Fewer TB deaths in India: WHO

India’s share in the number of TB deaths still remain high at 32%.G. KrishnaswamyG_Krishnaswamy

Death from tuberculosis in India saw a 12% decline from last year and the number of new cases, or incidence, saw a 1.7% decrease, according to a report from the World Health Organisation (WHO) on Monday.

With 1.7 million new cases in 2016, India continued to be the largest contributor to the global burden with up to a quarter of the 6.3 million new cases of TB (up from 6.1 million in 2015).

In spite of this year’s dip, India accounts for about 32% of the number of people worldwide who succumbed to the disease.

Rise in cases

Sunil Khaparde, who leads India’s tuberculosis-control programme, said the rise in cases was due to greater surveillance and the dip in mortality from 480,000 to 423,000 in 2016, due to improved drug management.

“Since last year, we’ve scaled up the use of molecular diagnostic tests to detect the infection…even on detection of drug-resistant TB there’s been an improvement,” he told *The Hindu* .

Globally, the TB mortality rate is falling at about 3% per year. TB incidence is falling at about 2% per year and 16% of TB cases die from the disease, according to the WHO.

“Overall, the latest picture is one of a still high burden of disease, and progress that is not fast enough to reach targets or to make major headway in closing persistent gaps,” the agency added in a summary to the report.

The government has committed to achieve a ‘90-90-90 target’ by 2035 (90% reductions in incidence, mortality and catastrophic health expenditures due to TB).

This is premised on improved diagnostics, shorter treatment courses, a better vaccine and comprehensive preventive strategies.

In 2016, the WHO said that India had many more deaths and incidence of the disease than had been estimated over the years.

This article has been corrected for a factual error.

END

Climate change and ill-health

A new research published by *The Lancet* medical journal talks of the various ways in which climate change has started affecting the health of people across the planet. 'The Lancet Countdown: Tracking Progress on Health and Climate Change' report says China, Bangladesh, India, and Indonesia are the countries that have registered the highest number of deaths linked to air pollution. Here is a look at the key numbers on how climate change affects health and labour produtivity:

46 — The global increase percentage in weather-related disasters since 2000.

50 — Number of years of gain in public health undermined due to anthropogenic climate change.

87 — The percentage of global cities that are in breach of WHO air pollution guidelines.

129 —Total economic loss in billion dollars due to weather events in 2016.

5.3 — The average fall in productivity (in %) for rural labour globally since 2000, due to rising temperatures.

9,20,000 — Number of people globally out of the workforce in 2016 due to rising temperatures.

4,18,000 — Number of Indian workforce out of jobs in 2016 due to rising temperatures.

1,000,000,000 — Number of people likely to migrate within 90 years, due to a rise in sea level caused by ice shelf collapse.

Jaggi Vasudev's Rally for Rivers claims they will, but this is not based on the most nuanced science

END

Mass bathing in Ganga aggravates anti-microbial resistance woes

Mass-bathing in the Ganga during pilgrimages may be contributing to anti-microbial resistance (AMR), says a government-commissioned report on the threat from AMR. Such resistance —previously acknowledged to be widespread in India — is said to be the reason for certain key antibiotics becoming ineffective against diseases, including tuberculosis.

Some years ago, researchers from the Newcastle University in the United Kingdom and the Indian Institute of Technology-Delhi sampled water and sediments at seven sites along the Ganga in different seasons.

In 2014, they reported in the peer-reviewed *Environmental Science and Technology* that levels of resistance genes that lead to “superbugs” were found to be about 60 times greater during the pilgrimage months of May and June than at other times of the year. The researchers had then said preventing the spread of resistance-genes that promote life-threatening bacteria could be achieved by improving waste management at key pilgrimage sites. The report of the Ganga as a reservoir for AMR genes sits alongside a 2016 study by the Council of Scientific and Industrial Research — still not made public — that portions of the the river had “anti-bacterial” properties.

The government report —— *Scoping Report on Antimicrobial Resistance in India* — made public on Wednesday cites this study too along with a compilation of all scientific studies done in India on the threat from AMR, causes and sources that aggravate it.

