ISARC to play a major role in harnessing and sustaining rice production in eastern India & similar ecologies in other South Asian and African countries: Shri Radha Mohan Singh

Press Information Bureau
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Ministry of Agriculture

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DAC&FW and IRRI sign Memorandum of Association (MOA) to establish the ISARC

In order to establish the ISARC, a Memorandum of Association (MOA) has been signed today between the Department of Agriculture, Cooperation and Farmers Welfare (DAC & FW) represented by Secretary, DAC&FW and International Rice Research Institute (IRRI), Philippines represented by Director General, IRRI. Union Agriculture and Farmers Welfare Minister, Shri Radha Mohan Singh graced the occasion.

Shri Singh said that the Center will be the first international Center in the eastern India and it will play a major role in harnessing and sustaining rice production in the region. It is expected to be a boon for food production and skill development in the eastern India and similar ecologies in other South Asian and African countries.

Agriculture Minister said this would be a Centre of Excellence in Rice Value Addition (CERVA) and will include a modern and sophisticated laboratory with the capacity to determine quality and status of heavy metals in grain and straw. The Centre will also undertake capacity-building exercises for stakeholders across the rice value chain.

ISARC will operate under the governance of the IRRI Board of Trustees who will appoint an appropriate IRRI staff member as Director. A Coordination Committee will be headed by Director General, IRRI as Chair and Secretary, Government of India, DACFW as Co-Chair. The other members of Coordination Committee are

Deputy Director General (Crop Sciences), ICAR; Director, NSRTC; IRRI representative in India, representative of Government of UP and representatives of Governments of Nepal & Bangladesh and Private Sector.

Shri Singh said that the rich biodiversity of India can be utilised to develop special rice varieties. This will help India to achieve higher per hectare yields and improved nutritional contents. India's food and nutritional security issues will also be addressed. The Centre will support in adopting value chain based production system in the country. This will reduce wastage, add value and generate higher income for the farmers. The farmers in Eastern India will benefit in particular, besides those in South Asian and African countries.

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Breastfeeding Week to promote breastfeeding

Breastfeeding Week is observed in the first week of August to focus attention on the important aspect of promotion and support of breastfeeding. The theme of this year's breastfeeding week is 'Sustaining Breastfeeding'. The Ministry of Health & Family Welfare has planned various activities at the national level during this week in association with IAP and Rammohan Lohia Hospital.

To intensify the efforts further for promotion of breastfeeding, the Health Ministry has initiated a nationwide programme called "MAA-Mother's Absolute Affection'' to bring undiluted focus on promotion of breastfeeding and provision of services towards supporting breastfeeding, along with ongoing efforts of routine health systems. In addition, "National Guidelines on Lactation Management Centres in Public Health Facilities" have been recently released to facilitate establishment of lactation management centres for ensuring that the sick and pre-term babies are fed with safe human breast milk.

The key components of the MAA programme are awareness generation, promotion of breastfeeding & inter personal counselling at community level, skilled support for breastfeeding at delivery points and monitoring and Award/ recognition of health facility. Under this programme, ASHA has been incentivized for reaching out to pregnant and lactating mothers and provide information on benefits and techniques of successful breastfeeding during interpersonal communication. ANMs at all sub-centres and health personnel at all delivery points are being trained for providing skilled support to mothers referred with issues related to breastfeeding.

Under NHM, funding support has been recommended for all States and UTs (since 2016) for successful implementation of the MAA programme. 23 States have started implementing various activities under MAA programme such as one day sensitization of health staffs, convergence meetings with line departments, Infant and Young Child Feeding (IYCF) training of staffs at health facilities, communication activities using mass media and mid-media etc. Around 2.5 lakhs ASHAs and 40,000 health staffs including programme managers at district and block level, doctors (MOs), staff nurses (SNs) and ANMs have been sensitized for breastfeeding promotion strategies under MAA programme and around 2800 health facility staffs (MOs, SNs and ANMs) are trained in 4 days IYCF training. In addition more than 75,000 mother's meetings were also carried out by ASHAs at village level to sensitize mothers regarding importance of appropriate breastfeeding practices.

Breastfeeding is an important efficient and cost-effective intervention promoting child survival and health. Breastfeeding within an hour of birth could prevent 20% of the newborn deaths. Infants who are not breastfed are 15 times more likely to die from pnuemonia and 11 times more likely to die from diarrhoea than children who are exclusively breastfed, which are two leading causes of death in children under-five years of age. In addition, children who were not breastfed are at increased risk for diabetes, obesity, allergies, asthma, childhood leukemia, sudden infant death syndrome etc. Apart from mortality and morbidity benefits, breastfeeding also has tremendous

impact on improved IQ.

The trend of breastfeeding has shown an upward trend. As per recent data, initial breastfeeding has been nearly doubled in last decade. i.e from 23.4 per cent to 41.6 per cent (NFHs-3, 2005-06 and 4, 2015-16). Significant improvement has also been reported for exclusive breastfeeding as proportion of children under age 6 months exclusively breastfed, has gone up to 54.9 (NFHS-4) per cent from 46.4 per cent (NFHS-3). However, there is further scope of improving initial breastfeeding rates considering the high proportion of institutional deliveries in the country.

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AGRI UDAAN- Food and Agribusiness Accelerator 2.0

ICAR-NAARM Technology Business Incubator (TBI), a-IDEA and Indian Institute of Management Ahmedabad's (IIM-A) incubator Center for Innovation, Incubation and Entrepreneurship (CIIE) announces "AGRI UDAAN"- Food and Agribusiness Accelerator 2.0. This programme will help to selected innovative startups who will be mentored in to scale up their operations in agri value chain for effective improvement in agriculture. This is a 6 month program in which shortlisted agri startups with promising innovative business models will be mentored & guided to scale up their operations.

Accelerators are 4-8 month program aiming at scaling up innovative startups with a working prototype and initial market traction. This is done through education, mentorship, and financing. Startups enter accelerators for a fixed-period of time, and as part of a cohort. The cohort is shortlisted by evaluation panel comprising of industry veterans, business experts, R&D scientists. Four distinct factors that make accelerators unique are fixed term, cohort based, mentorship driven and they culminate into demo day.

Forthcoming Food & Agribusiness accelerator: AGRI UDAAN

Looking at the impact created through NAARM TBI a-IDEA India's first Food & Agribusiness accelerator 2015 in partnership with IIM-A CIIE, National Science and Technology Entrepreneurship Development Board (NSTEDB), DST has come forward to support AGRI UDAAN – a unique initiative for upliftment of agri startups

Through AGRI UDAAN we will be reaching out to agri-startups across the country with a series of road shows in Chandigarh, Ahmedabad, Pune, Bangalore, Kolkata & Hyderabad. This initiative is backed by Caspian Impact Investments as Platinum Partner, Yes Bank as Banking Partner, NCDEX eMarkets Ltd (NeML) & Marico Innovation Foundation as Silver partners. AGRI UDAAN also received support from National Research Development Corporation (NRDC), Agrinnovate as tech transfer partners, and FICCI as outreach partner.

Unique selection process

The application is available at www.aidea.naarm.org.in. Applications will be evaluated by mentors from industry, business and partner organizations, based on the average scores top 40 startups will be shortlisted and allowed to pitch in front of panel of evaluators during cohort finalization programme on 9th and 10th of October 2017 at NAARM. Out of these about 8 to 12 startups will be selected for final cohort for capacity building workshop.

Rigorous mentoring and acceleration

The shortlisted cohort of startups will undergo a capacity building (CB) workshop in ICAR-NAARM. During this period, the startups will be trained in different aspects of technology commercialization, product validation, business plan preparation, risk analysis, customer engagement, finance management, fund raising etc. There will be a match making between startup-mentor. The accelerator program will culminate with demo day/ investors meet at Hyderabad and Mumbai.

Agri-Udaan Schedule

S. No	Date	Event Name	City
1	4th August, 2017	Program Launch	NASC, New Delhi
2.	8 August 2017	1st Road show	Chandigarh
3.	19 August 2017	2nd Road Show	Ahmedabad
4.	23 August 2017	3rd Road Show	Pune
5.	26 August 2017	4th Road Show	Bangalore
6.	29th August 2017	5th Road Show	Kolkata
7.	9 September 2017	6th Road show	Hyderabad
9.	15 September 2017	Close of applications	Hyderabad
10.	25 September 2017	Shortlisting 40 startups/ Announcement	Hyderabad
11.	9 & 10 October 2017	Cohort finalization programme	Hyderabad
12.	30 October – 3 November 2017	Capacity building workshop & Milestone setting, MENTOR MATCH (5 Days)	Hyderabad
13.	16-17 January 2018	Mock Demo day	Hyderabad
14.	18 January 2018	Demo Day 1	Hyderabad
15.	20 January 2018	Demo Day 2	Mumbai

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New Bill to allow States to drop no-detention policy

Remedial training will be provided to students whofail in the examinations. | Photo Credit: K. Murali Kumar

With some Bills pertaining to education already passing muster in either House of Parliament this session, the Ministry of Human Resource Development is looking to introduce a Bill to amend the Right of Children to Free and Compulsory Education Act, 2009, to enable States to do away with the no-detention policy if they wish.

The Cabinet has cleared the introduction of the Bill and the Ministry wants it introduced in this session itself and passed in the next session.

Twenty-five States had recently agreed with the idea of doing away with or tweaking the no-detention policy — wherein a child is not detained till Class 8 — to give a boost to levels of learning.

Tamil Nadu, Andhra Pradesh, Telangana and Maharashtra did not ask for a rollback of the policy, however.

The Centre has thus decided to allow States to take the call and to tweak the RTE Act to enable them to do so. The Bill is expected to permit States to introduce exams in Classes 5 and 8.

Students who fail in the exams — to be held in March — will be given remedial training and offered another chance to pass in May. Those who still fail will be detained in the same class.

Officials say there were complaints that the no-detention policy — aimed at retaining students in school and giving a fillip to education — led to learning levels taking a dip. The planned modification in the RTE Act is expected to arrest this trend.

“Dropout rates till Class 8 are just 4%, but they rise to above 20% after that. This is because of the no-detention policy,” said a top HRD Ministry source.

States may be permitted to introduce exams in Classes 5, 8

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Measles-Rubella (MR) Campaign widens its reach

2nd phase of MR vaccination campaign rolled out

India, along with ten other WHO South East Asia Region member countries, have resolved to eliminate measles and control rubella/congenital rubella syndrome (CRS) by 2020. In this direction, Ministry of Health & Family Welfare has initiated measles-rubella (MR) vaccination campaign in the age group of 9 months to less than 15 years in a phased manner across the nation. The campaign aims to cover approximately 41 crore children and is going to be the largest ever vaccination campaign worldwide. All children from 9 months to less than 15 years of age will be given a single shot of Measles-Rubella (MR) vaccination during the campaign. Following the campaign, MR vaccine will become a part of routine immunization and will replace measles vaccine, currently given at 9-12 months and 16-24 months of age of child.

The first phase of measles-rubella vaccination campaign has been successfully completed in five states, namely, Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry. More than 3.3 crore children were vaccinated, reaching out to 97% of the intended age group. The campaign was carried out in schools, community centers and health facilities. The next round is starting in 8 states/UTs (Andhra Pradesh, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Himachal Pradesh, Kerala, Telangana and Uttarakhand) from August 2017, aiming to cover 3.4 crore children.

The campaign aims to rapidly build up immunity for both measles and rubella diseases in the community so as to knock out the disease, therefore, all the children should receive MR vaccine during the campaign. For those children who have already received such vaccination, the campaign dose would provide additional boosting to them. In order to achieve maximum coverage during the campaign, multiple stakeholders have been involved, which includes, apart from Ministry of Health & Family Welfare, other Ministries, development partners, Lions clubs, professional bodies, for example, Indian Association of Pediatrics, Indian Medical Association, Civil Society Organizations etc.

The Measles-Rubella campaign is a part of global efforts to reduce illness and deaths due to measles and rubella/CRS in the country. Measles immunization directly contributes to the reduction of under-five child mortality, and in combination with rubella vaccine, it will control rubella and prevent CRS.

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Swachh Bharat launches Swachh Survekshan Gramin 2017

As the Swachh Bharat Mission approaches the third anniversary of its launch by the Prime Minister, Shri Narendra Modi, the Ministry of Drinking Water and Sanitation today launched a third party verification survey report to take stock of the progress already made by the Mission in rural India. The Quality Council of India (QCI) has conducted a transparent third-party assessment of the present status of rural sanitation in all States and UTs, called Swachh Survekshan Gramin 2017.

Under the Swachh Survekshan Gramin 2017, QCI surveyed 1.4 lakh rural households across 4626 villages, and found the overall toilet coverage to be **62.45%**. At the time of the survey, i.e. May-June 2017, the Swachh Bharat Mission (Gramin) MIS reported the coverage to be 63.73%. The survey also observed that **91.29%** of the people having access to a toilet, use it. The Swachh Survekshan Gramin 2017 report was launched at a press conference today in New Delhi by the Union Minister, Ministry of Drinking Water and Sanitation, Shri Narendra Singh Tomar, and the Secretary, Shri Parameswaran Iyer.

It was also announced at the press conference that, to encourage States and districts to improve their Sanitation coverage and Solid Liquid Waste Management (SLWM), the MDWS will also begin ranking all districts in India based on the data available on the SBM-G IMIS quarterly. The ranking will be done based on parameters of Performance, Sustainability and Transparency, and the first ranking will be announced on 2nd October, 2017 for the quarter July-September 2017. To instil healthy competition amongst districts, they will also be given awards based on this ranking on a quarterly basis. The formula for calculating these rankings will be:

Total score (100) = Performance (50) + Sustainability (25) + Transparency (25)

Further, in response to the Prime Minister's call to the nation to Quit Filth, it was announced by Shri Tomar that the Swachh Bharat Mission (Gramin) will celebrate the week leading up to the 70thIndependence Day as **"Khule Mein Shauch Se Azaadi"saptaah**. Highlights of this week are:

1. More than 24 States have prepared their Swachhta Action Plan for the week to reinforce their swachhta efforts by innovative methods and with community engagement.

2. On 12 August, 2017, MDWS and MoWR, RD & GR will jointly announce 24 Ganga Grams from five States, Uttarakhand (3), UP (10), Bihar (4), Jharkhand (5) and West Bengal (2) to make them Aadarsh Ganga Gram.

3. 30 SwachhtaRaths will be launched at Allahabad on August 12, 2017 in the presence of the Chief Minister of Uttar Pradesh, Union Minister of Water Resources, River Development and Ganga Rejuvenation and Shri Tomar.

4. Swachhta Raths will also be launched in other parts of the country.

Shri Tomar also announced that, in the run up to completion of three years of Swachh Bharat Mission, MDWS is planning various Swachhta events across the country from 25th September to 2nd October 2017. During this week, National Swachhta Awards will be given to grass root level swachhta champions, district officers, Best Pakhwada Ministries, outstanding contributions by Ministries, PSU sponsors for Swachh Iconic Places and Swachhta Action Plan.

