can turn into an emergency.

c) Maternal Death Review (MDR) is being implemented across the country both at facilities and in the community. The purpose is to take corrective action at appropriate levels and improve the quality of obstetric care.

d) A new initiative of "Prevention of Postpartum hemorrhage (PPH) through community based advance distribution of Misoprostol" by ASHAs/ANMs has been launched for high home delivery districts to prevent maternal deaths.

e) Operationalization of Safe Abortion Services at health facilities with a focus on "Delivery Points" is a priority. For operationalization of these services we are providing necessary funds to the states for procurement of drugs, equipments and capacity building of service providers in the skills required.

f) Training of health functionaries in SBA training, birth companion, use of Partograph, guidance note on induction and augmentation of labor and Dakshata for provision of ante partum, intra partum and post-partum care to pregnant women.

g) Funds were given to states for strengthening of labor rooms, Obstetric ICU and HDU.

h) Providing antenatal care services through outreach session at Village Health & Nutrition Days and identification and line-listing of high risk pregnancies followed by birth planning are other strategies for reduction of maternal deaths. The recently launched Pradhan Mantri Surakshit Matritva Abhiyan also focuses on fixed day, comprehensive and quality ANC services and is based on the premise that if each and every pregnant woman in India is examined by OBGY specialists/ physicians and appropriately investigated at least once during the PMSMA and then appropriately followed up, the Abhiyan can play a crucial role in reducing the number of maternal and neonatal deaths in our country.

1.49 The Committee also desired to know form the Ministry about the action being taken by the Government to promote and disseminate among women the essential knowledge about safe motherhood, unsafe abortion, issues related to hygiene and diet during pregnancy etc. The Ministry have replied that regular IEC/BCC is done including messages on early registration for ANC, regular ANC, institutional delivery, nutrition, and care during pregnancy etc. Funds are being provided to the States through PIPs for comprehensive IEC/ BCC on maternal and new born health. Standardized IEC/BCC packages are being prepared at National level and have been disseminated to the States. Safe motherhood booklet is given to all pregnant women during ANC registration for giving them information on diet and danger sign.

1.50 The Ministry have also cited the Ante-Natal care service status as per Rapid Survey of Children 2013-14. The status of States in relation to ANC is given in ***Annexure-V.***

1.51 The Ministry have informed the Committee that as per the RSOC(2013-14), women who received postnatal care within 48hrs of discharge/delivery is only 39.25% in India. The State-wise post-natal care services received within 48hrs of delivery/discharge is placed at ***Annexure-VI .***

1.52 Moreover, the Committee have been explained to that public health facilities such as the District Hospital (DH)/Sub-district Hospital(SDH)/Community Health Centre (CHC)/Primary Health Centre (PHC)/Sub- district Health Centre (SHC) are categorized

depending on the levels (1, 2 and 3) of maternal and child health care and service delivery. Among these levels, some have been categorized as delivery points based on their performance and case load. The Ministry have further told that as per the guidelines released to States/ UTs, they have been asked to focus on making delivery points functional on priority for provision of comprehensive RMNCH+A services including adolescent health and family planning services such as Post Partum IUCD services and safe abortion services. While approving annual State programme implementation plans under NHM, priority is accorded to proposals for strengthening of delivery points in terms of infrastructure up-gradation, additional human resources, procurement of equipments and capacity building of available human resources. Further to strengthen these facilities funds are provided for strengthening of labor rooms, Obstetric ICU and HDU as per the proposal received from states.

IX Contraception and Women's Health

1.53 As regards contraception and women's health, the Ministry have stated in its written reply that the methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. An additional method available is the emergency contraceptive pill which is to be used in cases of emergency.

a) **Spacing Methods:-**

i) Injectable Contraceptive DMPA under the ‘Antara’ programme was introduced recently.

ii) Oral contraceptive pills- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. Under the Home delivery of contraceptives, ASHAs deliver OCPs at the doorstep of beneficiaries and may charge a nominal amount. The brand “MALA-N” is available free of cost at all public healthcare facilities.

iii) Centchroman “Chhaya”- It is an once a week non-steroidal oral pill introduced recently.

iv) Condoms - The brand “Nirodh” is available free of cost at government health facilities and supplied at doorstep by ASHAs at a nominal cost.

v) Intrauterine contraceptive devices (IUCD) - These are highly effective method for long term birth spacing. There are two types:

Ω Cu IUCD 380A (10 yrs)

Ω Cu IUCD 375 (5 yrs)

There is emphasis on postpartum IUCD (PPIUCD) insertion by specially trained providers to tap the opportunities offered by institutional deliveries.

b) **Permanent Methods:-**

i) Female Sterilisation- there are two techniques:

o Minilap

o Laparoscopic

ii) Male Sterilization- there are two techniques being used in India:

o Conventional

o Non- scalpel vasectomy

Emergency Contraceptive Pills - The pill is to be consumed in cases of emergency arising out of unplanned/unprotected intercourse and is not a replacement for a regular contraceptive.

1.54 Replying to the Committee's concern that conception in India is primarily believed to be a female responsibility, assigning little importance on the option of male contraception, the Committee have been told that the current basket of choices under Family Planning is geared towards provision of family planning services to all desirous beneficiaries. There is special emphasis on increasing male participation and promoting Non- scalpel vasectomy (NSV) in an effort to improve male involvement in Family Planning. In order to revive male contraception the government has emphasized upon the following:

a) Promotion of operationalization of facilities for NSV services.

b) Activation of training centers for NSV.

c) Generation of a pool of skilled and trained Human Resources.

d) Stimulation of demand-generation activities for increasing male participation.

e) Celebration of Vasectomy Fortnight through mobilization phase and service delivery phase.

1.55 The Committee have also been informed that condoms are distributed free of cost in the public health system. Additionally ASHAs are also distributing the condoms to the beneficiaries at their doorstep in the privacy of their homes under the 'Home delivery of Contraceptive Scheme'. The government also promote the use of condoms through Social Marketing Scheme wherein the commodity is provided to the social marketers at the subsidized rates. Packaging of condoms has been redesigned and improved in an effort to stimulate its use. Recently government has also initiated Mission Parivar Vikas for 145 high fertility districts with male participation as one of its important strategies.

1.56 The Committee have been informed through the note of the Ministry on Reproductive and Child Health (RCH) that total fertility rate (TFR) has declined from 3.2 in 2000 to 2.3 in 2013.Though, 24 States and UTs have already achieved the replacement level of TFR, Bihar (3.4) and UP (3.1) are the only two States which have TFR more than 3. The Committee have also been told that six States have unmet family planning needs higher than the national average. These are Bihar, UP, Jharkhand, Meghalaya and J&K.

