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PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN
(2020-2021)

(SEVENTEENTH LOK SABHA)

'WOMEN'S HEALTHCARE: POLICY OPTIONS'

[*Action Taken by the Government on the recommendations contained in the Eleventh Report (Sixteenth Lok Sabha) of the Committee on Empowerment of Women (2017-2018) on 'Women's Healthcare: Policy Options'*]

FOURTH REPORT

सत्यमेव जयते

LOK SABHA SECRETARIAT
NEW DELHI

February, 2021*/ Magha, *1942 (Saka)

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Presented to Lok Sabha on ……., 2021

Laid in Rajya Sabha on ……., 2021

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INTRODUCTION

I, the Chairperson, Committee on Empowerment of Women, having been authorized by the Committee to submit the Report on their behalf, present this Fourth Report (Seventeenth Lok Sabha) on the action taken by the Government on the recommendations contained in their Eleventh Report (Sixteenth Lok Sabha) on 'Women's Healthcare: Policy Options'.

2. The Eleventh Report of the Committee on Empowerment of Women was presented to Lok Sabha and laid in Rajya Sabha on 3rd January, 2018. The Ministry of Health and Family Welfare has furnished the action taken replies to all the Observations/Recommendations contained in the Report.

3. The Committee on Empowerment of Women (2020-21) considered and adopted the Draft Action Taken Report at their sitting held on 9th February, 2021. Minutes of the sitting are given at Annexure-I.

4. An analysis of the action taken by the Government on the recommendations contained in Eleventh Report (Sixteenth Lok Sabha) of the Committee is given in Appendix II.

5. For facility of reference and convenience, the Observations and Recommendations of the Committee have been printed in bold letters in the body of the Report.

NEW DELHI;
09 February, 2021
20Magha,1942, (Saka)

DR. HEENA VIJAYKUMAR GAVIT,
Chairperson,
Committee on Empowerment of Women.

REPORT

CHAPTER I

This Report of the Committee on Empowerment of Women deals with the Action Taken by the Government on the Observations/Recommendations contained in the Eleventh Report (Sixteenth Lok Sabha) of the Committee on the subject 'Women's Health Care : Policy Options'. The Observations/ Recommendations in this Report pertain to the Ministry of Health and Family Welfare.

2. The Eleventh Report of the Committee was presented to Lok Sabha on 3rd January, 2018 and was simultaneously laid in Rajya Sabha on the same day.

3. Action Taken Replies in respect of all the 09 observations/ recommendations contained in the Report have been received from the Government. These have been examined and categorized as follows:-

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

Recommendation Para Nos.: 2.1, 2.2, 2.4, 2.6, 2.7 and 2.8

Total: 06
Chapter-II

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

Recommendation Para No.: NIL

Total: NIL
Chapter-III

(iii) Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee and which require reiteration:

Recommendation Para Nos: 2.3 and 2.5

Total: 2
Chapter-IV

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

Recommendation Para No. 2.9

Total: 01
Chapter-V

4. The Committee trust that utmost importance would be given by the Government to the implementation of their recommendations. In case where it is not possible for the Government to implement the recommendations in letter and spirit for any reasons, the matter should be reported to the Committee with reasons for non-implementation. The Committee further desire that the Final Action Taken Notes on the recommendations/observations contained in Chapter-I of this Report may be furnished to the Committee within three months of the presentation of this Report.

5. The Committee will now deal with those actions taken replies of the Government, which need reiteration or meritcomments.

A. Need to create pre-delivery hubs in remoteareas

Recommendation (Para No. 2.1)

6. The Committee in their Original Report recommended as under:-

"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 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 attendants and given medicine and diet appropriate to the health needs of the pregnant mother. 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 far-flung areas of Sunderbans, like Gosaba, PatharPratima 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, 1961to 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 delayto make this amendment a genuinely enablingstep, 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."

7. The Ministry of Health and Family Welfare, in their action taken reply on the aforementioned recommendation stated as under:-

> "1. The Government of India has taken necessary action in this regard by making provision for releasing funds to states/UTs in the Project implementation plan (PIP) for establishing 'pre delivery huts/ Birth waiting homes'. Currently, such huts are established in 7 states namely, West Bengal, Odisha, Kerala, Chhattisgarh, Telangana, Gujarat and Andhra Pradesh with intent to reduce the out-of-pocket expenses and reduce maternal deaths and other intrapartum complications due to en-route delays and other associated difficulties. Health being a State subject, the primary responsibility of ensuring availability of essential medicines, diagnostics, diagnostic tests and medical equipment in public health facilities lies with the respective state. Government of India plays a supportive role in implementation of various programmes.
>
> 2. Provision of funds to states under NHM for providing patient transport ambulances services using alternative models e.g. 108/102 is one of the hallmarks of NHM. Currently (as of Dec 2019) a total of 26368 ambulances are providing services out of which 10139 ambulances under '108', 10730 under '102' and 5499 other patient transport ambulances are providing transport service to pregnant women and children.

3. Under JSSK, following free referral transport entitlements are provided to pregnant women and sick infantsupto one year: transport from home to the health facility, referral to the higher facility in case of need, and drop back from the facility to home.

4. The provisions of the Maternity Benefit Act, 1961 are enforced and implemented by the respective State Governments in all sectors except in the Mines and Circus. Time to time, advisories are issued to State Governments for strict enforcement and compliance of the provisions of the Maternity Benefit Act, 1961.

Ministry of Labour & Employment in its Advisory dated 12.04.2017 to State/Union Territories, informed about the enactment of the Maternity Benefit (Amendment) Act, 2017 and the provisions that have been added to the Maternity benefit Act, 1961, including increased duration of paid maternity leave, work from home and 'Crèche' facility. In the advisory, clarifications to some of the queries received in the Ministry relating provisions of the Act have also been provided. States/UTs have been asked to make a note of the clarifications for compliance and circulate widely so as to make the pregnant working women aware of their rights. Another Advisory dated 17.11.2017 relate to taking action to frame and notify Rules for Creche facilities. Copies of these Advisories are annexed at I and II.

The Ministry of Health & Family Welfare has also decided to extend the provision of Maternity Leave, as per Maternity Benefit (Amendment), Act 2017, to all female Consultants working under National Health Mission(NHM)/ National Health System Resource Centre (NHSRC) on Contractual basis (under one year contract), for a period of 26 weeks or till the completion of their contract period whichever is earlier, subject to the condition that the female Consultant should have worked 80 days in last 12 months prior to proceeding on Maternity leave. The Maternity Leave will be fully paid leave, which will be in addition to one month leave being provided to the Consultants at present. The Consultants will be entitled to avail the extended provision of Maternity Leave with effect from the year 2020-21, as per terms & conditions of their contract. In this regard Letter No. Z.18015/21/2017-NHM-II/NHM-I dated 11th June, 2020 annexed at III".

Comments of the Committee

8. In order to reduce maternal/infant mortality rate, out-of-pocket expenses for poor and marginalized families, health complications due to en- route delays in travel to hospital and other associated difficulties, the Committee in their original report had recommended to build 'Pre-delivery hubs', for pregnant women where they could be brought much before the date of delivery and given proper diet and medical care. The Committee also desired the Government to issue suitable guidelines under Maternity Benefit (Amendment), Act 2017 regarding increased duration of paid maternity leave,

'Work from home' , and 'Crèche' facility for all working mothers both in the private and public sectors of the country.