Over 4.54 crore household toilets have been constructed since the launch of the Swachh Bharat Mission Gramin. 2,20,104 villages, 160 districts and 5 States declared ODF.Sanitation Coverage has increased from 39% in October 2016 to 66% in August 2017.

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NITI Aayog selects 3 States for transformative change in Health & Education sectors

In a major push to competitive, cooperative federalism, NITI Aayog, today, announces partnership with three States each to radically transform their Health and Education sectors.

NITI Aayog has selected Uttar Pradesh, Assam, and Karnataka to improve healthcare delivery and key outcomes in these States. In Education, Madhya Pradesh, Odisha, and Jharkhand have been selected for support to better learning outcomes. The six States have been chosen after a rigorous competitive process based on comprehensive metrics to determine potential for impact and likelihood of success.

States were called to, first, express intent of collaborating with NITI Aayog to better their Health and Education indices. States then made presentations for each sector which was assessed by a committee comprised of senior members of NITI Aayog and Health and Education ministries. The States highlighted the initiatives undertaken by them thus far, their willingness to accelerate improvement and justified why they should be selected for the institutional support being offered by NITI Aayog.

On thorough technical evaluation, the chosen States have committed to time-bound, governance reforms in both sectors. A Program Management Unit to push for efficiency and efficacy in governance structures and service delivery will now be available in the six chosen States for a period of 30 months. It is expected that these three years of focussed attention and support from the premier think tank will lead to a marked transformation and also provide a model for other States to replicate and adapt.

This three-way partnership between NITI, State Governments and a knowledge partner for each of the sectors is part of the Sustainable Action for Transforming Human Capital (SATH) initiative of NITI Aayog.

NITI Aayog has been working to foster co-operative federalism by ranking states through health, water, education, and agricultural indices. However, SATH has been launched to go beyond ranking states and to handhold them in improving their social sector indicators. SATH is a challenging and ambitious initiative as the baseline of various indicators and parameters of education and health in the States are in public domain. It defines a new dimension for cooperative federalism, where NITI Aayog and its knowledge partner will actively aid implementation of their recommendations, in addition to just policy inputs. All stakeholders will be under pressure from the day of signing of the MOU to initiate reforms or processes which will show improvement in education and learning outcomes.

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Shri J P Nadda launches National Deworming initiative

National Deworming initiative to benefit more than 27 crore children

Shri J P Nadda, Union Minister for Health and Family Welfare launched the National Deworming Day at a function in Hyderabad, today. Speaking on the occasion he said, “We will make sure that we do everything that it takes to assure that no child suffers of a cause that can be prevented”.

The Union Health Minister stated that India shall be in the forefront of the war against Neglected Tropical Diseases. He informed that the Ministry had first launched National Deworming Day (NDD) in 2015 which was implemented in 11 States/UTs across all Government and Government-aided schools and Anganwadi centres targeting children aged 1 to 19 years. The deworming initiative was implemented in 277 districts and 9.49 lakh frontline workers were trained for NDD 2015. The Minister further added that against a target of 10.31 crore children between ages of 1 to 19 years, a total of 8.98 crore children received deworming tablet (Albendazole) through 4.70 lakh schools and 3.67 lakh Anganwadi centres with an unprecedented coverage of 85%. The Minister said, “India is now launching National Deworming Day 2016 to cover the whole country, aiming towards a massive target of 27 crore children in 536 districts of the country”.

Sh Nadda also said that apart from the Health Ministry, Department of School Education and Literacy under the Ministry of Human Resource Development, Ministry of Women and Child Development, Ministries of Panchayati Raj, Drinking Water and Sanitation are collaborating to implement the National Deworming Day effectively for heightened impact.

Shri Nadda said: the National Deworming Day will mobilize health personnel, state governments and other stakeholders to prioritize investment in control of Soil Transmitted Helminth (STH) infections—one of the most common infections. Further he said, “It aims to create mass awareness about the most effective and low-cost STH treatment—administering Albendazole tablets. Along with Albendazole administration, behaviour change practices in terms of cleanliness, hygiene, use of toilets, wearing shoes/chappals, washing hands etc. is also important to reduce incidents of re-infection”.

India has the highest burden of parasitic worms in the world. Parasitic worms in children interfere with nutrient uptake, and can contribute to anaemia, malnourishment, and impaired mental and physical development. According to the 2012 report ‘Children in India’, published by the Ministry of Statistics and Programme Implementation, Government of India, 48% of children under the age of 5 years are stunted and 19.8% are wasted, indicating that half of the country’s children are malnourished.

School-based mass deworming program is safe, cost-effective, and can reach millions of children quickly. Deworming has been shown to reduce absenteeism in schools; improve health, nutritional, and learning outcomes; and increase the likelihood of higher-wage jobs later in life.

At the state and local level, community mobilisation and outreach efforts are underway to engage community-based health workers, like ASHAs, Gram Sabhas and others, to spread awareness and encourage participation in the program.

The Union Health Minister also administered Albendazole tablet to few school children, and also felicitated the school principal of the Telengana Social welfare Residential School (Girls) at Narsingi in the Ranga Reddy District, where the launch event took place.

Also present at the launch function were Dr. Charlakola Laxma Reddy, Telengana Minister of Health, Medical Education and Family Welfare; Dr P Mahendra Reddy, Telengana Minister of Transport. Senior Officers of the Health Ministry Shri C K Mishra, AS&MD and Dr Rakesh Kumar, JS (RCH) were also present.

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GM food crops: India in no hurry to grow GM food crops

NEW DELHI: The government is in no hurry to introduce genetically modified food crops in the country, three months after the sector regulator gave its nod to commercialisation of GM mustard, because of widespread opposition from different quarters.

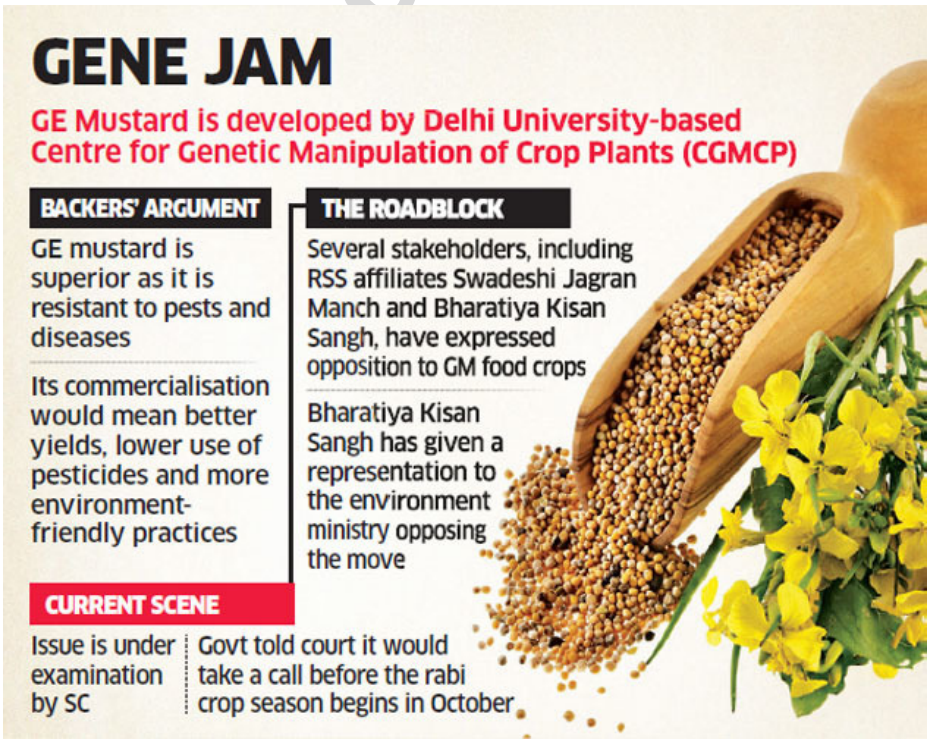
The government has decided to examine all objections raised by scientists and farmers before taking a decision on genetically engineered (GE) mustard, environment minister Harsh Vardhan has said. “Pursuant to recommendation of GE mustard by GEAC (Genetic Engineering Appraisal Committee), several representations and concerns have been raised by a wide range of stakeholders including scientists, policymakers, farmers and NGOs,” Vardhan told ET. “The issues raised are manifold, like long-term health and environmental impact, herbicide tolerance, loss to honey bees and pollinators, outperformance of native varieties, no enhancement in yields, etc. All these issues are under examination,” he said.

GEAC, India’s regulator for transgenic products, had given a green signal to GM mustard in early May, paving way for introduction of genetically modified food crops. After the regulator’s nod, the final call is taken by the government.

Developed by Delhi University-based Centre for Genetic Manipulation of Crop Plants (CGMCP), GE mustard is argued to be superior as it is resistant to pests and diseases. Suppor Supporters also claimed that its commercialisation would mean better yields, lower use of pesticides and more environment-friendly practices.

But several stakeholders, including Rashtriya Swayamsevak Sangh (RSS) affiliates Swadeshi Jagran Manch and Bharatiya Kisan Sangh, have expressed opposition to GM food crops. Bharatiya Kisan Sangh has already given a representation to the environment ministry opposing the move. Though impact of these organisations on Narendra Modi government’s decision making is questioned, sources believe this is one of the reasons for the government’s cautious approach.

Also, in its 2014 election manifesto, BJP had said, “GM foods will not be allowed without full scientific evaluation on its long-term effects on soil, production and biological impact on consumers.”



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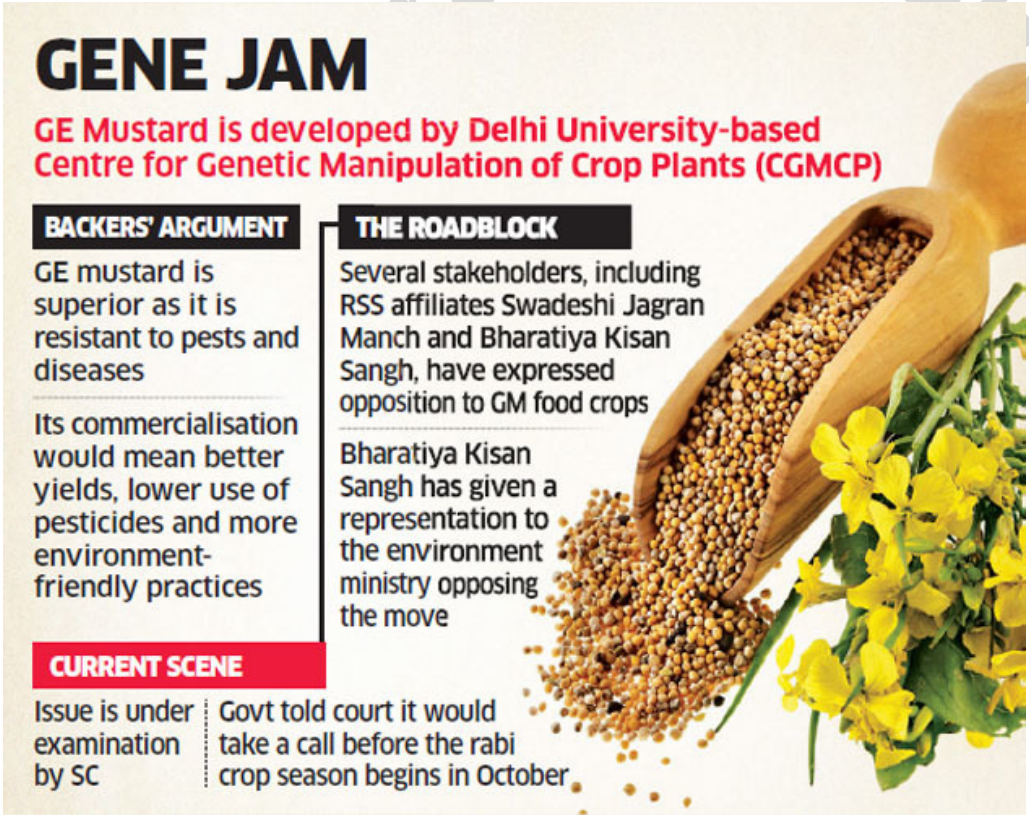

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minimum wage: Bill to fix minimum wage for unorganised sector introduced in Lok Sabha

NEW DELHI: The Code on Wages Bill that seeks to fix a national minimum wage for all categories of over 40 crore unorganised sector workers and provide a fixed timeline for their payment -- in some cases only through electronic means or cheque -- was introduced in the Lok Sabha today.

The Code provides for the government to determine the minimum wages every five years using factors like skills required for the job, arduousness of work, geographical location of work place and other aspects.

Such wages are to be fixed on recommendation of panels comprising an equal number of representatives of employers and employees, and independent persons, according to the Code on Wages, 2017, Bill.

Under this, the government will fix the number of hours of work that would include a day of rest every seven days. The payment for work on a day of rest will not be less than overtime rate.

Introducing the Bill, Labour Minister Bandaru Dattatreya said 'The Code on Wages' Bill will consolidate and amend the laws relating to wages and bonus.

The Bill seeks to amalgamate four laws -- the Payment of Wages Act 1936, the Minimum Wages Act 1948, the Payment of Bonus Act 1965 and the Equal Remuneration Act 1976.

"It is for simplification, rationalisation and making it less cumbersome. No way workers' right is being infringed... It is going to bring in a historical change in the wages for workers and universal minimum wages will be implemented for the first time in India," Dattatreya said.

The Bill will help generate employment and attract entrepreneurs, he said, adding that there are 44 labour laws which are being clubbed in four codes and the Bill introduced today deals with the code on wages.

"40 crore unorganised sector workers can avail of the universal minimum wage. The Bill has a very large perspective. As far as workers' right is concerned, it is in no way exploitation of workers," Dattatreya said.

As N K Premachandran (RSP) opposed the introduction of the Bill in such a short notice, the government sought to assuage the concerns, saying the Bill is being only introduced and discussion will take place later.

The Code stipulates that the wages are to be paid in coin or currency notes or by cheque or through digital or electronic mode or by crediting the wages in the bank account of the employee and the government may specify industrial or other establishment where the salary will be paid only through cheque or digital mode.

Daily wages have to be paid at the end of the shift while the weekly ones on the last working day of the week. Workers engaged in fortnightly employment will get wages before the end of the second day after the end of the working period.

For the monthly earner, the payment will have to be made before the expiry of the seventh day of the succeeding month.

Where an employee is removed or dismissed from service as also when he or she resigns, the wages payable shall be paid within two working days.

The Code provides employers with authority to make deductions from the wages only in case of fines imposed, absence from duty, damage or loss of goods expressly entrusted with the employee custody, housing accommodation and amenities and services.

A bonus at the rate of 8.3 per cent of wage earned or Rs 100, whichever is higher, will be paid.

Any employer paying to any employee less than the amount due in wages or bonus or any other dues will be punishable with a fine of up to Rs 50,000, the Code said.

Repeat offence within five years will be punishable with imprisonment of 3 months or fine of up to Rs 1 lakh, or with both.

The central government under the Code will fix the national minimum wage as also for different states or areas.