1.57 In response to a query raised by the Committee on worth-emulating experiences in various States/UTs regarding different contraception methods and successes achieved by them so far, the Ministry have cited the examples as under:

a) Tamil Nadu – In an effort to significantly reduce the unmet need for family planning in the postpartum period and promoting healthy spacing between children right after child birth, Tamil Nadu initiated the strategic introduction and scaling up of Postpartum Intrauterine Contraceptive Device (PPIUCD)/Postpartum Sterilization (PPS)

services in their public health system. The high delivery case load facilities at the district level were saturated with trained providers for providing PPIUCD/PPS services followed by sub district level facilities and lastly the PHCs (wherever applicable). A meticulously made district action plan from each district was followed for improved scale up of PPIUCD/PPS services in the state which was closely monitored through supportive supervision visits. This model has helped the state of Tamil Nadu to deliver Postpartum Family Planning (PPFP0 services to over 3.5 lakh women in the year 2015-16. The acceptance rate for postpartum sterilization in Tamil Nadu is the highest in the country and in the last five years there has been an increase of 16% in PPFP share.

b) Madhya Pradesh – In an effort to combat the issue of dearth of trainers and interruption in routine clinical duties, onsite trainings for postpartum IUCD services have been taken up in the state of Madhya Pradesh with support from GoI and IPAS. In this model, the trained provider from a facility ensures training of all the eligible team members in the same facility without interfering with their regular clinics. This also ensures hands-on experience of the trainees under supervision of the trainer. Onsite training not only improves the skills of the service providers but also the facility readiness to provide services to the clients. The onsite training has helped in increasing the pool of service providers with 878 providers trained in year 2015-16. The PPIUCD acceptance rate has increased from 2% in 2013-14 to over 15% in 2015-16

X Women's health & Non-communicable diseases (NCDs)

1.58 The Committee asked the Ministry about its views on the alarming rise of certain NCDs, such as, certain types of cancers, Polycystic Ovarian Disease (PCOS),Chronic Obstructive Pulmonary Disease (CPOD), diabetes etc. among women population of the county. The Committee also enquired of the Ministry about the policies of the Government to tackle the spread of NCDs among women. The Ministry in reply have stated that various programmes including National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCDS), National Programme for Control of Blindness (NPCB), National Programme for Healthcare of Elderly, National Deafness Control Programme and National Mental Health Programme, are being implemented for both men and women. However, certain activities are

exclusively for women like prevention, early diagnosis and treatment of cervical and breast cancer. The Ministry , the Committee have been informed, have recently taken a decision to also include Chronic Obstructive Pulmonary Diseases (COPD), which also affect women and young children living in households where bio-fuels are used for cooking.

1.59 On the crucial aspect of underlying causes behind the rise in such diseases and the possible measures to tackle the problem in the country, the Committee have been further enlightened that various studies, conducted by the Indian Council of Medical Research (ICMR) as well as burden of diseases conducted by WHO, have identified various risk factors for NCDs in the country. These include tobacco use (smoking as well as smokeless forms), unhealthy diet (rich in sugar, salt, saturated fat/trans-fat), lack of physical activity, obesity, exposure to air pollution (household as well as ambient pollution) and alcohol use. National Tobacco Control Programme is being implemented to control tobacco use in the country. Other risk factors are being addressed through various national health programmes. The Ministry has also formulated a multi-sectoral plan to address NCDs and their risk factors.

1.60 Since the consumption of gutka, tobacco and alcohol have direct links to the growth of non-communicable diseases, the Ministry have stated in its written replies that Global Tobacco Survey is being undertaken in the country periodically to assess the use of tobacco products in the country by both men and women. Various measures are being undertaken to control tobacco use including among young women through public awareness and implementation of Cigarettes and Other Tobacco Products Act (COTPA). The Ministry is also undertaking a national survey on NCD risk factors and burden of NCDs in the country through Indian Council of Medical Research to estimate current figures of various NCDs and their risk factors.

XI Mental Health & Women

1.61 The Committee asked the Ministry about the status of mental healthcare for women in the country and also the plan of action to provide treatment to women patients in Government run health facilities to mental issues arising out of depression,

sexual violence, domestic violence, work–life asymmetry, post menopausal imbalances, geriatric psychology etc. The Ministry in its reply have informed that the following:-

a) The mental health of women is an important area that needs to be addressed. Most Government hospitals in the country have general hospital psychiatry units that work in coordination and liaison with obstetric and general medical departments to handle specific problems related to women.

b) Some centers have dedicated services for women in pregnancy and the postpartum period.

c) NIMHANS Bangalore has a dedicated mother baby psychiatry unit and perinatal outpatient services. JIPMER, Pondicherry and IHBAS, Delhi also have perinatal psychiatry units which treat mothers with pregnancy and postpartum related mental health problems.

d) In addition, to handle issues related to Trauma and Domestic Violence (including sexual violence), some government hospitals have trained staff to handle psychological problems related to the above.

e) NIMHANS, Bangalore at its NIMHANS centre for well being runs a trauma recovery clinic and a dedicated clinic for women reporting intimate partner violence.

f) In Karnataka, the Department of Women and Child Welfare runs 51 Santwana Kendras or counselling centers in different districts. These centers deal with issues such as dowry, sexual harassment, marital problems and rape.

g) The psychiatrists and psychologists in Govt hospitals provide training in mental health and support to staff and counselors in the Santwana Kendras.

h) As part of Occupational and Industrial health programs, the departments of psychiatry, clinical psychology and psychiatric social work run training for HR departments of various organizations to enhance the mental health of employees and improve referrals to psychiatrists.

I) Special de-addiction facilities for women are available at NIMHANS and AIIMS de-addiction facilities. The Indian Psychiatric Society has constituted a task force on women's mental health and maternal mental health which has members from Government hospitals and medical colleges to enhance these services. IEC material for Women's Mental health has been developed by a collaboration between NIMHANS and an NGO, White Swan foundation, in six different Indian languages.

J) There is however a need to develop more gender sensitive mental health services in the country in order to ensure better care for women with both common and severe mental health problems. Obstetricians, gynecologists and pediatricians need to be trained in the identification, early treatment and referral for women with mental health issues associated with gynecological problems. Special groups for whom services will need to be developed in govt. institutions are - older women, adolescent girls and women with conditions such as HIV and Cancer.

1.62 The Committee, during the examination of the subject, expressed their concern for the rescue, treatment and rehabilitation of seriously mentally unsound women who are abandoned or driven out of homes and also about their safety and security from sexual harassments and other exploitations. The Ministry have told the Committee in response that the police as well as women and child welfare department in most states work closely with each other to help women with mental illness who have been abandoned or sexually assaulted. There are government shelter homes that work closely with the psychiatric hospitals and provide care. However, a large number of homeless mentally ill women are accommodated by NGOs such as Banyan in Chennai and Anjali in Kolkata. IHBAS also runs a program for homeless women with mental illness. Mentally ill women picked up by the police are admitted under the Mental Health Act to psychiatric hospitals. However, aftercare and rehab facilities are not adequate enough to handle the number of women who need help. In Bangalore, NIMHANS uses tele-psychiatry to provide mental healthcare for women in the Recovery and Rehabilitation centres including in facilitates for homeless individuals which house a large number of women with mental illnesses. More State run facilities are needed. Manuals have also been developed by NIMHANS for handling mental health issues of

partner violence and sexual violence. It has been funded and initiated by the Department of Health Research, Govt of India. NIMHANS has developed a manual for psychosocial care for women in shelters.

