PRERNA
Policies, Programme, Research, Resources, News and Action in Maternal and Adolescent Health
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IN THE NEWS

Cabinet clears National Health Policy

The policy makes health an entitlement but not a fundamental right as the draft policy had envisaged.

HAVING DEFERRED it twice before, the Union Cabinet on Wednesday approved the National Health Policy. Health Minister J P Nadda will make a suo motu statement in Parliament to make details of the new policy public as no policy announcement can be made outside the House while Parliament is in session. The policy makes health an entitlement but not a fundamental right as the draft policy had envisaged. It stops short of a legislative backing for right to health. A Right to Health legislation in the nature of right to education would need a constitutional amendment to bring health in the concurrent list from where it currently is on the state list.

In the current policy, health services are merely "assured". It, however, talks of imposing a health cess much like the education cess that

was imposed after RTE was legislated. It talks of increasing public expenditure on health to 2.5 per cent of GDP — as demanded by experts for a long time.

Read more: http://indianexpress.com/article/india/cabinet-clears-national-health-policy-4570857/

Dear Friends

Greetings from Voluntary Health Association of India!

VHAI is a non-profit organization working for the last four decades with large outreach through 27 State Voluntary Health Associations, 4500 member organizations and more than 1,00,000 grass-root level health workers across the country.

We would like to share our in-house newsletter PRERNA., that highlights a cross section of Policies, Programme, Research, Resources, News and Action in Maternal and Adolescent Health.Our goal in developing this publication is to keep everyone informed on some interesting developments around RMNCH+A. We want it to be a space which develops into one where development practitioners share updates and information.

Please write to us with your thoughts and ideas and send an email to Aditi at adititewari@vhai.org

(Chief Executive, (VHAI)

Cabinet nod for universal healthcare, free drugs & diagnostic facilities on the cards

NEW DELHI: The Union Cabinet cleared on Wednesday the National Health Policy which puts forward a concrete framework for universal healthcare and suggests policy directives to make free drugs and diagnostic facilities available across the country, besides involving the private sector to make the services widely available, sources said.

The policy, which was pending for over two years, also suggests raising public health expenditure to 2.5% of GDP from the current 1.2 per cent. Union health minister J P Nadda is expected to make a statement on the policy in Parliament on Thursday.

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The policy addresses issues of universal health coverage by making essential drugs, diagnostic facilities and insurance available for all. The idea is to reduce out of pocket expenditure on health.

Read more: http://timesofindia.indiatimes.com/india/cabinet-nod-for-universal-healthcare-free-drugs-diagnostic-facilities-on-the-cards/articleshow/57659935.cms

UID to be used to store health data

The move is aimed at creating a digital profile of each patient although it will not be made mandatory to provide an Aadhaar card to get treatment in government hospitals.

THE UNION Health and Family Welfare Ministry will introduce a Universal Identification Document (UID) to store electronic health data of citizens. On March 15, the ministry's technical committee will open bids to appoint a firm to run the programme, expected to be implemented in a year. The move is aimed at creating a digital profile of each patient although it will not be made mandatory to provide an Aadhaar card to get treatment in government hospitals.

A patient's health records, past ailments, allergies and diagnostic test results will be saved on the UID. At a meeting of cancer specialists at Mumbai's Tata Memorial Hospital, Indian Council of Medical Research director Dr Saumya Swaminathan said that IT firms were being approached to create software for storing health data of people through Aadhaar cards.

Read more: http://indianexpress.com/article/india/uid-to-be-used-to-store-health-data-4566075/

Budget Session 2017: Lok Sabha passes Maternity Bill

Women in organised sector allowed 26-week maternity leave for two kids.

Women in India's organised sector workforce will get paid maternity leave of up to 26 weeks, up from the existing 12 weeks, under the Maternity Benefit (Amendment) Bill, 2016, that was passed in the Lok Sabha on Thursday. The law will help 1.8 million women in the organised sector, but over 90 per cent of the country's female workforce that is in the unorganised sector will not get the benefit. It will be applicable to women working in Special Economic Zones too, Labour Minister Bandaru Dattatreya said.

The new law will apply to all establishments employing 10 or more people and the entitlement of 26 weeks' leave will be allowed for the first two surviving children of a woman. For the third child, the paid leave entitlement will be of 12 weeks.

