PREFACE

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Vulnerable Tribal Groups in Kerala

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There are seventy five groups who have been given the status of particularly vulnerable tribal groups in India; some of them are at the verge of extinction. They are distributed in various ecological zones beyond the state boundaries with immense variation in subsistence pattern and worldviews.

Kerala is a native soil for many tribal communities. Tribal population in Kerala are living on the hill ranges, mainly on the Western Ghats, bordering Karnataka and Tamil Nadu. As of now there are 36 communities listed as Scheduled Tribes in the State. Their total population according to 2011 census is 484839, which accounts for 1.45% of the total population of the state. Wayanad district recorded the highest percentage of tribal population with 18.53% and Trissur district with the lowest percentage of 0.30%. In Kerala five communities, namely Cholanaikkans, Kurumbas, Kattunaikans, Kadars and Koragas are recognised as PVTG. The total number of families belong to these five communities are 6671 with a total population of 26273 as per the Report on the Socio Economic Status of Scheduled Tribes in Kerala published by Government of Kerala in 2013. Among the population of 26273 members, 13073 are males and 13200 are females. Thus the family size is 3.88, registering the sex ratio among them as 1000:1010.

The data which forms the basis of this research article are collected mainly from secondary sources such as The Report on the Socio Economic Status of Scheduled Tribes in Kerala published by Government of Kerala in 2013 and Census Report of Government of India 2011. It is observed that the welfare measures implemented from time to time by the Government and Non Government Organisations (NGOs) have not focused on the felt needs of the tribal communities. Hence the result achieved is far away from the plans. Thus, for the all round development of these communities, tribe-specific need-oriented action with the active participation of the community members are essential. An overview of five PVTG of Kerala is given below.

1. Kadar

Kadar otherwise known as "Kadir" is the primitive inhabitants of Anamalai hills. Their hamlets are concentrated in places such as Parambikulam, Kuriyarkutty, Nelliyampathy, Kalchadi and Taliyakallu of Palakkad district and Vazhachal, Perigalkuthu and Sholayar forest areas of Thrissur district. They are found in Kozhikodu district also. They are short statured, dark skinned and platyrhine (flat nosed). Their original language is a mixture of Tamil and Malayalam. The hereditary headman of the settlement is called "Mooppan" who is in control of the social mechanism of the community. Traditionally they used to live in neatly constructed bamboo huts thatched with teak leaves. Their main livelihood is collection of Non Wood Forest Products (NWFP) and forest labour. They are non vegetarian by habit but cycas seeds are frequently consumed.

In Kadar community traditionally the bridegroom gave dowry to the bride and widow remarriage was never permitted. Polygamy used to be the practice. Worship of stone images was practised mainly that of the goddess "Kali". Kadars used to bury the dead.

In Kerala there are 1974 members in Kadar population spread across 545 families. Among them the numbers of males are 967 and females are 1007, which represents a sex ratio of 1000: 1 041. Literacy rate of Kadar community in Kerala is 58.74%. The average number of members in a family is 3.62. The Grama Panchayats where Kadar population inhibited are Mattathur, Athirappilly, Muthalamada, Vandazhy and Kondachery.

2. Kattunayakan

The Kattunayakan are distributed in Wayanad, Malappuram, Kozhikode and Palakkad districts. They are found in the neighboring states of Karnataka and Tamilnadu. A significant majority of them (85%) lives in Wayanad district. The term "Kattunayakan" is derived from the words "kattu" which means forest and "nayakan" which means lord. Thus the word Kattunayakan means the king of the jungle. The Kattunayakan are one of the earliest known inhabitants of the Western Ghats, who are engaged in the collection and gathering of forest produce, mainly wild honey and wax. The members of this community are short, have black skin, and have protruding foreheads. The headman of the hamlet is called "muthan" or "muthali". They worship animals, birds, trees, rocks and snakes and believe in ancestor worship as well as practicing black magic and sorcery. The men wear short dhotis and half sleeved shirts. The women attach a long single piece of cloth round their body just below the neck, leaving the shoulders and arms bare. Monogamy is the general rule among the Kattunayakan community. Kattunayakan believe in Hinduism and have a language, which is a mixture of all Dravidian languages. The main deity of the tribe is Lord Shiva under the name of Bhairava. Kattunayakan are non-vegetarians and are fond of music, songs and dancing.

Among PVTG in Kerala, Kattunayakan is the community with largest population. They constitute 4.69% of scheduled tribe population in the state. A total of 19995 members consisting of 9953 males and 10042 females spread across 5137 families are there in Kerala belongs to this community. Their average family size is 3.89 and the sex ratio is 1000:1009. The literacy rate of this community in the state is 59.37%. Kattunayakan families are settled in 51 Grama Panchayats.

3. Koraga

The Koragas are perhaps the poorest among the scheduled tribes in Kerala. They are distributed only in Kasargod district and in the adjoining area of Karnataka state. 'Kora' the first part of their name refers to the sun and the name may have originated from their conventional worship of the sun. The multilingual Koragas speak Koraga, Kannada and Tulu. Koragas are, a very quiet and inoffensive race, small and slight, the men seldom exceeding five feet six inches, black skinned, thick lipped, noses broad and flat, high-cheek bones and sloping foreheads, and with bushy rough hairs. The headman of their settlement is called 'koppu' or 'guru kara' who controls the social and cultural practices. Their principal occupation was basket making and food gathering. At present, they are engaged with many other occupations. Most of them are labourers. Their God is called Koraga Thaniya, which is the god of Koragas. In every Koraga colony we can find small stones, a few plants or trees representing different cults.

There are 445 Koraga families in Kerala having a total population of 1644 members (802 males and 842 females). The average family size is 3.69 and the sex ratio is 1000:1050. The literacy rate of Koraga community in Kerala is 78.35%. Koraga community are settled in eleven Grama Panchayat and One Municipality in Kasargod district.

4. Kurumbar

Kurumbars are the earliest inhabitants of Attappadi area of Palakkad district. Hamlet of the Kurumbar is known as ooru. Each ooru has a headman called Oorumoopan, who is assisted by Bhandari, Kuruthala and Mannookkaran. The Bhandari serves as a treasurer to social functions and the Mannookkaran is a traditional agricultural expert. The language spoken by them is a mixture of Tamil and Malayalam. Kurumbar mostly living in reserve and vested forest areas have been practising shifting cultivation called ' panja krishi'. They cultivate ragi, thuvara, chama etc. They are experts in cattle rearing. They are also collectors of non timber forest produces. They maintain a community life by sharing land and labour. Majority of the Kurumbar hamlets covered by drinking water schemes, but the tribe resort to natural sources. Among the five PVTG of Kerala, the younger generation of Kurumbar community have shown more interest than others in organising themselves and getting educated.

Kurumbar community is settled in Agali and Pudur Grama Panchayat of Palakkad district. Of them 98% are settled in Pudur Grama Panchayat. There are 543 families with a population of 2251.The family size is 4.14. As the population consists of 1128 males and 1123 females, the sex ratio is 1000:996.The literacy ratio of Kurumbar is 56.36%.

5. Cholanaickan

They primarily inhabit the southern Kerala, especially Silent Valley National Park, and are one of the last remaining hunter-gatherer tribes of the region. The Cholanaikkan call themselves as 'Malanaikan' or 'Sholanaikan'. They are called Cholanaikan because they inhabit the interior forests. 'Chola' or 'shoals' means deep ever green forest, and 'naikan' mean King. They are leading a semi-nomadic life in the forests and are having limited contact with the mainstream. The Cholanaikkans speak the Cholanaikkan language, which belongs to the Dravidian family. They are generally of short stature with well-built sturdy bodies. The complexion varies from dark to light brown. The faces are round or oval with depressed nasal root, their bridge being medium and the profile straight, lips are thin to the medium, hair tends to be curly. The Cholanaickan are distributed in various regions of the forest consisting of 2 to 10 families. Such a territory is called Chemmam, headed by 'Chemmakaran'. The Cholanaikans are very particular in observing the rules framed by their ancestors for the purpose of maintaining the territories under the Chemmam. Among the scheduled tribes of Kerala, Cholanaickan has a unique position. in the sense that they are the only community who depend solely on non timber forest produces for their consumption and for sale.

There are 101 Cholanaickan families in Kerala spreaded in three Grama Panchayats of Malappuram district. Their total population is 409 consisting of 223 males and 186 females. The family size of Cholanaickan community is 4.05 and the sex ratio is 1000:834. Their sex ratio is lowest among the scheduled tribe communities in Kerala. The literacy ratio of Cholanaickan is 39.63% which is the lowest among recognised communities in Kerala.

Analysis

1. District wise distribution of population of PVTG in Kerala

In Kerala, PVTG population are found only in seven districts particularly in north Kerala. Majority of (64.9%) PVTG population are concentrated in Wayanad district that also belong to a single community (Kattunayakan). Among the seven districts, Palakkad is the homeland of three distinct PVTG communities, and Malappuram and Kozhikkodu with two communities each. Among the five PVTG communities in Kerala, Kattunayakan occupies highest population and the lowest number is Cholanaickan.

District wise distribution of population of PVTG in Kerala

Sl No.	District	Community					Total	%
		Kadar	Kattu-nayakan	Koarga	Kurumbar	Chola-naickan		
1.	Idukki		4				4	0.015
2.	Trissur	1082					1082	4.118
3.	Palakkad	766	787		2251		3804	14.48
4.	Malappuram		2034			409	2443	9.299
5.	Kozhikkodu	126	119				245	0.933
6.	Wayanad		17051				17051	64.9
7.	Kasargod			1644			1644	6.257
	Total	**1974**	**19995**	**1644**	**2251**	**409**	**26273**	**100**

Source: Report on the Socio-economic status of Scheduled Tribes of Kerala, Govt. of Kerala 2013

2. Gender wise distribution of PVTG

Sex ratio among PVTG communities in Kerala is highest in Koraga with 1050 females per 1000 males and lowest in Cholanaickan with 834 females per 1000 males. It is to be noted that the sex ratio of all the five PVTG communities are lower than the average sex ratio of Kerala state which is 1084 per 1000 as per 2011 census

Gender wise distribution of PVTG in Kerala

Sl No.	Community	Male	Female	Total	Sex ratio
1.	Kadar	967	1007	1974	1041
2.	Kattunayakan	9953	10042	19995	1009
3.	Koraga	802	842	1644	1050
4.	Kurumbar	1128	1123	2251	996
5.	Cholanaickan	223	186	409	834

Source: Report on the Socio-economic status of Scheduled Tribes of Kerala, Govt. of Kerala 2013

3. Literacy rate of PVTG in Kerala

Though Kerala is a state with highest literacy rate in India as per 2011 census (93.91 %), PVTG communities in Kerala is less literate with a maximum of 78.35% among Koraga and with a minimum of only 39.63% among Cholanaickan community.