1.63 On the aspect of provision of insurance option for mentally ill patients undergoing treatment in health facilities, the Ministry have stated that Mental Health Care Bill, 2016 as passed by The Rajya Sabha on the 8th august, 2016 makes clear statement on providing health insurance for persons with mental illness under the clause 21. Every person with mental illness shall be treated as equal to persons with physical illness . To be specific, The MHC Bill 2016 Clause 21 (4) states that every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illnesses.

1.64 The Ministry have also enlightened the Committee about 'Swavlamban Health Insurance Scheme', run by the New India Assurance Company Ltd., providing affordable Health Insurance to persons with blindness, low vision, leprosy, hearing impairment, loco-motor Disability, mental Retardation and mental Illness. Salient features of the scheme are given below:

a) It covers all pre-existing conditions and There is no need for prior medical check-up and tests

b) Covers People With Disabilities (PwDs) (aged between 18-65 years age), spouse and upto 2 children for PwDs over the age of 18 years; for those PwDs below the age of 18 years, 2 guardians may also be covered under the family floater scheme.

c) Available for persons with disabilities with family annual income of Rs. 3 lacs and below on declaration basis in proposal form.

d) Family floater of Rs 2,00,000 per annum.

e) Provides for OPD treatment of Rs 3,000 for persons with mental retardation and mental illness.

f) Annual premium payable by PwD is ₹ 357/ annum (including service tax). This is 10% of the premium while the rest of the premium is paid by the Government of India.

1.65 The Committee have been informed that the Parliament have enacted Mental Healthcare Act, 2107, notified by the Gazette of India dated 7th April, 2017, to provide for the right to better healthcare for mentally- ill patients and it also now decriminalizes suicide. Among others, the bill ensures the following rights to a mentally-ill person:

- Ω Access mental health care.
- Ω Community living.
- Ω Equity and non-discrimination.
- Ω Information
- Ω Confidentiality
- Ω Access Medical Report
- Ω Personal Contacts and communication
- Ω Legal Aid
- Ω Make complaints about deficiencies in provision of services
- Ω Place restriction on release of information in respect of mental illness.

PART-II

OBSERVARTIONS/RECOMMENDATIONS OF THE COMMITTEE

Need to create pre-delivery hubs in remote areas

2.1 The Committee are of the opinion that a seamless synergy between the Centre and States policies only can bring in noteworthy changes in women's healthcare, particularly in relation to bringing down maternal mortality rates, infant mortality rates and increasing the quality of antenatal, intranatal and postnatal care in the country, and thereby contributing to the overall development in maternal and child health scenario in India. The Committee observed during the examination of the subject that the Ministry have not paid enough attention to the transportation problems of pregnant women, particularly during the time they face the onset of labor pains. The Committee have found that easy transportation of expectant mothers to the nearest delivery points still remain a arduous task in view of difficult geographical terrains, lack of transportation facilities, natural calamities, security threats from insurgents in some parts of the country, curfews, hartals as well as many other factors arising out of unforeseen circumstances that may have serious health complications for the women who are on the verge of delivering babies. Therefore, the Committee, recommend that

the Government start discussion with States/UTs to build 'Pre-delivery hubs', preferably very close to the delivery points, where they can be brought in 7 to 10 days ahead of Expected Date of Delivery (EDD) and finally be moved to the delivery points with the onset of labor or one day in advance of EDD; where they would be looked after by skilled medical attendants and given medicine and diet appropriate to the health needs of the time. The Committee also believe that it would help reduce the out-of-pocket expenses of mostly poor and marginalized families as well; who are forced to shell out hefty amounts to hire vehicles to take the expectant mothers to the far-off hospitals in many parts of the country. Besides, these hubs will significantly reduce maternal deaths and other intrapartum complications as quite a large number of mothers deliver their babies every year on the village roads due to en-route delays and other associated difficulties. Here, the Committee would also suggest the Government to explore the successes made by the State of West Bengal in creating such hubs in the rural and far-flung areas of Sunderbans, like Gosaba, Pathar Pratima and Sandeshkhali, and in the district of Murshidabad. Successes achieved through this innovative approach, the Committee have come to know, have helped the State to reduce MMR rates from 41 to 27 per thousand live births in the shortest possible time of a year, a feat which has also been recognized by the Ministry. through its 4th 'National Summit on Best Practice and Innovation in Public Healthcare' in the recent past. The Committee appreciate the amendment initiated by the Government to the Maternity Benefit Act, 1961 to increase the duration of paid maternity leave to 26 weeks from 12 weeks for all women employees . The Committee also expect the Government to issue suitable guidelines without delay to make this amendment a genuinely enabling step, not only with regard to increased duration of paid maternity leave but also for other empowering provisions like 'Work from home' and 'Crèche' facility for all working mothers both in the private and public sectors of the country.

Time to eliminate the anomalies in RSBY

2.2 The Committee appreciate the efforts made by the Government to introduce Rastriya Swasthya Bima Yojana (RSBY) for the below poverty line families as well as other defined categories of unorganized workers to reduce out-of-pocket (OPP) expenditures and increase their access to healthcare facilities. Yet, the implementation of the scheme, the Committee have come across, is laden with flaws that often continue to defeat the very objectives of the scheme in the country. One of the major hindrances to the effective implementation has been the exploitation of poor beneficiaries at the hands of private hospitals empanelled under RSB, often in the form of avoidable surgeries, wrong diagnosis and hospital admissions, to name a few irregularities. Other such obstacles include awfully low enrolment percentage of households, lack of awareness among the targeted population, varied and often mixed feedbacks gathered with regard to quality and accessibility of hospitals and scant data available on the RSBY programme in the public domain for independent scrutiny and assessment by the concerned individuals and agencies. The Committee would, therefore, like to recommend that a robust mechanism for oversight be made in all the districts across the country where RSBY is now being implemented. These oversight committees should be formed with the representation of both Central and State Government functionaries, local body members and credible social service organizations down to level of each district to identify the anomalies involved with the scheme as well as to take care of the grievances of aggrieved beneficiaries. The Committee also recommend that these committees be armed with necessary legal mandate to de-empanel hospitals/Nursing Homes after taking up the issue of de-empanelment with the similar high-powered committee functional at the State level in respective States and UTs. The Committee also understand the need to make RSBY beneficiaries fully aware of the scheme, for which the Committee underline the urgency of involving Panchayati Raj Institutions (PRIs) and NGOs to spread awareness among poor patients in addition to engaging them proactively with the enrolment of eligible families. Furthermore, the Committee also desire that data/information pertaining to RSBY be made available on public platforms, both on-line and off-

line, as has been done with the scheme like NREGA, to enable independent researches and public minded individuals to better assess and evaluate the impact of the scheme for the lager benefits of the society.