The Ministry in its reply has informed that Government of India has made provision for releasing funds to States/UTs in the Project Implementation Plan (PIP) for establishing 'pre delivery huts/ Birth waiting homes' and presently such pre delivery huts have been established in 07 states namely, West Bengal, Odisha, Kerela, Chhattisgarh, Telangana, Gujarat and Andhra Pradesh. The Ministry has also informed that the Ministry of Labour & Employment in its Advisory dated 12.04.2017 to State/Union Territories, informed about the enactment of the Maternity Benefit (Amendment) Act, 2017 and the provisions that have been added to the Maternity benefit Act, 1961, including increased duration of paid maternity leave, work from home and 'Crèche' facility. The Ministry of Health & Family Welfare has also decided to extend the provision of Maternity Leave, as per Maternity Benefit (Amendment), Act 2017, to all female Consultants working under National Health Mission(NHM)/ National Health System Resource Centre (NHSRC) on Contractual basis (under one year contract), for a period of 26 weeks or till the completion of their contract period whichever is earlier.

The Committee appreciate the steps taken by Ministry on their recommendation to release funds for establishing 'pre-delivery hubs' and are happy to note that such hubs have been established in 07 states. At the same time, Committee desire the Ministry to ensure that such hubs are established in all the remaining 22 states of country so that the benefit of this healthcare facility reach the maximum would-be mothers. They also desire to be apprised of the number of women beneficiaries who have availed the facility of 'pre- delivery hubs' in various States.

Further, the Committee are happy to learn about enactment and enforcement of provisions of the Maternity Benefit Act, 1961 in almost all sectors and the issuance of advisory by Ministry of Labour and Employment about enactment of the Maternity Benefit (Amendment) Act, 2017 and the provisions like increased duration of paid maternity leave, work from home and 'Crèche' facility that have been added to the Maternity benefit Act, 1961. The Committee also appreciate the efforts of the Ministry of Health & Family Welfare in extending additional maternity benefits to female Consultants working under NHM/ NHSRC on contractual basis. In this regard, the

Committee would like to be apprised about the number of contractual women who have availed the said benefits since the enactment of Maternity Benefit (Amendment) Act, 2017) .

B. Recognizing the demand of ASHAs and expanding the scope for others

Recommendation (Para No.2.3)

9. The Committee in their Original Report recommended as under:-

"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 are made to understand that the ASHAs are mandated to visit schools and monitor the students' health indicators as well as tracking tuberculosis cases. Yet, the Committee are rather amazed to know 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 across the length and breadth of 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 are of the firm view 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 having domain knowledge on 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".

10. The Ministry of Health and Family Welfare, in their action taken reply on the aforementioned recommendation stated as under:-

"The Parliamentary committee on empowerment of women has acknowledged the role of the ASHAs in pregnancy and safe delivery, in enabling entitlements, in TB and school health, besides being used by the State/UT governments for undertaking surveys, etc. ASHAs are also involved in range of other tasks related to newborns, children, care for chronic diseases, etc.

Public Health and Hospitals being a State subject, the implementation of ASHA program including the payment is done by the respective State/UT Governments.

Under National Health Mission, ASHAs are envisaged to be community health volunteers and are entitled only to task/activity based incentives. The fixed monthly incentive amount to ASHAs finalized at the national level, are regularly reviewed bythe Central Government and activities for which ASHAs will get incentives are expanded from time to time. However, the States/UTs also have flexibility to decide on type of incentive to be given to ASHAs as per specific context/need in addition to routine and recurring incentives under National Health Mission.

Further, in the year 2018, the ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package included

- Revision of routine and recurring incentives amount from Rs. 1000 pm to Rs. 2000 pm.
- Extending benefits of Life insurance, accident insurance and pension to eligible ASHAs and ASHA facilitators by enrolling eligible ASHAs and AFs under:-
    - Pradhan Mantri Jeevan Jyoti BeemaYojana (premium of Rs. 330 contributed by GOI)
    - Pradhan Mantri Suraksha BeemaYojana (premium of Rs. 12 contributed by GOI)
    - Pradhan Mantri Shram Yogi Maan Dhan (50% contribution of premium by GOI and 50% by beneficiaries)

List of ASHA incentives and Social Security Measures are at Annexure IV

An additional incentive of Rs. 1000 per month per ASHA and Rs. 500 per month per ASHA Facilitator has also been provisioned under NHM till June 30, 2020File No.Z-18015/4/2020-NHM-II(Part-IV)as appreciation for work done

by ASHAs and ASHA Facilitators in prevention and management of COVID-19 pandemic ,often going beyond the call of duty to support the community and health system, while also responding to their routine out reach activities. The EFC proposal to extend this incentive till 31/3/2021 looking into the current situation of situation of COVID 19 pandemic has already been processed by MoHFW.

Regarding the observation of the Parliamentary Committee related to the provision of sufficient number of trainers, infrastructure and equipment for training of ASHA and ASHA Facilitators, a tripartite MOU was signed between National Institute of Open Schooling (NIOS), Ministry of Health and Family Welfare (MoHFW) and National Health Systems Resource Centre (NHSRC) in 2014. The programme encompasses the following - Standardization of training curriculum, accreditation of training sites and certification of trainers and ASHAs and ASHA Facilitators. Refresher trainings are also arranged to ensure rendering of quality services by the ASHAs. Financial and technical support for trainers, training infrastructure and ensuring necessary training equipment is provided to the States/UTs through the NHM, @ the rate of Rs. 16,000 per ASHA per year to cover all these costs. National Health Systems Resource Centre (NHSRC) has been instrumental in sharing the training resource material related to ASHA training with the States/UTs. Recently, ASHAs were also provided training material and training regarding role in COVID 19pandemic alongwith various DOs and Donts in this regard.

Regarding filling up vacant positions of ASHAs, regular review on this issue is taken regularly by the Centre with the States/UTs during NHM review meetings, Common Review Mission (CRM) briefings, National Programme Coordination Committee (NPCC) meeting. The norms for selection of ASHA are relaxed for tribal and hilly areas so that the vacant positions can be filled. As per ASHA update, July2019 data of NHSRC, 96% (rural) and 85% (urban) of positions of ASHAs are filled. The details are attached at Annexure V

With the advent of the Ayushman Bharat – Health & Wellness Centre (AB-HWC) programme, the MOHFW is providing states with a male health worker, tocreate a primary health care team at the HWC level. The team at the health and wellness centre at the sub centre level comprises of a Community Health Officer, a Male multipurpose worker, a female multipurpose worker, and five ASHAs. Regarding recruiting ASHA also from the transgender community the suggestion of the committee is noted".

Comments of the Committee

11. Recognising the significant contribution of ASHA workers in the health programmes of government especially, women healthcare, the Committee had urged the Government to put up a proposal before the Ministry of Finance for assured

monthly wages not less than 3000/- per month for ASHA workers in addition to the existing performance based incentives given to them. The Committee had also recommended for advanced level training for ASHA workers and to fill up vacancies by recruiting of males and if possible, people from transgender community.

In reply, the Committee have been informed that the incentives for ASHA workers under National Health Mission under various heads have been increased from the year 2018. However, the Committee are constrained to note that that the Ministry's reply is silent on the proposal of assured monthly wages for ASHA workers. In view of the commendable work of ASHA workers in Government Health Programmes, the Committee reiterate their earlier recommendation and urge the Ministry to moot a proposal for assured monthly wages not less than Rs. 3000 per month and place the same before the Ministry of Finance for approval. This wages would be 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.

As regards filling up of the positions of ASHAs, the Committee are not happy that about 15% vacancies are still there in urban areas and 4% in rural areas. The Committee, therefore, reiterate that the State Governments/UTs that have considerably less number of ASHA workers against the set target may be urged to expedite steps to fill all vacancies including recruits from the transgender community also under intimation to this Committee.