Literacy rate of PVTG in Kerala

Sl No.	Community	Population above 5 years	Illiterates	Literacy rate
1.	Kadar	1704	703	58.74
2.	Kattunayakan	17436	7084	59.37
3.	Koraga	1483	321	78.35
4.	Kurumbar	1888	824	56.36
5.	Cholanaickan	323	195	39.63

Source: Report on the Socio-economic status of Scheduled Tribes of Kerala, Govt. of Kerala 2013

4. Family size and Families having own house among PVTG in Kerala

The family size of Kurumbar community is the highest among PVTG groups in Kerala (4.15) and lowest is in Kadar community (3.62). The family size of all the PVTG communities in Kerala is less than the state average of 4.3 members per family as per 2011 census. About 90% of PVTG families are residing in their own houses, which show no significant difference across the communities.

Family size and Families having own house among PVTG in Kerala

Sl No.	Community	Total Population	Total Families	Family size	Families having own house	Percentage of families having own house
1.	Kadar	1974	545	3.62	501	92
2.	Kattunayakan	19995	5137	3.89	4550	89
3.	Koraga	1644	445	3.69	409	92
4.	Kurumbar	2251	543	4.15	509	94
5.	Cholanaickan	409	101	4.05	90	89

Source: Report on the Socio-economic status of Scheduled Tribes of Kerala, Govt. of Kerala 2013

5. Socio-economic status of PVTG

Regarding economic status in terms of BPL category among PVTG in Kerala, Kadar and Koraga are more backward than the other three groups. Regarding malnutrition among the five groups, more than forty percentage of families belonging to Koraga, Kurumbar and Cholanaickan are affected by it.

Socio-economic status of PVTG in Kerala

Sl No.	Community	Total Families		BPL Families		Families affected by Malnutrition		Unelectrified houses		Houses without proper latrine
		No.	%	No.	%	No.	%	No.	%	
1.	Kadar	545	401	74	41	8	381	70	324	59
2.	Kattunayakan	5137	2803	55	1374	27	4213	82	3005	58
3.	Koraga	445	334	75	208	47	307	69	160	36
4.	Kurumbar	543	284	52	249	46	527	97	454	84
5.	Cholanaickan	101	53	52	41	41	100	99	79	78

Source: Report on the Socio-economic status of Scheduled Tribes of Kerala, Govt. of Kerala 2013

A major issue noticed among PVTG families in Kerala is that majority of their houses are un-electrified, which is severe among Kurumbar and Cholanaickan communities where more than 96 % families are un-electrified. The PVTG in Kerala is also facing the issue of lack of proper latrine facilities, which is very high among Kurumbar and Cholanaickan communities.

Conclusion

The general notion that PVTG in Kerala is below par in terms of many socio economic and cultural parameters can be established while going through the analysis of data available relating to them. The population of these tribal groups are significantly less which ranges from 409 to 19995. Cholanaickan population are numerically very less and are far below standard in terms of almost all socio-cultural and economic parameters such as literacy, sex ratio, malnutrition, electrification of home etc. All the five PVTG in Kerala are dangerously lacking standard socio-economic infrastructure which is essential for a decent living in the modern era.

It can be concluded that a time-bound evaluation and monitoring of the programmes implemented by government and other agencies are essential for the economic, social and cultural upliftment of the PVTGs. The proper utilization of the development strategies by the community people according to the needs and requirements should be there; otherwise, their actual situation will remain same as before or even become grimmer. There should be bottom up need-based approaches in terms of the specific PVTG rather than existing top down approaches for their development. The execution of programmes from paper to people also needs to be done quickly. As the myriad of developmental programmes implemented so far could not reach to the desired extent, it is suggested that an objective oriented planning from the state and its effective implementation by joining hands with the target groups is required for bringing up various PVTG in Kerala to the mainstream of socio-economic life.

SOTHERN ECONOMIST,
MARCH 1, 2015.

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Solar Power - A Promising Opportunity

K.P. Ganesan

Investigations into the history of economic growth of the countries of the world indicate that the share of India's GDP to the world GDP had been 24.4% during 1700AD. However during the subsequent alien rule the raw materials were exported and the country was virtually converted in to a market for the products from abroad. The economy had suffered and the share of GDP had nose-dived to 4.2% of the world GDP when the country got independence. It should be the endeavour of everyone to ignite the growth momentum in every sector and recapture the lost glory. Arutchelvar Dr. Mahalingam who had analysed the endowment of resources had identified that 'the economy of India has the potentials to emerge strong comparable to the combined economy of the European Union. When the resources are utilized innovatively the per capita income can expand to over $30,000 against $1000 at present.

World renowned economic analysts have identified that economy of India has the potentials to grow to $85 trillion by 2050 when the bottle necks hampering the growth are removed and the annual growth maintained over 8.00%. The enthusiasm among the entrepreneurs from across the world to invest in India evinced during the 'Vibrant Gujarat' meet drives us to regain confidence. In such an environment it becomes an urgent endeavour to identify and remove the constraints to empower the nation to accelerate growth to emerge as the largest economy of the world.

1. Prime Mover of Economy

Electricity is the prime mover of the economy. While the per capita consumption of electric power ranges between 4000 units and 8000 units in developed countries it is hovering around 800 units in India. It is worrisome to know that 30% of the populations remain deprived of access to electricity in our country.

2. Generation and Distribution

The country generates around one trillion units of electricity per year. It is unfortunate, around 20-25% of the electricity generated is lost due to transmission and distribution (T&D)

bottlenecks while it is below 6% in developed countries; Thus an avoidable loss of around 200 billion units of electricity with a potential to generate products and services valued over Rs.60,00,000 crores to the GDP is daunting the growth of economy. It has to be admired that Gujarat state by segregating the infrastructure for industry, domestic and agricultural sections has dramatically brought down the T&D losses. The other states can adopt such an innovative approach to contain the T&D losses.

3. Manufacturing Sector

The contribution of manufacturing sector to the GDP of the developed countries ranges between 25% and 35% while it remains below 16% in India. Shortage of electricity remains a major constraint for the growth of manufacturing sector and the economy as a whole. Uninterrupted supply of electricity will help to accelerate the growth of industry which will in turn expand employment opportunities to observe the surplus human resources saddled in the agriculture sector as under employed or unemployed during most part of the year.

4. Shortage of Electricity

Shortage of electric power has been estimated to be around 25% - 35%. Availability of quality power is essential to generate products and services to remain competitive in the global market are indispensable. Shortage of power due to supply constraints of fuel coal, variations in quality of fuel coal, lower levels of water in hydro power generation stations etc has hampered the growth of economy. The government is planning to double the power generation capacity over next five years with an investment of around Rs.1,50,000 crores. With the dawn of 'Make in India' era launched by our Hon'ble Prime Minister to make best use of the resources available domestically to generate products and services to cater to the world market it becomes a prime endeavor to expand our generating capacity to make quality power available 24x7 to infuse confidence among the entrepreneurs to invest in manufacturing sector.

5. Solar power - A perennial source

Unlike power generation based on coal or fuel oil solar power operation is admired as a clean energy. It is a perennial source. The governments have been planning to tackle the power shortages to ascertain extent through renewable sources viz wind power, biogas, solar power etc. The country is endowed with sunlight almost over 360 days in a year which can be harnessed to generate power and reduce dependence on fossil fuel. During the past decades efforts have been made to harvest solar energy from roof tops mostly to meet lighting requirements in a small way. Massive efforts have not been taken due to high cost of investment involved then.

6. Recent advances in Solar Power Technology

Thanks to the advances in solar power technology the cost of solar power has come down to around Rs.5.25 per kwh against RS.17.00 a decade ago. The burden on the government to bridge the viability gap has come down drastically. Gujarat state has been a fore runner in harnessing solar energy on a massive scale. Even embankments of canals tank bunds and barren lands have been brought under solar power generation installations. Besides roof tops of dwelling houses and offices several thousand square kilometers of roof tops of buildings of schools, colleges and factories across the country can be made effective use for harnessing solar energy. It is gratifying to know that the country has committed to expand solar power capacity to 1,00,000 mw by 2022. Andhra Pradesh, Karnataka and Rajasthan states have entered into Memorandum of Understanding (MoU) with leading solar energy producers of the world and have launched massive schemes to generate solar power. Other states have to adopt such a promising approach to maximize power generation. Power distribution infrastructure has to be modernized on the lines of Gujarat model. During the years ahead solar power may become cheaper when compared to power generated using coal, furnace oil etc since the raw material viz sunlight is available free. Solar powered flights are in the offing.

Let us hope that the day may not be far off when supply of quality power available 24x7 to make India a manufacturing power house of the world fueled by 'Make in India' to empower the nation emerge as one of the developed countries of the world and to recapture the lost glory.

KISAN WORLD,
MARCH 2015.

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ഡയാലിസിസ് കേന്ദ്രങ്ങൾ സുരക്ഷിതമോ?

സുചിത്ര പ്രിയദർശിനി

വൃക്കരോഗബാധിതരുടെ എണ്ണം കേരളത്തിൽ വർധിച്ചുവരുകയാണെന്നത് യാഥാർഥ്യമാണ്. എന്നാൽ, അതിനനുസരിച്ച് മതിയായ ഡയാലിസിസ് കേന്ദ്രങ്ങൾ ഇവിടെയില്ല. ഇതിന് പരിഹാരമെന്ന പേരിൽ ഓരോ ദിവസവും കൂണുകൾ പോലെ ഒട്ടേറെ ഡയാലിസിസ് കേന്ദ്രങ്ങൾ ഇവിടെ മുളച്ചു പൊന്തുന്നുമുണ്ട്. കേരളത്തിൽ ആകെ എത്ര ഡയാലിസിസ് യൂണിറ്റുകൾ ഉണ്ടെന്നതിനെക്കുറിച്ച് കൃത്യമായ കണക്കുകൾ ഒരിടത്തും ലഭ്യമല്ല. എന്നാൽ, ഇത്തരത്തിൽ ഡയാലിസിസ് കേന്ദ്രങ്ങൾ തുടങ്ങാനോ അവയുടെ പ്രവർത്തനങ്ങൾ വിലയിരുത്താനോ നിയന്ത്രിക്കാനോ കൃത്യമായ മാനദണ്ഡമോ മാർഗനിർദ്ദേശങ്ങളോ ഇവിടെയില്ലെന്നതാണ് ഞെട്ടിപ്പിക്കുന്ന വസ്തുത. ലൈസൻസ് ഇല്ലാത്ത ഒരു കള്ളുഷാപ്പ് പോലും തുറക്കാനാവാത്ത കേരളത്തിൽ മനുഷ്യജീവൻ രക്ഷിക്കുന്ന തന്ത്രപ്രധാനമായ സ്ഥാപനം തുടങ്ങാൻ ഒരുതരത്തിലുള്ള അനുമതിയോ മാനദണ്ഡമോ ആവശ്യമില്ലെന്നതാണ് വിരോധാഭാസം.