Of the 26 weeks of leave, a would-be mother can take eight weeks before the due date of delivery and the remaining after that.

In case the woman expects to become a mother for the third time or more, she can take a maximum of six weeks' leave before the delivery date.

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The amended Bill extends paid maternity leave to women who adopt a child aged three months or less, as well as commissioning mothers who have a child through surrogacy. In both cases, the paid leave will be for 12 weeks. The 12-week leave will be calculated from the date the child is handed over to the adoptive parent or the commissioning mother.

Read more: http://indianexpress.com/article/india/budget-session-2017-lok-sabha-passes-maternity-bill-4562603/

Un-notified cases thwart India's TB war

NEW DELHI: Even as India aims to eliminate tuberculosis by 2025, un-notified cases continue to pose a major challenge along with multiple drug resistance. India, which has the highest burden of TB in the world, also accounts for the majority of the 4.3 million gap between incident and notified TB cases, a latest WHO assessment shows.

According to the UN agency's report, 6.1 million new TB cases were notified globally in 2015 to national authorities and reported to WHO.

"This reflects a 4.3 million gap between incident and notified cases, with India, Indonesia and Nigeria accounting for almost half of this gap," the report said.

India is among those six countries which accounts for 60% of the 10.4 million new TB cases in 2015. Though the number of TB deaths and the TB incidence rate continued to fall globally and in India, the UN agency said un-notified cases are a reason for concern because they create an obstacle in surveillance.

Read more: http://timesofindia.indiatimes.com/india/un-notified-cases-thwart-indias-tb-war/articleshow/57545985.cms

Database over nutrition

In an unfortunate development, the Centre has recently announced that children at government schools will no longer receive their free midday meals unless they enrol for an Aadhar number. The 12-digit identity number, linked to biometric data, is now mandatory for schoolchildren and the "cook-cum-helpers" who serve them. Both children, as well as cook-cum-helpers, will have to apply for enrollment by the end of June. To be entitled to hot cooked meals from today until June 30, children will have to produce a whole host of documents—proof of having applied for Aadhaar, an undertaking by the parent or legal guardian that the child is not getting any meals from any other school, and a document to prove the child's relationship with the parent/guardian

A child could be refused a meal if he/she cannot produce the required documentation. In a country with the highest number of malnourished children in the world, one would hope that the government would be desperately devising ways to better the

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standards of nutrition and health of our children. Instead, the onus is now on children and their parents/legal guardians to apply for an identity number first, before availing of a hot-cooked meal.

More than 98% of adults in India have enrolled in the unique identification number scheme. The Economic Times, however, recently reported that of the 23.4 crore Indians who do not have an Aadhaar number till now, more than 90% are children. The move to make Aadhaar mandatory comes despite a Supreme Court interim order in October 2015 which allowed its voluntary use for availing of benefits but said no citizen could be denied a service or subsidy for want of the identification card.

However, the Centre found a route to bypass the court's order after enacting the Aadhaar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Bill in March last year. As per the new Aadhar Act passed last year by Parliament, an Aadhar card has become a necessary document for the "receipt of certain subsidies, benefits, and services". Early last month, the government made Aadhaar card mandatory for those availing subsidised food grains at Public Distribution System outlets. Some legal experts contend that such notifications are in violation of the apex court orders, which unequivocally makes Aadhaar "purely voluntary" till a final judgement is passed on the matter, and stands despite the passage of the government's Aadhaar Act. The case is now pending before a constitutional bench of the Supreme Court. Why is the midday meal scheme such an important instrument of state welfare? In action for more than a decade, the midday meal scheme, which is the world's biggest government-sponsored school lunch programme, seeks to improve the nutritional status of poor children. In the last financial year, more than 10.2 crore children were served meals. Many studies have shown how these meals provide parents with a strong incentive to send their children to school, thereby encouraging enrollment, not to mention better child nutrition and more effective learning.