The report was commissioned by the Department of Biotechnology and the UK Research Council and prepared by the Centre for Disease Dynamics and Economic Policy. It notes, like previous studies, that India has some of the highest antibiotic resistance rates among bacteria that commonly cause infections in the community and healthcare facilities.

Resistance to the broad-spectrum antibiotics fluoroquinolones and third generation cephalosporin was more than 70% in Acinetobacter baumannii, Escherichia coli, and Klebsiella pneumoniae, and more than 50% in Pseudomonas aeruginosa.

In 2014, India was the highest consumer of antibiotics, followed by China and the United States. However, the per-capita consumption of antibiotics in India was much lower than in several other high-income countries.

Other than ‘cultural factors’ such as bathing in the Ganga, the drivers of AMR included excessive use of antibiotics in the livestock industry and unchecked discharge of effluents by the pharmaceutical industry. However, in spite of the challenge, too little work had been done so far to understand it. “This mapping exercise indicates that AMR research studies in India were of limited scope in all areas, ” the researchers noted.

END

The war on TB

There is a glimmer of hope with India registering a slight drop in the number of new tuberculosis cases and TB deaths in 2016 compared with 2015. From an estimated 2.84 million new cases in 2015, the number dropped marginally to 2.79 million in 2016, according to the World Health Organisation's Global tuberculosis report, 2017. Incidence estimates for India are considered interim, pending a national TB prevalence survey scheduled for 2017-2018. In terms of mortality, the drop was from 0.51 million in 2015 to 0.43 million in 2016. The number of deaths and the incidence rate have been falling both globally and in India. The targets set in the End TB strategy are global reduction of 20% in incidence and 35% in mortality by 2020, taking 2015 as the base year. To reach that target, the global drop in incidence has to be 4-5% a year — currently it is about 2% a year. Also, the percentage of deaths should come down from the current 16% to 10%. With India accounting for the highest TB incidence (23%) and mortality (26%) globally, success in realising the End TB targets hinges largely on the country strengthening its systems. The first step in defeating the disease and achieving the targets is to record every diagnosed patient through case notification (that is, when a person is diagnosed with TB, it is reported to the national surveillance system, and then on to the WHO). There was a 34% increase in case notifications by health-care providers in the private sector between 2013 and 2015. It improved from 61% in 2015 to 69% in 2016. But much work remains to improve case notifications as only 1.9 million TB cases in the public and private sectors were notified in 2016, leaving a 25% gap between incidence and notification, the largest in the world. Though notification was made mandatory in 2012, multiple surveys and surveillance data still show large under-reporting of detected TB cases, especially in the private sector.

With a higher number of people with TB being tested for drug resistance, the percentage with resistance to the drug rifampicin alone more than doubled to 0.58 million in 2016 over the previous year. Also, the number of estimated multi-drug-resistant TB cases increased marginally to 84,000. But the number of people with MDR-TB enrolled for treatment improved marginally between 2015 and 2016 (from 26,996 to 32,914). For the first time, baby steps have been taken to offer preventive TB treatment to a small (5%) number of people who are HIV-positive, and 1.9% of children below five years who are household contacts of people recently diagnosed with pulmonary TB. Notably, domestic funding (74%, $387 million) for anti-TB work has been more than that from international sources (26%, $124 million). While better funding might help India inch closer to its stated goal of ending TB by 2025, much more is needed in terms of funding and commitment on all fronts.

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

END

Threefold rise in domestic budget for fight against tuberculosis

India's domestic budget for fighting tuberculosis showed a dramatic jump from about Rs. 700 crore in 2015 to Rs. 2,500 crore last year, according to a report from the World Health Organisation (WHO).

Typically most of India's budget to combat the bacterial infection —that claimed 4.2 lakh last year—used to be dominated by international funding.

But, for the first time this has flipped. Domestic resources accounted for 74% of the $525 million spent in India last year, while it was only 38% in 2015.

"The big difference is that nearly Rs. 1,000 crore of non plan expenditure got added… next year you will see an even bigger spend," A.K. Jha, Economic Adviser of the Union Health Ministry, said. "The role of the private sector is critical in reducing TB numbers," he added.