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

Recommendation (Para No.2.5)

12. The Committee in their Original Report recommended as under:-

"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 private 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 regular 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".

13. The Ministry of Health and Family Welfare, in their action taken reply on the aforementioned recommendation stated as under:-

"The National Programme of Mid-Day Meal in Schools, popularly known as the Mid-Day Meal Scheme (MDMS), is an on-going Centrally-Sponsored Scheme which covers all school children studying in Classes I-VIII of Government, Government-Aided Schools, Special Training Centres including Madarsas and Maqtabs supported under SamagraShiksha. The objectives of the Mid-Day Meal Scheme are to address two of the pressing problems for majority of children in India, viz. hunger and education by:

i. Improving the nutritional status of children studying in classes I – VIII.
ii Encouraging poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities.
iii Providing nutritional support to children of elementary stage in drought-affected areas during summer vacation.

2. However, the suggestion of the Committee regarding coverage of privately managed schools in tribal areas as well as out of school tribal children under MDMS have been noted and the States and UTs will be consulted in the matter.

3. It may also be mentioned that the Government has adopted an elaborate monitoring mechanism at Central, State and District levels to ensure quality food is served to children under the Scheme. At national level, an Empowered Committee,

headed by Minister of Human Resource Development and also a National level Steering-cum-Monitoring Committee (NSMC) as well as Programme Approval Board (PAB) monitor the scheme and suggest measures for its smooth and effective implementation. At the State level, a State level Steering–cum-Monitoring Committee headed by the State Chief Secretary and, at the District Level, a District Level Committee under the Chairpersonship of the senior-most Member of Parliament of Lok Sabha from the district monitors the implementation of the scheme. At local level Gram Panchayats/Gram Sabhas, members of Village Education Committees (VECs), Parent-Teacher Associations (PTAs) and the School Management Committees (SMCs) monitor the regularity and wholesomeness of the mid-day meal served to children, cleanliness in cooking and serving of the meal, timeliness in procurement of good quality ingredients, fuel, etc., implementation of variety in menu so as to make it attractive to children and ensuring social and gender equity on daily basis. In addition to directing States and UTs to carry out Social Audit, the Centre constitutes Joint Review Missions (JRMs) to review the scheme through field visits from time to time".

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Comments of the Committee

14. In order to address and mitigate the issue of malnutrition among the children of tribal community, the Committee had recommended to cover private schools in tribal areas as well as out of school tribal children under Mid-Day-Meal Scheme (MDMS). In this regard, it has been informed that the recommendation has been noted by the Ministry and the States and UTs would be consulted in the matter. The Committee find the response of the Ministry lackadaisical in nature and feel that if the Ministry were serious about the recommendation, the consultations in this regard should have been completed within the prescribed time lines before furnishing their response to the Committee. The Committee at this stage can only assert that their recommendation be taken up at top most priority and action taken be intimated to the committee at the earliest.

D. Mental health of women: urgent need to prioritize

Recommendation (Para No.2.9)

15. The Committee in their Original Report recommended as under:-

"There is no denying the fact that a huge population, considerable proportion among them women, suffer from mental illness. The Committee also feel that ours is largely an insensate society where deep societal prejudices, fear, stigma and ignorance often fail to recognize mental illnesses suffered by women within the confines of home and beyond. The Committee strongly condemn this attitude of the society and urge the Government to talk

relentlessly about mental illnesses that a woman can suffer in and the 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 counselling 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, counsellors, 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 illness, 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 modelled after the better-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".

16. The Ministry of Health and Family Welfare, in their action taken reply on the aforementioned recommendation stated as under:-

"The Government of India is proactively taking various initiatives for delivery of quality mental health services in the country. Initiatives of the Government are meant for all who are in need of mental health support, irrespective of gender, caste or religion.

To address the challenge of mental illnesses, the Government is implementing the National Mental Health Programme (NMHP) in the country. Under NMHP, implementation of the District Mental Health Programme (DMHP) has been approved for 655 districts of the country for early detection and management of mental disorders/illnesses. The activities covered under the DMHP also include targeted interventions like work place stress management, suicide prevention activities, life skills training, counselling in schools and colleges, community awareness generation activities and imparting short term training to various categories of healthcare workers. Information, Education and Communication (IEC) activities are an integral part of DMHP to generate awareness among masses towards mental illness. At the District level, funds up to Rs. 4 lakh are provided to each District under DMHP for IEC and awareness generation activities.

With the objective to address the shortage of qualified mental health professionals in the country, the Government is implementing Manpower Development Schemes for establishment of Centres of Excellence and strengthening/ establishment of Post Graduate (PG) Departments in mental health specialties. Till date, support has been provided for establishment of 25 Centres of Excellence and strengthening/establishment of 47 Post Graduate (PG) Departments in mental health specialties in the country. Tertiary level mental healthcare facilities are provided through dedicated Mental Health Institutions as well as Medical Colleges run by Central and State Governments. In addition to the Manpower Development Schemes of NMHP, the Government is also augmenting the availability of manpower to deliver mental healthcare services in the underserved areas of the country by providing online training courses to various healthcare service providers like medical officers, psychologists, social workers and nurses to deliver quality mental healthcare services throughout the country through the Digital Academies established at the three Central Mental Health Institutes.

The Mental Healthcare Act, 2017 came into force w.e.f. 29/05/2018. Objective of the Act is to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services. The Act has separate provisions for addressing specific needs of women receiving care and treatment in a mental health establishment, sensitization and training of Government Officials, including police officers about provisions of the Act, and to reduce stigma associated with mental illness. Provisions of the Act are to be implemented primarily by the State Governments. As per the provisions of the Act, the State Governments are required to take certain actions like framing of Rules and Regulations, establishment of State Mental Health Authorities, creation of State Mental Health Authorities Funds, establishment of Mental Health

Review Boards. The State Governments are also required to take necessary steps to integrate mental health services into general healthcare services at all levels of healthcare including primary, secondary and tertiary healthcare and in all health programmes run by the Government. MoHFW vide various D.O. letters has requested all the States/UT Governments to take necessary action for implementation of the Act. Till date State Mental Health Authority has been established in 20 States/UTs. As contemplated under the Act, the Central Government has framed Central Mental Health Authority and Mental Health Review Boards Rules, State Mental Health Authority Rules and Rights of Persons with Mental Illness Rules which came into force w.e.f. 29/05/2018".

Comments of the Committee

17. In order to create awareness to de-stigmatize mental health issues which women suffer, Committee in their original report had urged the Ministry to initiate flagship programmes in co ordination with State/UTs so that every vulnerable woman and girl be made aware of mental illness and its possible treatment in their vicinity. The Committee also recommended increase in Health Budget for this purpose and to frame rules under the Mental Health Act to make it really effective for women and girls who are the most vulnerable and don't generally discuss their mental health problems due to fear and stigma.

The Committee are happy to note that Government is implementing the National Mental Health Programme (NMHP) in the country under which implementation of the District Mental Health Programme has been approved for 655 districts in the country for early detection and management of mental disorder/illness. Though an amount of Rs 4 lac has been allocated per District of the country towards mental health programme under District Mental Health Programme (DMHP) for Education and Communication (IEC) the Committee feel that proactive hands on approach and timely interventions are the need of the hour.