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Daily wages have to be paid at the end of the shift while the weekly ones on the last working day of the week. Workers engaged in fortnightly employment will get wages before the end of the second day after the end of the working period.

For the monthly earner, the payment will have to be made before the expiry of the seventh day of the succeeding month.

Where an employee is removed or dismissed from service as also when he or she resigns, the wages payable shall be paid within two working days.

The Code provides employers with authority to make deductions from the wages only in case of fines imposed, absence from duty, damage or loss of goods expressly entrusted with the employee custody, housing accommodation and amenities and services.

A bonus at the rate of 8.3 per cent of wage earned or Rs 100, whichever is higher, will be paid.

Any employer paying to any employee less than the amount due in wages or bonus or any other dues will be punishable with a fine of up to Rs 50,000, the Code said.

Repeat offence within five years will be punishable with imprisonment of 3 months or fine of up to Rs 1 lakh, or with both.

The central government under the Code will fix the national minimum wage as also for different states or areas.

END

Odisha govt and Facebook launches 'SheMeansBusiness' programme to train women entrepreneurs

BHUBANESWAR: Chief minister Naveen Patnaik on Thursday launched 'She Means Business' programme of Facebook for women entrepreneurs in Odisha. Under the scheme 25, 000 women entrepreneurs and self-help group (SHG) members will be given training on digital marketing skills within next one year.

"Odisha government's partnership with Facebook aimed to reduce the digital divide and empower nearly 25,000 women entrepreneurs and SHGs. It is the job of government to empower people to aspire high with the faith that their aspirations will be turned into reality," said Naveen congratulating the MSME (micro, small and medium enterprises) department, the directorate of Mission Shaktiand Facebook for this joint initiative.

Twenty-nine year old Neelam's has been running a Biryani stall at Sum Hospital Square in the city. Every day she prepares 200 plates of biryani and her stock finishes within a couple of hours. Now she is planning to launch her food truck Me-Ma's. "Cooking is my passion. I cook when I am happy, when I am sad, stressed or angry or anxious or excited. So I started this business and could earn my break-even in two months. Now nine persons are working under me. This training on digital marketing skills will surely help a lot to spreading my customer base and business," said Neelam.

Like Neelam around 1100 women entrepreneurs and SHG members from across Odisha attended the training session where they learnt basic nuances of digital marketing like how to start your business in Facebook, how to make it real-time business, quick response to queries and timely delivery, quality assurance and so on.

Facebook will also make a database of entrepreneurs in the state and will monitor their growth, turnover and profit after one year. While success stories among them will be highlighted to inspire others, said MSME secretary L N Gupta.

"Women entrepreneurs will get hands on training on digital marketing free of cost and they need not create their website to promote their business. The platform will also facilitate vertical integration," said Gupta.

As many as 201 million monthly active people on Facebook in India on their mobile and 57% of people on Facebook in India are connected to at least one small business. Moreover, 1.99 billion interactions generated between businesses and people in India through Facebook. Number of new women-owned small and medium business pages on Facebook in India has increased approximately six-fold in the last four years (between 2012 and 2015), official sources said.

"We see amazing examples of how digital can be the equalizer on Facebook every day. How it gives women access to new opportunities, new markets, new ideas, all from their own home. Through Facebook's #SheMeansBusiness we hope to inspire more women across the country, including here in Odisha, to take the leap - and help close the gap on that untapped opportunity for

millions more women and in turn ensure our economy remains strong and thrives," said Ankhi Das, Public policy director of Facebook-India.

Among others MSME minister Prafulla Samal, chairman Odisha Skill Development Authority Subroto Bagchi, chief secretary Aditya Padhi and director of Mission Shakti Sujata Kartikeyan were present on the occasion.

END

Is generic drug deflation good? - OPINION

Not all drug prices are going up. Amid the public fury over the escalating costs of brand-name medications, the prices of generic drugs have been falling, raising fears about the profitability of major generic manufacturers.

This may seem like good news for consumers, but it's unclear how much they will save.

Why are prices falling?

Generic drugs are copycat versions of brand-name products and — to a point — their prices are expected to drop over time. When a brand-name drug first loses its patent protection, prices fall slowly. Over the next couple of years, as more competitors enter the market, the prices drop even more, until the pills become commodities and sell for pennies. Blockbuster drugs that have recently taken this path include Lipitor and Plavix, the cholesterol-lowering and blood-thinning pills that now cost as little as $10 for a monthly prescription.

Generic drug prices have been declining in the United States since at least 2010, according to an August 2016 report by the Government Accountability Office.

They have fallen even in the face of high-profile exceptions: Dozens of old generic drugs have risen in price in recent years, for reasons that include supply disruptions and competitors' leaving the market.

Despite these cases, the trend toward deflating generic prices appears to have accelerated as companies have more aggressively undercut each other's prices.

Making matters worse for the generics companies, they are missing out on peak profit potential because not as many brand-name products are losing patent protection. The six-month period after a drug goes generic is typically the most lucrative time for the first company to market. And the Food and Drug Administration has been clearing out a backlog of generic-drug approvals, meaning more competitors are now entering markets for certain drugs.

In a recent call with Wall Street analysts, George S. Barrett, the chairman and chief executive of Cardinal Health, a major drug distributor that reported declining profits last week, said generic deflation was not new, but that the company historically had been able to anticipate it. "It just looked a little different than we had seen," he said. In recent years, generic companies have gone on acquisition sprees in an effort to head off some of these challenges. But they have been outmanoeuvred by those who buy their products, a trend that has been intensifying. Major pharmacy chains, drug wholesalers and pharmacy benefit managers (which operate drug plans for insurers) have united into colossal buying groups.

So are consumers saving any money? The declining prices are broadly beneficial to the health care system, and may put some slight brake on rising premiums. But most of those with health insurance pay a fixed co-payment — $10, for example — for each generic prescription, and therefore don't pay more or less, regardless of any fluctuation in the actual price. And even those who pay cash for generics may not notice a drop in price because many are already cheap.

Retail drug prices dropped 2.4% over the last year, based on a weighted average of 92 generics that have been on the market for at least a year, according to an analysis conducted for *The New York Times* and ProPublica by GoodRx, a site that tracks prices that consumers pay at the pharmacy. (Weighted averages account for how often each drug is prescribed.) But that figure

hides vast variations.

Does this mean the problem with high drug costs has eased?

Overall drug spending is still on the rise because of the skyrocketing price of new, brand-name drugs.

Will this continue?

Generic manufacturers say they expect it will, and are worried that lower prices could put pressure on profits and threaten the viability of the companies. This could lead to a wave of mergers and acquisitions, reducing competition and leading to higher prices.NYT

This article was written through collaboration between The New York Times and ProPublica, the independent, nonprofit investigative journalism organisation.

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Telemedicine: Odisha shows the way

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A telemedicine project started by an Odisha-based social entrepreneur is slowly going national after the Central government adopted it as a model project two years ago. Started in 2009, the unique model that focusses on sustainability involves training of local youth in e-medicine services and enables them to set up e-health centres in government-run primary health-care centres (PHC), community health centres (CHC) and subdivisional hospitals. These centres have created job opportunities for over 500 youth in Odisha and reached out to over five lakh patients.

For jobs and health

“There are two main problems that ail us — unemployment and bad health. Through this micro-entrepreneurship programme we have attempted to tackle both,” says Kedarnath Bhagat, managing trustee of Odisha Trust of Technical Education and Training (OTTET) under the aegis of which the telemedicine model was conceptualised. At OTTET, local youth are trained for a month in an e-health assistance programme, after which they can apply for a bank loan to start an e-health centre in PHCs and CHCs. “On average, the cost of starting a telemedicine centre goes up to 6 lakh. A centre needs a staff of four people, including the entrepreneur,” explains Mr. Bhagat, adding that typically a centre is equipped with a laptop with video camera and basic diagnostic testing facilities like blood glucose meter, urine analyser, heart rate monitor, etc. So far, 127 such centres have been opened in Odisha at the village and district level (*see picture*).

“At no cost to the government, these centres help in offering basic testing facilities. Patients suspected to have major illness get the benefit of the telecommunication facility for consultations with senior doctors,” says Mr. Bhagat. The OTTET has tie-ups with government hospitals as well as private hospitals such as Apollo, Global and Narayana Hrudayalaya.

These telemedicine centres also create a database of personal health records of every patient walking in for future reference. Mr. Bhagat says for a centre to be viable, the PHC or CHC should have a footfall of about 50 patients a day. “The revenue comes from charges for tests and tele-consultation fees. In case patients are covered under any health scheme for the poor, these charges are borne by the scheme,” he says. The charges for tests and consultation are fixed by the government; a basic consultation costs 100 while that with a super-specialist costs 300.

Across other States

In 2015, a team of government consultants termed this project as one of the eight “best practices globally”. The World Health Organisation too believes telemedicine to be particularly beneficial for rural and underserved communities in developing countries.

While the OTTET plans to cover all 51,000 villages in Odisha, pilot programmes have begun in Gujarat, Jharkhand, Bihar, Himachal Pradesh and Uttar Pradesh while four other States are also in line. “Telemedicine offers phenomenal opportunities to doctors to reach out to patients,” says Dr. Devi Shetty of Narayana Hrudayalaya. “It acts as a good bridge.”

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Lifestyle-related risk factors are being cited, compounded by an inadequate number of treatment centres in the region

Without policies to stop the worrying spread of antimicrobial resistance, the mortality rate could be disturbing

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85 lakh milk producing animals identified and their data uploaded on INAPH data base.

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Pashu Sanjivni component under National Mission on Bovine Productivity scheme was initiated by the Government in November 2016. 88 million milk producing animals out of 300 million cattle and buffaloes are being identified using polyurethane tags with 12 digit unique identification (UID) number. Data of the identified animals is being uploaded on Information Network on Animal Health and Productivity (INAPH) data base. As on date 85 lakh milk producing animals have been identified and their data has been uploaded on INAPH data base.

The Pashu Sanjivni is crucial for control and spread of animal diseases, scientific management of animals, enhanced production and productivity, improvement in quality of livestock & livestock products, increase in trade of livestock and livestock products by meeting out sanitary and phtyosanitory issues.

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Cabinet approves creation of a single non-lapsable corpus fund for Secondary and Higher education from the proceeds of Cess for Secondary and Higher Education levied under Section 136 of Finance Act, 2007

Cabinet approves creation of a single non-lapsable corpus fund for Secondary and Higher education from the proceeds of Cess for Secondary and Higher Education levied under Section 136 of Finance Act, 2007

The Union Cabinet chaired by the Prime Minister Shri Narendra Modi has accorded its approval today for creation of a non-lapsable pool in the Public Account for secondary and higher, education known as "Madhyamik and Uchchtar Shiksha Kosh" (MUSK) into which all proceeds of "Secondary and Higher Education Cess" will be credited.

The funds arising from the MUSK would be utilized for schemes in the education sector which would be available for the benefit of students of secondary and higher education, all over the country.

In connection with the above fund, the Union Cabinet also accorded its approval to the following:

(i) Administration and maintenance of the above pool by Ministry of Human Resource Development.

(ii) Accruals from the Cess would be utilized in the ongoing schemes of Secondary and Higher Education. However, the Ministry of Human Resources Development can allocate funds for any future programme/scheme of secondary and higher education, based on the requirement, as per prescribed procedure,

(iii) In any financial year, the expenditure on ongoing schemes of the Department of School Education & Literacy and Department of Higher Education would be initially incurred from the gross budgetary support (GBS) and the expenditure would be financed from the MUSK only after the GBS is exhausted.

(iv) The MUSK would be maintained as a Reserve Fund in the non-interest bearing section of the Public Accounts of India.

The major benefit will be enhancing access to secondary and higher education through availability of adequate resources, while ensuring that the amount does not lapse at the end of financial year.

Features:

1. Accruals into the proposed non-lapsable fund will be made available for expansion of secondary education and higher education.

2. **For Secondary Education:** Presently, the Ministry of Human Resources Development envisages that the accruals from the Cess would be utilized in the secondary education for:

   ongoing Rashtriya Madhyamik Shlksha Abhiyan Scheme and other approved programmes including:

   National Means-Cum-Merit Scholarship Scheme and

   National Scheme for Incentives to Girls for Secondary Education.

3. **For Higher Education:** the accruals would be utilized for:

ongoing Schemes of Interest Subsidy and contribution for guarantee funds, Scholarship for College & University Students;

Rashtriya Uchchtar Shiksha Abhiyaan;

Scholarship (from Block Grant to the institutions) and National Mission on Teachers and Training.

However, the Ministry of Human Resources Development can allocate funds for any programme/scheme of secondary and higher education, based on the requirement & prescribed procedure.

The purpose of levying cess for secondary and higher education is to provide adequate resources for secondary and higher education.

The fund would be operationalised as per the present arrangements under Prarambhik Shiksha Kosh (PSK) wherein the proceeds of cess are used for Sarv Shiksha Abhiyan (SSA) and Mid-Day Meal (MDM) Schemes of the Department of School Education & Literacy.

Background:

(i) During the 10th Plan, an education cess of 2% on all central taxes was imposed w.e.f. 1.4.2004 to make available additional resources for basic education/elementary education to augment the existing budgetary resources. A need was felt to give a similar fillip to the effort of the Central Government in universalizing access to secondary education and expanding the reach of the higher education sector. Therefore, the Finance Minister, in his budget speech of 2007 proposed an additional cess of 1% on central taxes for secondary and higher education.

(ii) A cess @ 1% on central taxes, called the "Secondary and Higher Education Cess" was levied through Finance Act, 2007 to "fulfil the commitment of the Government to provide and finance secondary and higher education" (Section 136 of the Act).

(iii) In July, 2010, a draft cabinet note was circulated by the HRD Ministry wherein it was proposed to create a non-lapsable fund in the Public Account called "Madhyamik and Uchchatar Shiksha Kosh" (MUSK) as a receptacle for the proceeds of the Secondary and Higher Education Cess. The views of concerned Ministries viz the then Planning Commission, Ministry of North Eastern Region, and Department of Economic Affairs, Ministry of Finance were sought in this regard. The Department of Economic Affairs did not agree to the proposal on the grounds that the Budget allocations for the schemes of Secondary Education and Higher Education have been far more than the amount of 1% cess collected. Therefore, the amount of the cess collected is deemed to have been fully allocated for the schemes of Secondary and Higher Education in the respective financial years. Hence, funds on account of 1% cess for the past period are not available now for allocation.

(iv) Subsequently, the HRD Ministry sought the approval of the Department of Economic Affairs for revisiting the issue of creation of "Madhyamik and Uchchatar Shiksha Kosh" (MUSK) on 11th February, 2016. Department of Economic Affairs on 20th June, 2016 approved that this Ministry may move a draft Cabinet Note to seek the approval of the Cabinet for creation of. MUSK.

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AKT/VBA/SH

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Cabinet approves MoU between India and Sweden on IPRs

The Union Cabinet chaired by the Prime Minister Shri Narendra Modi today has given its approval to the Memorandum of Understanding (MoU) between India and Sweden on cooperation in the field of Intellectual Property (IPRs).