Recognizing the demand of ASHAs and expanding the scope for others

2.3 The Committee recognize the roles played by Accredited Social Health Activists (ASHAs) in flagship health programmes of the Government and also as a crucial link between the pregnant women and Government health facilities to promote institutional delivery in the country. ASHA workers provide support in tracking pregnant women, facilitate timely ANCs and assist the pregnant women in availing benefits such as JSY incentive and entitlements, apart from being utilized by State Governments for conducting various surveys and grass-root implementation of health programmes in vast rural tracts of our country. The Committee also note that they are mandated to visit schools and monitor the students' health indicators as well as tracking tuberculosis cases. Yet, it is amazing that ASHAs, being mere honorary volunteers, are entitled only performance-based incentives. They have no fixed wages to fall back on as they toil from northern-most top to southern-most bottom across this huge country. The Committee, during the course of examination of the subject, have also learnt that ASHAs have persistently demanded for a fixed wage component within their remuneration in many States of the country. The Committee have realized that it is high time that the country recognize the services rendered by them. Thus, the Committee would urge the Ministry to moot a proposal for assured monthly wages not less than Rs. 3000 per month and place the same before M/o Finance for approval, in addition to the existing performance-based incentives given to each ASHA worker, recognizing their roles and adding a tad of financial comfort to their families. Moreover, the Committee also recommend that existing impediments in the way of training mechanisms meant for ASHA workers; such as dearth of competent trainers, infrastructure and equipments be taken care of on war-footing to make ASHAs competent enough to cater better to the emerging needs of health sector as they receive advanced trainings through user-friendly

modules devised by the experts in knowledge of specific need of ASHA workers. The Committee also urge upon the Government to initiate urgent interactions with those State Governments/UTs that have considerably less number of ASHA workers against the target of expected ASHA workers set by the authorities. To bridge the gaps in remote and far-off areas, the Committee would like to recommend that males and, if possible, people from the transgender communities may be recruited for the job of ASHAs as well to expand the employment opportunities in the society.

Food fortification: the novel way to reduce anemia.

2.4 The Committee are rather perturbed to know that prevalence of anemia among women is 56.2% with rural areas faring even worse with the prevalence rate of 58.2% as compared to 51.5% of urban areas in the country. This is the scenario in spite of great strides made by the country towards increasing food-grains production since mid-sixties. The Committee are also surprised that iron deficiencies have not been mitigated in women and children even though National Food Security Act came into being in 2013, besides other food entitlement programmes like ICDS, mid-day meal scheme and the Public Distribution System being in existence in the country. The Committee, therefore, think that priority of the Government has so far been on the issue of increasing the availability of food alone, rather than ensuring nutritional aspects of it, particularly the iron supplements, that could have otherwise been taken care of by the government through innovative approaches like food fortification much earlier for the advantage of our society. The Committee, here, also recall that National Summit on Fortification of Food to address interventions was held in the past. But, no significant headway has been made since then. Therefore, the Committee, strongly recommend that fortification of cereals with iron must be taken up with priority by the Government and a synergic approach between the concerned ministries is the call of the hour. The Committee cannot but lay emphasis on food fortification since it does not alter the quality and nature of foods, is not culturally resisted, can be introduced quickly, and can produce

nutritional benefits for populations in a short period of time. Moreover, it is safe and cost effective, especially if advantage is taken of the existing technology and delivery platforms. The Committee would also like to stress the 'Food Safety and Standards (Fortification of Foods) Regulations, 2016', that may be followed by the Government as the guiding principles to set the standards for food fortification and encourage the production, manufacture, distribution, sale and consumption of fortified foods in the country.

Wider reach and better monitoring of Mid-day-meal scheme

2.5 The Committee have time and again highlighted the importance of various schemes and programmes, run by both Central and State Governments, to address and mitigate the issue of malnutrition in the country. The Committee have also observed that prevalence of chronic energy deficiency among tribal children is alarmingly high even if compared to the nutritionally deficient general population in India, a fact which has also been emphasized by the reports of National Institute of Nutrition, Hyderabad and National Nutrition Monitoring Bureau. In this context, the Committee believe that as many tribal children as may be possible need to be provided with hot cooked meal on daily basis to address and reverse nutritional deficiencies in tribal communities. Therefore, the Committee recommend that privately managed schools in tribal areas as well as out-of-school tribal children, who slog away for days in agricultural fields or are involved in other menial activities in or around the villages, should be covered by the MDMS. While the private schools in tribal areas may be monitored closely by the Government functionaries as regards meaningful implementation of MDMS, the funds should be allocated as per the existing norms by the Government to the school authorities. For the out-of-school tribal children or school drop-outs, a parallel arrangement for daily cooking and serving of cooked food may be done by local Panchayats. Besides, the Committee have encountered many a complaints vis-à-vis corruption, misappropriation and stealing of MDMS finances. Though, the Committee understand, the overall responsibility to ensure full and proper utilization of available resources for serving cooked meal lies with the

State Governments/UT administrations, the Central Government, through stringent and rigorous implementation of MDMS Guidelines should ensure minimal occurrence of such inconsistencies. The Committee would like the concerned Ministry to encourage States/UTs to start initiating frequent field-visits by their officials to identify those abnormalities along with taking up MDMS audits in feasible periodicity. The Committee, thus, insist on the Ministry of Health and Family Welfare to take up the issue with the concerned authorities and forward their responses to the Committee.

Unsafe abortions: Time to act for making it safe.

2.6 While the Committee acknowledge the initiatives being taken by the Government in the direction of better obstetric care and women health, one of the issues that remains to be a festering sore is the rising incidences of unsafe abortion in India. The poor and downtrodden women and girls are not only deprived of basic sexual and reproductive health in general but also they have very poor access to safe abortion services. The Committee underscore this as the prime reason for dreadfully high percentage of abortion deaths in the country, which, according to an estimate, constitute eight percent of all maternal deaths per year in the country. Moreover, the awareness about abortion is very low and the Committee are well aware that about 80 percent of women do not know that abortion is legal in our country, hence the rampant dependence on backstreet service providers by women and girls and their families seeking termination of unwanted pregnancies. Besides, the woman must seek legal recourse if the pregnancy has gone over 20 weeks to terminate the preganancy. The Committee have also found that judicial process is so slow that the victim's pregnancy more-often-than-not crosses the legal limit and she is unable to get the abortion done, thus pushing her further to the shoddy and shabby dealings of quacks in both rural and urban areas of our country. Therefore, the Committee strongly recommend the Government to amend The Medical Termination of Pregnancy Act, 1971 to remove these weak spots and raise the permissible period of abortions to 24 weeks with this bar not applying to unborn babies having serious

abnormalities. The word 'Married' should also be done away with so that anyone can get an abortion without having to depend on sham clinics as a last recourse. The Committee expect the Government to consider other objections raised against the extant act and never to confuse the role abortions play to facilitate reproductive right of women with the abortions done during the process of selective sex selections. The Committee also desire the family planning programme to spread awareness about the legal validity of the process, campaign extensively about safe abortion services available in Government facilities and also come down hard on illegal abortion clinics mushrooming in every nook and corner of the society.

Family planning and contraception: emphasize more on high TFR States.