Though, the Central Government has framed Central Mental Health Authority and Mental Health Review Boards Rules, State Mental Health Authority Rules and Rights of Persons with Mental Illness Rules as contemplated under the Mental Healthcare Act, 2017, the Committee note that the Ministry is silent on the recommendation of the Committee to increase the percentage of total health budget spent towards mental illness, besides upgrading the facilities at shelter homes. Instead, the Ministry has simply repeated their existing programmes putting the entire onus on the State governments for their implementation. Evidently, this does not reach finality and also does not serve any purpose as far as sensitive action on

the recommendations of the Committee is concerned. Without any specific data on how mentally ill persons, especially the women, have benefitted from the measures taken by the Central Government and the number of women rehabilitated, the Committee are helpless in understanding the ground situation in the country. The Committee, therefore, desire that the Ministry may come out with a comprehensive final reply/ action plan on these issues within three months of presentation of this report.

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

Need to create pre-delivery hubs in remote areas

(Recommendation No. 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 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 attendants and given medicine and diet appropriate to the health needs of the pregnant mother. 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 far-flung areas of Sunderbans, like Gosaba, PatharPratima 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.

Replies of the Ministry Health and Family Welfare

1. The Government of India has taken necessary action in this regard by making provision for releasing funds to states/UTs in the Project implementation plan (PIP) for establishing ‘pre delivery huts/ Birth waiting homes’. Currently, such huts are established in 7 states namely, West Bengal, Odisha, Kerala, Chhattisgarh, Telangana, Gujarat and Andhra Pradesh with intent to reduce the out-of-pocket expenses and reduce maternal deaths and other intrapartum complications due to en-route delays and other associated difficulties. Health being a State subject, the primary responsibility of ensuring availability of essential medicines, diagnostics, diagnostic tests and medical equipment in public health facilities lies with the respective state. Government of India plays a supportive role in implementation of various programmes.

2. Provision of funds to states under NHM for providing patient transport ambulances services using alternative models e.g. 108/102 is one of the hallmarks of NHM. Currently (as of Dec 2019) a total of 26368 ambulances are providing services out of which 10139 ambulances under ‘108’, 10730 under ‘102’ and 5499 other patient transport ambulances are providing transport service to pregnant women and children.

3. Under JSSK, following free referral transport entitlements are provided to pregnant women and sick infantsupto one year: transport from home to the health facility, referral to the higher facility in case of need, and drop back from the facility to home.

4. The provisions of the Maternity Benefit Act, 1961 are enforced and implemented by the respective State Governments in all sectors except in the Mines and Circus. Time to time, advisories are issued to State Governments for strict enforcement and compliance of the provisions of the Maternity Benefit Act, 1961.

Ministry of Labour & Employment in its Advisory dated 12.04.2017 to State/Union Territories, informed about the enactment of the Maternity Benefit (Amendment) Act, 2017 and the provisions that have been added to the Maternity benefit Act, 1961, including increased duration of paid maternity leave, work from home and 'Crèche' facility. In the advisory, clarifications to some of the queries received in the Ministry relating provisions of the Act have also been provided. States/UTs have been asked to make a note of the clarifications for compliance and circulate widely so as to make the pregnant working women aware of their rights. Another Advisory dated 17.11.2017 relate to taking action to frame and notify Rules for Creche facilities. Copies of these Advisories are annexed at I and II.

The Ministry of Health & Family Welfare has also decided to extend the provision of Maternity Leave, as per Maternity Benefit (Amendment), Act 2017, to all female Consultants working under National Health Mission(NHM)/ National Health System Resource Centre (NHSRC) on Contractual basis (under one year contract), for a period of 26 weeks or till the completion of their contract period whichever is earlier, subject to the condition that the female Consultant should have worked 80 days in last 12 months prior to proceeding on Maternity leave. The Maternity Leave will be fully paid leave, which will be in addition to one month leave being

provided to the Consultants at present. The Consultants will be entitled to avail the extended provision of Maternity Leave with effect from the year 2020-21, as per terms & conditions of their contract. In this regard Letter No. Z.18015/21/2017-NHM-II/NHM-I dated 11th June, 2020 annexed at III.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Recommendation of the Committee

(Please see para 8 of Chapter I of the Report

Time to eliminate the anomalies in RSBY

Recommendation (Para No.2.2)

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The Committee appreciate the efforts made by the Government tointroduce RastriyaSwasthyaBimaYojana (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, over-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 on 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.".

Replies of the Ministry Health and Family Welfare

Recommendations the Committee	Action taken update
The Committee appreciates the efforts made by the Government to introduce RastriyaSwasthyaBimaYojana (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 RSBY, 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. a. The Committee would, therefore, like to recommend that a robust mechanism for oversight be made	RashtriyaSwasthyaBimaYojana was subsumed within Ayushman Bharat Pradhan Mantri Jan ArogyaYojana (AB PM-JAY) when it was launched on 23rd September 2018. Ayushman Bharat PM-JAY is the largest health assurance scheme in the world which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.74 crores poor and vulnerable families (approximately 50 crore beneficiaries) that form the bottom 40% of the Indian population. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively. PM-JAY was earlier known as the National Health Protection Scheme (NHPS) before being rechristened. It subsumed the then existing RashtriyaSwasthyaBimaYojana (RSBY) which had been launched in 2008. The coverage mentioned under PM-JAY, therefore, also includes families that were covered in RSBY but are not present in the SECC 2011 database. 32 States and UTs are currently implementing AB PM-JAY. a. AB PMJAY has a three-tier grievance redressal structure to ensure timely redressal of grievances consisting of District, State and National level Grievance Redressal Committees. These

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. b. 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. c. 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	committees are represented by Government officials and investigate the grievances of all aggrieved stakeholders. Grievance can be registered by calling on the 24/7 call centre, online through web-portal (https://cgrms.pmjay.gov.in) or in physically by visiting the district, State or national office. b. For providing the benefits envisaged under the Mission, the State Health Agency (SHA) through State Empanelment Committee (SEC), chaired by the Chief Executive Officer of the State Health Agency will empanel or cause to empanel private and public health care service providers and facilities in their respective State/UTs as per these guidelines. The States are free to decide the mode of verification of empanelment application by conducting the physical verification through District Empanelment Committee (DEC). Process for Disciplinary Proceedings and De-Empanelment comes under the purview of these Committees. Penalties may be recommended by DEC and the SEC may inflict larger or smaller penalties depending on the severity/ regularity/ scale/ intentionality on a case to case basis with reasons mentioned clearly in a speaking order. The penalties by the hospital will be paid to the SHA in all the cases. c. AB PM-JAY is an entitlement-based scheme against RSBY which was enrolment based. However, as spreading awareness is required for empowering the beneficiaries, NHA has detailed IEC guidelines and beneficiary empowerment guidebook. d. The AB PM-JAY eligible beneficiary data is available online for searching eligibility. Anyone can log onto either at https://mera.pmjay.gov.in or call the

the enrolment of eligible families. d. 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.	helpline 14555 to check their eligibility. In addition, AB PM-JAY has a public dashboard available at https://pmjay.gov.in/ where utilisation related data is available at State level and district level.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Food fortification: the novel way to reduce anemia

Recommendation (Para No.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 urban areas with 51.5% 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.

