Sl.No.	Name	Forwarded for
4.	Mukesh Kumar	Sr Accounts Officer
5.	Brahmprakash	Accountant
6.	Tarakeswar Sha	Sr. Accounts Officer

B. List Of Staff Whose Applications Were Not Forwarded

Sl.No.	Name	Reasons
1.	Awani Kumar, LDC	Acute shortage of staff in clerical category
2.	Brham Prakash, LDC	Acute shortage of staff in clerical category
3.	Gyan Prakash, N/Attndnt	Shortage of group 'D' technical staff
4.	Yajuvender Kumar, LDC	Shortage of staff in clerical category
5.	Vikash Babu, Pharmacist	Persisting shortage of pharmacists in CGHS wellness centres
6.	Leena Taneja, Pharmacist	Persisting shortage of pharmacists in CGHS wellness centres
7.	Yajuvender Kumar	Not fulfilling the eligibility criteria (for the post of Auditor)

Disparity in under-five mortality rates

1912. SHRI ISHWAR SINGH:
SHRI N.K. SINGH:

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

(a) whether it is a fact that the under five mortality rate in rural areas is almost double to that of the under-five mortality rate in urban areas;

(b) if so, the reasons therefor;

(c) whether measures are being undertaken by Government to reduce this disparity;

(d) if so, the details thereof; and

(e) if not, the reasons therefor?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI GHULAM NABI AZAD): (a) As per Office of Registrar General of India SRS 2010 report, Rural Under-five mortality rate is 66 per 1000 live births whereas urban under-five mortality rate is 38 per 1000 live births.

(b) The possible reasons for higher under-five mortality rate in rural areas are lack of awareness, poor health seeking behaviour, inappropriate child care practices and inadequate access to quality health services.

(c) and (d) Yes. Under NRHM, higher financial resources are being provided to States and districts with weak health indicators. Further, the following interventions under RCH progamme under National Rural Health Mission (NRHM), are being implemented to reduce U5 MR in rural areas:

(1) **Promotion of Institutional Delivery through Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK):** Promoting Institutional delivery to ensure skilled birth attendance is key to reducing both maternal and neo-natal mortality. JSY incentivizes pregnant women to opt for institutional delivery and provides for cash assistance. JSSK entitles all pregnant women to absolutely free and zero expense delivery including caesarean section operation in Government health facilities and provides for free to and fro transport, food, drugs and diagnostics. Similar entitlements have also been put in place for sick neonates.

(2) **Strengthening Facility based newborn care:** Newborn care corners (NBCC) are being set up at all health facilities where deliveries take place to provide essential newborn care at birth to all new born babies; Special New Born Care Units (SNCUs) at District Hospitals and New Born Stabilization Units (NBSUs) at FRUs are being set up for the care of sick newborn. As on date 399 SNCUs, 1542 NBSUs and 11508 NBCCs are functional across the country.

(3) **Home Based Newborn Care (HBNC):** Home based newborn care through ASHA has recently been initiated to improve new born care practices at the community level and for early detection and referral of sick new born babies. The schedule of home visits by ASHA consists of

at least 6 visits in case of institutional deliveries, on days 3, 7, 14, 21, 28 and 42nd days and one additional visit within 24 hours of delivery in case of home deliveries. Additional visits will be made for babies who are pre-term, low birth weight or ill.

(4) **Capacity building of health care providers:** Various trainings are being conducted to build and upgrade the skills of doctors, nurses and ANMs for early diagnosis and case management of common ailments of children and care of newborn at time of birth. These trainings include Integrated Management of Neo-natal and Childhood Illness (IMINCI) and Navjaat Shishu Surakshta Karyakaram (NSSK). A total of 5.5 lakh health care workers have been trained in IMNCI in 471 districts and 88,428 health workers trained in NSSK so far.

(5) **Management of Malnutrition:** Emphasis is being laid on reduction of malnutrition which is an important underlying cause of child mortality. 594 Nutritional Rehabilitation Centres have been established for management of Severe Acute Malnutrition (SAM). Iron and Folic Acid is also provided to children for prevention of anaemia. Recently, weekly Iron and Folic Acid is proposed to be initiated for adolescent population. As breast feeding reduces infant mortality, exclusive breastfeeding for first six months and appropriate infant and young child feeding practices are being promoted in convergence with Ministry of Woman and Child Development.

(6) **Village Health and Nutrition Days (VHNDs)** are also being organized for imparting nutritional counseling to mothers and to improve child care practices.

(7) **Universal Immunization Program (UIP):** Vaccination against seven diseases is provided to all children under UIP. Government of India supports the vaccine program by supply of vaccines and syringes, cold chain equipments and provision of operational costs. UIP targets to immunize 2.7 crore infants against seven vaccine preventable diseases every year. 21 states with more than 80% coverage have incorporated second dose of Measles in their immunization program. Pentavalent vaccine has been introduced in two states of Kerala and Tamil Nadu and proposed to be scaled up in six more states. Year 2012-13 has been declared as 'Year of intensification of Routine Immunization'.

(8) **Mother and Child Tracking System:** A name based Mother and Child Tracking System has been put in place which is web based to enable tracking of all pregnant women and newborns so as to monitor and ensure that complete services are provided to them. States are encouraged to send SMS alerts to beneficiaries reminding them of the dates on which services are due and generate beneficiary-wise due list of services with due dates for ANMs on a weekly basis.

(e) Does not arise.

Measures for reducing MMR and IMR

1913. SHRI Y.S. CHOWDARY: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) in the country for the last three years, yearwise;

(b) whether it is a fact that MMR and IMR rates are on much higher side in India as compared to other countries; and

(c) if so, the steps taken or being taken by Government to reduce the MMR and IMR?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI GHULAM NABI AZAD): (a) Survey data on Maternal Mortality Ratio (MMR) is available from the Report of Registrar General of India Sample Registration System (RGI-SRS) at three year intervals and is not provided every year. The latest available data on MMR is for the period 2007-09. During this period, the MMR of India was 212 per 100,000 live births.

As per the same source, data for Infant Mortality Rate (IMR) in India is available for the years 2009, 2010, and 2011. The latest IMR for the country as per SRS 2011 is 44 per 1000 live births. The IMR for year 2009 was 50 and for year 2010, it was 47.

(b) As per the latest MMEIG (Maternal Mortality Estimation Inter-Agency Group-WHO, UNICEF, UNFPA, World Bank) report titled "Trends in Maternal Mortality: 1990 to 2010" India is ranked 126 out of 180 countries when countries are arranged in ascending order of MMR.