2.7 The Committee are happy to note basket of choice for family planning has widened in the country. This has resulted in the decline of Total Fertility Rates (TFR) in most of Indian States/UTs. Yet, the Committee feel that there is no room for complacency for the Government as the figures form high fertility districts are enough to dampen the apparent successes achieved so far. The Committee also are perturbed to note that high fertility rates are still prevailing in States of Bihar and Uttar Pradesh. The Committee also feel that these States, big ones indeed, both geographically and demographically, do have the potential to rock the boat, if the Government fail to bring down the TFR at immediate urgency. Therefore, the Committee advise the Government to draw-up special plans, specific to the needs of these States, and implement them in a mission-mode, considering the diverse rural-urban, rich-poor, socio-cultural realities manifested by deeply entrenched patriarchy in those States of the country. Best examples of family-planning adopted in other States/UTs may be remodeled and recalibrated and put to use with innovative schemes of incentives and disincentives to fulfill the objectives. Moreover, the Committee believe, this

mission can be successful only through the participation of all stakeholders, and, thus, both Central and State Governments, political, social and religious organizations, NGOs, popular figures of the society, doctors, nurses and health workers be encouraged to join hands to take the messages to the targeted communities. Hence, the Committee recommend the Ministry to draft the road-map, formulate an elaborate execution mechanism and hit the ground running within next six months to help these States catch up with other better performing States of the country.

Non-communicable diseases: need to take a leap forward

2.8 It is now a well known fact that Chronic non-communicable diseases (NCDs) have replaced communicable diseases as the most common causes of morbidity and premature mortality worldwide. The Committee are very much aware that scourge of NCDs among women population in India is showing a steady upward trend, posing a serious health challenge before the country and driving the poor families to penury as the costs borne by the affected individuals and families are exorbitant and the treatment is long term and expensive. Therefore, the Committee are pleased to note that the Government have started the National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) to address NCDs . Although, the programme was launched back in the year 2010, the efforts towards health promotion, prevention, early detection, referral services, drugs and diagnostics and adequate management leave a lot to be desired. In this regard, the Committee are of the view that operational guidelines of NPCDCS drafted by the Government have not been successfully communicated to the States. There remain distressingly low usage of services at the sub-centre and PHC levels. The Committee recommend the drugs and diagnostics to be made available either free or at very cheap prices to the people belonging to economically backward categories. The Committee would also suggest the Ministry to ensure steady supply of better-quality generic drugs to women as well as male patients visiting health facilities. The Committee strongly recommend that the Ministry should

strengthen monitoring of the programme country-wide and constantly urge States/UTs to use these guidelines as a framework to act judiciously to help communities in general and women in particular to deal better with NCDs in the country.

Mental health of women: urgent need to prioritize

2.9 There is no denying the fact that a huge population, considerable proportion among them women, suffer from mental illnesses. The Committee also feel that a deep societal prejudice, fear, stigma and ignorance often fail to recognize mental illnesses suffered by women. The Committee strongly condemn this attitude of the society and urge the Government to create awareness about mental illnesses that a woman can suffer from and provide possible remedies to it. This, the Committee feel, will help de-stigmatize mental health issues and bring more women from varied backgrounds to receive treatment and counseling in public and private healthcare facilities. The need of the hour is to have seamless co-operation between all agencies-Gram Panchayats, Panchayat Samities, Police, local administration, educational institutions, psychiatric departments, counselors, caregivers and society at large to campaign extensively about mental issues in the country. The Committee recommend that the Ministry should initiate formal talks with States/UTs to give it a formal shape in the form of a flagship programme to reach out to every vulnerable women and girls in the country to inform them about various facets of mental illnesses and the possible treatment opportunities they can avail themselves of in their respective vicinities. Thus, the Committee strongly recommend to increase percentage of total health budget spent towards mental illnesses, besides making sincere efforts towards upgrading the facilities at shelter homes as conditions of most of them are far from being satisfactory. These are to be modeled after the best performing shelter homes not only of the country but also international benchmarks. The Committee applaud the grand humane vision of the Mental Healthcare Act in ensuring various rights pertaining to mental healthcare and services for persons with mental illnesses in terms of community living, protection form cruel inhuman

and degrading treatment, equality and non-discrimination, right to information, confidentiality, restriction on release of information in respect of mental illnesses, right to access of medical records, right to personal contacts and communication, right to legal aid, right to make complaints about deficiencies in provision of services etc. The Committee are concerned at the fact that that rules pertaining to the various provisions have still not been framed. The Committee recommend that the Ministry may take proactive efforts in framing the rules and ensure that the Act is implemented in letter and spirit at the earliest. The Committee feel it bounden duty to remind the Ministry that compassion and an attitude to impact justice for the weaker and vulnerable sections is required in order to ensure that legislations are implemented in their spirit and justice reaches the last person of the society. In tune with this felt need, a comprehensive sensitization exercise with a training programme and awareness workshops be conducted by the Ministry to ensure sensitizations of front end who actually deliver services. The Committee direct the Ministry to develop a comprehensive and effective training plan, real-time feedback mechanism regarding the working of the Act in terms of access to services and inform the steps taken in this regard to the Committee.

NEW DELHI	**BIJOYA CHAKRAVARTY,**
<u>03 January, 2018</u>	**Chairperson,**
<u>13 Pausa, 1938 (Saka)</u>	**Committee on Empowerment of Women.**

Annexure –I

INSTITUTIONAL DELIVERY & MMR

State	Institutional delivery		MMR	
	2005-06 (NFHS-3)	2013-14 (RSOC)	2004-06 (SRS)	2011-13 (SRS)
Uttar Pradesh	20.6	62.1	517	285
Uttarakhand	32.6	68.5	517	285
Odisha	35.6	81.3	358	222
Bihar	19.9	65.3	371	208
Chhattisgarh	14.3	56.1	379	221
Madhya Pradesh	26.2	78.1	379	221
Rajasthan	29.6	82.7	445	244
Jharkhand	18.3	56.6	371	208
J & K	50.2	72.9	MMR not available	
Assam	22.4	74.3	490	167
Arunachal	28.5	63.7	MMR not available.	
Manipur	45.9	68.5		
Meghalaya	29.0	66.5		
Mizoram	59.8	94.1		
Nagaland	11.6	18.6		
Sikkim	47.2	86.6		
Tripura	46.9	79.5		

Annexure –II

INSTITUTIONAL DELIVERY

State	NFHS-3 (2005-06)	RSOC 2013-14	% increase
Assam	22.4	74.2	231.25
Bihar	19.9	65.3	228.14
Chhattisgarh	14.3	56.1	292.31
Jharkhand	18.3	56.6	209.29
Madhya Pradesh	26.2	78.1	198.09
Odisha	35.6	81.3	128.37
Rajasthan	29.6	82.7	179.39
Uttar Pradesh	20.6	62.1	201.46
Uttarakhand	32.6	68.5	110.12
Andhra Pradesh	64.4	91.1	41.46
Arunachal Pradesh	28.5	63.7	123.51
Delhi	58.9	83.4	41.60
Goa	92.3	99.5	7.80
Gujarat	52.7	87.9	66.79
Haryana	35.7	76.4	114.01
Himachal Pradesh	43	68.7	59.77
Jammu & Kashmir	50.2	72.9	45.22
Karnataka	64.7	92	42.19
Kerala	99.3	99.4	0.10
Maharashtra	64.6	90.3	39.78
Manipur	45.9	68.5	49.24
Meghalaya	29.0	66.5	129.31
Mizoram	59.8	94.1	57.36
Nagaland	11.6	18.6	60.34
Punjab	51.3	80.4	56.73
Sikkim	47.2	86.6	83.47