Replies of the Ministry Health and Family Welfare

Ref. No	Reference Para	ATR by FSSAI
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.	FSSAI has taken the lead on Food Fortification and the following is the Action Taken Report since the National Summit on Fortification of Food was held in 2016: **Regulatory Support** **1.** Food Safety and Standards Authority of India (FSSAI) has gazette notified the **Food Safety and Standards (Fortification of Foods) Regulation, 2018** dated 2nd August, 2018 on fortification of food in key staples like **Oil and Milk (with Vitamin A and D)**, **Wheat Flour and Rice (with Iron, Folic Acid and Vitamin B 12),** and **Double Fortified Salt (with Iodine and Iron).** **2.** The**Logo (+F)** for fortified foods, has created a rallying point for the industry to adopt fortification, placing fortification firmly on the national agenda. Various advisories for premix supplier, endorsement of +F logo, and Scientific Health Claims for label declaration of fortified foods approved

	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	by the Scientific Panel on Nutrition and Fortification were also released. **3.** Corrigenda, Compendium released (October 2018 & September 2019) for amendments in the regulations. Endorsement for +F logo through FLRS license system of FSSAI for food businesses. SOP created for Premix and FRK Manufacturers created on FFRC portal. **4.** FSSAI has setup the **Food Fortification Resource Centre (FFRC),** http://ffrc.fssai.gov.in/, as a nodal point to provide the required technical support to stakeholders. Resource material have been developed commodity-wise e.g. Tool Kits including technical handbooks, training manuals, FAQs, creation of standard operating procedures for accredited premix suppliers and equipment manufacturers, list of NABL accredited labs for testing of micronutrients **Open Market Availability** **5.** Voluntary fortification has begun for 5 staples. **114 top companies and regional brands have ~ 157 brands of all 5 fortified staples** are presently available in the open market with a PAN India and regional presence. 80 brands of fortified oil, 55 brands of fortified milk, 12 brands of fortified wheat flour, 2 brands of fortified rice and 8 brands of double fortified salt. **Towards Mandatory Fortification** **6.** FSSAI has moved its proposal for mandatory fortification of edible oil

	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.	and milk. **Government Food Safety Net Programmes** **7.** The **Ministry of Women and Child Development & Ministry of Human Resource Development (Department of Education and Literacy)** had issued advisories for mandatory fortification of Wheat Flour, Edible Oil and Double Fortified Salt, vide letter No 25/16/2015-NUTRITION DESK, dated 10th July,2018 and 14-10/2016MDM 1-2(EE.5) dated 2ndAugust, 2017 respectively in **ICDS and MDM**. Recently, MWCD has issued advisory including fortified rice under ICDS and SABLA vide no 25/16/2015-Nutrition Desk dated 28th February 2019. **Ministry of Consumer Affairs, Food & Public Distribution** also had issued a circular no. 13-4/2016-BP-II, directing States which are distributing wheat flour (only 7 States) to use only Fortified Atta for distribution under PDS, dated December 22nd, 2016 and a reminder dated 17th September, 2018. Further, the Department of Food and Public distribution has issued an advisory vide D.O.No.14-VP(1)/2008 dated 1st October, 2018 encouraging publicity of fortified oil in the States/UTs. Further, PDS is introducing a Central Scheme to promote fortification of rice in PDS. **8.** Order issued by Ministry of Women and Child Development (D.No. 25/16/2015-Nutrition Desk) dated February, 28th 2019 directing States for mandatory use of Fortified Rice in addition to Fortified wheat flour, fortified edible oil and double fortified

		salt under ICDS and SABLA. **9.** Order issued by Department of school Education and Literacy (F.no 1-4/2018-Desk (MDM) to look at fortification of food items in a systematic manner through Food Corporation of India (FCI) Starting with rice. **10.** Administrative approval granted by the Government of Centrally Sponsored Pilot Scheme on Fortification of rice and its distribution under the Public Distribution System. Approval granted for a period of three years beginning 2019-20 with a total budget outlay of INR 147.61 crores. **11.** **22 States**Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Goa, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Tripura, Uttrakhand, Uttar Pradesh, West Bengal and **5 UTs**Andaman & Nicobar Island, Chandigarh, Dadar& Nagar Haveli, Daman & Diu and Delhi have adopted fortification of several commodities across the government safety net programmes (SNP) namely ICDS, MDM and PDS. **Training and Capacity Building** **12.** 425 FSOs trained on food fortification across 18 States **13.** FBOs trained on process of food fortification across commodity **14.** 48 FSSAI notified NABL lab personnel trained on testing of micronutrients in oil, milk, wheat flour **15.** Sensitization Workshop for 127 store In-charges of Kendriya Bhandar

		Events and Consumer Awareness **16.** Mention of food fortification by Prime Minister in Mann Ki Baat (November 2017) **17.** National street food festival (Jan 2018) **18.** Project Dhoop (09th April 2018) **19.** World Milk Day (1st June 2018) **20.** DFS cited as a strategy to combat anemia by Hon'ble PM in his address to frontline health workers (September 2018) **21.** Swasth Bharat Yatra (October 2018 - January 2019) **22.** Eat Right Mela (Dec 2018 and 2019) **23.** Eat Right India Run (fortification) for 200 schools across Delhi (April 2019) **24.** Mascot Activation on Food Fortification in 600 schools across India (July 2019) **25.** Engagement with CROs for awareness generation towards food fortification in four States. **26.** TVC, Radio Spots, Videos, State specific collaterals, FFRC website and other IEC content created and disseminated. **27.** Premise branding for fortification in 140+ retail stores and outlets in Delhi/NCR, First fortified food store on e-retail, separate category of fortified staples on Amazon website.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Unsafe abortions: Time to act for making it safe

Recommendation (Para No.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 pregnancy. 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 cranny of the society.

Replies of the Ministry Health and Family Welfare

- The Medical Termination of Pregnancy (Amendment) Bill, 2020 was introduced and passed in Lok Sabha upon discussion in March 2020. The Bill is yet to be passed in Rajya Sabha.
- The Bill proposed the extension of upper gestational limit for abortion from 20 to 24 weeks for vulnerable categories of women.
- The amendment proposes no upper gestational limit to be applied for abortion in case of substantial foetal anomalies as diagnosed by a Medical Board.
- To increase the access of safe abortion services to all women, the provision of abortion services is proposed for all women irrespective of their marital status.
- The proposed Bill is a step towards safety and well-being of women and will enlarge the ambit and access of women to safe and legal abortion without compromising on safety and quality of care. The proposal will also ensure dignity, autonomy, confidentiality and justice for women who need to terminate pregnancy.

- To increase awareness on safe abortion services, IEC activities on Comprehensive Abortion Care is supported by the Government of India in all States and UTs.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Family planning and contraception: emphasize more on high TFR States

Recommendation (Para No.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. The Committee have also gathered from various reliable sources that fertility is falling faster than expected in India and the country is on track to reach replacement levels of fertility by the time it reaches 2020. Yet, the Committee feel that there is no room for complacency for the Government as the figures from high fertility districts are enough to dampen the apparent successes achieved so far. The reports of the Sample Registration Survey, 2013, conducted by the Registrar General of India, point to very high fertility rates still prevailing in most of the Hindi Heartland States of the country as well as few areas of North-East India. If some States of country have done remarkably well in the past decades, it is these high-TFR States, among which U.P, Rajasthan, Bihar, MP, Jharkhand, Meghalaya etc, all having TFR well above the national average, that have thrown spanner to population stabilizing efforts of the Government in the country. The Committee also feel that most of these States, big ones, both geographically and demographically, do have the potential to rock the boat, if the Government fail to bring down the TFR in the immediate future. 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.

Replies of the Ministry Health and Family Welfare

It is heartening to note that the Committee has appreciated the expansion of the basket of choice for family planning by the Government. On its Recommendation to draw up special plans for high fertility states like Bihar and Uttar Pradesh, the Government has launched a well planned scheme, the **Mission ParivarVikas** in 146 high fertility districts (Total Fertility Rate>3) of seven high focus states that constitute 44% of the country's population:

- Uttar Pradesh (57 districts),
- Bihar (37 districts),
- Madhya Pradesh (25 districts),
- Rajasthan (14 districts),
- Jharkhand (9 districts),
- Chhattisgarh (2 districts) and
- Assam (2 districts).