The MoU establishes a wide ranging and flexible mechanism through which both countries can exchange best practices and work together on training programs and technical exchanges to raise awareness on IPRs and better protect intellectual property rights.

Impact:

The MoU will enable India to exchange experiences in the innovation and IP ecosystems that will substantially benefit entrepreneurs, investors and businesses on both sides. The exchange of best practices between the two countries will lead to improved protection and awareness about India's range of Intellectual creations which are as diverse as its-people. It will be a landmark step forward in India's journey towards becoming a major player in global Innovation and will further the objectives of National IPR Policy, 2016.

Features:

A Joint Coordination Committee (JCC) with members from both sides will be formed to decide cooperation activities to be taken under the MoU in following areas:

a) Exchange of best practices, experiences and knowledge on IP awareness among the public, businesses and educational institutions of both countries;
b) Collaboration in training programmes, exchange of experts, technical exchanges and outreach activities;
c) Exchange and dissemination of best practices, experiences and knowledge on IP with the industry, universities, R & D organisations and Small and Medium Enterprises (SMEs) through participation in programs and events in the matter, organized singly or jointly by the Parties;
d) Exchange of information and best practices for disposal of applications for patents, trademarks, industrial designs, copyrights and Geographical Indications, as also the protection, enforcement and use of IP rights;

e) Cooperation in the development of automation and implementation of modernization projects, new documentation and information systems in IP and procedures for management of IP;

f) Cooperation to understand how Traditional Knowledge is protected; and the exchange of best practices, including traditional knowledge related databases and awareness raising of existing IP systems;

g) Exchange of information and best practices regarding Intellectual Property law infringements in the digital environment, especially regarding Copyright issues; and

h) Other cooperation activities as may he decided by the Parties with mutual understanding.

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India and US to co-host the Global Entrepreneurship Summit at Hyderabad in November 2017

PM says, GES is a unique opportunity for bringing together entrepreneurs and start ups with global leaders

India and US will be co-hosting the Global Entrepreneurship Summit (GES) at Hyderabad from 28-30 November, 2017.

In a series of tweets from his account the Prime Minister, Shri Narendra Modi said:

"India and US will co-host the Global Entrepreneurship Summit at Hyderabad from 28-30 November 2017.

The Summit is a unique opportunity for bringing together entrepreneurs and start ups with global leaders.

Look forward to Ms. Ivanka Trump’s presence at Global Entrepreneurship Summit 2017-Hyderabad as the leader of the US delegation."

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Safeguarding the interests of farmers

“The PDS in Tamil Nadu is intact and continues to retain the feature of universal coverage even after implementation of the National Food Security Act, 2013.” A PDS outlet in Coimbatore. | Photo Credit: M. Periasamy

Transformational changes are taking place in India currently, improving the way we live. These changes are impacting all our lives in small or significant ways. It is gratifying to know that the citizens at large are happy with these changes. However, for some who have fed themselves on the fodder that such changes are not for the near future, there is consternation. Even worse, these people find it difficult to comprehend that technology and policy are working together to remove discretion and opaqueness.

The ongoing discourse, particularly in Tamil Nadu, on the Public Distribution System (PDS), the procurement of grains/pulses from farmers, public storage in Food Corporation of India godowns, commitments made in the World Trade Organisation (WTO), Direct Benefit Transfer, etc. is interesting. However, there are strands in this discourse which are impressionistic and not based on data. They create a populist narrative and distract from the core issues. It is necessary, therefore, to infuse facts into the discourse.

The PDS in Tamil Nadu is intact and continues to retain the feature of universal coverage even after implementation of the National Food Security Act, 2013 (NFSA). Although the guidelines under the NFSA prescribe identification of priority households, there is no denial of any benefit under the PDS. There is no reduction even in the total coverage from the earlier Targeted Public Distribution System, which was effective till Tamil Nadu joined the NFSA in November 2016. The average annual offtake or the annual allocation has remained 36.78 lakh tonnes. The major part of the subsidy for the distribution of foodgrains (90.81% for rice and 91.70% for wheat) is borne by the Government of India.

The implication of this subsidy allocation to Tamil Nadu alone on the Government of India is approximately 843 crore per month and approximately 10,120 crore per year. Since the central issue price under the NFSA is much lower compared to the erstwhile Targeted Public Distribution System, the burden on the State government has come down. On implementing the NFSA, the savings for the State exchequer on account of this subsidy, thanks to the lower central issue price, is approximately 436.44 crore per year.

Union Consumer Affairs Minister Ram Vilas Paswan on August 1 stated in a series of tweets the data for Tamil Nadu and also highlighted the fact that Tamil Nadu gets the highest allocation in the country as ‘tide over’ allocation of 12.52 lakh metric tonnes of foodgrains. The narrative in Tamil Nadu cannot be devoid of these facts.

Another disturbing strand in this narrative in Tamil Nadu is that the Indian government has callously sold away the interests of our farmers at the WTO by agreeing to the Trade Facilitation Agreement. Nothing can be further from the truth than this!

The Trade Facilitation Agreement was agreed on in 2013 in Bali and came into force from February 2017 after two-thirds of the WTO’s 164 members ratified it. Several trade-related issues such as transparency, predictability and efficiency at the ports, faster clearance procedures, and improved appeal rights for traders are to be addressed by countries. They shall notify various provisions to bring in the facilitation, over three years or more. Only the basic set of provisions will be implemented within one year. The Trade Facilitation Agreement allows for consultations before any new trade rules are notified. A WTO study indicated that when the Trade Facilitation

Agreement is fully implemented, trade costs for member countries will decrease by an average of 14.3%. It is also estimated that the time taken to export and import will come down drastically. Finance Minister Arun Jaitley has made budgetary allocations for bringing in single-window clearance and improving customs clearance at the ports. A high-level committee chaired by the Cabinet Secretary will monitor logistics and efficiency at ports and related issues.

Thus, it can be seen that the Trade Facilitation Agreement is not about market access but inter alia about facilitating and bringing trade transparency. By ratifying the Trade Facilitation Agreement, India has not forgotten the developmental agenda lying unfulfilled at the WTO.

The Public Stock Holding issue remains unresolved at the WTO. Although agreed on in Bali in 2013 and reiterated in Nairobi in 2015, that a permanent solution for Public Stock Holding be found by 2017, it is still a 'work-in-progress'. The existing WTO rules would have allowed a legal challenge to our Public Stock Holding and minimum support price-based procurement programme in case we breached 'the limit' on procurement. 'The limit' is defined as 10% of the value of production of the particular grain being procured.

WTO rules classify procurement and holding of public stocks for food security purposes as 'Green Box' or non trade-distorting. However, if foodgrains for the public stocks are procured through an administered price/minimum support price and if this minimum support price is higher than the archaic fixed reference price (calculated on base period 1986-88), then it is considered as trade-distorting agriculture support. Such trade-distorting support should be within 'the limit', which is 10% of the value of production of the particular grain being procured.

One of the first things that this government did in 2014 was to intensely engage with the WTO to obtain a 'peace clause' so that even if we did breach 'the limit', no one shall challenge our programme till such a time a permanent solution is found, agreed on, and adopted by the WTO membership. Prime Minister Narendra Modi, on this matter, personally engaged with global leaders, and by November 2014 we obtained an open-ended peace clause from the General Council of the WTO, which was later reaffirmed at the Nairobi Ministerial. So Prime Minister Modi has safeguarded the interests of the farmer and ensured that India's sovereign right to protect them is not diluted.

Providing food to the poor or targeted groups at subsidised prices is fully WTO-compatible. This does not figure at all in the WTO calculations. We have not undertaken any commitment in the WTO for any kind of limit on the food supplied under the NFSA .

An informed discourse based on facts is welcome and I believe such a discourse shall strengthen public policy.

Nirmala Sitharaman is Minister of State (Independent Charge) for Commerce and Industry, Government of India

The new U.S. Fed Chairman is unlikely to opt for policies that might upset the President's plan

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ICMR inks deal to promote vaccine development

The Indian Council of Medical Research (ICMR) has signed an MoU with the International Vaccine Institute (IVI) for collaborating on vaccine research and development.

India will commit $5,00,000 (3.20 crore) annually for a stake in IVI— an amount approved during a Cabinet meeting in January.

Boost to medicine

The MoU was signed between Soumya Swaminathan, the Director General of ICMR and Secretary, Department of Health Research, Manoj Jhalani, Additional Secretary and managing director, National Health Mission, and IVI Director General Jerome H. Kim.

Successful project

IVI has been partnering with Indian vaccine manufacturers, research institutes, government, and public health agencies on vaccine development, research, and training. One of the most successful collaborations was with Shantha Biotech on the development of Shanchol, the world's first low-cost oral cholera vaccine.

The vaccine was licensed in India in 2009 and WHO-prequalified in 2011.

Dr. Swaminathan said: "We have been working closely with IVI in India for more than a decade now. We are confident that this collaboration will elevate the vaccine R&D capacity at IVI as well as benefit Indian labs and the vaccine industry."

Affordable vaccines

Dr. Kim said the MoU was a step towards providing affordable vaccines across the globe.

"India is a vaccine industry powerhouse that supplies 60% of the world's vaccines. The signing of the MoU is a continuation of our partnership with India to provide safe, effective and affordable vaccines for people around the world,'' he said.

Despite the National Green Tribunal's orders on construction dust and open burning of waste, there is little compliance on the ground. Ashok Kumar talks to residents of the Millennium City who are getting fed up with the administration's apathy in implementing rules that help can curb air pollution

Data reveal injuries were more common among children belonging to the age group of 1-5 years

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Meet the bacteria that save babies

A big, successful test “The researchers chose Lactobacillus plantarum after carefully studying its ability to colonise the infant gut over a long period.” | Photo Credit: Splendens/Getty Images/iStockphoto

That babies born by Caesarean section are at a slightly higher risk of developing obesity, asthma and other ailments than children born vaginally is now well known. The reason: in a vaginal birth, a baby ingests some of the microbes present in the vagina during the time of delivery. These bacteria colonise the newborn’s gut and keep it healthier when compared with babies born through a C-section.

However, in the case of India, infants born even vaginally are more prone to infection and sepsis, which causes many deaths. Now, a community-based trial carried out on newborns in rural Odisha has found that administering synbiotics for a week beginning 2-4 days of life could bring about 42% reduction in sepsis.

With 30 per 1,000 live births, the incidence of hospital-based sepsis is huge in India and about a fifth of neonates with sepsis die in the hospital; community-based studies indicate an incidence as high as 17% of all live births. About 30% of sepsis-related deaths occur in the second week, whereas it is around a fifth in the third and fourth weeks, according to a paper in the *Journal of Perinatology* (December 2016).

There was also a reduction in lower respiratory tract infections such as pneumonia, which was “completely unexpected”. The reduction in respiratory tract infections suggests that synbiotics not only enhanced the gastrointestinal immunity but also overall immunity in the newborns. The week-long treatment costs about $1.

Synbiotics are a combination of probiotic or live microorganisms that provide health benefits and prebiotic which promote growth and sustain colonisation of the probiotic strain. In this case, *Lactobacillus plantarum* was used as a probiotic. A carbohydrate (fructooligosaccharides) that occurs naturally in plants such as onion, garlic and banana was chosen as the prebiotic. The researchers chose *L. plantarum* after carefully studying its ability to colonise infant gut over a long period. The bacteria have been shown to protect infants during the early weeks of life. “The bacteria is safe and does not cause problems in sick and even immunocompromised babies,” says Dr. Sailajanandan Parida from the Department of Paediatrics, S.C.B. Medical College, Cuttack, Odisha, and one of the authors of the paper. “The bacteria colonise the gut and do not allow harmful bacteria to grow. They stimulate the immune system so babies are able to produce antibodies against pneumonia and sepsis-causing bacteria.”

Researchers from the University of Nebraska Medical Center, U.S. and India studied over 4,550 infants born to mothers from 149 villages in Odisha, where neonatal and infant mortality rates are among the highest in India. The babies were at least 2 kg at birth and had completed at least 35 weeks of gestation. To eliminate any kind of bias in the conduct of the trial, the newborns were randomly assigned to receive either the synbiotics or a dummy. Neither the researchers nor others knew who received what. Half the participants received the synbiotics while the other half received the dummy. The babies were monitored for 60 days, the most critical period when they get sick and die.

The researchers had anticipated only 20% reduction in sepsis but as the reduction was more than twice than what was anticipated, the trial was stopped midway. It is not uncommon for trials to be stopped midway when the results are overwhelmingly positive. Denying newborns the benefits of

the synbiotics, which have been found to be beneficial, would be considered unethical if the trial is continued. The results were published a few days ago in the journal *Nature*.

“The synbiotics can be introduced as a preventive measure for sepsis. It should be given for seven days, 2-3 days after birth,” says Dr. Parida.

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Lifestyle-related risk factors are being cited, compounded by an inadequate number of treatment centres in the region

Without policies to stop the worrying spread of antimicrobial resistance, the mortality rate could be disturbing

END

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Researchers from the University of Nebraska Medical Center, U.S. and India studied over 4,550 infants born to mothers from 149 villages in Odisha, where neonatal and infant mortality rates are among the highest in India. The babies were at least 2 kg at birth and had completed at least 35 weeks of gestation. To eliminate any kind of bias in the conduct of the trial, the newborns were randomly assigned to receive either the synbiotics or a dummy. Neither the researchers nor others knew who received what. Half the participants received the synbiotics while the other half received the dummy. The babies were monitored for 60 days, the most critical period when they get sick and die.

The researchers had anticipated only 20% reduction in sepsis but as the reduction was more than twice than what was anticipated, the trial was stopped midway. It is not uncommon for trials to be stopped midway when the results are overwhelmingly positive. Denying newborns the benefits of

the synbiotics, which have been found to be beneficial, would be considered unethical if the trial is continued. The results were published a few days ago in the journal *Nature*.

“The synbiotics can be introduced as a preventive measure for sepsis. It should be given for seven days, 2-3 days after birth,” says Dr. Parida.

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Without policies to stop the worrying spread of antimicrobial resistance, the mortality rate could be disturbing

END

Meet the bacteria that save babies

A big, successful test “The researchers chose Lactobacillus plantarum after carefully studying its ability to colonise the infant gut over a long period.” | Photo Credit: Splendens/Getty Images/iStockphoto

That babies born by Caesarean section are at a slightly higher risk of developing obesity, asthma and other ailments than children born vaginally is now well known. The reason: in a vaginal birth, a baby ingests some of the microbes present in the vagina during the time of delivery. These bacteria colonise the newborn’s gut and keep it healthier when compared with babies born through a C-section.

However, in the case of India, infants born even vaginally are more prone to infection and sepsis, which causes many deaths. Now, a community-based trial carried out on newborns in rural Odisha has found that administering synbiotics for a week beginning 2-4 days of life could bring about 42% reduction in sepsis.

With 30 per 1,000 live births, the incidence of hospital-based sepsis is huge in India and about a fifth of neonates with sepsis die in the hospital; community-based studies indicate an incidence as high as 17% of all live births. About 30% of sepsis-related deaths occur in the second week, whereas it is around a fifth in the third and fourth weeks, according to a paper in the *Journal of Perinatology* (December 2016).