Annexure –III

STATE-WISE PREVALENCE OF ANAEMIA IN WOMEN OF REPRODUCTIVE AGE GROUP (15-49)

Sr. No.	STATES	(NFHS 3, 2005 -06)	NFHS 4 (2015-16)
1	AN Islands	NA	65.8
2	Andhra P.	62.9 (undivided)	60.2
3	Assam	69.1	46.1
4	Bihar	68.2	60.4
5	Goa	37.9	31.4
6	Haryana	55.2	63.1
7	Karnataka	50.8	44.8
8	Madhya P.	55.8	52.4
9	Maharashtra	48.0	48
10	Manipur	35.7	26.4
11	Meghalaya	45.4	56.5
12	Puducherry	NA	53.4
13	Sikkim	59.4	35.2
14	Tamil Nadu	53.1	55.4
15	Telengana	NA	56.9
16	Tripura	65.6	54.5
17	Uttarakhand	54.8	45.1
18	West Bengal	63.2	62.8

Annexure –IV

PERCENTAGE OF WOMEN HAVING BELOW NORMAL BODY MASS INDEX (BMI)

Name of the State	NFHS-III(2005-06)	NFHS-IV(2015-16)
	Percentage of Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2	Percentage of Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2
India	35.6	-
Haryana	31.4	15.8
Uttarakhand	30.0	18.4
Madhya Pradesh	41.7	28.3
Bihar	45.0	30.4
West Bengal	39.1	21.3
Assam	36.5	25.7
Manipur	14.8	8.8
Meghalaya	14.6	12.1
Sikkim	11.2	6.4
Tripura	36.9	18.9
Goa	27.9	14.7
Maharashtra	36.2	23.5
Andhra Pradesh	33.5	17.6
Karnataka	35.4	20.7
Tamil Nadu	28.4	14.6

Annexure –V

ANTE-NATAL CARE SERVICE STATUS

S.No.	States/UTs	Received at least one ANC (%) *(AS PER RSOC 2013-14)*
1.	India	85.2
2.	Andhra Pradesh	94
3.	Arunachal Pradesh	83.9
4.	Assam	93.2
5.	Bihar	84.7
6.	Chhattisgarh	95.7
7.	Goa	98.4
8.	Gujarat	88.2
9.	Haryana	80.7
10.	Himachal Pradesh	90.5
11.	Jammu & Kashmir	79.1
12.	Jharkhand	80.7
13.	Karnataka	93.7
14.	Kerala	96.2
15.	Madhya Pradesh	75.4
16.	Maharashtra	92.4
17.	Manipur	88.4
18.	Meghalaya	86
19.	Mizoram	89.9
20.	Nagaland	25.1
21.	Delhi	85.9
22.	Odisha	92
23.	Punjab	86.5
24.	Rajasthan	82.2
25.	Sikkim	99.4
26.	Tamilnadu	98.2
27.	Tripura	78.1
28.	Uttar Pradesh	61.5
29.	Uttarakhand	78.7
30.	West Bengal	98.3

Annexure –VI

POST-NATAL CARE SERVICES

Sl. No.	States/UTs	PNC (%) *(RECEIVED WITHIN 48 HOURS OF DELIVERY/DISCHARGE AS PER RSOC 13-14)*
1	India	39.2
2	Andhra Pradesh	77.9
3	Arunachal Pradesh	12.8
4	Assam	7.0
5	Bihar	6.4
6	Chhattisgarh	45.9
7	Goa	95.0
8	Gujarat	47.5
9	Haryana	23.5
10	Himachal Pradesh	13.1
11	Jammu & Kashmir	10.3
12	Jharkhand	12.7
13	Karnataka	75.6
14	Kerala	94.0
15	Madhya Pradesh	60.3
16	Maharashtra	77.1
17	Manipur	3.5
18	Meghalaya	19.0
19	Mizoram	8.1
20	Nagaland	5.6
22	Odisha	10.5
23	Punjab	15.6
24	Rajasthan	9.5
25	Sikkim	10.7
26	Tamilnadu	94.7
27	Tripura	15.9
28	Uttar Pradesh	12.1
29	Uttarakhand	12.2
30	West Bengal	9.1

Appendix I

COMMITTEE ON EMPOWERMENT OF WOMEN (2015-2016)

MINUTES OF THE FOURTH SITTING OF THE COMMITTEE HELD ON
Thursday, 18 November, 2015

The Committee sat from 1500 hrs. to 1630 hrs. in Committee Room 139, Parliament House Annexe, New Delhi.

PRESENT

Smt. Bijoya Chakravarty - **Chairperson**

MEMBERS
LOK SABHA

2. Smt. Anju Bala
3. Smt. Jyoti Dhurve
4. Smt. Rama Devi
5. Smt Bhavana Gawali
6. Smt Satabdi Roy
7. Smt. Renuka Butta

RAJYA SABHA

8. Smt. Mohsina Kidwai
9. Smt. Kanak Lata Singh
10. Shri. Bimla Kashyap Sood
12. Kahkashan Perween

SECRETARIAT

1. Smt. P.V.L.N Murthy - Joint Secretary
2. Shri S.C. Chaudhary - Director
3. Smt. Reena Gopalakrishnan - Deputy Secretary

Representatives of the Population Foundation of India, an NGO

1. Ms Poonam Mutterja - Executive Director, Population Foundation of India.
2. Ms. Sona Sharma - Addl. Director (Advocacy & Communication), Population Foundation of India.
3. Ms. Lopamudra Sanyal - Project Coordinator, Advocacy, Population Foundation of India

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have an interaction with the representatives of the NGO, Population Foundation of India, in connection with examination of the subject 'Women's Healthcare: Policy Options'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson read out Direction 55, regarding confidentiality of the proceedings. The Chairperson, in her initial remarks, reminded the impediments still stifling the progress of women's healthcare in India and also desired them to delve deep into the specific health concerns of women in the country. The issues accentuated thereon by the Hon'ble Chairperson comprised, among others, access and affordability to quality healthcare services, maternal and reproductive health, family planning and nutrition issues, mental health, HIV/AIDS awareness etc. and asked the NGO representatives to shed light on diverse policy options that might ensure better healthcare to the women in the country.