In 2016, India recorded a 12% dip in the number of TB deaths from the previous year though the incidence dipped marginally by 1%.

The number of notified cases of drug-resistant tuberculosis (MDR-TB) jumped from 79,000 to 84,000 in 2016, a government official said, pointing to the deployment of better diagnostics. "Since last year, we've scaled up the use of molecular diagnostic tests to detect the infection… even on detection of drug-resistant TB there's been an improvement," he told *The Hindu* on Monday.

However, with 1.7 million new cases in 2016, India still continues to be the largest contributor to the global burden with up to a quarter of the 6.3 million new cases of TB (up from 6.1 million in 2015). In spite of the dip, India accounts for about 32% of the number of people worldwide who succumbed to the disease.

The government has committed to achieve a '90-90-90 target' by 2035 (90% reductions in incidence, mortality and catastrophic health expenditures due to TB). This is premised on improved diagnostics, shorter treatment courses, a better vaccine and comprehensive preventive strategies. In 2016, the WHO said that India had many more deaths and incidence of the disease than had been estimated over the years.

However, several activists say that in spite of the government commitments, TB is still stigmatized and under-reported — especially from the private sector — and top-line drugs are still inadequate to treat people who suffer from the drug-resistant forms of the disease.

END

Why we cannot breathe easy after the Lancet study on indoor pollution

Come winter, India, especially north India, gets all worked up about air pollution. For researchers, this also becomes the prime time to release reports on this critical issue. The latest one has come from the premier medical journal, Lancet, highlighting the need to have climate policies that curb air pollution. One of the key findings of the report is this: indoor air pollution was linked to more than 1.24 lakh deaths across India in 2015, which was higher than the number of deaths caused by pollution emanating from coal power plants (80,368 fatalities) and other industries (95,800 fatalities).

The Lancet report is a timely reminder that we ought to take indoor pollution much more seriously . For example, household pollution in India (especially in the rural areas) is caused by the use of polluting fuel sources such as wood, charcoal and animal dung. Women pay heavily for it. The elderly, too, suffer from this kind of pollution because they spend so much time indoors.

To tackle this challenge, authorities must spread awareness among people about the issue and the serious threat it poses to their health and wellbeing. This should help people in finding different ways of reducing exposure with better kitchen management and protection of children at home. Second, change in pattern of fuel use. At present, majority of low-income families rely solely on direct combustion of biomass fuels as this is the cheapest and easiest option available to them. This has to be rectified by promoting the use of cleaner energy sources. Third, there must be some modification in redesigning the cooking stove, like adding a chimney; and last, but not the least, improvement in ventilation.

Along with having direct health effects, pollution of any nature also has a long-term impact not just on the person but also on the goals of a nation. Can India meet the targets of Sustainable Development Goals — for example, Goal number 3 talks about “Ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development” — without tackling pollution on a war footing?

END

Cabinet approves amendment in the National Council for Teacher Education Act, 1993

The Union Cabinet chaired by the Prime Minister Shri Narendra Modi has given its approval for introduction of a Bill in Parliament to amend the National Council for Teacher Education Act, 1993, namely the National Council for Teacher Education (Amendment) Act, 2017 to grant retrospective recognition to the Central/State/Universities who are found to be conducting teacher education courses without NCTE permission.

The amendment seeks to grant retrospective recognition to the Central/State/Union Territory funded Institutions/Universities conducting Teacher Education Courses without NCTE recognition till the academic year 2017-2018. The retrospective recognition is being given as a onetime measure so as to ensure that the future of the students passed out/enrolled in these institutions are not jeopardized.

The amendment will make students studying in these Institutions/Universities, or already passed out from here, eligible for employment as a teacher. With a view to achieve above mentioned benefits, Deptt. of School Education & Literacy, Ministry of Human Resource Development has brought about this amendment.

All institutions running Teacher Education Courses such as B.Ed. and D.El.Ed. have to obtain recognition from the National Council for Teacher Education under section 14 of the NCTE Act. Further, the courses of such recognised Institutions/Universities have to be permitted under section 15, of the NCTE Act.