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Why India fails to deliver health and education

The tragic death of scores of children recently at the BRD Medical College hospital in Gorakhpur has reopened the discussion on India's weak state capacity. In the last 70 years, the Indian state has clearly failed at delivering quality education and public health to its citizens. This raises a couple of troubling questions: 1) Why have democratic institutions not been able to generate sufficient pressure upon successive governments to deliver better health and education services? 2) Why has high economic growth in the last quarter-century not created an improvement in government provision of services?

The work of Monica Das Gupta of the Maryland Population Research Center has been quoted in this newspaper earlier in the context of the first question. But it is worth reiterating her arguments because they are crucial to finding the answers to the second question as well. In general, democratic institutions in India have negatively affected the provision of public health because—as Das Gupta writes—"electorates typically prefer public funds to be used to provide private goods (such as medical care), rather than public goods (such as sanitary measures to protect the health of the population as a whole)." In fact, she notes, the non-democratic regimes of East Asia were more successful in delivering quality public health services. Going further, Das Gupta blames "elite capture" which helps divert public funds meant for primary healthcare towards provision of tertiary medical services.

This brings us to the second question. It should be noted that there is not much evidence to link higher economic growth to better institutions. The causality is better established in the other direction. However, there is some evidence that higher economic growth may actually lead to degradation in governance quality. A 2002 paper by Daniel Kaufmann and Aart Kraay came to this very conclusion and the duo speculated that "elite influence and state capture" might be the reason that a virtuous cycle between economic growth and quality of governance doesn't manifest.

If neither democratic institutions nor economic growth guarantees higher state capacity, what does? A deeper understanding of state capacity itself would be required to reach some conclusions. In his 16th UNU-WIDER (United Nations University-World Institute for Development Economics Research) annual lecture, Lant Pritchett of Harvard University goes into the details of the state capacity question. The key for us here is the distinction that Pritchett draws between "thick accountability" and "thin accountability". For an organization, thin accountability is based on measures of objective performance and is judicable. On the other hand, thick accountability comprises justification of organizational actions to internal culture and external stakeholders.

For example, thin accountability will have parameters like the attendance record of teachers in schools and nurses in hospitals, and thick accountability will involve quality of diagnosis of a patient and the learning outcome of students. It is evident that an organization with weak capacity may well be able to deliver on thin accountability metrics but will always struggle with thick accountability.

Setting the curriculum for schools is, therefore, something states with a weak capacity will be able to deliver much better than ensuring teaching standards. In healthcare, similarly, tertiary healthcare service is easier than making doctors deliver in primary healthcare centres. Now, one can clearly see that both weak electoral demand and weak state capacity are reinforcing the same consequence, which, in healthcare for instance, is prioritization of tertiary medical services over primary healthcare.

The actual puzzle is that the same Indian state which struggles at primary healthcare and

education is able to organize the world's largest elections, enrol billions of people in a biometric Aadhaar programme, and send *Mangalyaan* to orbit Mars—the only nation to do it in the first attempt. Pritchett's insights can explain most of these isolated achievements. The parameters of accountability in these cases—number of voters in elections, number of registrants in Aadhaar, the cost of an orbiter mission—are objective and judicable. Moreover, these organizations have all been driven by a mission-oriented focus. The culture of internal accountability in a mission-oriented organization is much better. In a 2005 paper, Timothy Besley and Maitreesh Ghatak established that matching the missions of citizens (principal) with those of the public bureaucracies (agent) reduces the need for pecuniary incentives for the latter. In any case, incentives can work only when, as Pritchett says, the contingent facts in the incentive formula are judicable.

What makes a good Reserve Bank of India governor or a good Isro (Indian Space Research Organisation) chairman is not amenable to judicable facts but the two organizations have still been able to consistently get capable and worthy leaders. The same goes, broadly speaking, for judges in the Supreme Court and high courts. This is, at least partly, the result of a successful infusion of a sense of mission in these organizations. But the engendering of such attitudes in an organization takes time and is not always successful. This will involve creating a few initial successes, replicating, repeating and multiplying them. And then crafting organizational narratives around those successes. The governments at the centre and in the states should embark on this task with a "missionary" focus.

Can India's economic growth continue even with weak state capacity? Tell us at views@livemint.com

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Many probes, few answers

Ensuring supply: A hospital employee checks newly arrived oxygen cylinders at the Baba Raghav Das Medical College Hospital in Gorakhpur on August 12. AP Rajesh Kumar Singh

News of children dying in a district hospital in Gorakhpur reached Delhi as a newsflash from ANI's Twitter handle at 7.22 a.m. on August 11. It said 23 children had died in the Intensive Care Unit of the district hospital after "supply of liquid oxygen was disrupted y'day (sic) due to pending payment". At 8.26 p.m., the official Twitter handle of Uttar Pradesh government tweeted a complete denial, insisting that the deaths were not related to oxygen shortage: "*Gorakhpur mein BRD Medical College mein oxygen ki kami se kisi rogi ki mrityu nahin hui hai*."

Since August 11, five parallel investigations — a three-member Central government-appointed committee, a State government-appointed committee, by the Indian Medical Association (IMA), the National Human Rights Commission (NHRC), and lastly the police — have been set up, apart from the District Magistrate's report, to answer one question: did medical negligence lead to a spike in deaths, in a hospital showing high mortality rates annually during the monsoon season due to Japanese encephalitis (JE)?

The State government-appointed committee hand-picked by Chief Secretary Rajive Kumar included Health Secretary Alok Kumar, Finance Secretary Mukesh Mittal, and Hem Chandra, medical superintendent of the Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGI), Lucknow. In effect, the Health Secretary, who holds the additional post of Mission Director of National Health Mission, under which the JE programme is implemented, investigated his department. Similarly, the Finance Secretary investigated the issue of delay in payments of his own department. The SGPGI professor is the only one in this committee without a conflict of interest.

This conflict of interest has been flagged by Amnesty International India, which in a statement issued on August 19 said that it "remains concerned about the thoroughness and impartiality of these investigations… Furthermore, the findings of investigations released so far have shown serious discrepancies. The Central government inquiry found that the deaths did not take place due to a lack of oxygen. Simultaneously, a probe by the district administration found that 63 of these deaths were linked to a shortage of oxygen. A criminal complaint was also filed against the oxygen supplier."

On August 12, Uttar Pradesh Health Minister Sidharth Nath Singh held a press conference and said no post-mortems were done as they "died due to their illnesses". However, no attempt has been made by the government to establish if that statement, made within a day of the deaths, was in fact backed by evidence.

More pertinently, medical records, which document the line of treatment of the patients, have not been handed over by the hospital to at least seven families contacted by this newspaper; interviews revealed that most families are denied hospital records when bodies are handed over. Brahmdev, a father of twins who died, alleges that the hospital made him 'forfeit' medical records without informed consent before handing over the death certificates. Zahid, whose five-year-old daughter Khushi also succumbed, says he didn't get the medical records either. Bahadur, whose four-year-old boy Deepak died on August 10, is still trying to retrieve medical records from the hospital.

In the absence of autopsies, the medical records could have helped to establish what the children were being treated for, why they needed oxygen support, and most importantly, did the ailment

cause the death or was it medical negligence?

For any meaningful inquiry, the original medical records contemporaneously maintained (not updated later) and the post-mortem reports are the most important pieces of evidence — which the State government appears to be frantically trying to erase.

The families now face an uphill task in proving that the spike in fatalities on August 10 and 11 was caused by criminal negligence on the part of the entire health system at the State and district level. While the odds are against the families, there are several questions that remain unanswered in the wake of some quick decisions taken by the U.P. government to fix accountability. The central pattern emerging from the interviews with families is that the hospital administration actively dissuaded them from conducting autopsies by withholding medical information.

Further, despite the State government denying that a shortage of oxygen caused the deaths, why was Pushpa Sales, the oxygen supplier, charged? And why suspend the principal of the Gorakhpur medical college if there was no negligence on the part of the hospital?

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A minute for Macaulay

Thomas Babington Macaulay has long been a favourite whipping boy for both the Right and Left in India. To many he is associated with the Western idiom, the reason why an English-educated elite ruled the country for more than a century. Of course several members of this elite later turned on their masters and joined, if not led, the movement for national sovereignty, or independence from colonial rule. Nevertheless, ‘Macaulayism’ is the term given to the deliberate policy of an imperial power to redirect a subject people’s education in an attempt to influence their thought and self-understanding.

The signal moment that is cited is Macaulay’s Minute on Education in 1835, a tract in which he set out to explain his proposal for promoting English education in India at the expense of Arabic, Persian and Sanskrit, which were being taught in colonial schools.

I contend, nonetheless, that the Macaulay Minute is both overrated and somewhat misjudged in Indian cultural studies. It is true that it came from a man who was directly charged with the formation of a loyal local herd that would be indebted in serving the colonial administration. He was, after all, a bureaucrat of high standing, obliging the Supreme Council of India for five years.

But Macaulay also fancied himself as a politically liberal and cosmopolitan intellectual. One needs to ask what such a claim (of intellectual integrity in particular) might imply, coming as it does from a long tradition going back to the pre-Socratics and the Vedanta.

For most, intellectual activity would simply be the task of asking philosophically rigorous questions about objects in the world and our relationships with them. It also places emphasis on the how, by asking what are the correct ways for people, governments and organisations to act in any given situation. Intellectual honesty demands that we engage with others’ ideas as well with sincerity.

Of course, intellectuals are often not themselves honest in their words and actions; this could stem from ignorance as well as ideology. In our time, neoliberalism has proven to be an ideology that generated enormous harm to hundreds of millions. Yet many intellectuals have defended neoliberalism’s rules of the ‘free market’, notwithstanding the destruction it continues to engender.

For Macaulay, the belief that colonialism was a moral right of the British Empire constituted such an ideology. That is why his wide-ranging essay is well worth reading in full. Unfortunately, even scholars tend to focus on select passages pertaining mainly to his suggested deployment of English-educated natives for the Empire’s strategic purposes.

Indians, and perhaps Arabs too, are rightly indignant when Macaulay claims that in his conversations with learned men in India, no one would deny that “a single shelf of a good European library was worth the whole native literature of India and Arabia”. Still, I believe it is important to try to unravel the logic of the minute from other perspectives as well, without thereby excusing its egregious power claims and the cunning of British imperial politics.

Take, for instance, an extended comparison Macaulay makes with the case of Russia. Russia, in Macaulay’s time, has “a large educated class, abounding with persons fit to serve the state in the highest functions, and in no wise inferior to the most accomplished men who adorn the best circles of Paris and London. There is reason to hope that this vast empire, which in the time of our grandfathers was probably behind the Punjab, may, in the time of our grandchildren, be pressing close on France and Britain in the career of improvement. And how was this change effected? Not by flattering national prejudices: not by feeding the mind of the young Muscovite with the old women’s stories which his rude fathers had believed: not by filling his head with lying legends

about St. Nicholas: not by encouraging him to study the great question, whether the world was or was not created on the 13th of September: not by calling him “a learned native,” when he has mastered all these points of knowledge: but by teaching him those foreign languages in which the greatest mass of information had been laid up, and thus putting all that information within his reach. The languages of Western Europe civilized Russia. I cannot doubt that they will do for the Hindoo what they have done for the Tartar.”

Macaulay here is speaking of a nation’s progress towards a more cosmopolitan outlook, but he is not thereby denigrating its own native cultures and practices. For instance, he speaks very highly of 19th century England and English literature and poetry of course, but also makes the claim that had the English literati not familiarised themselves with ancient Greek and Roman writings, they would never have produced a Shakespeare. “What the Greek and Latin were to the contemporaries of [16th century writers Thomas] More and [Roger] Ascham, our tongue is to the people of India.”

India today sits on the edge of greatness in its political and social influence in the world. The latter especially stems from its rich heritage of multicultural democratic polities and the novel ethics of ahimsa, the Dhammapada, and the grand philosophy of existence expressed in the Gita, not to mention numerous other traditions that are becoming resurgent.

But this growing presence surely also signals our inter-connectedness in a much larger planetary context, with numerous global ecological limits emerging in addition to geopolitical challenges, as well as other multicultural examples to learn from.

Indeed, it would be hard to imagine anyone asserting that a cosmopolitan education is less important or valuable today than it was two centuries ago. By default, that language and idiom are now English (it could well be Chinese in a few decades, but that is not so evident).

Similarly, like Macaulay himself, none would deny the value of alternative modes of education (from activity-based learning to gurukul structures) that dot the Indian landscape. These cannot be divided into Macaulite and non-Macaulite forms. I value my ‘Macaulite’ education greatly, at least as much or even more than my training in Carnatic classical music, but they are also mingled with the types of lessons my mother and father taught me from Indian epics, and so on.

Indeed, I would not be able to engage in this discussion here or with a wider group of colleagues from South Africa and Brazil to Indonesia, if I were not fluent in English. But engagement across cultures matters to me and, I suppose, to billions more across the world.

Moreover, given the vast disparities of caste, class and other markers of social status, excellence in education even in pre-colonial India was restricted to the elites, with a few Ekalavyas barely managing to get access to the gurukuls and other traditional schools. A Right to Education never existed prior to Macaulay and it would be disingenuous to claim otherwise.

What then are our pedagogical options? I believe it behoves us to find new hybrid forms that draw on a multiplicity of folk traditions but continue to place central emphasis on common curricula with universal access to English across the country. Otherwise, we will simply perpetuate our many ills and continue to blame Macaulay for them.

Sudhir Chella Rajan is Professor, Humanities and Social Sciences, IIT-Madras

The new U.S. Fed Chairman is unlikely to opt for policies that might upset the President’s plan

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Gorakhpur’s Japanese encephalitis malady

When you make a mistake, there are only three things you should ever do about it: admit it, learn from it, and do not repeat it.

—Paul “Bear” Bryant

Baba Raghav Das (BRD) Medical College in Gorakhpur became the epicentre of a controversy after more than 60 children there died earlier this month. Even as the confusion continued about the cause of death, the debate shifted back to the old culprit—Japanese encephalitis (JE)—the child killer disease.

JE is a viral disease that is transmitted by the infective bite of the Culex species of mosquitoes. The infection can lead to high fever, headache, stiffness in muscles, seizures, coma, and in worst cases, death. It primarily affects children because of their weaker immune systems.

In 2016, Uttar Pradesh (UP) contributed 25.5% of JE deaths in India. The last time JE made news in UP was in 2005 when 5,737 people were affected by the disease in seven districts of eastern UP and 1,344 people died. The centre of outbreak was Gorakhpur.

As long as Gorakhpur’s JE problem will be looked at from the narrow prism of only providing for beds and medicines, it will continue to haunt the district. It is important to understand that factors that influence propagation of vector-borne diseases are complex and sometimes fall outside the purview of the health department.

Climate: Gorakhpur has a climate that makes it vulnerable to JE. The temperatures in Gorakhpur range from 8.9 degrees Celsius to 38.3 degrees Celsius. The district receives rainfall between June and August with an average of 52.2 days in a year. In their research (goo.gl/sYh1S8), U. Suryanarayana Murty, M. Srinivasa Rao and N. Arunachalam found that 28 degrees Celsius temperature with 50-55% relative humidity is the most appropriate condition for increase in mosquito density.