4. Thereafter, during the course of discussion, a range of issues which have direct relevance on women's healthcare formed the kernel of the deliberations. The conversations centered around, to name a few, sterilizations and its successes, training of ASHA workers, decision of women themselves in family planning choices and need for a more participative society. The representatives of the NGO also put forth their views and elaborated on successes achieved by them in ensuring and providing community medicine, community centers and community monitoring of various schemes in the country with special reference to UP and Bihar, the two states where bulk of their operations are presently underway. The issues of shortage of Doctors in the rural and district health-centers as well as the plight of patients, including women, in the face of other systemic inadequacies of healthcare facilities in the country were also discussed. The witnesses also informed the Committee about a production series, spanning about 100 episodes, on the related subjects and showed its abridged version to the Members, which the Committee was appreciative of. The queries on which the information was not readily available, the NGO was directed to furnish written replies to the Secretariat at the earliest.

[The witnesses then withdrew]

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

The Committee then adjourned.

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Appendix II

COMMITTEE ON EMPOWERMENT OF WOMEN (2015-2016)

MINUTES OF THE NINTH SITTING OF THE COMMITTEE HELD ON WEDNESDAY, 11 May, 2016

The Committee sat from 1530 hrs. to 1645 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Smt. Bijoya Chakravarty - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Anju Bala
3. Smt. Renuka Butta
4. Kum. Sushmita Dev
5. Smt. Rama Devi
6. Smt Raksha Khadse
7. Smt. Poonam Ben Hematbhai Maadam
8. Smt. Jayshreeben Patel
9. Smt. Riti Pathak
10. Smt. Rajya Laxmi Shah
11. Smt. Supriya Sule
12. Smt. Rita Tarai
13. Smt. Savitri Thakur

RAJYA SABHA

14. Smt. Vandana Chavan
15. Smt. Kahkashan Perween
16. Shri. A.V.Swamy
17. Smt. Wansuk Syiem

SECRETARIAT

1. Shri N.C.Gupta. - Joint Secretary
2. Smt. Reena Gopalakrishnan - Deputy Secretary

Representatives of MAMTA Health Institute For Mother & Child

1. Dr. Sunil Mehra - Executive Director
2. Shri Rajesh Ranjan Singh - Chief Operating Officer

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have a briefing and presentation by the representatives of the MAMTA, Health Institute for Mother & Child in connection with examination of the subject 'Women's Healthcare: Policy Options'

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson read out Direction 55 regarding confidentiality of the proceedings. In her initial remarks the Chairperson mentioned about the efforts made by successive Governments since independence to bring qualitative changes in women's healthcare schemes in the country. She observed that critical gaps continue to fester in many areas, such as, maternal and child health, communicable and non-communicable diseases and those related to reduction of mortality rates among women, tackling of HIV and TB infections, persisting nutritional deficiencies etc. A power-point presentation on the subject followed was made by the representatives of MAMTA, Health Institute for Mother & Child.

4. During the course of discussion, the issue of lack of education among marginalized women was underlined as one of the foremost reasons behind the apparent failures of such schemes. Thereafter, the dilemma of healthcare programme not reaching the targeted beneficiaries was deliberated upon, The representatives of the NGO also stressed the need to link school education with employment opportunities through skill development programmes. They highlighted that if skill development programmes are imparted along with the extension of Right to Education Act up to 18 years of age, it would arrest both incidences of child marriages and poverty, thereby ushering in wider ramifications in terms of noticeable improvements on women healthcare in the county. MAMTA, the NGO, cited its experience of working in the

State of Bihar and also in North-eastern parts of the country, viz. Assam, Manipur and Meghalaya, and they informed the Committee that they work in-collaboration with other NGOs with MAMTA providing technical and financial support to them. Further, during the discussion, the issue of Sexuality and Reproductive Health Education was raised by a Member and the NGO was of the view that sex education should be an integral part of Adolescent Education Programme in schools.

5. Other points discussed during the course of the sitting encompassed around the need for awareness campaign and early detection of cervical and breast cancers and diabetes among women. In this regard, successes achieved in Gujarat was highlighted. Moreover, the NGO particularly mentioned to the Committee regarding its contribution towards providing training to Medial officers across Indian States in collaboration with M/o Health & Family Welfare and National Institute of Health & Family Welfare in the field of adolescent healthcare and health of young people. The need for male involvement in contraception, capacity building in primary health centers for contraception techniques as well as the importance of making women empowered to enable them taking decisions about it were unequivocally addressed in the sitting. Suggestions of including Panchayat Raj Institution (PRI) members in the Village Heath & Sanitation and Village Health & Nutrition Committees were also put forward by the NGO to improve women and child nutrition along with overall family nutrition in the country.

[The witnesses then withdrew]

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

The Committee then adjourned.

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Appendix III

COMMITTEE ON EMPOWERMENT OF WOMEN (2016-2017)

MINUTES OF THE THIRD SITTING OF THE COMMITTEE HELD ON FRIDAY, 11 NOVEMBER, 2016

The Committee sat from 1130 hrs. to 1300 hrs. in Committee Room '53', Parliament House, New Delhi.

PRESENT

Smt. Bijoya Chakravarty - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Anju Bala
3. Smt. Renuka Butta
4. Smt. Rama Devi
5. Smt. Jyoti Dhurve
6. Smt. Darshanaben Jardosh
7. Smt. P.K.Sreemathi Teacher
8. Smt R.Vanaroja

RAJYA SABHA

9. Smt. Kahkashan Perween
10. Ms. Dola Sen

SECRETARIAT

1. Shri N.C.Gupta. - Joint Secretary
2. Shri T.S.Rangarajan - Director
3. Shri Khakhai Zou - Addl. Director (EW&F)

Representatives of M/o Home Affairs

1.	Ms. Leena Nair	- Secretary, M/o Women and Child Development
2.	Dr. Arun Kr. Panda	- Addl. Secretary & Mission Director, M/o Health & Family Welfare
3.	Ms. Rashmi Saxena Sahni	- Joint Secretary, M/o Women and Child Development
4.	Ms. Vandana Gurnani	- Joint Secretary, M/o Health & Family Welfare

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have a discussion with the representatives of the M/o Health & Family Welfare (Department of Health and Family Welfare) and M/o Women & Child Development in connection with examination of the subject 'Women's Healthcare: Policy Options'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson drew their attention to the provisions of 55 of the Directions by the Speaker regarding confidentiality of the proceedings. The Chairperson, in her initial remarks, touched upon the issues like impact and extent of malnutrition on women and girl children, impact of steps taken by the Government to control them so far, challenges encountered in the journey etc. She also pointed out the urgent need to tackle the bane of malnutrition through a comprehensive and effective implementation mechanism in the country.

4. While deliberating upon the issue of malnutrition, a Member sought attention to the sub-standard food given to Children in *Anganwadi* centers in the districts of U.P and wanted these food-items to be checked and inspected regularly before being served to the Children, especially, in the areas of Sitapur, Kanpur and Hardoi districts of the State. Issues of dreadful malnourishment in three districts of Odisha, namely, Kalahandi, Balangir and Korput, and death of many children there due to encephalitis, exacerbated further by instances of debilitating malnourishment, were also discussed . The Chairperson reminded the officials about the position of India as measly 97 in the global malnutrition index. Members strongly favored a robust monitoring system, auditing, in-time checks of schools and brought to light the dodgy entries that can even escape the much touted digital surveillance. Most importantly, Members emphasized the need to

standardize foods given to children through ICDS and Mid-day meal schemes to women and children. As the discussions progressed, threads of more complex issues like inter-connectedness between malnutrition and anemia, child marriages, stunted growth of children emerged reflecting on the intricacies of the subject.