Read more: http://www.millenniumpost.in/editorial/database-over-nutrition-218396

Lok Sabha Passes Maternity Benefits (Amendment) Bill, 2016

Lok Sabha passed today on 9th March, 2017 the Maternity Benefit (Amendment) Bill, 2016 which inter-alia includes increasing maternity benefit to woman covered under the Maternity Benefit Act, 1961 from 12 weeks to 26 weeks up to two surviving children in order to allow the mother to take care of the child during his/her most formative stage, providing maternity benefit of 12 weeks to Commissioning mother and Adopting mother, facilitate "work from home" to a mother with mutual consent of the employee and the employer, making mandatory in respect of establishment having fifty or more employees , to have the facility of crèche either individually or as a shared common facility within such distance as may be prescribed by rules & also to allow four visits to the crèche by the woman daily, including the interval for rest allowed to her and every establishment to intimate in writing and electronically to every woman at the time of her initial appointment about the benefits available under the Act

The bill was presented in the Lok Sabha by the Minister of State (IC) for Labour and Employment, Shri Bandaru Dattatreya.

Read more: http://pib.nic.in/newsite/PrintRelease.aspx?relid=159046

IN OPINION

Why there is not a lot new in National Health Policy; key issues unaddressed

Coming after 15 years, policy repeats several old ideas, dodges 2015 promise of a Right to Health.

The National Health Policy cleared by the Union Cabinet on Wednesday has fallen short of the promise of its 2015 draft. The policy duplicates portions of the Health section of Finance Minister Arun Jaitley's 2017 Budget speech, reiterates health spend targets set by the High Level Expert Group (HLEG) set up by the erstwhile Planning Commission for the 12th Five Year Plan (which ends on March 31, 2017), and fails to make health a justiciable right in the way the Right to Education 2005 did for school education. India last issued a National Health Policy in 2002.

No Right to Health

On Thursday, Health Minister J P Nadda told Parliament: "...The Policy proposes raising public health expenditure to 2.5% of the GDP in a time-bound manner. The Policy advocates a progressively incremental assurance-based approach. It envisages providing larger package of assured comprehensive primary health care through the 'Health and Wellness Centres' and denotes important change from very selective to comprehensive primary health care package which includes care for major NCDs [non-communicable diseases], mental health, geriatric health care, palliative care and rehabilitative care services.

"It advocates allocating major proportion (two-thirds or more) of resources to primary care. It aims to ensure availability of 2 beds per 1,000 population distributed in a manner to enable access within golden hour [the first hour after traumatic injury, when the victim is most likely to benefit from emergency treatment]. In order to provide access and financial protection, it proposes free drugs, free diagnostics and free emergency and essential health care services in all public hospitals."

Read more: http://indianexpress.com/article/explained/why-there-is-not-a-lot-new-in-national-health-policy-key-issues-unaddressed-4572373/

Baby Steps

The Maternity Benefit (Amendment) Bill, 2016, is welcome. More needs to be done.

The Lok Sabha passing the Maternity Benefit (Amendment) Bill, 2016, guaranteeing 26 weeks' paid leave to new mothers in the organised sector, is an enormously welcome step. Upping paid maternity leave from an earlier 12 weeks, India now claims good standing on an international stage where China offers 14 weeks, Australia 18 weeks, Norway 36-46 weeks (pay varying from 100 to 80 per cent of wages) and Denmark gives 52 paid weeks. With its clear 26-week duration, India's policy appears simpler than even Canada's, which offers 52 weeks leave, but only 55 per cent wages for 17 weeks. The US offers only 12 weeks, which don't come with guaranteed pay. India's legislation applies to establishments employing 10 people or more, also allotting 12 weeks' paid leave to mothers adopting or having a child through surrogacy. Significantly, the Bill stipulates that all establishments employing 50 or more people provide creche facilities, allowing women to visit four times a day. Organisations must now communicate these rights to female employees via writing.

Global studies show strong links between paid maternity leave and ensuring that women return to the workforce after childbirth. For an individual, this offers the opportunity to enrich life with a child — who is ensured better healthcare — and be financially strong during a sensitive time. Economically, this offers companies a valued employee's return, some studies showing women work longer hours upon rejoining. Socially, this means a much better chance of women staying in the workforce.