Agricultural and husbandry: JE vectors thrive in irrigated paddy fields. Large swathes of land in the district are cultivated for paddy. Approximately 63% of the total workforce of Gorakhpur is directly engaged in agricultural activities. Families that depend on agriculture supplement their income with cattle rearing. Pigs and birds are considered to be primary carriers of the JE virus.

Urban development and management: Previously, it was believed that the JE virus resides in rural areas. However, emerging research suggests that JE virus may not be constrained to rural environments. *Culex tritaeniorhynchus* and *Culex gelidus* are two important Culex vectors in India. Murty et al found that while *Culex tritaeniorhynchus* was more prevalent in rural areas, *Culex gelidus* was common in urban areas. Gorakhpur is a bowl-shaped city with high groundwater tables. The gradient of the city is low to flat, which leads to problems of water logging and flooding. This creates ample habitation for JE vectors to thrive in urban areas.

Public health infrastructure: There is a shortage of sub-centres and primary health centres in rural areas. More than 81% of Gorakhpur’s population is rural. Due to unavailability of health facilities and medical attention within 5-10km, patients go to far-off district hospitals such as BRD Medical College—one of the major government health facilities in the region.

Vector-borne diseases like JE require intersectoral coordination. Going forward, the following steps ought to be taken.

Address agro-climatic concerns: It is important to converge climate and agriculture to tackle the issue of vectors. Irrigation technologies like alternate wetting and drying (AWD) methods can help with vector control. AWD refers to intermittent drying and re-flooding the rice fields without stressing the plants. This technique improves land and water usage, and lack of standing water also helps with vector control.

Address husbandry practices: Gorakhpur should be studied as a case for poultry as potential carriers of JE vectors. The total number of pigs in Gorakhpur is only 1.3% of UP's total pig population. Also, 86% of Gorakhpur's livestock comprises poultry. Natalie B. Cleton, Angela Bosco-Lauth, Michael J. Page, and Richard A. Bowen have found that young poultry between the age of two and 42 days, have high viremia and if they catch JE infection they can be amplifying hosts (goo.gl/tobu6Y). The state government should run campaigns to make citizens aware that pigs and poultry need to be segregated from humans.

Address urban development issues: In Gorakhpur, more than 80% of the rural population defecates in the open. This puts children at risk as their immunity is compromised. Thus, a cycle of disease is perpetuated. Climate change is likely to increase rain events throughout Gorakhpur over the next 50 years. Therefore, flood-resilient housing, solid waste management and sewage treatment should be pursued on priority.

Address public health issues: Immunization is a good strategy but coverage remains low due to low levels of awareness among people and low availability of vaccines. The pure public good in vector-borne disease is surveillance of all types of vector-borne diseases. Mosquito population counts should be done for all cities and local entomological knowledge repositories should be maintained to strategize vector control.

Vector-borne diseases are determined by a set of complex interrelated social, economic, and environmental factors. This means that health cannot be left to the health sector alone: it requires intersectoral coordination, cooperation and action. Traditionally, much of the government works in silos. Intersectoral action for health would require government departments to work with each other horizontally (inter-ministry cooperation) as well as vertically (at national, regional and local levels). Without intersectoral action, health outcomes will remain underachieved.

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To read and write better

Getty Images/iStockphoto | Photo Credit: Getty Images/iStockphoto

The Right of Children to Free and Compulsory Education (Second Amendment) Bill of 2017 aims to maintain the standard of elementary education along with the avowed objective of providing compulsory education to children between the ages of six and 14.

The new Bill introduced in the Lok Sabha proposes to substitute Section 16 in the Right of Children to Free and Compulsory Education Act of 2009, which provides that “no child admitted in a school shall be held back in any class or expelled from school till the completion of elementary education.” The provision was made in the original Act because examinations were often used to hold back children who obtained poor marks. Parliament had no intention to demotivate a child by compelling him or her to repeat the same class or leave school altogether.

However, the recent years have seen several States and Union territories raise the adverse impact of Section 16 on elementary education. Authorities claimed that there was a steady dip in the learning standards of students in elementary classes.

The new Bill has substituted Section 16 “in order to improve the learning outcomes in the elementary classes”. The Centre said this step has been taken after “wide deliberations with all the stakeholders”.

The Bill provides for a regular examination to be conducted in the fifth and eighth classes at the end of every academic year. If a child fails in the examination, he or she shall be given “additional instruction” and granted an opportunity for re-examination within the next two months.

In case the child fails in the re-examination too, the appropriate State government would be empowered with the authority to allow schools to either hold back or not hold back the child in the same class. No child, however, shall be expelled from a school till the completion of elementary education, the Bill clarified.

Earlier this year, the NITI Aayog had called for a review of the provisions of the 2009 Act on the ground that the best intentions enumerated under Section 16 were actually proving detrimental to elementary learning processes. Stakeholders argued that the situation was such that a child could be promoted till eighth class without probably being even able to read or write.

The new U.S. Fed Chairman is unlikely to opt for policies that might upset the President’s plan

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70 years of Independence

Special Feature – I-Day 2017

Ensuring Health through Immunization

Mission Indradhanush to accelerate the coverage

***Sarita Brara**

It was only after the successful eradication of small pox in the 1970s that systematic immunization on a global scale was recognised as a practical possibility. Today it is considered key to protect children from life threatening diseases and conditions and the most cost effective intervention for child survival.

In India, Immunization programme, the largest in the world in terms of quantity of vaccine used, number of beneficiaries and Immunisation session organised, geographical spread and diversity of areas covered, was initiated in 1978 and then expanded to Universal Immunization Programme in 1985. From six antigens in 1985, the National Immunization programmes presently includes 12 vaccines, four of which were included in UIP by the present government.

All these vaccines are available free of cost under UIP. India is free from the crippling disease of Polio. Immunization and other health interventions has helped in reducing infant mortality rate in the country which is down to 39 per 1000 live births as per the latest government data and the country has achieved millennium development goal in infant mortality . India's current under five mortality rate is 45 per 1000 live births against the MDG target of 42

The immunization programme has been put on the fast track under mission Indradhanush to increase its coverage to 90 per cent by 2018 with the commitment to reach a situation where no child died from Vaccine Preventable Diseases.

To begin with Expanded Programme of Immunization (EPI) was launched in 1978 with the introduction BCG, OPV, DPT and typhoid-paratyphoid vaccines. Typhoid-paratyphoid vaccine was dropped from EPI in 1981.Tetanus toxoid vaccine for pregnant women was added in EPI in 1983. But as the vaccination under the programme was offered through major hospitals and largely restricted to the urban areas its coverage was understandably very low.

The Immunization programme got a major push with the launch of Universal Immunisation programme in 1985. The programme began six antigens, measles vaccine was added in the same year and in 1990 Vitamin A supplementation was included in the programme. The programme was initiated with the objective of increasing immunization coverage, reducing mortality and morbidity due to six vaccine preventable diseases (VPDs), improving the quality of service, establishing a reliable cold chain system, a district-wise system for monitoring and evaluation, and achieving self-sufficiency in vaccine production and manufacturing of cold chain equipment. The immunization received additional importance when it was added to the Prime Minister's 20 point programme.

It was in year 1995 that Polio programme was put in eradication mode with the adoption of special strategy and innovative methods to rid India of this crippling disease. The success of polio eradication programme in India is attributed to strong commitment and political will, partnership with WHO, UNICEF and Rotary International the dedication of frontline workers and volunteers, and the unequivocal support of all sections of the society. A need based strategy was adopted to reach maximum children during each polio immunization campaign. Heightened surveillance for poliovirus has been the backbone of the polio eradication initiative in India. One of the major challenges was overcoming the physical and social barriers, coverage of the most vulnerable new born babies and migrant population. No wild polio virus was reported after January 2011 and India was declared Polio free in 2014.

Mission Indradhanush Accelerating the coverage

There was just a four per cent increase from 61 per cent to 65 per cent in immunization coverage from 2009 to 2013. In order to accelerate the rate the NDA government launched Mission Indradhanush on 25th December 2014. The objective was to extend immunization coverage to all children across India by year 2020. The target date has since been preponed to 2018. Mission Indradhanush, depicting seven colours of the rainbow, targets to immunize all children against seven vaccine preventable diseases namely Diphtheria, Pertussis, Tetanus, Childhood Tuberculosis, Polio, Hepatitis B and Measles. 247 lakh children and 67 lakh pregnant women have been covered in 528 districts across the country under the programme in four phases The programme has helped India attain nearly seven per cent increase in immunisation coverage .

The NDA government has also included four more vaccines to the Immunization programme. The newly included vaccines in the Universal Immunisation Programme (UIP) are Rotavirus vaccine, Injectable Polio vaccine (IPV), Rubella vaccine, and Japanese Encephalitis (JE) 1 vaccine (for adults). The indigenously developed rotavirus vaccine is aimed at preventing deaths from diarrhoea in children under five. Rotavirus is one of the leading causes of severe diarrhoea and death among children less than five years of age.

While measles is a viral infection that can be fatal, congenital rubella syndrome is responsible for irreversible birth defects. The Union health ministry’s campaign against the two diseases intends to cover approximately 41 crore children in a phased manner, making it the largest-ever worldwide. The first phase of the campaign was launched across five states Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry— in February this year. More than 3.3 crore children were vaccinated, reaching out to 97% of the intended age group. The drive was carried out at schools, community centres and medical institutes, covering children between the ages of nine months and 15 years. In the second phase which started early this month nearly 3.4 crore children across eight states and union territories Andhra Pradesh, Chandigarh, Himachal Pradesh, Kerala, Telangana, Uttarakhand, Dadra and Nagar Haveli and Daman and Diu will be covered.

PCV which launched in May this year protects children against severe forms of pneumococcal disease, such as pneumonia and meningitis. Currently, the vaccine is being rolled out to

approximately 21 lakh children in Himachal Pradesh and parts of Bihar and Uttar Pradesh in the first phase. This will be followed by introduction in Madhya Pradesh and Rajasthan next year, and eventually be expanded to the country in a phased manner.

The Injectable Inactivated Polio Vaccine (IPV) in India was launched in 2015 as part of its commitment to the "Global Polio Endgame Strategy". New evidences now clearly show that IPV and OPV together will further strengthen the children's immune system and will provide double protection against polio.

An adult vaccine against Japanese encephalitis (JE), is being introduced in 179 endemic districts in nine states. Most human infections are asymptomatic or result in mild symptoms, however, a small percentage of infected persons develop inflammation of the brain with symptoms including sudden headache, high fever, disorientation, coma, tremors and convulsions.

"The introduction of four new life-saving vaccines will play a key role in reducing the childhood and infant mortality and morbidity in the country. The government will now ensure that the benefits of vaccination reach all sections of the society, regardless of social and economic status," the Prime Minister said while introducing the vaccines.

These vaccines could prevent the deaths of at least 100,000 infants, and of people in the working age group.

The Universal Immunization Programme in India now provides free vaccines against 13 life threatening diseases to 27 million children annually.

The Government has initiated a SMS based electronic vaccine intelligence network (e- VIN) to enable real time monitoring of vaccine stocks eVIN (Electronic Vaccine Intelligence Network) is an indigenously developed technology system in India that digitizes vaccine stocks and monitors the temperature of the cold chain through a smartphone application. The innovative eVIN is presently being implemented across twelve states in India. eVIN aims to support the Government's Universal Immunization Programme by providing real-time information on vaccine stocks and flows, and storage temperatures across all cold chain points in these states. The technological innovation is implemented by the United Nations Development Programme (UNDP).eVIN aims to strengthen the evidence base for improved policy-making in vaccine delivery, procurement and planning for new antigens in India.

However, despite all the efforts, there are still some gaps in the immunisation programme. There is a need for raising the awareness levels so that the target of 90 percent immunisation coverage is achieved within the stipulated time frame.

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Views expressed in the article are author's personal.

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Lessons not learnt: On swine flu

The number of influenza A (H1N1) virus cases and deaths reported from across India this year has already crossed 19,000 and 900, respectively. These are lower than the 2015 toll of 32,000 cases and 2,000 deaths, but the revived spread is alarming. In the last month or so there has been a sharp increase in the number of cases and deaths — over 6,000 and 300. Gujarat is the worst-affected, with about 250 deaths recorded so far: Rajasthan, Punjab and Maharashtra and Delhi too have been badly hit. The number of H1N1 cases in the southern States is also high compared with last year, with Tamil Nadu reporting nearly 3,000 cases about a month ago. According to the Pune-based National Institute of Virology, the virus has not undergone any significant mutation and the virulence has remained nearly unchanged. It has however undergone point mutations which resulted in a new strain — the Michigan strain — replacing the California strain that has been prevalent since the 2009 pandemic. While both strains were co-circulating last year, as per surveillance data only the Michigan strain has been circulating this year. The increased caseload and mortality this year compared with last year could be because pre-existing immunity through exposure to the California strain is no longer effective, and people are therefore not immune to the new strain. More research is needed to fully understand the epidemiology of H1N1 caused by the Michigan strain, and who may be more vulnerable.

Despite the high numbers, there is no system in place to release data periodically and frequently. Compare this with the regular updates provided by the U.S. Centers for Disease Control and Prevention, especially during an epidemic. There has also been a near-complete failure on the part of governments to spread awareness about prevention strategies. Uptake of influenza vaccination by people, especially by those belonging to the high-risk category, has been extremely poor, with only about 10,000-12,000 doses of H1N1 vaccine sold in the last six months by the Pune-based vaccine manufacturer. Since the 2009 pandemic, H1N1 has become a seasonal flu virus strain in India even when the temperature soars during the summer months. Vaccination of health-care workers and people in high-risk categories is the only way to reduce the toll. That guidelines for H1N1 vaccination of people belonging to high-risk categories such as pregnant women, very young and old people and those with certain underlying illnesses were released only last month by the Health Ministry is evidence that India has not learnt any lessons from the 2015 H1N1 epidemic. Urgent measures are needed to ramp up preparedness in dealing with epidemics.

Rajasthan’s ordinance shields the corrupt, threatens the media and whistle-blowers

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Public health isn’t about state-run hospitals

Nearly all democracies use two modalities of modern medicine to keep citizens healthy—public health and disease-care. Public health is what the state does to prevent diseases and to protect health. In contrast, disease-care includes the different types of biomedical interventions that are carried out to restore health after an individual falls ill. Therefore, disease-care is popularly called “healthcare”. Healthcare is labour-intensive, given by one worker to one client at a time. Clinics and hospitals are visible infrastructure and sought after as a felt need in times of distress.

Public health, on the other hand, is invisible infrastructure, working in society to mitigate social determinants of diseases and in the environment to mitigate environmental determinants of diseases. Usually, this is managed by a ministry of public health or at least a separate public health department under the health ministry.

For a set of complicated reasons going back to the beginning of self-government in the late 1940s and early 1950s, India abolished the public health wing of the earlier British Raj. To this day it has not been reinstated, in spite of innumerable pleas and recommendations from public health experts.