NCTE wrote to all Central Universities and /State Obvernrnents / State Universities / District Institutes of Education and Training (DIETs) informing them about the legal provisions making it mandatory to seek prior permission for starting Teacher Education Courses and giving them time till 31-03-2017 to inform NCTE if any such Institution/University is running a course without permission of NCTE, for a one-time resolution of past issues.

Background:

The NCTE Act, 1993 came into force on 1st July, 1995 and is applicable throughout the country, except the State of Jammu and Kashmir. The main objective of the Act Is to provide for the establishment of a NCTE to achieve planned and coordinated

development of the teacher education system, regulation and ensure proper maintenance of norms and standards in the said system. In order to achieve the objectives of the Act, separate provisions have been, made in the Act, for recognising Teacher Education courses and to lay down guidelines for compliance by recognized Institutions/Universities.

AKT/VBA/SH

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President of India inaugurates Global Clubfoot Conference

The President of India, Shri Ram Nath Kovind, inaugurated the Global Clubfoot Conference being organised by the CURE India in partnership with the Ministry of Health and Family Welfare, Government of India, in New Delhi today (November 1, 2017).

Speaking on the occasion, the President said that clubfoot is one of the most common orthopaedic birth defects. It can cause permanent disability if not treated early. This affects the child's mobility and confidence. Inevitably, education and schooling suffer – and the child cannot fulfil his or her potential.

The President said that in India the burden of disability affects more than 10 million people. The differently-abled or Divyang as we call them deserve equal opportunities in all avenues of life. Mainstreaming their social and professional experience is a commitment for all of us. Having said that, many of these disabilities are preventable or curable – which is often forgotten. Prevention, treatment and mainstreaming have to go in parallel.

The President said India is proud to have eradicated new cases of poliomyelitis. Polio was once a serious cause of loco-motor disability, but over the past six years we have not had a single case of paralytic poliomyelitis. This has been a major milestone in the history of public health not only in India but globally. It must motivate us to work towards eliminating other disabilities and other diseases and take on the challenge of clubfoot.

The President said he was happy to note that public hospitals are partnering with CURE International India to reach out to as many children as possible. The programme is now active in 29 states of India. He stated that despite these successes, we cannot ignore that at the current rate only 8,000 fresh cases are brought into the ambit of treatment every year. This is a small number if one considers the 50,000 children who are born annually in India with clubfoot. In 2022, India completes 75 years of its Independence. It should be a national resolve that by then every child born with clubfoot gets access to treatment services as soon as the condition is diagnosed.

AKT/AK/VK

END

SC wants norms fixed for distance education courses

The court chided the UGC for lack of effective oversight on deemed-to-be universities.jA ;THAKUR AJAY PAL SINGH

Questioning the role of the University Grants Commission (UGC) in checking the commercialisation of education, the Supreme Court on Friday restrained deemed-to-be universities from conducting distance education in any course unless all the courses were approved by the statutory authorities.

“We restrain all deemed-to-be universities to carry on any courses in distance education mode from the academic session 2018-2019 unless it is permissible to conduct such courses in distance education mode and specific permissions are granted by statutory/regulatory authorities in respect of each of those courses and unless the off-campus centres/study centres are individually inspected and found adequate by the statutory authorities,” the Supreme Court ordered in a 118-page judgment.

A Bench of Justices A.K. Goel and U.U. Lalit found that these institutions conducted distance education, including in technical disciplines, without proper inspection or checks.

The court directed that permission for distance education courses should be given only after off-campus centres or study centres of the institutions were individually inspected and found adequate by the statutory authorities. The approvals have to be course specific, the court directed.

The court further directed the UGC to take appropriate steps to restrain the deemed-to-be universities from using the word ‘university’ within one month from Friday.

The present case dealt with certain deemed-to-be universities whose technical education courses conducted through the distance education mode were found to be in “flagrant violation of norms and policies laid down by the authorities for the deemed-to be universities. In fact, the court found that the All India Council for Technical Education (AICTE) had been “illegally kept out” and their study centres had never been inspected.