Read more: http://indianexpress.com/article/opinion/editorials/baby-steps-maternity-benefit-amendment-bill-lok-sabha-budget-session-women-workers-maternity-leave-4564094/

IN THE POLICIES

The Rights of Persons with Disabilities Bill, 2014

Highlights of the Bill

- The Bill replaces the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Instead of seven disabilities specified in the Act, the Bill covers 19 conditions.
- Persons with at least 40% of a disability are entitled to certain benefits such as reservations in education and employment, preference in government schemes, etc.
- The Bill confers several rights and entitlements to disabled persons. These include disabled friendly access to all public buildings, hospitals, modes of transport, polling stations, etc.
- In case of mentally ill persons, district courts may award two types of guardianship. A limited guardian takes decisions jointly with the mentally ill person. A plenary guardian takes decisions on behalf of the mentally ill person, without consulting him.
- Violation of any provision of the Act is punishable with imprisonment up to six months, and/or fine of Rs 10,000. Subsequent violations carry a higher penalty.

Key Issues and Analysis

- The Bill is being brought in to fulfill obligations under an international treaty. The question is whether it is appropriate for Parliament to impose legal and financial obligations on states and municipalities with regard to disability, which is a State List subject.
- The Financial Memorandum does not provide any estimate of the financial resources required to meet obligations under the Bill.
- The Bill states that violation of any provision in the Act will attract imprisonment and/or fine. Given the widespread obligations (such as making all polling booths accessible to the disabled), many acts of omission or commission could be interpreted as criminal offences.
- In "extraordinary situations" district courts may appoint plenary guardians for mentally ill persons. The Bill does not lay down principles for such determination, in a consistent manner, across various courts. The Bill overrides the Mental Health Act, 1987 but the safeguards against misuse of powers by guardians are lower.
- The Bill is inconsistent with other laws in some cases. These include conditions for termination of pregnancy and the minimum penalty for outraging the modesty of a woman.

Read More: http://www.prsindia.org/billtrack/the-right-of-persons-with-disabilities-bill-2014-3122/

JUVENILE MATURITY AND HEINOUS CRIMES: A RE-LOOK AT JUVENILE JUSTICE POLICY IN INDIA

On December 22, 2015, the Juvenile Justice (Care and Protection of Children) Act, 2015 received parliamentary approval, bringing forth an entirely new regime with respect to juveniles above the age of sixteen, accused of committing heinous offences. The background for its introduction was set by the horrific rape of a young student in 2012. The government justified the law as a measure which would

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have a deterrent effect on potential juvenile offenders. However, the opponents argue that the law would defeat the objective of having a separate juvenile justice system, and would not serve the goal of deterrence. They instead suggest that efforts be expended in ensuring more effective implementation of the Juvenile Justice (Care and Protection) Act, 2000. The paper analyses the viability of the mechanism proposed by the new measure. It also evaluates the potency of the counter claim which proposes that the existing law be better implemented, and thereby examines the necessity for the introduction of a new approach governing juvenile policy in India.

INTRODUCTION

India has had a chequered history with regard to the determination of the age of juveniles in conflict with law. The Children Act, 1960 ('1960 Act') was the first central legislation post-independence that aimed at conceptualising a system, separate from the criminal justice system under the Code of Criminal Procedure, 1973, for the treatment of juvenile delinquents. It defined a "child" to be a boy who has not attained the age of sixteen years or a girl who has not attained the age of eighteen years. However, during this period, each state was allowed to frame its own laws on the subject as the 1960 Act extended only to the Union Territories. This resulted in similar cases of juvenile delinquency being dealt with differently by courts of each state, thereby leading to discrepancy in judicial practice.3

This discrepancy prompted the Supreme Court to observe that a parliamentary legislation on the subject of juvenile justice was desirable.4 It would not only bring about uniformity in provisions relating to children but also ensure better and more effective implementation of the same.5 This led to the enactment of the Juvenile Justice Act, 1986, the first comprehensive legislation, which had countrywide application, except the state of Jammu and Kashmir. Notably, the provision relating to the age limit of juveniles was carried forward from the 1960 Act and was kept unchanged.

In 1992 India signed the United Nations Convention on the Rights of the Child, 1989 ('CRC'). The CRC defined a child as "every human being below the age of eighteen".6 Being a signatory, India sought to fulfill its international obligation by enacting the Juvenile Justice (Care and Protection of Children) Act, 2000 ('2000 Act'). Importantly, this led to the age of juvenile irrespective of gender, being fixed at eighteen years.7