The objectives of the scheme are:

- Delivering assured services
- Initiating Promotional Schemes
- Ensuring commodity security
- Capacity building for enhanced service delivery
- Creating enabling environment.

The Government reviews progress in these districts by monitoring and studying their performance. The districts have shown increased uptake of family planning services under Mission ParivarVikas:

- Sterilization performance has shown an improvement of 12.4% in 2019-20 compared to 2018-19.
- Male sterilization cases have increased by 32%, from 2017-18 to 2019-20.
- PPIUCD acceptance Rate has increased from 12.1% in 2018-19 to 14.5% in 2019-20.
- Over 7.9 lakh doses of injectable contraceptive Medroxy Progesterone Acetate (Antara program) given in 2019-20.

Additionally, demand generation and awareness activities like 'SaasBahuSammelans', 'NayiPehel Kits' for newly-weds and 'Saarthi- Awareness on Wheels' are some of the noteworthy initiatives taken in these districts:

- The NayiPehel Kits are intended for improved spousal communication and breaking the hindrance to discuss important yet taboo issues like contraception among newlyweds. These have been widely welcomed by the community. In 2018-19, ASHAs distributed 4,18,575NayiPehl Kits in MPV districts of 5 states.

- The SaasBahuSamellan is aimed to facilitate improved communication and awareness on family planning among pairs of daughters-in-law and mothers-in-law through interactive games and exercises. In 2018-19, 1,86,997SaasBahuSammellan (SBS) were conducted in MPV districts with average 25 participants per Sammellan.
- SAARTHI is a vehicle equipped with interactive communication devices, IEC material and FP commodities. The number of blocks covered by SAARTHI in 2018-19 was 1517.

In addition, the Government currently is focusing on:

- Promotion of post-partum family planning services
- More emphasis on spacing methods
- Streamlining distribution and supply of family planning commodities
- Capacity development of service providers
- Holistic media campaign for awareness generation

Successes achieved:

As a result of these efforts, India has made impressive gains:

- The Total Fertility Rate (TFR) has declined from 2.9 in 2005 to 2.2 in 2017 (SRS)
- 24 out of 36 States/UTs have already achieved the replacement level fertility of 2.1 or less and only Bihar (3.2, SRS 2017) has TFR more than 3.
- The Crude Birth Rate (CBR) has declined from 23.8 in 2005 to 20.2 in 2017 (SRS)
- The Decadal growth rate has declined from 21.54% in 1990-2000 to 17.64% during 2001-11.
- India's Wanted Fertility Rate was 1.9 in NFHS III which has further declined to 1.8 in NFHS IV.
- The teenage birth rate has halved from 16% (NFHS III) to 8% (NFHS IV).
- The teenage marriage rate has declined halved from 47.4% (NFHS III) to 26.8% (NFHS IV)

It is evident that the impact of the interventions is now beginning to yield dividends. Today, India is knocking at the door of achieving replacement level fertility, and has made remarkable strides in improving reproductive health services.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Non-communicable diseases: need to take a leap forward

Recommendation (Para No.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 ruinous because 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. It is a blind-spot that needs urgent attention for ensuing a continuum of care from community to secondary to tertiary levels. The Committee recommend the drugs and diagnostics to be made available either free or in 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.

Replies of the Ministry Health and Family Welfare

In order to address the rising challenge of non-communicable diseases, the Govt. is implementing National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) under National Health Mission (NHM) in all States/UTs in the country, with focus on strengthening infrastructure, human resource development, health promotion, early diagnosis, management and referral. For activities upto district level and below, States are given financial assistance under NHM in the ratio of 60:40 (90 : 10 in case of NE and hilly States). Under NPCDCS, 616 District NCD Clinics, 3975 CHC NCD Clinics , 176 district Cardiac Care Units, 210 District Day Care Centre have been set up.

Population based prevention and control, screening and management initiative for common NCDs (Diabetes, Hypertension and common cancers viz. Oral, Breast and Cervical Cancer) is being implemented as a part of comprehensive primary health care under National Health Mission (NHM). Under this initiative, persons more than 30 years of age are targeted for screening for common NCDs. Prevention, control & screening services are being provided through trained frontline workers (ASHA & ANM), and the referral support and continuity of care is ensured though PHC, CHC, District Hospitals and other tertiary care institutions. PBS can help in better management of diseases by the way of early stage of detection, follow

up, treatment adherence. Training Modules have been developed for training of various categories of health staff viz. Nurses, ANMs, ASHAs and MOs.

Screening of common NCDs is also an integral part of service delivery under Ayushman Bharat-Health and Wellness Centres. Till date 40,477 HWCs have been operationalized out of the target of 1.5 lakhs throughout India. The number of persons screened so far through Health and Wellness Centres includes 3.55 crore for diabetes, 4.23 crore for hypertension, 1.25 crore for breast cancer and 82.5 lakh for cervical cancer.

Population based screening for NCDs also generates awareness on the risk factors of NCDs. Awareness for prevention of NCDs and early detection is being carried out at all levels through print and electronic media as well as social media. The National Cancer Awareness Day and World Cancer Day are also observed on 7th November & 4th February, respectively every year. During India International Trade Fair (IITF), at PragatiMaidan, New Delhi, special screening camps for awareness and early detection of NCDs are carried out every year. State Governments are also requested and funded to carry out health awareness campaign from time to time.

To enhance the facilities for tertiary care of cancer, the Central Government is implementing 'Strengthening of Tertiary Care Cancer facilities' Scheme. Under the scheme, support is provided to States/UTs for setting up of State Cancer Institutes (SCIs) and Tertiary Care Cancer Centres (TCCCs) in different parts of the country. Till date 39 institutions (19 SCI and 20 TCCC) have been approved.

Progress under NPCDCS is reviewed periodically with the State Governments during meetings and through video conferencing . Recently, three meetings were held with States /UTs in Delhi (two) and Bengaluru (one) in the month of December, 2019, to review the programme. Further the programme is getting reviewed annually through the Common Review Missions (CRM) of National Health Mission (NHM). During Quarterly Review Meeting held with State Health Secretaries and Principal Secretaries in September, 2019, all the programmes under NHM, including those aimed at prevention and control of NCDs, were reviewed. Central Council of Health & Family Welfare (CCHFW) also reviews the activities carried out by Ministry of Health and Family Welfare. A meeting of CCHFW was held on 10th October, 2019 at New Delhi under the Chairmanship of Union Health Minister and was attended by Health Ministers of States.

Treatment of NCDs is either free or subsidized in the Government Institutions. Under free drug initiative of NHS, drugs and diagnostics are made available free of cost in public health facilities upto District level. Further, financial assistance is provided to poor patients for their treatment under the Health Minister's Cancer Patient Fund component of the Umbrella scheme of the RashtriyaArogya Nidhi (RAN). Affordable Medicines and Reliable Implants for Treatment (AMRIT), a novel initiative, was launched by the Ministry of Health & Family Welfare that aims to provide affordable life-saving medicines, other drugs and medical disposables for treatment. AMRIT scheme is being implemented since November, 2015, which is now known as AMRIT Deendayal Pharmacy. Presently, there are more than 200 AMRIT pharmacies, spread across States/UTs, selling more than 5,200 drugs, implants, surgical disposables and other consumables at significant discount of upto 50% on market rates. As on 15th February, 2020, 187.35 lakh patients have benefitted from AMRIT pharmacies. The value of drugs dispensed at MRP in 1974.82 crore and patients have benefitted with a savings of Rs. 1000.22 crores from AMRIT stores thereby reducing their out of pocket expenditure.

