Measures to check preterm births

*218. SHRIMATI VANDANA CHAVAN: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the number of preterm delivery of babies which resulted in the birth of stillborns in India during the last three years, year-wise;

(b) whether Government is aware that India has the highest number of preterm births in the world and it accounts for 35 per cent of the world's total, if so, the measures taken by Government to reduce this number; and

(c) the measures taken by Government to check the presence of Group B Streptococcus bacteria in female body which causes preterm birth and stillbirths?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI JAGAT PRAKASH NADDA): (a) to (c) As per available estimates, 33.4 lakh preterm births took place in India in 2015 and this contributes to 22% of the world's preterm births. According to Registrar General of India report 2014, preterm births and low birth weight contributes to 29.3% of total under five child mortality. Many preterm births result in still births. The important reasons for preterm births are early and repeated pregnancies, multiple pregnancies, diabetes, high blood pressure and infections including group B streptococcus infection in mother.

In order to address the problem of preterm births, Government has taken several steps in the form of delaying age of child birth, promoting birth spacing, improving quality of antenatal care including screening for hypertension, diabetes and infection. Besides this, provision has been made for management of preterm births in Special Newborn Care Units established at district level under National Health Mission.

Bringing the rural areas under health care purview

*219. SHRI SURENDRA SINGH NAGAR: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether the private sector is actively engaged in secondary and tertiary health care sectors in urban areas;

(b) whether there is a need to focus on primary health care and bring rural areas under the health care purview which have remained under-served;

(c) whether shortage and lack of trained medical practitioners and support staff is an issue that needs to be addressed urgently; and

(d) if so, the reaction of Government thereto?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI JAGAT PRAKASH NADDA): (a) As per findings from National Sample Survey Organisation (NSSO) 71st Round, in urban areas, around 79% of out-patient care is provided by the private sector, while 21% is provided by public sector. Out of the 79% OPD care, 50% is provided at the level of a private doctor or clinic (primary level) and 29% is provided by a private hospital (secondary or tertiary). For inpatient care, 32% patients use public facilities, while 68% use private facilities in urban areas.

(b) The primary health care is imperative because primary care yields better health and development outcomes at much lower cost. The health outcomes of rural areas such as Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), Total Fertility Rate (TFR) etc. are relatively poor as compared to urban areas and there is thus continued need to focus on healthcare needs of rural areas.

(c) and (d) As per Rural Health Statistics (RHS) 2015, there is a shortage of medical practitioners and support staff in public health facilities in rural areas. Public Health being a State subject, the primary responsibility to provide health care services to the poor and vulnerable population including urban and rural areas, arrangements of trained medical and paramedical staff, etc. lies in the domain of respective State/UT Governments. However, under the National Health Mission (NHM), technical and financial support is provided for strengthening of healthcare systems in States/UTs including support for engagement of human health resources on contractual basis, trainings, hard area and performance linked allowances, etc. based on the proposals submitted by the States/UTs in their Programme Implementation Plans (PIPs). The Government has taken the following steps to further augment the availability of doctors and nursing personnel in the country:–

(i) The ratio of teachers to students has been revised from 1:1 to 1:2 for all MD/MS disciplines and 1:1 to 1:3 in subjects of Anaesthesiology, Forensic Medicine, Radiotherapy, Medical Oncology, Surgical Oncology and Psychiatry.

(ii) Enhancement of maximum intake capacity at MBBS level from 150 to 250.

(iii) Enhancement of age limit for appointment/extension/re-employment of faculty in Medical Colleges.

(iv) Relaxation in the norms for setting up of a medical college in terms of requirement for land, faculty, staff, bed/bed strength and other infrastructure.

(v) Centrally sponsored schemes for medical education to augment the availability of doctors, specialists and nurses:–

(a) Strengthening/upgradation of State Government Medical Colleges for starting new PG courses/Increase of PG seats.

(b) Establishment of New Medical Colleges by upgrading district/referral hospitals preferably in underserved areas of the country.

(c) Strengthening/ upgradation of existing State Government/Central Government Medical Colleges to increase MBBS seats.

Eradication of Leprosy

*220. SHRI TIRUCHI SIVA: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the number of persons affected from leprosy in the country, State-wise, particularly in Tamil Nadu; and

(b) the measures being taken under the National Leprosy Eradication Programme to eradicate leprosy and the achievements made so far?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI JAGAT PRAKASH NADDA): (a) Total number of Leprosy cases on record are 102178 including 3550 cases in Tamil Nadu as on 30th September, 2016. A statement showing State/UT-wise details of total number of cases on record as on 30th September, 2016 is given in Statement (*See* below).

(b) At present, the National Leprosy Eradication Programme (NLEP) is focused on early case detection and complete treatment of all cases in order to reduce the transmission of the disease thereby reducing the case load in the community to such an extent that transmission is very negligible.

A three pronged strategy for early detection of leprosy cases in the community has been initiated which are as below:–

(I) Leprosy Case Detection Campaign for high endemic districts:- In order to supplement the efforts of the state and eliminate leprosy from high endemic areas, Leprosy Case Detection Campaigns (LCDC), in line with pulse polio campaign, a unique initiative of its kind under NLEP, is initiated in high endemic districts *i.e.,* districts with Prevalence Rate of more than 1/10000 population during any of last three years. Under LCDC, house to house