To confuse the common man, the term “public health” has been misappropriated by policy leaders and medical professionals to mean healthcare in the public sector. Healthcare is not and cannot be called public health—though the quality and cost of healthcare can be scrutinized under the public health mandate, to make sure healthcare is achieving the goal of restoring health. This is obviously a threat to the free-for-all game of healthcare.

Where public health is under government control, two sets of officers can enter any premises for inspection—the police for law, order and crime prevention, and the public health officer for health, hygiene and disease prevention.

Public health must be managed by professionals trained in public health and empowered to work for the health security of all people—urban and rural, poor and rich. Such professionals must be part of a cadre-like structure and career track. This will help attract the best brains to public health.

Not everyone realizes that medical colleges teach only disease diagnosis, treatment and individual preventive medicine, but not public health, which entails environmental and community risk factors and remedial interventions. Sure, there are departments of community medicine in medical colleges that do expose students to the potential of public health, but they do not teach the practice of public health.

Global peer pressure forced India to establish a few community-level interventions to prevent certain diseases. For example, in the absence of an overarching public health infrastructure, India created stand-alone vertical projects against tuberculosis (TB), malaria, leprosy, filariasis, childhood cluster of infectious diseases and acquired immune deficiency syndrome (AIDS). Today all of them remain silos without being integrated into the public health infrastructure.

And it is precisely for this reason that none of these individual verticals has delivered its potential in disease prevention. The most obvious is TB, which has reached a point where we are afraid it may have become uncontrollable due to rampant drug resistance. The drug resistance was man-made, a result of the lack of application of public health expertise in TB control tactics.

This is one part of the story. The other involves water- and food-related diseases like typhoid fever, cholera, viral hepatitis A and E, the ever-present influenza that kills a lot of otherwise

healthy adults, scrub typhus, leptospirosis, brucellosis and many other infectious diseases. In these cases, there was no external peer pressure and hence there have been no specific programmes to control them.

In the absence of a public health framework that can supervise disease prevention, we vaccinate against Japanese encephalitis, but without controlling the disease; we vaccinate against hepatitis B, but without monitoring the benefit; meanwhile, measles continues to kill children even as we have a major measles vaccination thrust. Leprosy is being eliminated but new cases occur unabated.

Monitoring of all disease burdens can be done only by public health. Without monitoring by public health, most of our disease-control projects are flying blind.

Democracies are for the welfare of all people. Disease prevention is about equitable use of resources since the benefits are enjoyed by everyone. Healthcare can never be equitable unless we emulate Cuba and England. Diseases drain our economy in two ways—loss of productivity and expenditure for healthcare.

Non-communicable diseases are becoming epidemics—they are not easily prevented, except by huge changes in behaviour. But communicable diseases are preventable; and not preventing all preventable diseases is gross neglect of public welfare by the state. India must reinstate a functional public health infrastructure without any further loss of time. Its citizens deserve nothing less.

This article is the first in a series on public health in India.

T. Jacob John is professor emeritus at Christian Medical College, Vellore.

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70 years of Independence

Special Feature – I-Day 2017

India on the path to make affordable care available to all

*Savita Verma

With Indian doctors' prowess giving foreigners a confidence to seek treatment here, India has come a long way since independence in healthcare. The country has a booming medial tourism industry, coupled with improved score in health indicators like life expectancy, infant mortality and fertility rate. India now has a strengthened network of primary health centres, community health centres and tertiary care super specialty hospitals along with an army of trained medical personnel to provide health care to its people. Simultaneously, more hospitals are being opened, drug prices being regulated, technology being made affordable for masses, network on communicable diseases being strengthened and efforts being made to invest more in the healthcare.

The Gross Domestic Product per capita, which indicates a country's standard of living, has increased 21 times from the 1960 level when it was $81.3 to $1709.4 in 2016, according to World Bank estimates. The life expectancy at birth, the average number of years a person is expected to survive if existing patterns of mortality stayed the same throughout their life has increased by 65.8 percent or 27 years between 1960 when it was 41 years and 2015 at 68 years. Crude birth rate has also reduced from 37 in 1970 to 22.2 in 2012 (per 1000 population). Population stabilisation efforts have paid off with total fertility rate for the country going down to 2.3 while some states like Delhi at 1.7, Kerala at 1.8, Tamil Nadu at 1.7, Maharashtra at 1.8, West Bengal at 1.6 and Himachal Pradesh at 1.7 attaining fertility rates even lower than the replacement rate of 2.1 children per woman.

The country has shown impressive progress in bringing down the infant mortality rate - the number of babies per 1000 who die before their first birthday. From 165 deaths per 1000 children in 1960, the IMR has come down to 38 deaths in 2015. A major reason for this is the country's vaccination program. After launching its first vaccine – BCG - in 1962 as part of the national tuberculosis control program, India now has come a long way. An expanded program on immunization as part of the World Health Organisation's initiative was launched in India in 1978 which included BCG, DPT and typhoid vaccine. Oral Polio vaccine was included in the program in 1979. In 1985, the program was converted into Universal Immunization Program (UIP) with a goal to cover all the children.

Over the years new vaccines like those against hepatitis B and Japanese encephalitis have been added. The thrust on vaccination has made India polio free. The country was removed from the endemic countries' list on February 25, 2012 by the WHO. Vaccination has also contributed to the decline in under-five mortality rate from around 233 to around 47.7 per 1,000 live births in 2015 in last five decades, though in numbers this is huge burden - an estimated 5.9 million children died under the age of five in 2015, 45 percent of them being newborns.

Despite the progress, health sector in India still faces some challenges. For example, a large proportion of population - two-thirds of children and more than half of the women – suffer from anemia and malnutrition. High cost of care is a cause of concern which makes accessing care difficult for the poor and the weaker sections. Statistics show that even the well-to-do families reach the brink of poverty if faced with a serious illness. This is because of low government investment in health and private sector becoming the main source of healthcare.

New National Health Policy

However, the government has initiated landmark measures in the past three years to overcome these problems. It has brought out of a new national health policy which aims to provide universal access to good quality services at affordable cost. There is an emphasis on strengthening of the public health system by increasing public expenditure on health to 2. 5 per cent of the GDP in a time bound manner. The policy also proposes free drugs, free diagnostics and free emergency care services in all public hospitals to reduce financial burden of health care on people. The policy envisages giving choice of treatment to patients by co-location of AYUSH remedies in public facilities. Yoga should be introduced in schools and work places as part of promotion of good health, it says. The policy advocates strengthening of district level services so that people get secondary care there itself rather than in medical college hospitals, and recommends proactive

engagement with the private sector.

In line with the intention of health policy, government has already initiated measures to reduce cost of medicines and medical equipment while bringing more people under the health insurance net. There are plans to provide about 500 medicines free of cost in government district hospitals across the country. Fifty basic medicines will be provided free in primary health centres and 300 medicines in community health centers. The government has opened 83 outlets under the Affordable Medicines and Reliable Implants for Treatment (AMRIT) program. It also intends to empower citizens to access quality healthcare services using better mobile and internet connectivity. Aiming for equitable care, the government has been opening new AIIMS, including the latest approved for Assam.

Affordable medical care is the focus of this government. The National Pharmaceutical Pricing Authority has added 30 more essential drugs in the price control list taking the total medicines under price control to about 760. A draft national medical device policy aimed at bringing most medical devices within the ambit of price regulation and boosting their local manufacturing has also been prepared. Currently, only a few critical medical devices are under indirect price control and 80 per cent of all devices are imported products. The government has already fixed the ceiling prices of orthopaedic implants used in knee surgeries to prevent unethical profiteering at the cost of patients. In addition, medical devices which are notified as drugs must now carry maximum retail price (MRP) on the packs. There are 22 medical devices notified as drugs under the Drugs and Cosmetics Act, 1940 and the Drugs and Cosmetics Rules, 1945. These include cardiac stents, bone cements and heart valves.

Government has included several new vaccines in the Universal Immunisation Programme – vaccine against rotavirus, injectable polio vaccine, pentavalent vaccine one shot of which protects against diphtheria, pertussis and tetanus (DPT), hepatitis B and Hib, and anti-pneumonia vaccine which protects against severe forms of pneumococcal disease, such as pneumonia and meningitis. These vaccines were already available in the private sector. By including these in the national program, the government has ensured equitable access. A government program, “Mission Indradhanush” launched on December 25, 2014 is already on to increase full immunisation coverage by approximately five per cent annually from 65 per cent in 2014 to at least 90 per cent children in five years.

To overcome the problem of widely prevalent severe acute malnutrition, the health ministry is working on guidelines and a toolkit to help frontline workers reach out to parents and orient them

on their role in ensuring early childhood development. The Ministry of Women & Child Development has also been implementing several schemes to address the issue of malnutrition.

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Views expressed in the article are author's personal.

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India’s public health and the looming threat of US pharma giants

More than 1,200 people lost their lives due to floods in India, Bangladesh and Nepal last week. This year’s monsoon season destroyed thousands of homes, schools and hospitals and affected up to 40 million people. The increased rainfall and deadly flooding in South Asia is linked to climate change. In his book *The Great Derangement: Climate Change and the Unthinkable*, Amitav Ghosh offered a chilling account of how climate change is going to wreak havoc in India and elsewhere.

Worse still, the floods caused by climate change have left a trail of water-borne and other diseases. The people who are subjected to these diseases are invariably the poor of India. With more than 1.2 billion people, India, according to several studies and estimates by the World Health Organization, carries the highest disease burden. The country, for example, ranks first among nations in incidence of tuberculosis and pneumonia, malnutrition, and other contagious diseases. That there is an obvious relationship between the social determinants such as water sanitation, nutrition, air pollution, and health is well known. The recent ghastly death of children in Uttar Pradesh is a grim reminder of the deteriorating state of public health in India.

Sadly, the country also remains unprepared to respond to potential outbreaks, including the fast spreading swine flu and meningitis. “Today, countries such as India are more global and mobile than ever before and people can carry infections across the world (in and out of the countries) in hours,” says Unni Krishnan, director of Save the Children, a non-profit that works for child rights. “It is absolutely crucial that pandemic preparedness and response is taken up as a priority, and the disaster management maxim teaches that if you prepare well for one disaster, it helps to prepare for several,” he told *Mint* during the recent World Health Assembly.

Against this disturbing backdrop, the latest decision of the Indian patent office to grant a patent to the US pharmaceutical behemoth Pfizer for pneumococcal conjugate vaccine (PCV) 13, marketed as Prevnar 13, has caused a flutter. Despite the availability of life-saving vaccines, annually around one million children under the age of five years and most of them from the poorest sections of the society, fall victim to pneumonia.

Pfizer’s Prevnar13 and GlaxoSmithKline’s Synflorix (PCV10), which are priced at around $59 per dose (Rs3,800) and three doses are required for vaccination, are an effective treatment for pneumonia globally. These two vaccines protect children from life-threatening infections and lower antimicrobial resistance. Little wonder that the two pharmaceutical behemoths earned more than $40 billion from sales between 2009 and the second quarter of 2017.

Pfizer’s patent, according to a press release issued by Medicines Sans Frontieres (Doctors Without Borders), “involves the method of conjugating (assembling) together serotypes of streptococcus pneumonia into a single carrier.” Obviously, this method of conjugating is essential for PCV developers. The patent secured by Pfizer involves mere addition of serotypes to the already well-established seven-valent pneumococcal conjugate vaccine (PCV7). It does not meet “the inventive step” requirement. In 2014, the European Patent Office revoked Pfizer’s patent on grounds that it does not qualify for the patentability requirement—comprising inventive steps and non-obviousness. “The method Pfizer is trying to patent is too obvious to deserve a patent under India law, and is just a way to guarantee an extended market monopoly for the corporation for many years to come,” said Leena Menghaney, South Asia head for MSF’s Access Campaign.

Significantly, the decision of the Indian patent office has come at a time when the government is reportedly under renewed pressure from the US pharmaceutical lobbies for relaxing the overall standards of patentability. It is well documented, particularly in the annual Special 301 watch list

reports, that the amended Indian Patent Act poses a major barrier for the American pharmaceutical companies, particularly Pfizer, in securing patents for their controversial inventions. The provisions in the Act enable patent authorities to deny the evergreening of patents by powerful pharmaceutical companies to extend the period of patent protection through minor and insignificant changes of compounds.

And ever since the Supreme Court rejected the patent for Novartis's cancer drug Gleevec in 2013, the US trade lobbies and the successive administrations exerted intense pressure on successive Indian governments to allow evergreening practices. Last year, the Indian government issued IPR policy guidelines in the face of renewed pressure from American pharma lobbies.

More important, the Indian patent office's decision has come almost a year after the United Nations high-level panel on access to medicines urged governments to use "flexibilities" accorded to them in the World Trade Organization's TRIPS (trade-related intellectual properties) agreement to ensure that patents for life-saving drugs are only awarded for "genuine innovation."

The TRIPS flexibilities involve "the freedom to determine patentability criteria", including concepts such as "novelty", "inventive step" and "industrial applicability." The UN panel also urged governments, particularly in the developing world, to determine the terms upon which "compulsory licences" are issued to pharma companies for "securing the availability and affordability of health technologies".

India has endorsed the UN panel report and campaigned for its implementation. Yet, media reports continue to circulate that the government gave an assurance to the US business lobbies that it will not use compulsory licences, which are treated as weapons of mass destruction by the US pharmaceutical giants. "And on compulsory licences, I can say that India has not given any assurance to anybody," the commerce and industry minister Nirmala Sitharaman said in an interview on 19 July.

Nevertheless, by granting a patent to Pfizer's Prevnar 13, the Indian patent office has raised new doubts about whether it would properly implement the stringent provisions in the amended patent Act in the days to come.

The Narendra Modi government has an opportunity to squash the criticism of global health pressure groups by issuing a compulsory licence for the pneumonia vaccine. Otherwise, it would be seen as an administration ready to genuflect to the diktats of American lobbies.

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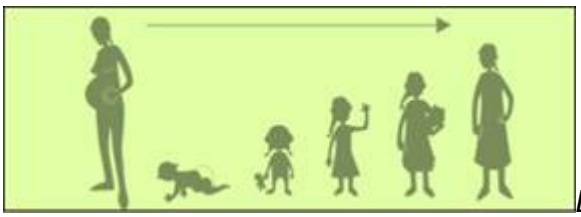
Special Feature: National Nutrition Week – 1st to 7th Sep 2017

Breaking Inter-generational Cycle of Malnutrition & Optimising the IYCF Practices

Santosh Jain Passi*
Akanksha Jain**

Malnutrition among populations – particularly the children, is an interplay of multiple factors like illiteracy, ignorance, poverty, large families, lack of resources including food/nutrition insecurity and poor access to health care services. Since long, our government's endeavour has been to reduce morbidity/mortality rates by implementing multipronged strategies for breaking the intergenerational cycle of under-nutrition. Events leading to malnutrition often predate child-birth; maternal under-nutrition, teenage pregnancies, closely spaced child-births and high parity are the major contributors to pre-term/low birth weight deliveries. Escalating malnutrition among children aged below 2 years is indicative of poor infant feeding practices. Therefore, appropriate infant feeding practices coupled with adequate maternal nutrition are crucial for healthy growth/development of the child; and for this a life cycle approach is imperative.