Pradhan MantriBhartiyaJanaushadhiPariyojana (PMBJP) is being implemented by Bureau of Pharma PSUs of India (BPPI), under Department of Pharmaceuticals, Government of India, for making quality medicines available at affordable prices for all, particularly the poor and disadvantaged, through exclusive outlets "Pradhan MantriBhartiyaJanaushadhiKendras", so as to reduce out of pocket expenses in healthcare. A total of 900 drugs and 154 surgicals and consumables are currently included in the product basket of Pradhan MantriBhartiyaJanaushadhiPariyojana (PMBJP). More than 5000 Jan AushadhiKendras have been set up under the scheme.

Pradhan Mantri Jan ArogyaYojana (PMJAY) aims at providing health insurance cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.74 crores poor and vulnerable families (approximately 50 crore beneficiaries). The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively. Since the inception of the scheme, treatment for NCDs is includedin the benefit packages of PM-JAY.

As can be seen, Government has taken steps to address the increasing burden of NCDs. These interventions are meant for the population at large, including women. Also, as mentioned above, there is

focus on breast and cervical cancers in the population based screening programme of Government for early detection, diagnosis and treatment.

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

CHAPTER III

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

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

Recognizing the demand of ASHAs and expanding the scope for others

Recommendation (Para No.2.3)

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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 are made to understand that the ASHAs are mandated to visit schools and monitor the students' health indicators as well as tracking tuberculosis cases. Yet, the Committee are rather amazed to know 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 across the length and breadth of 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 are of the firm view 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 having domain knowledge on 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.

Replies of the Ministry Health and Family Welfare

The Parliamentary committee on empowerment of women has acknowledged the role of the ASHAs in pregnancy and safe delivery, in enabling entitlements, in TB and school health, besides being used by the State/UT governments for undertaking surveys, etc. However, ASHAs are involved in range of other tasks related to newborns, children, care for chronic diseases, etc.

Public Health and Hospitals being a State subject, the implementation of ASHA program including the payment is done by the respective State/UT Governments.

Under National Health Mission, ASHAs are envisaged to be community health volunteers and are entitled only to task/activity based incentives. The fixed monthly incentive amount to ASHAs finalized at the national level, are regularly reviewed by the Central Government and activities for which ASHAs will get incentives are expanded from time to time. However, the States/UTs also have flexibility to decide on type of incentive to be given to ASHAs as per specific context/need in addition to routine and recurring incentives under National Health Mission.

Further, in the year 2018, the ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package included

- Revision of routine and recurring incentives amount from Rs. 1000 pm to Rs. 2000 pm.
- Extending benefits of Life insurance, accident insurance and pension to eligible ASHAs and ASHA facilitators by enrolling eligible ASHAs and AFs under:-
    - Pradhan Mantri Jeevan JyotiBeemaYojana (premium of Rs. 330 contributed by GOI)
    - Pradhan Mantri Suraksha BeemaYojana (premium of Rs. 12 contributed by GOI)
    - Pradhan MantriShram Yogi MaanDhan (50% contribution of premium by GOI and 50% by beneficiaries)
    -

List of ASHA incentives and Social Security Measures are at Annexure IV

An additional incentive of Rs. 1000 per month per ASHA and Rs. 500 per month per ASHA Facilitator has also been provisioned under NHM till June 30, 2020 File No.Z-18015/4/2020-NHM-II(Part-IV) as appreciation for work done by ASHAs and ASHA Facilitators in prevention and management of COVID-19 pandemic ,often going beyond the call of duty to support the community and health system, while also responding to their routine outreach activities. The EFC proposal to extend this incentive till 31/3/2021 looking into the current situation of situation of COVID 19 pandemic has already been processed by MoHFW.

Regarding the observation of the Parliamentary Committee related to the provision of sufficient number of trainers, infrastructure and equipment for training of ASHA and ASHA Facilitators, a tripartite MOU was signed between National Institute of Open Schooling (NIOS), Ministry of Health and Family Welfare (MoHFW) and National Health Systems Resource Centre (NHSRC) in 2014. The programme encompasses the following - Standardization of training curriculum, accreditation of training sites and certification of trainers and ASHAs and ASHA Facilitators. Refresher trainings are also arranged to ensure rendering of quality services by the ASHAs. Financial and technical support for trainers, training infrastructure and ensuring necessary training equipment is provided to the States/UTs through the NHM, @ the rate of Rs. 16,000 per ASHA per year to cover all these costs. National Health Systems Resource Centre (NHSRC) has been instrumental in sharing the training resource material related to ASHA training with the States/UTs. Recently,ASHAs were also provided training material and training regarding role in COVID 19 pandemic alongwith various DOs and Donts in this regard.

Regarding filling up vacant positions of ASHAs, regular review on this issue is taken regularly by the Centre with the States/UTs during NHM review meetings, Common Review Mission (CRM) briefings, National Programme Coordination Committee (NPCC) meeting. The norms for selection of ASHA are relaxed for tribal and hilly areas so that the vacant positions can be filled. As per ASHA update, July 2019 data of NHSRC, 96% (rural) and 85% (urban) of positions of ASHAs are filled. The details are attached at Annexure V

With the advent of the Ayushman Bharat – Health & Wellness Centre (AB-HWC) programme, the MOHFW is providing states with a male health worker, to create a primary health care team at the HWC level. The team at the health and wellness centre at the sub centre level comprises of a Community Health Officer, a Male multipurpose worker, a female multipurpose worker, and five ASHAs. Regarding recruiting ASHA also from the transgender community the suggestion of the committee is noted".

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Comments of the Committee

(Please see para 11 of Chapter I of the Report

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

Recommendation (Para No.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 private 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 regular 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.

Replies of the Ministry Health and Family Welfare

The National Programme of Mid-Day Meal in Schools, popularly known as the Mid-Day Meal Scheme (MDMS), is an on-going Centrally-Sponsored Scheme which covers all school children studying in Classes I-VIII of Government, Government-Aided Schools, Special Training Centres including Madarsas and Maqtabs supported under SamagraShiksha. The objectives of the Mid-Day Meal Scheme are to address two of the pressing problems for majority of children in India, viz. hunger and education by:

i. Improving the nutritional status of children studying in classes I – VIII.
ii. Encouraging poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities.
iii. Providing nutritional support to children of elementary stage in drought-affected areas during summer vacation.

2. However, the suggestion of the Committee regarding coverage of privately managed schools in tribal areas as well as out of school tribal children under MDMS have been noted **and the States and UTs will be consulted in the matter.**

3. It may also be mentioned that the Government has adopted an elaborate monitoring mechanism at Central, State and District levels to ensure quality food is served to children under the Scheme. At national level, an Empowered Committee, headed by Minister of Human Resource Development and also a National level Steering-cum-Monitoring Committee (NSMC) as well as Programme Approval Board (PAB) monitor the scheme and suggest measures for its smooth and effective implementation. At the State level, a State level Steering–cum-Monitoring Committee headed by the State Chief Secretary and, at the District Level, a District Level Committee under the Chairpersonship of the senior-most Member of Parliament of Lok Sabha from the district monitors the implementation of the scheme. At local level Gram Panchayats/Gram Sabhas, members of Village Education Committees (VECs), Parent-Teacher Associations (PTAs) and the School Management Committees (SMCs) monitor the regularity and wholesomeness of the mid-day meal served to children, cleanliness in cooking and serving of the meal, timeliness in procurement of good quality ingredients, fuel, etc., implementation of variety in menu so as to make it attractive to children and ensuring social and gender equity on daily basis. In addition to directing States and UTs to carry out Social Audit, the Centre constitutes Joint Review Missions (JRMs) to review the scheme through field visits from time to time".