The brutal gang rape and murder of a female physiotherapy intern in Delhi in December, 2012, by six men, one of whom was a seventeen-year-old juvenile, retriggered the debate on the age limit of juveniles. Under the existing law, the maximum punishment that could be awarded to juveniles was three years of detention in a remand home, irrespective of the gravity of the offence.8 This led to tremendous public outcry demanding a change in the juvenile justice laws, lowering the age limit of juveniles, and stricter punishment for juveniles committing grave offences like rape and murder.9 The Committee on Amendments to Criminal Laws, headed by Justice J.S. Verma, was constituted to examine the deficiencies in the existing criminal law regime governing sexual assault against women.10 The Committee categorically rejected the demand for lowering the age of juveniles to sixteen.11 Instead, it opined that there was a pressing need to reform and restructure the existing juvenile justice and welfare system and called for stricter implementation of the 2000 Act.12 It found no merit in reducing the age of juveniles for certain offences and relied, among others, on the fact that recidivism had fallen from 8.2 percent in 2010 to 6.9 percent in 2011.13

Read More: http://nujslawreview.org/2017/03/26/juvenile-maturity-and-heinous-crimes-a-re-look-at-juvenile-justice-policy-in-india/

IN THE PARLIAMENT

UNSTARRED QUESTION NO. 2667
TO BE ANSWERED ON 17th MARCH, 2017

NATIONAL HEALTH MISSION

SHRI KANWAR SINGH TANWAR:
SHRI SHIVKUMAR UDASI:
SHRI INNOCENT:

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the details along with salient features and objectives of the National Health Mission (NHM);

(b) whether the Government has failed to achieve its objectives and targets under NHM and if so, the details thereof and the reasons therefor;

(c) whether the Government has conducted evaluation of various programmes running under the NHM and if so, the details thereof, State/U'I' -wise; (d) whether the Government is aware that funds released under NHM are not being utilised by the States, if so, the details thereof; and (e) the details of funds allocated, released and expenditure incurred by the States during the last three years?

ANSWER

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRI FAGGAN SINGH KULASTE)

(a): The National Health Mission (NHM) aims for attainment of universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health.

Under NHM, support to State s/U'Ts is provided for five key programmatic components:

(i) Health Systems Strengthening including infrastructure, human resource, drugs & equipment, ambulances, MMUs, ASHAs etc under National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM).
(ii) Reproductive, Maternal, Newborn, Child and Adolescent Health Services (RMNCH + A)
(iii)Communicable Disease Control Programmes
(iv)Non-Communicable Diseases Control Programme interventions up to District Hospital level
(v) Infrastructure Maintenance- to support salary of ANMs and LHVs etc.

The objectives ofNHM are summarised as under:
i. Reduction in child and maternal mortality
ii. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
III. Access to integrated comprehensive primary health care.
iv. Population stabilisation, gender and demographic balance.
v. Revitalize local health traditions & mainstream A YUSH.
vi. Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation.
vii. Promotion of healthy life styles.

(b): The NHM has been successful in accelerating the decline of Maternal Mortality Ratio (MMR), Under 5 Mortality Rate (U5MR), Infant Mortality Rate (IMR) and Total Fertility Rate (TFR). It has also achieved many of the disease control targets.

The key targets and achievements ofNHM are given at Annexure-I.
(c): Various programmes running under the NHM has been regularly evaluated, inter-alia, through external surveys such as, National Family Health Survey (NFHS), District Level Household Survey (DLHS) and Sample Registration System (SRS). Further, Common Review Missions (CRMs) also undertake a review ofNRHMINHM annually.

The details on different evaluations are available in public domain as under:

NFHS-4: http://nrhm-mis.nic.inlSitePagesINFHS.aspx
DLHS 4: https:llnrhm-mis.nic.inlSitePagesIDLHS-4.aspx
SRS: http://www.censusindia.gov.inl20 II-CommonlSample Registration System.html
CRM reports: http://nhm.gov.inlmonitoring/common-review-mission.html

(d) & (e): A statement showing StatelUT-wise Central Release and Expenditure during the last three years is placed at Annexure-H.

As evident from the annexed Statement, most of the States have been able to utilise most of the funds.