The Supreme Court ordered the direct suspension of degrees for students enrolled during academic sessions 2001-2005 in these institutions. It ordered the annulment of degrees of students admitted in these universities after academic sessions of 2001- 2005. The apex court has also ordered a CBI probe.

Expert panel

The court ordered the Centre to constitute a three-member panel in a month to examine and suggest a roadmap for setting up a regulatory mechanism in the relevant field of higher education and allied issues within six months.

The Centre would place the report of the committee before the Supreme Court, which will consider it on September 11, 2018.

END

Don’t fall prey to lifestyle deceases: Vice President

Inaugurates Mega Health Camp

The Vice President of India, Shri M. Venkaiah Naidu has cautioned people against falling prey to illnesses caused by modern and sedentary lifestyles. He was addressing the gathering after inaugurating a Mega Health Camp at Swarna Bharat Trust, Vijayawada, Andhra Pradesh today. The Minister for Health and Medical Education, Andhra Pradesh, Dr. Kamineni Srinivas, the Minister for Water Resources Management, Andhra Pradesh, Shri Devineni Uma Maheswara Rao and other dignitaries were present on the occasion.

The Vice President expressed concern that lack of physical activity and modern dietary habits were causing lifestyle deceases. He further said that people should take physical activities like walking, jogging, cycling and practicing Yoga to lead a healthy life.

The Vice President appealed the medical fraternity to educate and create awareness on the dangers of modern lifestyle deceases and the need to adopt preventive measures. Expressing his concern at the lack of adequate health infrastructure in rural areas, he pointed out that the governments alone cannot meet the growing healthcare demands and wanted the private sector and NGOs to supplement the efforts of the government. He urged the Centre and State governments to focus on improving healthcare services in rural and backward areas.

The Vice President lamented that innovative functioning of some government hospitals was forcing the people to get treated at private hospitals. He further said that as against the WHO norm of one doctor per 1,000, there is one doctor per 1,700 population in India. To overcome the shortage of medical professionals in the country, a high-level committee of Planning Commission (Now NITI Aayog) has recommended the setting up of 187 more medical colleges by 2022, headed.

The Vice President visited the Medical Camp and interacted with the patients undergoing treatment.

KSD/BK

END

Unplanned urbanisation blamed as dengue claims 40 lives in Bengal

Rapid, unplanned urbanisation is the main reason behind the current outbreak of dengue in West Bengal, medical professionals have said. They are of the opinion that large-scale construction work in Kolkata as well as semi-urban areas provide ample breeding grounds to the female *Aedes aegypti* mosquito, the vector of the disease which breeds in clean, stagnant water. As per the latest government estimates, 40 people have died due to dengue while at least 20,500 have been diagnosed with the disease.

Elaborating on the urban nature of dengue, virologist Amitava Nandi said the *Aedes aegypti* mosquito mostly breeds in stagnated water in containers. “Social change due to urbanisation has triggered a sharp increase in the use of artificial containers in cities. Products which were earlier sold in paper bags are sold in plastic packets and containers, providing more breeding space to the mosquito,” Dr. Nandi told *The Hindu* .

With container use becoming popular in semi-urban and rural areas, dengue is no longer confined to large cities, he added.

The medical professionals also pointed out that unplanned building construction without a proper drainage system in the semi-urban and rural areas contributed to the spread of dengue.

“Even in the rural areas of North 24 Paraganas district [which, according to the State government, is the worst affected by dengue], unplanned building construction has increased over the last decade,” said Shanta Dutta, director of the National Institute of Cholera and Enteric Diseases (NICED).

Till September this year, about 15% of the blood samples at NICED tested positive for dengue, she said. “Since late September, it has gone up to 40 to 45%,” she added.

The severity of the situation can be seen from the fact that 108 dengue patients are admitted in the State run Beliaghata Infectious Diseases (ID) hospital. “Apart from these 108 patients, 214 have been admitted with fever. If they are diagnosed with dengue, the number of such patients will increase,” said U.K. Bhadra, principal of the hospital.

They also point out that no curative medicine is available for dengue — only supportive treatment can be provided.