[Ministry of Ministry Health and Family Welfare F. NO. M-12015/80/2017-MCH dated 13th July, 2020]

Comments of the Committee

(Please see para 14 of Chapter I of the Report)

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

D. Mental health of women: urgent need to prioritize

Recommendation (Para No.2.9)

According to a report, World Health Organization predicts that 20% of Indian population will suffer from mental health illnesses by the year 2020. And there is no one to gainsay that a huge population among them would be women. The Committee also feel that ours is largely an insensate society where deep societal prejudices, fear, stigma and ignorance often fail to recognize mental illnesses suffered by women within the confines of home and beyond. The Committee strongly condemn this attitude of the society and urge the Government to talk relentlessly about mental illnesses that a woman can suffer in and the 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 counselling in public and private healthcare facilities. The need of the hour is to have seamless co-operation between all agencies-Gram Panchayats, Panchayat Simitis, Police, local administration, educational institutions, psychiatric departments, counsellors, 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. In India, only 1-2% of health budget is spent on mental health, a meagre amount in comparison to severity of the problem in the society. Thus, the Committee strongly recommend to increase its share at least to 5-6% of the total health budget of the country. The Committee would also strongly recommend to upgrade the facilities at shelter homes as conditions of many of them are hellish to say the least. These are tomodelled after the better-performing homes of the country.

The replies of The Ministry of Health and Family Welfare

The Government of India is proactively taking various initiatives for delivery of quality mental health services in the country. Initiatives of the Government are meant for all who are in need of mental health support, irrespective of gender, caste or religion.

To address the challenge of mental illnesses, the Government is implementing the National Mental Health Programme (NMHP) in the country. Under NMHP, implementation of the District Mental Health Programme (DMHP) has been approved for 655 districts of the country for early detection and management of mental disorders/illnesses. The activities covered under the DMHP also include targeted interventions like work place stress management, suicide prevention activities, life skills training, counselling in schools and colleges, community awareness generation activities and imparting short term training to various categories of healthcare workers. Information, Education and Communication (IEC) activities are an integral part of DMHP to generate awareness among masses towards mental illness. At the District level, funds uptoRs. 4 lakh are provided to each District under DMHP for IEC and awareness generation activities.

With the objective to address the shortage of qualified mental health professionals in the country, the Government is implementing Manpower Development Schemes for establishment of Centres of Excellence and strengthening/ establishment of Post Graduate (PG) Departments in mental health specialties. Till date, support has been provided for establishment of 25 Centres of Excellence and strengthening/establishment of 47 Post Graduate (PG) Departments in mental health specialties in the country. Tertiary level mental healthcare facilities are provided through dedicated Mental Health Institutions as well as Medical Colleges run by Central and State Governments. In addition to the Manpower Development Schemes of NMHP, the Government is also augmenting the availability of manpower to deliver mental healthcare services in the underserved areas of the country by providing online training courses to various healthcare service providers like medical officers, psychologists, social workers and nurses to deliver quality mental healthcare services throughout the country through the Digital Academies established at the three Central Mental Health Institutes.

The Mental Healthcare Act, 2017 came into force w.e.f. 29/05/2018. Objective of the Act is to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services. The Act has separate provisions for addressing specific needs of women receiving care and treatment in a mental health establishment, sensitization and training of Government Officials, including police officers about provisions of the Act, and to reduce stigma associated with mental illness. Provisions of the Act are to be implemented primarily by the State Governments. As per the provisions of the Act, the State Governments are required to take certain actions like framing of Rules and Regulations, establishment of State Mental Health

Authorities, creation of State Mental Health Authorities Funds, establishment of Mental Health Review Boards. The State Governments are also required to take necessary steps to integrate mental health services into general healthcare services at all levels of healthcare including primary, secondary and tertiary healthcare and in all health programmes run by the Government. MoHFW vide various D.O. letters has requested all the States/UT Governments to take necessary action for implementation of the Act. Till date State Mental Health Authority has been established in 20 States/UTs. As contemplated under the Act, the Central Government has framed Central Mental Health Authority and Mental Health Review Boards Rules, State Mental Health Authority Rules and Rights of Persons with Mental Illness Rules which came into force w.e.f. 29/05/2018".

Comments of the Committee

(Please see para 17 of Chapter I of the Report

NEW DELHI;
09 February, 2021
20 Magha,1942, (Saka)

DR. HEENA VIJAYKUMAR GAVIT,
Chairperson,
Committee on Empowerment of Women.

COMMITTEE ON EMPOWERMENT OF WOMEN (2020-2021)

MINUTES OF THE FIRST SITTING OF THE COMMITTEE HELD ON TUESDAY, THE 9th FEBRUARY, 2021

The Committee sat from 1400 hrs. to 1500 hrs. in Committee Room 1, Block A, First Floor, Extension to Parliament House Annexe, New Delhi.

PRESENT

Dr. Heena Vijaykumar Gavit - Chairperson

MEMBERS

Lok Sabha

2. Smt. Sangeeta Kumari Singh Deo
3. Km. Shobha Karandlaje
4. Smt. Raksha Nikhil Khadse
5. Smt. Jaskaur Meena
6. Smt. Queen Oja
7. Smt. Shardaben Anilbhai Patel
8. Smt. Riti Pathak
9. Smt. Navneet Ravi Rana
10. Smt. Satabdi Roy (Banerjee)
11. Smt. Sarmistha Sethi

Rajya Sabha

12. Smt. Jharna Das Baidya
13. Smt. Vandana Chavan
14. Smt. Chhaya Verma

SECRETARIAT

1. Smt. Kalpana Sharma - Additional Secretary
2. Smt. Maya Lingi - Director
3. Smt. Reena Gopalakrishnan - Additional Director

2. At the outset, the Chairperson welcomed the Members to the first sitting of the Committee on Empowerment of Women (2020-2021) convened to consider Memorandum No.1 regarding selection of subjects. Thereafter, the Chairperson in her opening remarks gave a brief account of the scope and functions of the Committee and the work done by the Committee during the previous term.

3. xxxxxxxx xxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxx

4. The Committee also took up for consideration the draft Report on Action Taken on the recommendations contained in the 11th Report (16th Lok Sabha) of the Committee on Empowerment of Women (2017-2018) on the subject 'Women's Healthcare : Policy Options'. After some deliberations, the Committee adopted the draft Report without any modification and authorized the Chairperson to finalize and present the same to both the Houses of Parliament.

5. The Committee also decided to undertake a study visit in the month of April, 2021 in connection with the examination of the subjects selected.

The Committee then adjourned.

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xxxxx matter not related to the Report

APPENDIX II

[Vide Para NO. 4 of the Introduction]

ANALYSIS OF ACTIN TAKEN BY GOVERNMENT ON THE OBSERVATIONS/RECOMMENDATIONS CONTAINED IN THE ELEVENTH REPORT OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2017-2018) (SIXTEENTH LOK SABHA) ON "WOMEN'S HEALTHCARE : POLICY OPTIONS"

(i) Total No. of Recommendations: 09

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

Recommendation Para Nos.: 2.1, 2.2, 2.4 ,2.6, 2.7 & 2.8

Total: 06
Percentage : 66.66%

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

Recommendation Para Nos.: Nil

Total: 00
Percentage :0%

(iv) Observations/Recommendations in respect of which repliesof the Government have not been accepted by the Committeewhich require reiteration:

Recommendation Para No.: 2.3 and 2.5

Total: 02
Percentage :22.22%

(v) Observations/Recommendations in which the Government have furnished interim replies:

Recommendation Para No.: 2.9

Total:01
Percentage : 11.11%