ഒരു ഡയാലിസിസ് യന്ത്രവും കെട്ടിടവും സ്വന്തമായുണ്ടെങ്കിൽ ആർക്കും തുടങ്ങാവുന്ന സ്ഥാപനമായി മാറിയിരിക്കുന്നു ഡയാലിസിസ് കേന്ദ്രങ്ങൾ. പാവപ്പെട്ട രോഗിയുടെ നിസ്സഹായവസ്ഥയാണ് അറിഞ്ഞോ അറിയാതെയോ ഇവിടെ ചൂഷണം ചെയ്യപ്പെടുന്നത്. ജീവിതകാലം മുഴുവൻ നിലനിൽക്കുന്ന ഒരു രോഗം എന്ന നിലയ്ക്കും ചികിത്സ ചെലവ് ഏറ്റവും അധികം വേണ്ടുന്ന രോഗങ്ങളിൽ ഒന്ന് എന്ന നിലയ്ക്കും വൃക്കരോഗം ഗുരുതരമായ സാമൂഹികപ്രശ്നമായി മാറിക്കഴിഞ്ഞു.

പൊതുനിരത്തിൽ കൂടി സഞ്ചരിക്കുന്ന വാഹനങ്ങൾക്ക് വാഹനവകുപ്പിന്റെ ഫിറ്റ്നസ് സർട്ടിഫിക്കേറ്റും ആർ.സി. ബുക്കും അതിന്റെ ഡ്രൈവർമാർക്ക് നിയമ

പ്രാബല്യമുള്ള ലൈസൻസും വേണമെന്നുള്ളതിന് കർക്കശമായ നിയമവ്യവസ്ഥ യുണ്ട്. വാഹനങ്ങളിലേയും പൊതുനിരത്തുകളിലേയും യാത്രികരുടെ സുരക്ഷയും ജീവരക്ഷയുമാണ് ഇത്തരം നിയമങ്ങളുടെ കാതൽ. എന്നാൽ, മനുഷ്യരക്തം നേരിട്ട് ശുദ്ധീകരിച്ചെടുക്കുന്ന പ്രക്രിയയായ ഡയാലിസിസ് നടത്തുന്ന യൂണിറ്റുകൾ തുടങ്ങാനും നടത്താനും മാനദണ്ഡങ്ങൾ നിർവചിക്കപ്പെട്ടിട്ടില്ല എന്നത് ആപത്കരമായ സ്ഥിതിവിശേഷമാണ് ഉണ്ടാക്കുന്നത്-തൃശൂർ അമല മെഡിക്കൽ കോളേജിലെ നെഫ്രോളജിസ്റ്റ് ഡോ.ജയന്ത് തോമസ് മാത്യു പറയുന്നു. അനുയോജ്യമായ രീതിയിൽ ഡയാലിസിസ് ചെയ്യാത്തതുമൂലം ആരോഗ്യനില കൂടുതൽ മോശമാകുന്ന ഒട്ടേറെ രോഗികളുണ്ട്. ഇവിടെയാണ് ഡയാലിസിസ് സെന്ററുകൾക്ക് കൃത്യമായ മാനദണ്ഡങ്ങൾ വേണമെന്ന് ആവശ്യപ്പെടുന്നതിന്റെ പ്രാധാന്യം.

പതിയിരിക്കുന്ന അപകടങ്ങൾ

ജീവിതവും മരണവുമായുള്ള ഒളിച്ചുകളിയാണ് ഡയാലിസിസ് എന്ന് പറയാം. മരണത്തിന്റെ വക്കിൽ നിന്ന് ഒരു ജീവനെ രക്ഷപ്പെടുത്താനുള്ള കഠിനശ്രമമാണ് ഇവിടെ നടക്കുന്നത്. ശരീരത്തിൽ നിന്നും രക്തം ട്യൂബ് വഴി പുറത്തൊരു യന്ത്രത്തിൽ കയറ്റി ശുദ്ധീകരിച്ചെടുക്കുന്ന പ്രക്രിയ മാത്രമല്ല ഇത്. തുടങ്ങി അവസാനിക്കുന്നതുവരെ ഏതു നിമിഷവും ജീവനെടുത്തേക്കാവുന്ന കുഴപ്പം പ്രത്യക്ഷപ്പെടാം. അതിനാൽ, വിദഗ്ധഡോക്ടർമാരുടെയും അംഗീകൃതയോഗ്യതയുള്ള നഴ്സുമാരുടെയും ടെക്നീഷ്യൻമാരുടെയും മേൽനോട്ടത്തിലും പരിചരണത്തിലും വേണം ഡയാലിസിസ് നടത്താൻ.

മുൻകൂട്ടി കാണാൻ കഴിയാത്ത മഞ്ഞപ്പിത്തം പോലുള്ള അണുബാധകൾക്ക് ഡയാലിസിസ് ഇടവരുത്താം. ഡയാലിസിസ് രോഗികളിൽ ഒരാൾക്ക് മഞ്ഞപ്പിത്തമുണ്ടെന്നു കരുതുക. ഇത് പരിശോധിക്കാതെ അശ്രദ്ധമായി ഡയാലിസിസ് ചെയ്യുന്ന പക്ഷം മറ്റു രോഗികൾക്കും ഇതുമായി ബന്ധപ്പെട്ട് നിൽക്കുന്ന ഡോക്ടർക്കും ജീവനക്കാർക്കുമെല്ലാം മഞ്ഞപ്പിത്തം പകരാനിടയുണ്ട്. കർശന നിരീക്ഷണത്തിലൂടെ മാത്രമേ ഈ പ്രശ്നം ഒഴിവാക്കാനാവൂ. ഡയാലിസിസ് കഴിഞ്ഞ് ഡയലൈസറും മറ്റും വൃത്തിയാക്കുന്ന സ്ഥലത്ത് മതിയായ സൗകര്യങ്ങൾ ഇല്ലെങ്കിലും രോഗം പകരും. വൃക്കരോഗത്തിനു പുറമെ ഇത്തരം അണുബാധകൾ കൂടിയുണ്ടാകുന്നത് രോഗിയെ ഗുരുതരമായി ബാധിക്കും. വൃക്ക മാറ്റിവെക്കൽ ശസ്ത്രക്രിയ നടത്തുമ്പോൾ വിജയസാധ്യതയും കുറയും.

ഹൃദയസ്തംഭനം, അപസ്മാരം, രക്തം ചോർന്ന് പോവുക, രക്തസമ്മർദം കുറയുകയോ കൂടുകയോ ചെയ്യുക, രക്തത്തിലെ പഞ്ചസാരയുടെ നില താഴുക,

രക്തപ്രവാഹത്തിൽ വായുകുമിളകൾ കടന്നുകയറുക, പേശീവലിവ്, ഡയാലിസിസ് നടത്താൻ ശരീരത്തിൽ കത്തീറ്റർ ഘടിപ്പിച്ച സ്ഥാനങ്ങളിൽ അണുബാധ, ഛർദി, ഓക്കാനം, പനി, വിറയൽ എന്നിങ്ങനെ ഗുരുതരങ്ങളായേക്കാവുന്ന പല അവസ്ഥകളും ഡയാലിസിനിനിടെ വന്നുചേരാം. ഇതിൽതന്നെ, ഹൃദ്രോഗികൾക്കും മഞ്ഞപ്പിത്ത ബാധിതർക്കും അർബുദരോഗികൾക്കും ഡയാലിസിസ് ചെയ്യുമ്പോൾ പ്രത്യേക ശ്രദ്ധ നൽകേണ്ടതുണ്ട്.

നിർബന്ധമാക്കേണ്ട മാനദണ്ഡങ്ങൾ

ആസ്പത്രികളുടെ മേൽനോട്ടം ഡയാലിസിസിനിടെ ഒരു പ്രശ്നമുണ്ടായാൽ നിങ്ങൾ എവിടെ വേണമെങ്കിലും പൊയ്ക്കോ എന്ന നിലപാട് ചില സെന്ററുകാർ രോഗികളോട് പുലർത്താറുണ്ട്. ഇത്തരം സാഹചര്യങ്ങളിൽ എവിടെ പോകണമെന്ന് പാവപ്പെട്ട രോഗികൾക്ക് അറിയുകയുമില്ല. അതിനാൽ, സ്വതന്ത്രമായി പ്രവർത്തിക്കുന്ന ഓരോ ഡയാലിസിസ് യൂണിറ്റും എല്ലാ അടിയന്തിര ചികിത്സാ സൗകര്യങ്ങളുമുള്ള ഒരു ആസ്പത്രിയുടെ ഉത്തരവാദിത്തത്തിലും മേൽനോട്ടത്തിലും വേണം പ്രവർത്തിക്കാൻ.

ഡോക്ടറുടെ സേവനം നിർബന്ധം: അംഗീകൃതയോഗ്യതകൾ ഉള്ള ഒരു നെഫ്രോളജിസ്റ്റിന്റെ കീഴലായിരിക്കണം എല്ലാ ഡയാലിസിസ് പ്രക്രിയകളും നടക്കേണ്ടത്. അല്ലെങ്കിൽ, അനുഭവപരിചയമുള്ള ഒരു ഡോക്ടർ മുഴുവൻ സമയവും മേൽനോട്ടത്തിനായി വേണം പെട്ടെന്ന് ഉണ്ടാകുന്ന സങ്കീർണ്ണതകൾ കൈകാര്യം ചെയ്യാനാണ് ഇത്. ഇന്ന് നമ്മുടെ നാട്ടിൽ സ്വതന്ത്രമായി പ്രവർത്തിക്കുന്ന ധാരാളം ഡയാലിസിസ് യൂണിറ്റുകൾ ഉണ്ട്. ദൗർഭാഗ്യകരമെന്ന് പറയട്ടെ, അംഗീകൃത വിദ്യാഭ്യാസ യോഗ്യതയുള്ള ഒരു വൃക്കരോഗവിദഗ്ധന്റെ മേൽനോട്ടത്തിലല്ല ഇവയിൽ മിക്കവയും പ്രവർത്തിക്കുന്നത്. രോഗികളുടെ ജീവൻതന്നെ അപകടത്തിലാകുന്ന വിധത്തിൽ, അവരെ ആപത്തിലേക്ക് തള്ളിവിടുകയാണ് ഈ സ്ഥിതി കൊണ്ട് ഉണ്ടാകുന്നത്.

ജീവനക്കാരും മുൻകരുതൽ എടുക്കണം: രക്തത്തിലൂടെ പകരുന്ന രോഗാണുക്കൾ അടക്കമുള്ള പകർച്ച വ്യാധികൾ ഇല്ലെന്ന് ഉറപ്പുവരുത്തി വേണം ജീവനക്കാരെ നിയമിക്കാൻ. എല്ലാ ജീവനക്കാർക്കും മഞ്ഞപ്പിത്തമടക്കമുള്ള പകർച്ചവ്യാധികൾക്ക് എതിരെ നിർദ്ദേശിക്കപ്പെട്ട കുത്തിവെപ്പുകളും നൽകണം. ഹീമോഡയാലിസിസ് പ്രക്രിയ നടത്തുമ്പോഴും ഡയലൈസറും അതിലേക്ക് ഘടിപ്പിക്കുന്ന രക്തക്കുഴലുകളും ശുദ്ധീകരിക്കുമ്പോഴും ഡയാലിസിസ് ജീവനക്കാർ അണുവിമുക്തമാക്കിയ കൈയുറകളും സംരക്ഷണകവചങ്ങളും ധരിക്കുന്നുണ്ടെന്ന് ഉറപ്പുവരുത്തണം. അല്ലെങ്കിൽ രോഗികളിൽനിന്നു ജീവിനക്കാർക്ക് അണുബാധ

യേൽക്കാനോ ജീവനക്കാർക്ക് അണുബാധയുണ്ടെങ്കിൽ അത് രോഗികൾക്ക് പക രാനോ സാധ്യതയുണ്ട്.