“Dengue deaths can be avoided with early detection and proper treatment. Increasing public awareness on the disease is the key,” said Dr. Dutta.

END

India Signs Loan Agreement with World Bank for US$ 119 Million for “Odisha Higher Education Programme for Excellence and Equity (OHEPEE) Project

India Signs Loan Agreement with World Bank for US$ 119 Million for “Odisha Higher Education Programme for Excellence and Equity (OHEPEE) Project

A Financing Agreement for IBRD loan of US$ 119 million (equivalent) for the “Odisha Higher Education Programme for Excellence & Equity (OHEPEE) Project” was signed with the World Bank here today. The Financing Agreement was signed by Mr. Sameer Kumar Khare (Joint Secretary, Department of Economic Affairs) on behalf of Government of India and Mr. Hisham A. Abdo Kahin, Acting Country Director, World Bank (India) on behalf of the World Bank. A Project Agreement was also signed by Mr. G.V.V. Sarma, Additional Chief Secretary, Department of Higher Education, Government of Odisha and Mr. Hisham A. Abdo Kahin, Acting Country Director, World Bank.

The Objective of the project is to improve the quality of 'students’ equitable access to selected institutions and enhance governance of the higher education system in Odisha.

Project Component : Result Areas are (I) Improved quality of and students’ equitable access to selected institutions of higher education : Institutional Development Plan (IDP) Grants (performance –based Financing (II) Enhanced governance of the higher education system: (i)Improvement of governance in colleges (ii)Improvement of financial and procurement management and accounting in all government and government-aided colleges.

The closing date for the project is 30th November, 2022.

DSM/SBS/KA

END

India under serious burden of anaemia, obesity: report

India is facing a serious burden of of malnutrition as well as obesity, according to a global report which shows that while half the country's women suffer from anaemia, at least 22% of adult women are overweight.

The *Global Nutrition Report 2017*, which looked at 140 countries including India, found 'significant burdens' of three important forms of malnutrition used as an indicator of broader trends.

These include childhood stunting, anaemia in women of reproductive age, and overweight adult women.

Latest figures show that 38 per cent of children under five are affected by stunting — children too short for their age due to lack of nutrients, suffering irreversible damage to brain capacity.

About 21 per cent of children under 5 are defined as 'wasted' or 'severely wasted' — meaning they do not weigh enough for their height.

Over half of women of reproductive age — 51% — suffer from anaemia — a serious condition that can have long term health impacts for mother and child.

More than 22% of adult women are overweight, a rising concern as women are disproportionately affected by the global obesity epidemic, according to the report.

While the country has shown some progress in addressing under-5 stunting, it has made no progress or presents worse outcomes in the percentage of reproductive-age women with anaemia, and is off course in terms of reaching targets for reducing adult obesity and diabetes, the report said.

"The Global Nutrition Report highlights that the double burden of undernutrition and obesity needs to be tackled as part of India's national nutrition strategy," said Purnima Menon, independent expert on the *Global Nutrition Report*.

"For undernutrition, especially, major efforts are needed to close the inequality gap," said Menon, Senior Research Fellow in the International Food Policy Research Institute (IFPRI)'s South Asia Office in New Delhi.

The *Global Nutrition Report 2017* calls for nutrition to be placed at the heart of efforts to end poverty, fight disease, raise educational standards and tackle climate change.

"We know that a well—nourished child is one third more likely to escape poverty," said Jessica Fanzo, Professor at Johns Hopkins University in the US.

"They will learn better in school, be healthier and grow into productive contributors to their economies. Good nutrition provides the brainpower, the 'grey matter infrastructure' to build the economies of the future," said Fanzo, also the Global Nutrition Report Co-Chair.

The report also found that 88% of countries studied face a serious burden of two or three forms of malnutrition.

It highlights the damaging impact this burden is having on broader global development efforts.

The report found that overweight and obesity are on the rise in almost every country, with two billion of the world’s seven billion people now overweight or obese and a less than one per cent chance of meeting the global target of halting the rise in obesity and diabetes by 2025.

In India, 16% of adult men and 22% of adult women are overweight.