Appropriate/optimal Infant and Young Child Feeding (IYCF) practices emphasise on early initiation of breastfeeding *(within the 1st hour of child-birth)* without giving any pre-lacteals, exclusive breastfeeding for the first six months of life *(not even water, only prescribed medicines/tonics, if any);* and after 6 months, age-appropriate complementary foods with continued breastfeeding up to two years and beyond. In the light of this, theme for this year's National Nutrition Week is **'Optimal IYCF Practices: Better child health'.**

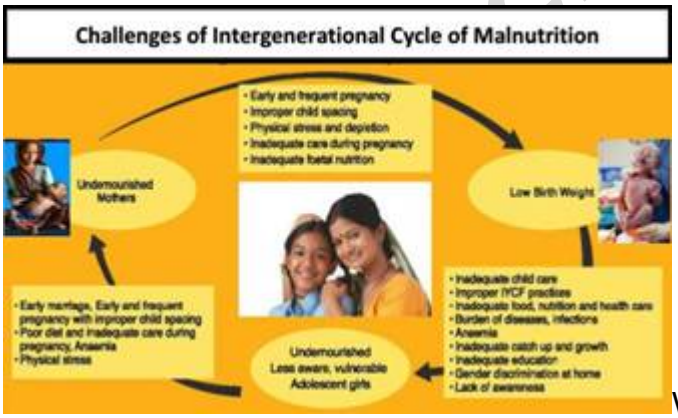


Every year, ***National Nutrition Week*** *is celebrated from*

1st to 7th September for intensifying nutrition/health related awareness among the masses. Launched by the Food & Nutrition Board in 1982, it is envisaged that the nutrition education/training programmes carried out by the governmental/non-governmental organizations will have far reaching implications on productivity, economic growth and ultimately the nation's development.

Optimum nutrition coupled with regular physical activity is the cornerstone of good health/well-being. Importance of proper nutrition in survival, health and development of the current as well as the succeeding generations cannot be undermined. Healthy children learn better and adequately nourished individuals are more productive. On the other hand, poor nutrition can result in lowered immunity, impaired physical growth/mental development, increased morbidity and thereby, reduced productivity.

WHO/UNICEF have designated the first 1000 days of life (270 days in-utero + 2 years post-birth) as the critical window for infant/young child nutrition interventions. This period being vital for brain growth/development, any malnutrition can cause stunting and suboptimal mental development. Breastfeeding – the gold standard feeding option for babies needs to be promoted; therefore, mothers as well as the other caregivers need to be made cognizant of its benefits, both for the baby and the mother. During pregnancy itself, effective counselling (inter-personal/small groups) should be carried out to highlight the advantages of breastfeeding vs. the dangers of artificial feeding; and thus, prepare the expectant mothers for successful breastfeeding.



When a child - particularly the girl child - is not provided enough nourishment, an inter-generational cycle of malnutrition may set in. Both the individual level and intergenerational *(from one generation to the next)* cycles of under-nutrition and ill health operate simultaneously posing grave consequences. A low-birth-weight baby-girl borne by a malnourished mother becomes a stunted/malnourished girl child à stunted/ malnourished adolescent à malnourished woman; and in turn, gives birth to a second-generation low-birth-weight baby. This clearly illustrates how poor in-utero nutrition from an under-nourished mother (both during & prior to pregnancy/lactation) extends through the life-course affecting nutrition/health status of generation-by-generation. This is further heightened by teenage pregnancies where the adolescent girls have to bear the dual-burden of their own growth and that of the developing foetuses leading to still poorer pregnancy outcome. Further, closely spaced high

parity pregnancies often exacerbate nutritional deficits which get passed on to their offspring/s too. Micro-nutrient (iron, zinc, iodine & vitamin A) deficiencies in young girls too can catalyze the intergenerational malnutrition cycle. This can mar the nation's development due to physically/mentally affected workforce with reduced work capacity.

In the light of these adversaries, nutrition has become an integral component of all the maternal and child health programmes such as:

- **Integrated Child Development Services (ICDS)**, launched on 2nd Oct 1975 has been universalized in the country. The target group comprises children (<6 years), pregnant/nursing mothers & women in reproductive ages (15-44 years) as well as adolescent girls for improving their nutrition/health status by providing a package of services right at the grass-roots level.

- **Reproductive, Maternal, Newborn, Child and Adolescent Health Programme (RMCH+A,** launched in 2013) addresses the major causes of mortality among women, children & adolescents along with the reasons for delayed access/utilization of health care services. This strategic approach highlights the importance of 'continuum of care' during various stages of life.

- **Janani Shishu Suraksha Karyakaram (JSSK)** – launched on 1st June, 2011 aims to provide better women/child health services such as cost-free/cashless facilities for pregnant women (normal deliveries/caesarean section operations) and sick new-borns (≤30 days post-partum) through government health institutions in rural/urban areas.

- **Pradhan Mantri Matritva Vandana Yojana (PMMVY)** is a maternity benefit program implemented by Ministry of Women & Child Development, Government of India. It is a conditional cash transfer scheme for pregnant/nursing mothers (aged >19 years) for first two live births to partially compensate the childbirth/childcare linked wage-loss. In addition, it provides adequate facilities for safe delivery and breastfeeding/infant feeding.

- ***Pradhan Mantri Surakshit Matritva Abhiyan*** (PMSMA) aims to reduce maternal and infant mortality rates in the country through safe pregnancies and safe deliveries. It provides quality comprehensive antenatal care to pregnant women on a designated day - 9th of every month.

- **The Mother and Child Tracking System** – Monitors the health care system to ensure all mothers & their children to have an easy access to various health-care services like care during pregnancy/child-birth and complete maternal & child immunization.

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MAA (Mothers' Absolute Affection) – an intensified flagship programme of the MoHFW was launched in 2016. It aims to enhance optimal breastfeeding practices in the

country through a set of comprehensive activities for protecting, promoting and supporting breastfeeding/child feeding, both at community & the facility level. The programme emphasises on generating community awareness, strengthening inter-personal communication skills of the functionaries and providing necessary support for breastfeeding at delivery points/public health facilities along with the need for adequate family support to the nursing mother.

- Recent **amendment of the Maternity Benefit Act** (April 2017) enshrines paid maternity leave for 26 weeks even in private sector; however, for the pregnant women already having 2 living children, it remains unchanged (12 weeks) and the same is for adoptive/commissioning mothers too. Crèche facility and the option for work from home are other features of this amended Act.

- **India Newborn Action Plan (INAP),** launched in September 2014, aims to end preventable new-born deaths and stillbirths so as to achieve single digit neonatal mortality/stillbirth rates by 2030.

- **Adolescent Reproductive and Sexual Health (ARSH) programme** comprises the package of preventive, promotive, curative and counselling services for addressing their reproductive and sexual issues.

Other programmes/schemes targeting adolescent girls include ***Kishori Shakti Yojana***, ***Balika Samridhi Yojana***, **Scheme for Adolescent Girls *(SABLA)***, **Weekly Iron and Folic Acid Supplementation (WIFS) programme, Menstural Hygiene Scheme** and many more. These programmes aim at empowering the adolescents with improved nutrition/health related awareness as well as better nutritional status so that they enter matrimony and motherhood with better nutrient stores.

Under UIP, ***Mission Indradhanush*** is cost-free expanded immunization coverage for children against 7 vaccine preventable diseases (Diphtheria, Pertussis, Tetanus, Childhood-Tuberculosis, Polio, Hepatitis B and Measles) by 2020. Further, ***Swachh Bharat, 'Beti Bachao Beti Padao' abhiyan*****, adolescent friendly clinics** also address critical nutrition-sensitive issues.

It is thus, possible that through concerted efforts, the intergenerational cycle of malnutrition can be turned virtuous and improvements in maternal nutritional status and pregnancy outcome can be achieved. Better diet quantity/quality, micronutrient supplementation and improved health services can be the catalytic strategies for bringing about the desired change. As per the continuum of care approach, focusing on girl child to women along the lifecycle is imperative for achieving the Sustainable Development Goals (SDGs) and overcoming poverty, malnutrition and ill-health.

"Optimum IYCF practices coupled with good nutrition along lifecycle can retain the individuals' health…..break the inter-generational cycle of malnutrition….and eventually make India a healthy & productive nation"!!

*__Dr Santosh Jain Passi__ - *Public Health Nutrition Consultant; Former Director, Institute of Home Economics, University of Delhi*

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Views expressed in the article are author's personal.

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Why go to school?

Notebook Icon on Flat Color Circle Buttons This Flat Graphic Design is 100% royalty free vector illustration featuring the main icon pictured in black inside a white circle. The alternative color options in blue, green, yellow, red, purple, indigo, orange and black are on the right of the icon and are arranged in two vertical column.

Governments are too often urged to actively promote formal school and college education among citizens. Many even go on to say that it is the basic duty of the government to make sure every child is given quality education at least until a certain age, and parents should be held accountable for it. If not, several experts argue, the fruits of education may never reach a vast majority of the population who are ignorant of its immense economic benefits.

“Economic Freedom and Human Capital Investment,” a 2017 paper by Horst Feldmann published in the *Journal of Institutional Economics*, however, offers an alternative view of how education works. Feldmann argues that education is no different from any other investment that seamlessly occurs whenever people are given the **economic freedom** to fully enjoy its benefits. There might then be very little need for a government to actively promote education among citizens, as they are likely to invest in it anyway. After all, when the right conditions exist, investment in education should happen just as a matter of course. In fact, Feldmann argues, this is very similar to how investment in physical capital works.

A factory, for instance, gets built whenever taxes are not too high and laws not too burdensome to discourage investors. Low taxes and stable property rights encourage investors to invest in risky ventures without any unreasonable fear about the future. Similarly, the author argues, people will invest in education whenever they are granted the economic freedom to fully enjoy its benefits. Again, this is for the obvious reason that the return on education increases as the level of economic freedom rises. When people, thanks to lower tax rates, are allowed to retain most of the higher income that they gain from each incremental level of education, it makes emminent sense to invest in education. On the other hand, when the government decides to tax the higher incomes of educated individuals at even higher rates, it makes very little sense to invest in educating oneself further. The same incentives apply to parents who decide on whether to invest in their children's education.

Feldmann in his study uses data on enrolment in secondary education in a total of 109 countries over four decades as a proxy to measure the effect of economic freedom, as measured by the “Economic Freedom of the World” index, on capital investment. He finds that economic freedom indeed has a substantial positive impact on building up human capital. Meanwhile, poverty is quite often cited to invalidate this argument. Many poor families, after all, cannot afford to invest in education. On this point, the author argues that poor families will find it far easier to access capital markets when there is greater economic freedom. Investors looking for profits are more likely to invest in funding a poor child’s education when their returns on such investment are enhanced by economic freedom.

The new U.S. Fed Chairman is unlikely to opt for policies that might upset the President’s plan

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National Nutrition Week to be observed from 1st to 7th September

The National Nutrition Week will be observed throughout the country from 1st to 7th September. The theme of the National Nutrition Week for 2017 is "Optimal Infant & Young Child Feeding Practices: Better Child Health". The basic objective of this annual event is to intensify awareness generation on the importance of nutrition for health which has an impact on development, productivity, economic growth and ultimately National development.

The Food and Nutrition Board of Ministry of Women & Child Development, through its 43 Community Food and Nutrition Extension Units (CFNEUs) located in 30 States/UTs, will coordinate with concerned Department of the State/UT Governments, National Institutions, NGOs and organize State/UT Level Workshops, Orientation Training of Fields Functionaries, Awareness Generation Camps, Community meetings during the week on the specified theme.

Large numbers of State, district and village level activities are being organized during this week. One day workshops will be held to sensitize and for capacity building of State/Districts Level officers on importance of nutrition for better health. There will be lecture cum demonstration on low cost nutritious recipes for grassroots level functionaries like school teachers, anganwadi workers and helpers, village women and mahila samitis. Mini exhibition on nutrition displaying low cost nutritious diets for different age groups will also be organized at grassroots level. Awareness generation on weight management and its importance through Body Mass Index will be held for adolescent boys and girls. Besides there will be large number of activities like quiz competition on nutrition and competition on preparation of nutritious recipes. Awareness programmes will be held at village level through puppet shows, skits, dance & dramma, films, slide shows, AV Spots, nutrition rallies etc.

Nutrition is an issue of survival, health and development for current and succeeding generations. Child born underweight have impaired immune function and increased risk of diseases such as diabetes and heart diseases in their later life. Malnourished children tend to have lower IQ and impaired cognitive ability, thus affecting their school performance and then productivity in their later life. It has to be realized that the nutritional health and all age groups represent say National Economic Asset.

As, improving the nutritional status of the population is imperative for National Development. Under nutrition in young children continues to be a major public health problem in India. The NFHS4 has not shown an encouraging improvement in the nutritional status, especially among women and children. As per NFHS-4 the level of underweight has decreased by 6.8% and is stunting by 9.6%. Level of anaemia has decreased by 11% as compared to NNHS-3 figures.

Malnutrition is not to be viewed merely as an offshoot of poverty having adverse effects on health and development of individuals but as a national problem that results in loss of productivity and economic backwardness. Time has come to create a moment so as to improve nutrition at the individual level. Thus, series of convergent and well coordinated actions in different sectors are required to be undertaken in the mission mode approach to address this big network problem of malnutrition

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India’s public health crisis: Mint’s reading list

The recent death of several children suffering from Japanese encephalitis in Gorakhpur grabbed headlines and sparked public outrage across the country. It also put the spotlight on India’s failing healthcare system. This series takes a deep dive into the issues that plague public health in India, particularly child health, and offers innovative ideas on how the government, civil society and industry can contribute to improving the situation.

Public health isn’t about state-run hospitals

Nearly all democracies use two modalities of modern medicine to keep citizens healthy—public health and disease-care. Public health is what the state does to prevent diseases and to protect health. In contrast, disease-care includes the different types of biomedical interventions that are carried out to restore health after an individual falls ill. Read more

Uttar Pradesh’s child death crisis

The recent tragedy of more than 85 children and newborns who died in Gorakhpur has, not for the first time, put the spotlight starkly on the country’s ailing public health system. The lack of all things important to human settlements—sanitation, disease surveillance, primary healthcare, tertiary hospitals, resources, life-saving equipment, political will and public health response—was so dramatic, if someone were to document the state of affairs of a crumbling health system, one couldn’t have described it better. Read more

A healthy future for mothers and babies

Despite the remarkable global progress made in maternal and newborn survival over the last decade, 4.6 million babies still die in their first year of life—nearly three million in the first 28 days. India loses more children under age 5 each year than any other country. Read more

A jobs scheme to improve public health

The tragedy of children with encephalitis dying in a Gorakhpur hospital has caused much outrage about hospital mismanagement. Far more outrageous is the fact that encephalitis threatens many thousands of lives every year in Gorakhpur alone, and this in the 21st century. Read more

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