അടിസ്ഥാന സൗകര്യങ്ങൾ: രോഗിയുടെ നില വഷളായാൽ പെട്ടെന്ന് ആസ്പ ത്രിയിൽ എത്തിക്കാൻ സൗകര്യമുണ്ടായിരിക്കണം. രണ്ടാംനിലയിലാണ് യൂണിറ്റ് സ്ഥിതി ചെയ്യുന്നതെങ്കിൽ താഴേക്ക് കൊണ്ടുവരാൻ ലിഫ്റ്റ് വേണം. അല്ലെങ്കിൽ റാമ്പ് വേണം. കഴിവതും സെന്റർ താഴത്തെ നിലയിൽതന്നെയാകുന്നതാണ് നല്ല ത്. അല്ലെങ്കിൽ രോഗിയെ താഴെയെത്തിക്കുന്നതിന് വേണ്ടിവരുന്ന ഒന്നോ രണ്ടോ മിനുട്ടിന്റെ കാലതാമസം പോലും രോഗിയുടെ ജീവൻ നഷ്ടപ്പെടുത്തിയേക്കാം.

മുൻകൂട്ടി കാണാൻ കഴിയാത്ത ആരോഗ്യപ്രശ്നങ്ങളും അടിയന്തിരഘട്ടങ്ങളും നേരിടാൻ ഓരോ ഡയാലിസിസ് യൂണിറ്റിനൊപ്പവും വെന്റിലേറ്ററോട് കൂടിയ തീവ്ര പരിചരണ സംവിധാനവും ശ്വാസോച്ഛ്വാസ പരിചരണ സംവിധാനവും ഉണ്ടായിരി ക്കണം.

ജീവനക്കാർക്ക് സഞ്ചരിക്കാനും രോഗലക്ഷണശമനോപാധികൾ രോഗികളുടെ അടുത്തേക്ക് എളുപ്പത്തിൽ എത്തിക്കാനും ആവശ്യമായ സ്ഥലസൗകര്യം നൽക ത്തക്കവണ്ണം ഓരോ ഡയാലിസിസ് യന്ത്രത്തോടും ചേർന്ന് ചുരുങ്ങിയത് 70 ചതു രശ്ര അടിയെങ്കിലും ഉണ്ടായിരിക്കണം. ഡയാലിസിസ് യന്ത്രങ്ങൾ ദിവസേന 10 മുതൽ 12 മണിക്കൂർ വരെ പ്രവർത്തിപ്പിക്കേണ്ടി വരുന്നതിനാൽ ഡയാലിസിസ് യൂണിറ്റുകളിൽ ഈ താപനില നിലനിർത്തിയില്ലെങ്കിൽ യന്ത്രങ്ങൾ ചൂടുപിടിക്കാനും പ്രവർത്തനരഹിതമാകാനും ഇടയുണ്ട്. അതിനാൽ, ഓരോ ഡയാലിസിസ് യൂണി റ്റിലും എപ്പോഴും 21 മുതൽ 25 ഡിഗ്രി സെൽഷ്യസ് വരെ താപനില നിലനിർത്തേ ണ്ടതാണ്. ഇതിനായി എയർ കണ്ടീഷൻ സൗകര്യങ്ങളും സജ്ജമാക്കണം.

പകർച്ചവ്യാധികൾ ഉള്ള രോഗികൾക്കായി പ്രത്യേകം വിഭാഗവും ക്രമീകര ണവും നൽകേണ്ടണ്ടതും പ്രധാനമാണ്. ഈ വിഭാഗത്തിനായി പ്രത്യേകം ജല വിതരണവും ജലനിർഗമന സംവിധാനവും വേണം. രോഗികളെ ശുശ്രൂഷിക്കുന്ന എല്ലാ സ്ഥലങ്ങളിലും കൈകൾ ശുചിയാക്കാനുള്ള സൗകര്യങ്ങളും ആൽക്ക ഹോൾ നിർമ്മിതമായ ശുചീകരണലായനിയോ മറ്റ് അണുവിമുക്തലായനികളോ ലഭ്യമാക്കുകയും വേണം.

ഡയാലിസിസ് പ്രക്രിയ്ക്ക് ശേഷം ഡയലൈസർ ശുചിയാക്കാനും ശുദ്ധീക രിക്കാനും പ്രത്യേകം വിഭാഗവും സ്ഥലസൗകര്യവും ആവശ്യമാണ്. മഞ്ഞപ്പിത്ത രോഗബാധയും മറ്റ് പകർച്ചവ്യാധികളും ഉള്ള രോഗികളുടെ ഡയലൈസറുകൾ ശുചീകരിക്കാനായി പ്രത്യേക ശുചീകരണവിഭാഗം സ്ഥാപിക്കണം. ശുദ്ധീകരണ

പ്രക്രിയ ശരിയായ വിധത്തിലല്ല നിർവഹിക്കുന്നതെങ്കിൽ ഒരു വ്യക്തിയിൽനിന്ന് മറ്റൊരു വ്യക്തിയിലേക്ക് അണുബാധ പകരാം.

ജലശുചീകരണ സംവിധാനം: ഓരോ ഡയാലിസിസിനും ഒരു രോഗിക്ക് 120 ലിറ്റർ ജലം ആവശ്യമുണ്ട്. ഒരു വ്യക്തി ഒരു ദിവസം കുടിക്കുന്ന ദ്രാവകത്തിന്റെ ഏകദേശം 40 ഇരട്ടിയാണിത്. ആമാശയക്കുഴലിന്റെ സംരക്ഷിതകവചത്തിലൂടെയല്ല ഈ ജലം രോഗിയുടെ ശരീരത്തിലെത്തുന്നത്. വൃക്ക തകരാറിലാകുന്നതോടെ വിഷവസ്തുക്കൾ ശരീരത്തിൽനിന്നു നീക്കാനുള്ള കഴിവും നഷ്ടമാകും. ഇവയെല്ലാം, ജലത്തിലെ രാസപദാർത്ഥങ്ങളുടെയും പരമാണുക്കളുടെയും സാന്നിധ്യമുണ്ടാക്കുന്ന വിഷബാധയുടെ അപകടസാധ്യത വർധിപ്പിക്കും. ശുചീകരണസംവിധാനത്തിന്റെ ക്രമീകരണത്തിന്റെയും ഉപയോഗിക്കുന്ന ജലത്തിന്റെയും ഗുണനിലവാരത്തിന് അനുസൃതമായിട്ടായിരിക്കും. അതിനാൽ, എ.എ.എം.ഐ നിർദ്ദേശിച്ചിട്ടുള്ള ഗുണനിലവാരം കണിശമായി പാലിക്കുന്ന ജലം ലഭിക്കുന്ന വിധത്തിലായിരിക്കും ഓരോ ഡയാലിസിസ് യൂണിറ്റുകളുടെയും ജലശുചീകരണസംവിധാനം നിലനിർത്തേണ്ടത്. നിഷ്കർഷയോടെ ശുദ്ധീകരണപ്രക്രിയ നടത്തിയിട്ടുള്ള ജലമല്ല ഡയാലിസിസിനായി ഉപയോഗിക്കുന്നതെങ്കിൽ രോഗാണുക്കളും മറ്റ് രാസഘടകങ്ങളും നേരിട്ട് രോഗിയുടെ രക്തത്തിലേക്ക് പ്രവേശിക്കും. ഇതിന്റെ ഫലമായി അണുബാധയും ചിലപ്പോൾ മരണം തന്നെയും സംഭവിക്കാം.

രാസപദാർഥ ശുദ്ധത: ശുചീകരിച്ച ജലത്തിന്റെ സാമ്പിൾ മൂന്ന് മാസത്തിൽ ഒരിക്കലെങ്കിലും വിശദമായ രാസപദാർഥ വിശകലനത്തിനായി പര്യാപ്തമായ സൗകര്യങ്ങളുള്ള ഏതെങ്കിലും ഒരു അംഗീകൃതപരീക്ഷണശാലയിൽ നൽകണം. ഈ വിശകലനത്തിന്റെ ഫലങ്ങൾ കണിശവും കൃത്യവുമായ രേഖകളായി സൂക്ഷിക്കണം.

സൂക്ഷ്മാണു ശുദ്ധത: ശുചീകരിച്ച ജലത്തിന്റെ സാമ്പിൾ 30 ദിവസത്തിൽ ഒരിക്കലെങ്കിലും ജീവാണുസാന്നിധ്യ പരിശോധനയ്ക്കായി നൽകേണ്ടതും അതിന്റെ ഫലങ്ങൾ കൃത്യമായി സൂക്ഷിക്കേണ്ടതുമാണ്.

രോഗാണു പരിശോധനയും ചികിത്സയും: രക്തത്തിലൂടെ പകരുന്ന രോഗാണുക്കളെ കണ്ടെത്താനുള്ള പരിശോധനയും ചികത്സയും എല്ലാ യൂണിറ്റുകളിലും വേണം. ഡയാലിസിസ് യൂണിറ്റിലേക്ക് ആദ്യമായി പ്രവേശിപ്പിക്കുന്നതോ മറ്റ് യൂണിറ്റുകളിൽനിന്ന് വരുന്നതോ ആയ ഓരോ രോഗിയേയും ഹെപ്പറ്റൈറ്റിസ് ബി, ഹെപ്പറ്റൈറ്റിസ് സി, എച്ച്.ഐ.വി. എന്നീ പരിശോധനകൾക്ക് വിധേയമാക്കേണ്ടത് വളരെ പ്രധാനമാണ്. ഹീമോഡയാലിസിസ് തുടരുന്ന എല്ലാ രോഗികളിലും മൂന്നു മാസം കൂടുമ്പോൾ ഈ പരിശോധനകൾ ആവർത്തിക്കണം. ഹെപ്പറ്റൈറ്റിസ് ബി

പരിശോധനാ ഫലം നെഗറ്റീവ് ആണെന്ന് കാണുന്ന ഓരോ രോഗിക്കും അംഗീകൃത ചട്ടങ്ങൾക്കനുസൃതമായി മഞ്ഞപ്പിത്തത്തിനെതിരെയുള്ള കുത്തിവെപ്പ് നൽകണം.