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Annexure-I

Targets as per NHM Framework for Implementation

S.no.	Targets (2012-17)	Achievements
1	Reduce IMR to 25/1000 live births	IMR has reduced to 37 in 2015 (SRS).
2	Reduce MMR to 100/1,00,000 live births	MMR has reduced to 167 in 2011-13 (SRS).
3	Reduce TFR to 2.1	TFR has reduced to 2.3 in 2014 (SRS).
4	Reduce annual prevalence and mortality from Tuberculosis by half	Tuberculosis Prevalence and mortality reduced to half as compared to 1990 level. Incidence reduced from 300/ lakh in 1990 to 217/ lakh in 2015 Mortality reduced from 76/ lakh in 1990 to 32/ lakh in 2015 Data Source: WHO Global TB report 2016
5	Reduce prevalence rate of Leprosy to <1/10000 population in all districts.	Prevalence rate of Leprosy reduced to Less than 1/10000 population in 551 Districts as on 31st March 2016.
6	Annual Malaria Incidence to be <1/1000	Annual Malaria Incidence is 0.67 in 2016 (Prov)
7	Less than 1 per cent microfilaria prevalence in all districts	Out of 256 LF endemic districts, 222 districts have reported Mf rate less than 1 as per reports of 2016.
8	Kala-Azar Elimination by 2015, <1 case per 10000 population in all blocks	Out of 628 endemic blocks 492 (78) have already achieved elimination till 2016.

Annexure-II

Statement Showing State/UT-wise Central Release and Expenditure under NHM from the F.Y. 2013-14 to 2015-16

Rs. in crore

Sl. No.	States	2013-14		2014-15		2015-16	
		Central Release	Expendi-ture	Central Release	Expenditure	Central Release	Expenditure
1	Andaman & Nicobar Islands	29.06	29.12	23.36	24.33	37.30	11.47
2	Andhra Pradesh	878.73	1,044.81	519.73	902.91	643.52	1,090.17
3	Arunachal Pradesh	78.60	92.03	139.41	69.50	162.65	146.27
4	Assam	1,077.81	956.89	877.13	915.88	971.35	1,186.01
5	Bihar	1,110.32	1,480.68	1,148.32	1,427.40	1,159.49	1,621.67
6	Chandigarh	11.46	14.42	12.15	15.26	23.89	20.98
7	Chattisgarh	355.98	805.50	500.41	716.04	412.26	758.28
8	Dadra & Nagar Haveli	9.23	9.83	8.40	8.56	14.37	15.54
9	Daman & Diu	6.50	8.40	6.91	7.67	10.53	15.69
10	Delhi	129.78	132.59	154.04	222.64	163.80	137.29
11	Goa	19.35	30.58	26.03	29.50	16.77	24.92
12	Gujarat	833.72	977.48	832.86	873.66	693.78	1,272.42
13	Haryana	315.94	423.79	273.60	438.18	291.96	493.23
14	Himachal Pradesh	205.29	158.60	185.84	306.92	246.49	281.26
15	Jammu & Kashmir	395.10	391.10	335.51	393.29	367.90	420.94
16	Jharkhand	396.38	521.49	359.62	372.01	411.50	590.18
17	Karnataka	611.11	812.56	697.24	858.18	740.45	1,141.61
18	Kerala	360.98	673.07	521.99	509.83	304.14	632.88
19	Lakshadweep	3.20	2.28	5.08	1.36	5.69	2.72
20	Madhya Pradesh	865.94	1,583.60	1,162.50	1,738.02	1,132.19	2,046.60
21	Maharashtra	1,218.51	1,806.86	1,431.76	1,834.40	1,085.92	1,734.44
22	Manipur	88.93	74.57	128.81	86.91	112.16	105.51
23	Meghalaya	125.51	71.53	104.13	70.72	102.22	133.55
24	Mizoram	77.43	91.89	103.28	93.29	94.68	172.38
25	Nagaland	99.73	90.40	114.92	63.04	104.85	81.05
26	Orissa	604.20	901.65	667.16	944.10	652.62	1,205.77
27	Puducherry	18.10	25.43	22.56	23.35	18.61	21.77
28	Punjab	333.47	437.57	379.35	460.59	295.23	649.49
29	Rajasthan	922.93	1,457.06	1,115.96	1,722.69	1,287.84	1,799.11
30	Sikkim	45.91	44.82	51.60	41.36	41.01	50.71
31	Tamil Nadu	906.24	1,430.28	952.75	2,248.06	1,093.22	1,633.37
32	Tripura	140.15	101.93	123.11	130.15	136.29	118.77
33	Uttar Pradesh	3,024.60	2,924.38	2,431.06	3,671.26	2,862.83	4,451.78
34	Uttarakhand	245.25	255.28	270.55	324.42	276.41	335.95
35	West Bengal	948.51	1,271.71	1,058.62	1,196.78	959.51	1,487.62
36	Telangana	-	-	378.72	334.68	436.63	505.55
	Total	16,493.93	21,134.19	17,124.48	23,076.94	17,370.07	26,396.94