5. During the further course of discussion, the representatives of the Ministry rather candidly conceded lack of synergies between multiple Ministries/Departments to tackle the menace of malnutrition in the country. Later, the representatives of the Ministry also informed the Committee Members about the on-going process of digitization to tackle the problems of monitoring and of 'National Nutrition Mission', that is yet to be approved by the Cabinet. Furthermore, they talked of doing away with the old practice of maintaining of registers, replacing it with new-age gadgets that will present manifold benefits like enhancing the attendance of workers on ground, making the procedures easy and rooting out falsehood and anomalies form the whole system. On a positive note, the representatives of the Ministry put forth the benefits ensured by 'National Iron Plus Initiative' and 'Mother's Absolute Affection' programmes as well as 965 Nutrition Rehabilitation Centers in district hospitals and some of the community health centers. The Committee Members were also told about a joint initiative between two Ministries, whereby 'Village Health and Nutrition Days' are being organized for mother and child protection with regard to addressing malnutrition and issues involved therein. In addition, facets of different inter-linked subjects, such as, 'National Iodine and Salt Survey', emergent need for food fortification, PMs 'Safe Motherhood Programme', 'Mother and Child Tracking System' (MCTS) etc. were deliberated upon.

[The witnesses then withdrew]

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

The Committee then adjourned.

Appendix IV

COMMITTEE ON EMPOWERMENT OF WOMEN (2016-2017)

MINUTES OF THE TENTH SITTING OF THE COMMITTEE HELD ON FRIDAY, 02 JUNE, 2017

The Committee sat from 1500 hrs. to 1645 hrs. in Committee Room 'A', Ground Floor, Parliament House Annexe, New Delhi.

PRESENT

Smt. Bijoya Chakravarty - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Anju Bala
3. Smt. Rama Devi
4. Smt. Jyoti Dhurve
5. Smt. Bhawna Gawali
6. Smt. Rita Tarai
7. Smt. P.K.Sreemathi Teacher
8. Smt. Savitri Thakur
9. Smt. R.Vanaroja

RAJYA SABHA

10. Smt. Vandana Chavan
11. Smt. Rajani Patil
12. Smt. Kahkashan Perween
13. Ms. Dola Sen
14. Shri A.V.Swamy

SECRETARIAT

1. Shri N.C. Gupta. - Joint Secretary
2. Shri T.S. Rangarajan - Director

Representatives of the M/o Health & Family Welfare

1. Shri C.K. Mishra - Secretary
2. Dr. Arun Kumar Panda - Additional Secretary
3. Ms. Vandana Gurnani - Joint Secretary

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have oral evidence of the M/o Health & Family Welfare in connection with the examination of the subject 'Women's Healthcare: Policy Options'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson drew their attention to the provisions 55 of the Directions by the Speaker regarding confidentiality of the proceedings. The Chairperson, though, in her initial remarks expressed satisfaction over the increased attention over women's healthcare, yet she underlined the long road that is yet to be covered before a comprehensive, equitable and accessible healthcare is made available to women in the country.

4. While deliberating upon the issue, representatives of the Ministry put forth some encouraging facts in relation to reduction in Maternal Mortality Rate (MMR), increase in institutional deliveries and also referred to schemes like Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram in bringing overall benefits to maternal and child health in the country. Other issues the representatives of the Ministry touched upon were Mission Indradhanush, RMNCH+A, National Iron Plus Initiative, Pradhan Mantri Surakshit Matritya Abhiyan, Mothers Absolute Affection for breast feeding, referral transports, 'Kilkari', Mission Pariwar Vikas, universal screening for hypertension, diabetes, cervical cancer, breast cancer and oral cancer, 24x7 maternity child wards as well as National Health Policy, HIV Bill, Mental Health Bill etc to factor in concerns of women healthcare in the country.

5. During further course of discussion, the Committee reminded the Ministry about the pressing issues like increasing trend towards C-section deliveries, need for innovative family planning schemes and

monitoring of resources made available by the Centre to the states, employment of Ambulance drivers in rural and remote areas, food fortification and prevalence of HIV/AIDS in the country.

6. Responding to the issues raised, the representatives of the Ministry apprised the Committee of the responsibility of states to recruit drivers for ambulances, 'Test & Treat' policy adopted by the Governments for treatment of patients suffering from HIV/AIDS in the country, successes achieved through Pre-conception and Pre-natal Diagnostic Technique Act, 1994 to curb female foeticides as well as initiatives taken by the Ministry towards food-fortification and provision of low-cost sanitary napkins to girls in high-schools. The Ministry also apprised the Committee of the successes achieved in tackling AIDS. The global average decline of AIDS related deaths is 41% since 2006, while our country has achieved a decline of 54%. The NACO model, which is community driven, has been appreciated for its effectiveness the world over. The Committee was also informed about an unique experience gathered from the state of Nagaland where village level traditional home-deliveries match the competencies and skills of institutional deliveries to make Nagaland among the lowest on MMR in the country. The Ministry promised to send written replies to the questions on which facts and figures were not readily available during the meeting.

[The witnesses then withdrew]

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

The Committee then adjourned.

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Appendix V

COMMITTEE ON EMPOWERMENT OF WOMEN (2017-2018)

MINUTES OF THE FOURTH SITTING OF THE COMMITTEE HELD ON THRUSDAY, 21 DECEMBER, 2017

The Committee sat from 1500 hrs. to 1530 hrs. in Chairperson's Chamber, Parliament House Annexe, New Delhi.

PRESENT

Smt. Bijoya Chakravarty - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Anju Bala
3. Smt. Renuka Butta
4. Smt. Jyoti Dhurve
5. Smt. Jayshreeben Patel
6. Smt. Riti Pathak
7. Smt. P.K.Sreemathi Teacher
8. Smt. Darshanaben Jardosh
9. Smt. Sushmita Dev
10. Smt Supriya Sule
11. Smt Satabdi Roy (Banerjee)
12. Smt. Mala Rajya Laxmi Shah
13. Smt Savitri Thakur

RAJYA SABHA

14. Smt. Vandana Chavan
15. Smt. Rajani Patil
16. Ms. Dola Sen

SECRETARIAT

1. Shri N.C. Gupta. - Joint Secretary
2. Shri T.S. Rangarajan - Director

2. At the outset, the Chairperson welcomed the members to the sitting of the Committee. The Committee thereafter took up for consideration the Draft Report on the subject 'Women's Healthcare : Policy Options'. After discussing the Draft Report in detail, the Committee adopted the Draft Report without modifications.

3. The Committee also authorized the Chairperson to finalize the Draft Report and present the same to both the Houses of Parliament

The Committee, then, adjourned.

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