സർക്കാർ ഇടപെടൽ വേണം

രോഗദുരിതങ്ങൾ അനുഭവിക്കുന്ന വൃക്ക രോഗികളെ കൂടുതൽ ദുരന്തങ്ങളിലേക്ക് തള്ളിവിടാതെ ഗുണനിലവാരമുള്ള പരിചരണം അവർക്ക് നൽകാൻ സർക്കാരിനും ഉത്തരവാദിത്തമുണ്ട്. അതുകൊണ്ടാണ്, ഡയാലിസിസിലുണ്ടാകുന്ന പാകപ്പിഴകളുടെ പേരിൽ രോഗിയുടെ ജീവൻ തന്നെ നഷ്ടമാകുന്ന അവസ്ഥ ഒഴിവാക്കാൻ സർക്കാർ അനുമതിയോടെ, നിശ്ചിത മാനദണ്ഡങ്ങൾ പാലിച്ച് മാത്രമേ ഡയാലിസിസ് സെന്റർ തുടങ്ങാവൂ എന്ന് ആരോഗ്യരംഗത്തെ വിദഗ്ധർ ശഠിക്കുന്നത്. ഇക്കാര്യങ്ങൾ ചൂണ്ടിക്കാട്ടി ഡയാലിസിസ് സെന്ററുകൾ പാലിക്കേണ്ട ചില മാർഗനിർദേശങ്ങൾ തയ്യാറാക്കി ഇന്ത്യൻ സൊസൈറ്റി ഓഫ് നെഫ്രോളജി സർക്കാറിന് സമർപ്പിച്ചിട്ടുണ്ട്. ഇതിൻമേൽ ഇതുവരെ നടപടികളൊന്നും ആയിട്ടില്ല.

കൃത്യമായ ഇടവേളകളിൽ ഡയാലിസിസ് സെന്ററുകൾ ഉത്തരവാദപ്പെട്ടവർ വന്ന് പരിശോധിക്കണമെന്നും ഇവർ ആവശ്യപ്പെടുന്നു. കേരളത്തെ മൂന്നു മേഖലയായി തിരിച്ച് സർക്കാർ മെഡിക്കൽ കോളേജ്, സ്വകാര്യ മേഖല എന്നിവിടങ്ങളിൽ നിന്ന് ഓരോ ആരോഗ്യവിദഗ്ധരും ഒരു സർക്കാർ പ്രതിനിധിയും ഉൾപ്പെട്ട സമിതി രൂപവത്കരിച്ച് ഈ പരിശോധനകൾ നടത്തണമെന്നാണ് ആവശ്യം. അടിസ്ഥാന സൗകര്യങ്ങൾ ഇല്ലാത്തവർക്ക് അതുണ്ടാകാൻ ആദ്യം ഒരു നിശ്ചിത സമയം നൽകിയാൽ പരാതികൾ ഒഴിവാക്കാനുമാകും. പോരായ്മകൾ പരിഹരിച്ചശേഷം പരിശോധനകൾ നടത്താം. ഇതുവഴി ഡയാലിസിസ് സെന്ററുകൾ കൂടുതൽ സുരക്ഷിതവും ഡയാലിസിസ് അപകടരഹിതവുമാക്കാനാകും. അത് അവയുടെ സേവനം അനുഭവിക്കുന്ന രോഗികളുടെ ജീവന് സുരക്ഷയേകാനും അവർക്ക് നേരിടേണ്ടി വരുന്ന ആരോഗ്യ പ്രശ്നങ്ങൾക്ക് ഒരു പരിധിവരെ പരിഹാരമേകാനും സഹായിക്കും. അതിനാൽ, ഹീമോഡയാലിസിസ് നടത്തുന്ന യൂണിറ്റുകളിലെല്ലാം മേൽപ്പറഞ്ഞ ചുരുങ്ങിയ മാനദണ്ഡങ്ങളെങ്കിലും പാലിക്കണമെന്ന കർക്കശമായ ചട്ടങ്ങൾ ആവിഷ്കരിക്കേണ്ടത് അത്യന്താപേക്ഷിതമാണ്.

മാതൃഭൂമി ആരോഗ്യമാസിക,
മാർച്ച് 2015.

Slippery Slope for Public Health Services

Anant Phadke

From the point of view of common people, the background to the National Health Policy 2015, Draft (hereafter draft NHP) could not have been very inspiring. Instead of the long-awaited jump in the healthcare budget, the 2014-15 budget showed hardly any rise in allocation for health, making a mockery of its declaration of a "Health Assurance Mission." In December 2014 the central government reportedly cut Rs 7,000 crore from an already low budget due to fiscal pressure. Further, if we consider the views of Arvind Panagariya, vice-chairman of the newly formed NITI Aayog, it has to be assumed that the NHP will be cast in a full-blown neo-liberal framework. Panagariya has argued for cash transfer to the poor instead of providing public health services:

> Once the poor have been provided the financial resources necessary to pay for their health care expenditures, there does not remain a case for additionally free provision of the service by the government.....We estimate that...excluding administrative costs, the government can provide at least a modest health care cover for the bottom half of the population for just three-quarters of a percent of the GDP (Panagariya et al 2014 cited by Kurian 2014).

In response to the draft NHP, the Jan Swasthya Abhiyan (People's Health Movement) has, pending detailed criticism, circulated a short critical response. The National Human Rights Commission too has been critical (Times of India 2015). As pointed out by the Jan Swasthya Abhiyan, the draft NHP has no review of the approach and results of the 2002 Health Policy; it makes no reference to the High Level Expert Group's Universal Health Coverage report and the Twelfth Plan document. It has no defined goals or time-bound objectives against which progress towards the policy objectives can be assessed. There are so many such lacunae and omissions regarding a whole range of issues. This short note deals with only two critical issues in the draft NHP- the issue of using public finance to shape healthcare and the issue of regulation of private healthcare.

Public Funds

The most important change seen in the draft NHP is related to the use of public funds in the health sector. According to the overall policy on the objective and method of using public funds in the health sector is:

> To reduce out of pocket expenditures, catastrophic expenditures and eliminate impoverishment, tax based financing would remain the predominant source of financing for at least 70% of the population who are poor and vulnerable ... Free primary care provision by the public sector supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and private sector would be the main financing strategy of assuring health care services. Current publicly financed National Health Insurance schemes would be aligned with this strategy and States would also be encouraged to do the same ("Financing of Health Care & Engaging the Private Sector" Section 6.1).

In Section 4.3.3, "Reorienting Public Hospitals," the draft NHP says

> An important change in policy mind-set is to move away from imagining public hospitals as social enterprises that ideally must recover the costs of their functioning, to re- imagining them as part of a tax financed single payer health care system in which, what public hospitals deliver is not free care, but rather pre-paid care (like in commercial insurance) and which is cost efficient in addressing health care needs of the population .... The other corollary of viewing public services-not as free, but as prepaid is that quality of care would become an imperative and all public facilities must have periodic measurements and certification for level of quality and must be financed and incentivized to meet and retain quality standards.

The draft NHP has proposed a policy of "strategic purchasing" which means that the government will use public funds to purchase public health services and private health services. In Section 4.3.2.4 it says

> Strategic purchasing refers to the Government acting as a single payer -purchasing care from public hospitals and private providers as part of a strategic plan for district health systems development ... One element of strategic purchasing is that there is preference to public facilities - justified by the needs of national health programmes, many of which are not and never will be commercially remunerative, by the need to retain adequate reserve capacity for public health emergencies, by the fact that private sector regulation, especially as regards costs, remains a challenge and would be possible only in the presence of a vibrant public sector. Even within the private sector a strategic preference for not for profit hospitals which are prepared to work on cost recovery principles and address public health goals in a spirit of service would require to be prioritized.

The new approach to financing of healthcare is to be

> Part of the public investment, especially that going to core infrastructure and a part of human resources and supplies would be through budgetary allocation, but an increasing part would be through reimbursement for services provided or in other words a resource allocation that is responsive to quantity, diversity and quality of caseloads provided care. Another part of this is purchasing care from private hospitals to close critical gaps in public provisioning of services.

These formulations imply, at least do not rule out, that the public and private facilities would be treated on par; a kind of economic/commercial competition between public and private hospitals would be enforced, unmindful of the fact that public hospitals have to deal with public health emergencies, have legal duties and many of them are involved in teaching as well. (Note that district hospitals are also likely to become teaching hospitals.)

This approach of purchasing public health services is explained in Section 6.2 of the draft NHP:

> The policy therefore calls for major reforms in public financing even for public facilities where a significant part of the funds - especially most of those related to operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Fixed costs, which include items like infrastructure development and maintenance, the non-incentive cost of the human resources, i.e., salaries, much of administrative costs would however continue to flow on a budget basis.

Cost Efficiency?

Despite various caveats in the draft NHP that it favours equity, it is clear that the public health services would be assessed on the basis of "cost-efficiency" measured in monetary terms. It clearly says, "Inclusion of cost-benefit and cost effectiveness studies in programme design and evaluation would also contribute significantly to increasing efficiency of public expenditure".

What is the implication of this approach? In many areas where public health services have not been available so far, when a new public health facility is opened initially, very few needy people may come to avail of the facility. This low attendance may not be a reflection of the efficiency or commitment of the public health facility. But the funding of such a facility will be low because if the draft NHP is implemented, funding will be based on the amount of caseload handled by the institutions. Given such implications, one would argue that a direction to make public health facilities function with the same market parameters as private enterprises is not a welcome idea.

This new approach is based on the premise that the funds for public health facilities are not being used efficiently. But as the draft NHP itself says:

> In terms of comparative efficiency, public sector is value for money as it accounts (based on the NSSO 60th round) for less than 30% of total expenditure, but provides for about 20% of outpatient care and 40% of inpatient care. This same expenditure also pays for 60% of end-of-life care (RGI estimates on hospital mortality), and almost 100% of preventive and promotive care and a substantial part of medical and nursing education as well.

There are certain problems with the functioning of public health facilities. But applying monetary logic to them is not the answer to their problems. In a devious way, the draft NHP fosters a new, slippery path for fostering the logic of the market in the public health system.

One important disturbing trend in the financing of health care in India is the rapid growth of venture capital in the field of health. The draft NHP takes note of this trend.

> Indeed in one year alone 2012-13, as per market sources, the private health care industry attracted over 2 billion dollars of FDI much of it as venture capital. For International Finance Corporation, the section of the World Bank investing in private sector, the Indian private health care industry is the second highest destination for its global investments in health. While recognizing that the growth of such industry brings in revenue through medical tourism and that it provides employment, there is a necessity and a rationale for the Health Ministry to intervene and to actively shape the growth of this sector for ensuring that it is aligned to its overall health policy goals, especially with regards to access and financial protection.

But the draft does not specify any specific strategy to curb this tendency.

Regarding strategic purchasing of private health services, the draft NHP is neither clear nor consistent. On the one hand, it says that in strategic purchasing, preference will be given to purchasing public health services and non-profit health care providers. But as regards urban areas, it says, "Given the large presence of private sector in urban areas there is considerable scope for developing sustainable models of partnership with the for profit and not for profit sectors for health care delivery". It is not clear what is the approach of NHP towards the corporate section in private healthcare, which is progressively becoming dominant.