Note:
1. The above Releases relate to Central Govt. Grants & do not include State share contribution.
2. The above releases are as per revised allocation
3. Expenditure (As per FMR submitted by States/UTs) includes Expenditure against Central Release, State release & Unspent balances at the beginning of the year.

IN OUR STATES

State health department to set up a committee to deal with foeticides

With the illegal female foeticide at Sangli serving as a rude reminder about the existence of the sex determination rackets in Maharashtra, the state government is planning to review the loopholes in the implementation of the laws.

"We are planning to set up a committee of technical experts to go into issues like any loopholes in the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PCPNDT), and problems in its implementation," a senior state health department official told DNA.

"The committee will also advise the state government on how these problems can be overcome and the necessary amendments to the act," he added. The committee is likely to include the deans of government medical colleges as members.

The Sangli police have arrested homeopath BA Khidrapure after 19 foetuses were found dumped at Mhaisal village near Miraj in Sangli district. The police were investigating the death of a 26-year old woman following medical termination of pregnancy (MTP). The woman's husband Praveen Patangrao Jamdade, who had taken his wife to the hospital for abortion as she was carrying a girl child for the third time, was under arrest.

Read more: http://www.dnaindia.com/health/report-state-health-department-to-set-up-a-committee-to-deal-with-foeticides-2347055

For quality treatment, Delhi government makes its health pitch with outsourcing

NEW DELHI: The Delhi government has decided to outsource pharmacies at its top five hospitals. High-end diagnostic services have already been outsourced.

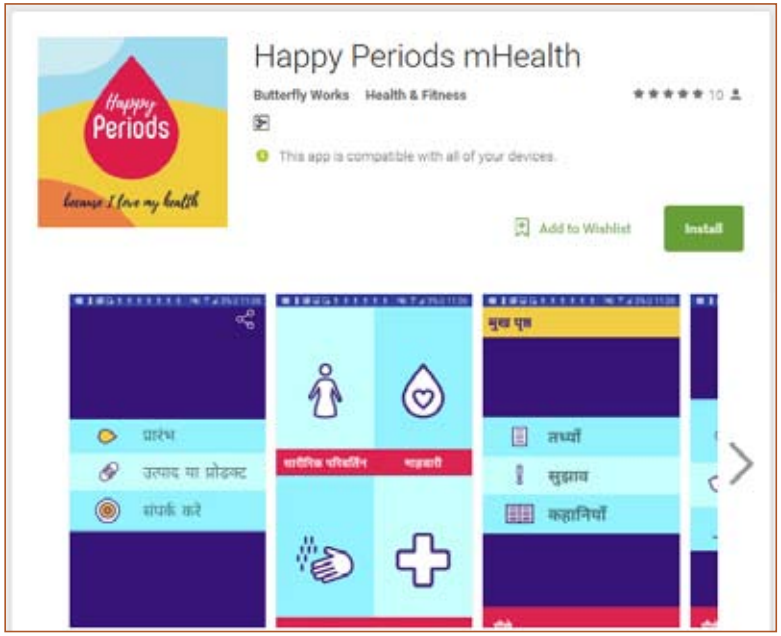
The budget also mentions the government's plan to partner with 41 private sector hospitals with NABH accreditation to deliver "quality treatment" in 30 critical and life-saving surgeries if the same service is not readily available in government hospitals.

"Under the scheme, patients who are undergoing treatment in Delhi government hospitals and have a long waiting period, will be referred to a private hospital. The government will reimburse the private hospital at CGHS rate," the finance minister explained.

Health officials claim outsourcing will help ensure prompt service to people but experts warn this could shift focus from augmenting infrastructure in public hospitals, many of which are in a state of neglect.

Read more: http://timesofindia.indiatimes.com/city/delhi/for-quality-treatment-delhi-government-makes-its-health-pitch-with-outsourcing/articleshow/57545581.cms

ON THE ONLINE SHELF



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