Second, on the one hand it recognizes the problems of insurance-based health-care because of issues like "fragmentation of funds available for health care; especially selective allocation to secondary and tertiary care over primary care services" as well as problems of "denial of services, over-supply of some services and various fraudulent practices, including informal payments." Added to this are other problems with health insurance which the draft NHP has not mentioned-like adding a layer of profiteering, failing to ensure rationality in the provision

of care, unaccountability. But as seen above, the current insurance schemes will have an important place in the scheme things proposed by the draft NHP.

In various ways, the draft NHP indicates the superiority of and preference for public health services. But there is no specific plan to undertake the much needed massive strengthening and expansion of the public health services. The likely result would be continued, progressive domination by private health services, and continued erosion and corruption of public health services by the dominant private sector.

Ignoring Regulation

On the crucial issue of regulation of the private sector, the draft NHP has very little of substance to say and is quite unsatisfactory. At one level the draft NHP recognizes the problems posed by private health service and says

> It is clear that without a regulatory structure in place, it would be difficult to ensure that public private partnerships or insurance based purchasing would deliver on either health outcomes or financial protection. Much greater emphasis must therefore go into making regulation work.

However, instead of specifying what improvements should be made in the Clinical Establishment Act 2010, to make the regulation effective, just and user-friendly, it suggests "Accreditation of clinical establishments and active promotion and adoption of standard treatment guidelines would be one starting point." It glosses over the fact that accreditation, a voluntary mechanism has hardly even started in the last 60 years and hence there is no alternative to legal, mandatory regulation. It notes objections of "some stakeholders" that the act is "intrusive" etc, but does not mention the objections of civil society groups to the absence of a standard charter of Patient's Rights, of grievance redressal, of autonomous regulatory structure, etc.

Regarding the regulatory framework for professional medical education, in reference to medical councils, the draft NHP merely mentions the need for "major reform and strengthening of these bodies and their accountability" but does not offer anything beyond expressing some general principles and concerns. There is no clear statement on the need to ban capitation fee/ donation collecting private medical colleges, which distorts the entire health care sector.

Regulating the private pharmaceutical sector is an essential, crucial part of the regulation of the private health sector. But the draft NHP does not even mention the huge challenges faced by the Indian pharma industry due to the moves of multinationals to take over Indian companies, the United States' pressure to dilute the already weakened Indian Patent Act 2005, the failure of the Jan Aushadhi Scheme to supply generic medicines etc. The draft NHP is vague and non-committal. Regarding the crucial issue of regulation of prices of medicines, it merely states "Regulation of drug pricing is under the Department of Pharmaceuticals and this has been

playing an active and effective role in monitoring prices and taking actions." This is a vacuous claim. The fact remains that the pharma industry continues to fleece people through very high prices and that the Drug Price Control Order 2013 which adopted a market-based price control regime, is a sham; it has only legitimised high prices of medicines. It covers only about 18% of medicines and the average reduction in prices has been only 6%, when it is widely known that prices are many times the cost of production due to profiteering of the pharma industry and pharma trade.

The NHP also says, "Pricing for drugs shall continue to be regulated for an increasing range of essential drugs" and "Timely revision of NELM along with appropriate price control mechanisms for generic drugs". It fails to appreciate that it is useless to keep price control only for generic medicines, because today most medicines are branded medicines. Before concluding, it may be recalled that Universal Health Coverage, the 2012 report of the High Level Expert Group appointed by the Planning Commission, was a milestone document. Any subsequent document of the government on health policy should go beyond it and overcome that report's lacunae. However, an examination of the draft NHP on two crucial components of health policy - the issue of using public finance to shape healthcare and the issue of regulation of private health sector - one has to conclude that the 2015 draft NHP is a disappointment.

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Driven to distress

R. Krishna Kumar

Kerala once again drawing attention to itself, this time for a persistent trend of a large number of households being pushed into financial ruin because of the expenses incurred for medical care.

Several studies have now found evidence for the many facets of this worrying development in a State that was known until the mid-1980s for its health care model that offered "good health at low cost" and for its health care indices that were comparable to those in more developed countries. However, today, the highest rate of health-related impoverishment in India is being noticed in Kerala, according to researchers, who also warn that all over the country high private health care spending and high out-of-pocket spending are placing a substantial financial burden on urban and rural households.

A committee of health care experts constituted by the Kerala State Planning Board has also cautioned that the health care infrastructure in Kerala and the finances of the common man have come under severe stress, with the State recording the highest per capita public and private health expenditure among major States. The highest out-of-pocket expenditures on health in the country have also been noticed in Kerala, said a concept note prepared in November 2014 by the committee, which was constituted as part of the implementation of the 12th Five Year Plan proposals on the health sector.

The committee said that the high cost of treatment and out-of-pocket expenditure led to a large section of people falling below the poverty line (BPL). It said, a study done by Peter Berman and Rajeev Ahuja ("The Impoverishing Effect of Health Care Payments in India: New Evidence and Methodology", published in India Health Beat by the Public Health Foundation of India and the World Bank unit in New Delhi in December 2009) using National Sample Survey Office (NSSO) 2004 survey data estimated that around 12 per cent of rural households and 8 per cent of urban households in Kerala were pushed below the poverty line in that year because of health care expenditure.

"A Kerala Sastra Sahitya Parishad [KSSP, the People's Science Movement] study in 1987 showed that the average health expenditure per person per annum in Kerala then was Rs.89. It increased to Rs.549 in 1997 and Rs. l,837 in 2004. The results of the latest KSSP survey in 2012 showed that the average per capita out-of-pocket health expenditure in the State was Rs.5,269.05," said Dr B. Ekbal, public health activist, former president of the KSSP, and national convener of the Jan Swasthya Abhiyan (People's Health Movement India).

"There is no doubt that the highest annual out-of-pocket health expenditure is in Kerala. The data obtained from the latest [2014J NSSO survey [conducted every 10 years] are being analysed and the results will be known in a few months. That will show if the RSBY [Rashtriya Swasthya Bima Yojna, the Government of India's national health insurance programme for BPL households] and other government-financed risk protection schemes introduced in the past decade have had any impact," said Arun B. Nair, a consultant (health economics and financing) with the National Health Systems Resource Centre.

Health care costs are indeed one of the important causes of impoverishment in all States in India. Berman and Ahuja's study found, among other things, that, compared with other developing countries, private health care spending in India was much higher than government spending; the share of out-of-pocket health spending within private health spending was much higher; and outpatient care, which involved relatively small but more frequent payments, was more impoverishing than inpatient care.

According to the Draft National Health Policy 2015 document prepared by the Ministry of Health and Family Welfare last December, over 63 million people are pushed into poverty every year in India because of expenditure on health care. Nearly 18 per cent of all households in 2011-12 faced catastrophic expenditures because of health costs compared with 15 per cent in 2004-05-a reflection surely of the failure of public investment in health to cover the entire spectrum of people's health care needs, according to the document. The Berman and Ahuja study also found that there were significant variations between major States, in comparison with the national average, regarding health-related impoverishment, with Kerala showing the highest effect, and Madhya Pradesh (a State "with high levels of base poverty, low education, and lower access to health care overall") showing a relatively low rate of health-related impoverishment.

''The cost of health care is very high in Kerala because, one, nearly 87 percent of the people in the State use modern medical facilities; two, there has been an increase in the number of people suffering from non-communicable and chronic diseases that require continuous care and affordable medicines; three, the State had witnessed large-scale and unregulated privatisation of health care facilities in the past decades and even the poor are now forced to depend on them; and four, the costs of medicines have gone up," Dr Ekbal told Frontline.

BURDEN OF NCDS

Kerala has been witnessing a ‘’high morbidity and low mortality” trend, which is increasingly influenced by the replacement of infectious diseases and nutrition-related and maternal and child health-related health issues by non-communicable and chronic diseases, including cardio-vascular diseases, diabetes, cancer and hypertension.

While the growing burden from non-communicable diseases (NCDs) is a reality all over India, the demographic transition in Kerala has meant a dramatic increase in its population of the aged, a higher burden of NCDs, and increasing health-seeking behaviour by its educated population, a trend marked by a growing preference for new and costly technology.

Kerala, where the foundation for a modern medical care system accessible to all was already in existence at the time of its formation in 1956, greatly expanded its government health facilities from 1961 to 1986. But what followed thereafter until the early 1990s was a period of intense fiscal crisis for successive State governments, when, in order to meet increasing expenditure on salary, they began to cut back spending on supplies, including drugs and other essentials, to the public hospitals. In a historical analysis of the development of health care facilities in Kerala, published in the journal Health Policy and Planning (OUP, 2000), Dr V. Ramankutty, Professor at the Achutha Menon Centre for Health Science Studies, Thiruvananthapuram, recorded how this neglect destroyed Kerala’s secondary health sector, especially the district and taluk government hospitals and the primary sector, consisting of primary health centres. Even as early as 1987, he said, an extensive survey of 10,000 households by the KSSP found that only 23 per cent of the households regularly used government health services for reasons that included “non-availability of drugs in the government hospitals”, ‘’lack of proper attention” and “better behaviour in private institutions”. “There was a shift away from secondary care, with a drastic reduction in funds available for district and taluk government hospitals. Even now, despite the involvement of local bodies and the availability of funds through them, I am not sure all is well with the secondary care centres. Only some are doing well though the primary health system remains largely protected through a lot of direct central funding. Large-scale privatisation of the Kerala health sector took place during the same time,” Dr Ramankutty told Frontline.

Kerala’s Draft Health Policy notes that the public health care expenditure (as a proportion of the gross state domestic product, or GSDP) decreased by 35 per cent between 1990 and 2002, making Kerala one of the States with the highest reduction in public sector contributions and the highest increase in private funding for health care. The decline in public sector spending for health resulted in an overwhelming expansion of the private sector.

For example, the amount allocated for health care in the 2012-13 Kerala Budget was only 0.99 per cent of the GSDP. But, significantly, researchers say, private expenditure on health care was almost nine times as high and nearly two-thirds of the poor sought private sector facilities.

According to the National Health Accounts (2004-05), of the total health expenditure in Kerala, the share of the private sector was the highest in the country with 90.27 per cent; the public sector accounted for only 9.7 per cent.

The prospering private super speciality hospitals with high-tech facilities are a result of the failure of the government health system to meet the demand for secondary and tertiary care and to manage the growing NCD burden. "But we have also started seeing a new trend of small and medium private hospitals being closed down in significant numbers in the State, making health care inaccessible to a large number of people or forcing them to approach bigger care facilities," Dr Ekbal said.

According to Dr Ramankutty, many entrepreneurs are entering the field and buying or selling off established private hospitals. "The profit motive has come to the fore. Hospitals are seen as an investment option for easy profits: there is enough demand; there are no labour disputes in the sector, for example. There is inadequate public health spending by the government and health care is free only in principle in most government institutions. Moreover, facilities for treatment of NCDs are limited and are not completely free in the public sector. The private sector has made use of this opportunity, equipping itself well with the latest technology and facilities, and even the poor are forced to depend on them -at a heavy cost."

"Government support has been a key factor in the advancement of health care in the State. An expansion or strengthening of the public health system based on today's requirements has not taken place even as people's aspirations about health care needs have gone up. The care that the State used to provide in the 1980s is not what is required today," he told Frontline. Thus, the State is facing a situation where, because of the growing burden of NCDs, health care costs are leading more and more people (not just low-income families) to financial distress. Hospitalisation, even in the government sector, is leading to catastrophic health expenditure, distress financing and its aftermath; existing insurance and similar financial support schemes are inadequate and offer services only for a limited spectrum of diseases and procedures.

A dearth of micro-level studies, especially looking at how this impacts individuals, has meant a general lack of understanding about the seriousness of the evolving situation: of how NCD burden could over-whelm the State's troubled health sector and drive vulnerable sections of Kerala society deeper into poverty and lifelong dependency.

"It is important to ensure that treatment options and medicines are accessible and affordable to all. The government has to spend more on health care and should not allow a change to a system where despite the availability of all the facilities in the public or private sector, a substantial section of people are still denied health care," Dr Ekbal said.

Most health care researchers, therefore, argue for the reintroduction of the system of accessible and affordable primary care, like the British system of general practitioners or by

strengthening the system based on community (public) health centres; more government spending on health, especially to deal with the emerging NCD burden; better regulation and quality control in the private sector; introduction of better financial risk protection measures and their better coordination to help patients deal with catastrophic health expenditure; and measures to ensure availability of medicines and bring down costs in all government facilities.

"Public health governance has taken a back seat in Kerala, and hospital administrators are not properly trained to deal with the emerging professional and financial challenges. There is a general complacency when it comes to issues relating to health. We tend to bask in our past glory, smug about our early achievements, when new challenges are already overwhelming us and, in truth, other States are stealing a march over us," Dr Ramankutty said.

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Idea of inclusion

Venkitesh Ramakrishnan

Professor T.K. Oommen's work as an Indian social scientist spans over five decades. He has addressed the Indian social reality in all its diversity. The complex historical processes that have contributed to the development of Indian society, its social and religious pluralism as well as its diverse stratifications based on caste, community, gender and class, along with society's democratic demands and struggles for social and economic justice have all been reflected in the scores of books, monograms and reports he has authored.

If one were to try and summarise the key theme or concept of this multidimensional intellectual pursuit, it would have to be done by placing Oommen as a modernist and progressive Indian sociologist who has a clear understanding of the concept being Indian and the advancement of sociology, particularly Indian sociology, as a social science. Unlike many of his predecessors and peers, Oommen has sought to situate the idea of Indian sociology within the constitutional framework of the Indian Republic, the vision enshrined in the Constitution about the kind of society and citizenship that it wanted to evolve. In other words, the understanding in terms of the constitutional frame-work of what India should be and not as a perspective, which perceived India as a mere extension of past traditions and Indian sociology as something that was primarily based on this.

More specifically, he questioned the concept that sociological training in India is grounded in Sanskrit or any such language in which the traditions have been embodied as symbols and the argument that social research in India will be limited and deficient if it did not conform to these parameters. In advancing this distinct approach, Oommen also emphasised the relevance of having perspectives from below to "apprehending social reality in a hierarchical society". Naturally, his own work encapsulates the varied perspectives from below.

Oommen's latest book, Social Inclusion in Independent India: Dimensions and Approaches, marks a logical progression of this thematic approach. In fact, he states that the "idea of this book has been in the making for the last three decades". However, he adds an important qualification in the very beginning of the book. This comes in the form of a categorisation of social inclusion in independent India and its dimensions and approaches and the assertion that its contents need to be perceived differently from other sociology-related treatises. Oommen points out that "Indian sociologists are accused by planners, administrators and even fellow social scientists of their disinclination to pursue research themes which are relevant to social policy" and goes on to add that "this book is conceived as a modest beginning to break this impasse".

In the next 287 pages, he makes an attempt to "locate the causes of deprivations to which different excluded categories are subjected to" and also suggest and evolve some prescriptions that could be taken for their inclusion.

As in all his works, Oommen goes about his argument methodically, bringing together the micro and macro perspectives with nuanced objectivity. In terms of broad classification, Social Inclusion in Independent India is divided into 11 chapters, each dealing with a specific subject of exclusion or lack of inclusion. Starting with the overall colonial track record, this categorised discourse covers the plight of Dalits, Adivasis, the Other Backward Classes (OBCs), the religious and linguistic minorities, women, migrants (including refugees, outsiders, foreigners) with a special reference to north-eastern India, the poor and persons with disabilities. A wide range of data pertaining to each of these categories is marshaled while discussing each of them. These, along with the thematic projections, add value to the discourse.

Dealing with the specifics of each of these categories, Oommen points out that "inclusion is the buzzword in contemporary societies, and people from all walks of life -politics, business, academia and religion-advocate it, although they do not have a shared understanding of the meaning of inclusion". The discussion in terms of each of the specific categories highlights these myriad understandings, which from time to time work against each other and against the real processes for inclusion. The importance of the detailed discussions in Social Inclusion in Independent India is that it seeks to address these varied perspectives and related themes in terms of the subject under consideration, the various approaches that are being advanced by various vested interests, and the modus operandi and methodologies they employ to advance their case and cause.

An example of this kind of detailed delineation of the multiple nuances and dimensions relating to inclusion is evident in Oommen's discourse of gender and Dalit exclusion. The book specifically points out that factors such as patriarchy, heterogeneity and hierarchy cause multiple deprivations for a poor Muslim woman of Dalit background while an upper-caste Hindu woman would only face deprivation relating to patriarchy. Social Inclusion in Independent

India underscores the need to carefully identify the parameters of exclusion in order to devise effective inclusion strategies.

It suggests that various forms of discrimination and marginalisation that continue to persist in large parts of contemporary India can be eradicated only by ensuring social, economic and political justice for the socially and educationally backward classes of citizens through the implementation of clearly defined, inclusive, growth policies and plans. Oommen also signifies the continuing relevance of affirmative action or positive discrimination in various sectors.

Beyond the specific India-related factors dictated by stratifications based on caste, community, gender and class, Social Inclusion in Independent India also addresses universal factors that have been decisive in terms of exclusion and inclusion. Oommen says the three moments crucial in this context are European colonialism, the Cold War and globalisation. Issues raised by the current context of globalisation are discussed in relation to each of the categories and also in terms of the solution which Oommen terms "towards a category specific social inclusion policy for India". The detailing on this policy summation focuses on four points. "One, recognising and nurturing cultural diversity within the national state; two, institutionalising political pluralism; three, abandoning the centre-periphery distinction (both spatial and social); and four, de-legitimising caste hierarchy."

Indeed, the formulation and the discourse that leads to it do impart a broad prescription to follow for the drivers of contemporary Indian society, particularly its political and administrative classes. But, on account of its methodological approach Social Inclusion in Independent India is also a valuable tool for practitioners and students of sociology, social anthropology and political science. Over and above all this, at the ideological level, the book underscores Oommen's steady contention that "as a discipline, sociology should endorse, and its practitioners should internalise the value package contained in the Indian Constitution, the differing interpretation of these values notwithstanding". The importance of a work like this is immense in the current juncture in Indian polity, when the constitutional framework is being challenged from different quarters and by varied vested interests, both within the established power structure and from ideological, political and organisational structures proximate to it.

FRONTLINE,
MARCH 20, 2015.

Arunachal Pradesh Legislative Assembly

RESUME OF WORK TRANSACTED FROM 28TH JANUARY, 2015 TO 30TH JANUARY, 2015

The Third Session of the Sixth Legislative Assembly of the State of Arunachal Pradesh commenced on 28 January 2015 and concluded on 30 January 2015. His Excellency, the Governor of Arunachal Pradesh addressed the House at 10.00 A.M. on the opening day of the Third Session i.e., on 28.01.2015. After the Governor's Address, the House re-assembled at 11 30 hrs. and a copy of the Address was laid on the Table of the House. After that, Hon'ble Speaker made obituary references in respect of Late Jarfrorn Gamlin, sitting Member and late Sobeng Tayeng and late Setong Sena, former Members. The Hon'ble Speaker and other members paid glowing tributes and respectful homage to the departed soul.

Shri Nikh Kamin, MLA moved a Motion of Thanks on the Governor's Address, which was seconded by Shri Gabriel Denwang Wangsu, MLA. Discussion on the motion took place on 29 January, 2015. Shri Nikh Kamin initiated the discussion followed by participation of 11 (Eleven) members. The Chief Minister replied to the debates. The motion was unanimously adopted.

Hon'ble Speaker announced the Panel of Chairmen for the current Session. Hon'ble Deputy Speaker presented the Second Report of the Business Advisory Committee. Shri Wanglin Lowangdong, Minister of Parliamentary Affairs moved a motion to adopt Second Report of the Business Advisory Committee and the motion was adopted.

The following papers were laid on the Table of the House on the Second day of the Session:

(i) Resolution for ratification of the Constitution (One hundred and Twenty-First Amendment) Bill, 2014.

(ii) 24th Annual Report of Arunachal Pradesh Public Service Commission for the year 2011-12.

(iii) 25th Annual Report of Arunachal Pradesh Public Service Commission for the year 2012-13.

(iv) The Annual Audit Report of the State Electricity Regulatory Commission for the year 2011-12.

The following Bills passed by the Fifth Legislative Assembly during its Thirteenth Session and Sixth Legislative Assembly during its Second Session and assented to by His Excellency, the Governor of Arunachal Pradesh laid by the Secretary on the Second day of the Session:

i) The Arunadaya University Arunachal Pradesh Bill, 2014.

ii) The North East Frontier Technical University (NEFTU) Arunachal Pradesh Bill, 2014.

iii) The Arunachal Pradesh Appropriation (No.1) Bill, 2014.

iv) The Arunachal Pradesh Appropriation (Vote on Account) (No.2) Bill, 2014.

v) The Arunachal Pradesh Unlawful Activities (Prevention) Bill, 2014.

vi) The Arunachal Pradesh State Housing Board Bill, 2014.

vii) The Arunachal Pradesh Appropriation (No.2) Bill, 2014.

The following Committee reports were presented to the House:

i) 64th Report of Committee on Public Accounts of the Sixth Legislative Assembly

ii) First Report of the Select Committee of Sixth Legislative Assembly of Arunachal Pradesh to examine the Arunachal Pradesh District Planning Committee (Amendment) Bill, 2014.

The following Bills were introduced, considered and passed by the House during this Session.

i) The Societies Registration (Extension to Arunachal Pradesh) (Amendment) Bill, 2015.

ii) The Arunachal Pradesh Panchayat Raj (Amendment) Bill, 2015.

iii) The Arunachal Pradesh District Based Entrepreneurs and Professionals (Incentive, Development and Promotional) Bill, 2015.

As suggested by members, Hon'ble Deputy Speaker, under Rule 75 (2) (b) of Rules of Procedure and Conduct of Business of Arunachal Pradesh Legislative Assembly has referred the Global University Arunachal Pradesh Bill, 2015 to the Select Committee.

The questions hour was maintained for 2 (Two) days i.e., on 29 and 30 January, 2015. Notices of 36 Starred Questions and 14 Unstarred Questions were received out of which 32 Starred Questions and 14 Unstarred Questions were admitted. All the Starred Questions were asked and answers given. Replies to all the Starred Questions and Unstarred Questions were laid on the Table. 2 (Two) nos. of Notices were received out of which 1 (One) no. was admitted and the Hon'ble Chief Minister made a statement on the matter.

The House was adjourned sine die by Hon'ble Deputy Speaker at the conclusion of its Sitting on 30 January, 2015.

Chhattisgarh Legislative Assembly

RESUME OF WORK TRANSACTED FROM 15TH DECEMBER, 2014 TO 17TH DECEMBER, 2014

The Third Session of the Fourth Chhattisgarh Legislative Assembly commenced from 15th December, 2014 and concluded on 17th December, 2014. During this period the House had three sittings in which the House transacted business for 06 hours and 15 minutes.

As per the convention in the Chhattisgarh Legislative Assembly, the first sitting on 15th December, 2014 opened with the playing of National Song "Vande Mataram....." and thereafter the House condoled the sad demise of Shri Reshamlal Jangde, Ex-Member of Parliament and undivided Madhya Pradesh Legislative Assembly, Shri Vishal Singh, Ex-Member of undivided Madhya Pradesh Legislative Assembly, Shri Shiv Pratap Singh Ex-Member of Rajya Sabha and Chhattisgarh Legislative Assembly and Security personnel who laid their lives during the naxal attack on 01 December, 2014.

Financial Business

On 16th December, 2014 Second Supplementary Grants for the financial year 2014-2015 were presented in the House by Dr. Raman Singh, Chief Minister and also Finance Minister. Entire Second Supplementary Grants for the financial year 2014-2015 were passed in a consolidated form by the House on 17th December, 2014 and thereafter the Chhattisgarh Appropriation (No-4) Bill, 2014 was introduced, considered and passed.

Earlier, General discussion on the Second Supplementary Grants for the financial year 2014-2015 was held. The Appropriation (No-4) Bill,2014 (Rs.1480,92,73,875 - One Thousand Four Hundred Eighty Crore, Ninety Two Lakh Seventy Three Thousand Eight Hundred Seventy Five Rupees) was passed by the House on 17th December, 2014.

Legislative Business (Bills)

On 15th December, 2014 Principal Secretary laid details of the following bills assented to by the President of India and Governor of Chhattisgarh State on the Table of the House:-

(i) The Chhattisgarh Niji Vyavsayik Shikshan Sanstha (Pravesh Ka Viniyaman Avam Shulk Ka Nirdharan (Sanshodhan)) Bill, 2014.

(ii) The International Institute of Information Technology (lIlT) University (Amendment) Bill, 2014.

(iii) The Chhattisgarh KushaBhau Thakre Patrakarita Avam Jansanchar University (Amendment) Bill, 2014.

(iv) The Chhattisgarh Private Universities (Establishment and Operation) (Amendment) Bill, 2014

(v) The Chhattisgarh Swami Vivekanand Technical University (Amendment) Bill, 2014

(vi) The Chhattisgarh Land Revenue Code (Amendment) Bill,2014

(vii) The Chhattisgarh Appropriation (No-3) Bill, 2014.

(viii) The Chhattisgarh Co-Operative Societies (Amendment) Bill,2013.

During the above Session following Bills were introduced, considered and passed by the House:-

(i) The Chhattisgarh Panchayat Raj (Sanshodhan) Bill, 2014.

(ii) The Chhattisgarh Co-Operative Societies (Amendment) Bill, 2014.

(iii) The Chhattisgarh Vidhan Sabha Sachivalaya Seva (Sanshodhan) Bill, 2014.

(iv) The International Institute of Information Technology (lIlT) University (Amendment) Bill, 2014.

(v) The Chhattisgarh Rent Control (Amendment) Bill, 2014

(vi) The Chhattisgarh Appropriation (No-4) Bill, 2014.

Petitions

As regards petitions, 29 Notices of the Petition were received, out of which 11 Notices of the Petition were admitted, however only 06 Petition were presented in the House. 02 Notices of the Petition were disallowed, 05 Notices of the Petition lapsed.

Reports of the Committee

During the Session under reference 01 Report of the Business Advisory Committee was presented in the House.

08 Notifications and 11 Reports of Various Department of the Government, Report of the Comptroller and Auditor General of India on (Report no.-l) and (Report no.-2) for the year 2013-14; was laid on the Table of the House.

Calling Attention Notices

Under Rule-13 8 as many as 182 Calling Attention notices were received out of which 18 notices were admitted, however only 04 notices were discussed in the House, 17 notices were converted into Zero Hour notices under Rule-267-A. 132 notices of Calling Attention were disallowed, 15 notices of the Calling Attention lapsed.

Questions

During the Session under reference as many as 1371 notices of Question were received, out of which 913 (486 Starred + 427 Unstarred) Questions were admitted. Out of the admitted Questions, only 01 was actually answered or deemed to have been answered in the House with the following break-up:-

Questions	Received	Admitted	Answered
Short Notice	0	0	0
Starred	818	486	01
Unstarred	553	427	-
Total	1371	913	01

On 16th December, 2014, 30 members of Indian National Congress Party and On 17th December, 2014, 26 members of Indian National Congress Party, were suo moto suspended Under Rule-250(1) of the Rules and Procedure and Conduct of Business of Chhattisgarh Legislative Assembly. Subsequently the Hon'ble Speaker however revoked the suspension.

On the last day of the session Hon'ble Speaker expressed gratitude to the Leader of the House, Leader of the Opposition, Members and one and all for their co-operation in conducting the business of the House and then adjourned the House sine-die on 17th December, 2014.

THE LEGISLATIVE BODIES IN SESSION DURING THE MONTH OF MARCH 2015

Sl No.	Name of Assembly/Council	Duration
1.	Loksabha	23.02.2015 - 20.03.2015
2.	Rajyasabha	23.02.2015 - 20.03.2015
3.	Andhra Pradesh Legislative Council	07.03.2015 - 27.03.2015
4.	Andhra Pradesh Legislative Assembly	07.03.2015 - 27.03.2015
5.	Arunachal Pradesh Legislative Assembly	07.03.2015 - 27.03.2015
6.	Assam Legislative Assembly	02.03.2015 - 31.03.2015
7.	Bihar Legislative Assembly	11.03.2015 - 22.04.2015
8.	Bihar Legislative Council	11.03.2015 - 22.04.2015
9.	Chhattisgarh Legislative Assembly	02.03.2015 - 07.04.2015
10.	Delhi Legislative Assembly	24.03.2015 - 25.03.2015
11.	Goa Legislative Assembly	23.03.2015 - 27.03.2015
12.	Harayana Legislative Assembly	09.03.2015 - 25.03.2015
13.	Himachal Pradesh Legislative Assembly	11.03.2015 - 10.04.2015
14.	Jammu and Kashmir Legislative Assembly	18.03.2015 - 09.04.2015
15.	Jammu and Kashmir Legislative Council	27.02.2015 - 30.03.2015
16.	Jharkhand Legislative Assembly	10.03.2015 - 24.03.2015
17.	Karnataka Legislative Assembly	13.03.2015 - 30.03.2015
18.	Karnataka Legislative Council	13.03.2015 - 31.03.2015
19.	Madhya Pradesh Legislative Assembly	18.02.2015 - 27.03.2015

20.	Mizoram Legislative Assembly	27.02.2015 - 25.03.2015
21.	Odisha Legislative Assembly	06.02.2015 - 06.04.2015
22.	Rajasthan Legislative Assembly	25.02.2015 - 27.03.2015
23.	Tamil Nadu Legislative Assembly	17.02.2015 - 23.03.2015
24.	Uttar Pradesh Legislative Assembly	25.02.2015 - 25.03.2015
25.	Uttar Pradesh Legislative Council	25.02.2015 - 25.03.2015
26.	West Bengal Legislative Assembly	19.02.2015 - 03.03.2015
27.	Telengana Legislative Assembly	09.03.2015 - 26.03.2015

Site Address of Legislative Bodies in India

Sl.No	Name of Assembly/Council	Site Address
1.	Loksabha	loksabha.nic.in
2.	Rajyasabha	rajyasabha.nic.in
3.	Andhra Pradesh Legislative Council	aplegislature.org
4.	Andhra Pradesh Legislative Assembly	aplegislature.org
5.	Arunachal Pradesh Legislative Assembly	arunachalassembly.gov.in
6.	Assam Legislative Assembly	assamassembly.nic.in
7.	Bihar Legislative Assembly	vidhansabha.bih.nic.in
8.	Bihar Legislative Council	biharvidhanparishad.gov.in
9.	Chhattisgarh Legislative Assembly	cgvidhansabha.gov.in
10.	Delhi Legislative Assembly	delhiassembly.nic.in
11.	Goa Legislative Assembly	goavidhansabha.gov.in
12.	Gujarat Legislative Assembly	gujaratassembly.gov.in
13.	Harayana Legislative Assembly	haryanaassembly.gov.in
14.	Himachal Pradesh Legislative Assembly	hpvidhansabha.nic.in
15.	Jammu and Kashmir Legislative Assembly	jklegislativeassembly.nic.in
16.	Jammu and Kashmir Legislative Council	jklegislativecouncil.nic.in
17.	Jharkhand Legislative Assembly	jharkhandvidhansabha.nic.in
18.	Karnataka Legislative Assembly	kar.nic.in/kla/assembly
19.	Karnataka Legislative Council	kar.nic.in/kla/council/council
20.	Madhya Pradesh Legislative Assembly	mpvidhansabha.nic.in
21.	Maharashtra Legislative Assembly	mls.org.in/Assembly

22.	Maharashtra Legislative Council	mls.org.in/Council
23.	Manipur Legislative Assembly	manipurasembly.nic.in/
24.	Meghalaya Legislative Assembly	megassembly.gov.in/
25.	Mizoram Legislative Assembly	mizoramassembly.in
26.	Nagaland Legislative Assembly	http:/nagaland.nic.in
27.	Odisha Legislative Assembly	odishaasembly.nic.in
28.	Puducherry Legislative Assembly	www.py.gov.in
29.	Punjab Legislative Assembly	punjabassembly.nic.in
30.	Rajasthan Legislative Assembly	rajassembly.nic.in/
31.	Sikkim Legislative Assembly	sikkimasembly.org
32.	Tamil Nadu Legislative Assembly	assembly.in.gov.in
33.	Tripura Legislative Assembly	tripuraassembly.nic.in/
34.	Uttar Pradesh Legislative Assembly	uplegassembly.nic.in
35.	Uttar Pradesh Legislative Council	upvidhanparishad.nic.in
36.	Uttarakhand Legislative Assembly	ukvidhansabha.uk.gov.in
37.	West Bengal Legislative Assembly	wbassembly.gov.in/
38.	Telengana Legislative Assembly	telenganalegislature.org.in