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

How to fix accountability in school education

For some time now, accountability has become the buzzword in school education. Everyone seems to have suggestions about “fixing” education by holding teachers accountable for student test scores. But we should ask ourselves whether test scores are the only way to assess how well education systems are performing; whether teachers are the only ones to blame for low-performing systems; and whether ‘blame’ itself is the right approach at all.

UNESCO’s new Global Education Monitoring Report 2017/18 is a comprehensive and nuanced look at the role of accountability in global education systems in the effort to achieve the vision of the UN Sustainable Development Goal (SDG) 4: to ensure inclusive and quality education for all, and to promote lifelong learning.

The report points out that providing universal quality education depends not on the performance of teachers alone, but is the shared responsibility of several stakeholders: governments, schools, teachers, parents, the media and civil society, international organisations, and the private sector. It does indeed take an entire village.

Teachers, doing a complex and difficult job against many odds, are only one rung in the complex chain that makes up the education system. Hence it is both unfair and short-sighted to turn every discussion of the performance of education systems into a blame game and fix responsibility only on teachers, disproportionately, for poor test scores and absenteeism. Using poor test scores to punish teachers is a bad idea for many reasons, including the risk that it might result in teachers simply teaching ‘to the test’. Teaching to the test is never a good way forward for any education system: examination scores by themselves are an inadequate way of assessing the complex process of teaching and learning. Not only does an exclusive focus on test scores have the risk of leaving weaker students behind, it also leaves academically better-performing students with a narrow understanding of what education is all about.

Don’t blame teachers

As for teacher absence, very often the reasons for this are beyond the teachers’ own control. It is unfair to hold them responsible for factors that are not in their hands. For example, nearly half of teacher absenteeism in Indonesia in one year was due to excused time for study, during which substitutes should have been provided.

In this context one recalls an important study of teacher absenteeism in 619 schools across six States carried out by the Azim Premji Foundation. It found that while the overall percentage of teachers not in school was 18.5%, most of these were either out of school on other official duty, or on bonafide leave. Actual teacher absenteeism because of teachers’ truancy was 2.5%.

If the larger problem is of teacher shortages, perhaps it is time to talk of accountability with a constructive focus on the role of each stakeholder in the education system. How can we better fund and resource schools and colleges? How can we better train and support our teachers? How can we help communities to ensure that every child is in school? How can we support parents, so many of whom never went to school themselves, in helping their children learn?

Accountability mechanisms should be developed for education systems that are supportive, constructive and focus as much on the fundamental issues of access, equity and inclusion as on quality.

Uma Mahadevan-Dasgupta is in the IAS, currently based in Bengaluru. The views expressed are

personal

The definition of harassment needs to be constantly updated, and the process for justice made more robust

END

A responsibility to care

Alzheimer's disease, which accounts for 60 to 80 per cent of dementia cases, is a progressive, degenerative brain disease affecting a person's memory, thinking, and the ability to interact socially. Unfortunately, there is yet no cure for it and scientists are still searching for causes of this disease which affects about one in 10 people over the age of 65 and almost one in four over 85 years. People under the age of 65 years also are prone to the disease which is known as early onset of Alzheimer's.

Certain estimates indicate there are over four million affected by dementia in India and as per the India Dementia Report 2010 about Rs 43,000 annually per family is spent to take care of a person affected by dementia. The cost is high for many. As the ageing of the population is rapidly increasing, the economic and social burden of the disease is going to rise in the coming years. Ways to reduce the burden of the disease need urgent attention particularly in countries like India, which along with China, has the highest number of older people and where geriatric services are under-developed and talking of mental health issues carries stigma.

The World Health Organisation (WHO) global plan on dementia adopted at the 70th World Health Assembly in May this year prompts nations to take action now. It calls on governments to meet targets for the advancement of dementia awareness, risk reduction, diagnosis, care and treatment, support for care partners and research. Only 29 out of 194 WHO member countries have a plan of action on dementia, with India not having taken the initiative yet. Critically, countries need to take immediate steps to fight the disease as the treatment gap in most countries is huge and particularly in developing nations where the WHO estimates that only about 10 per cent of individuals are diagnosed

Current treatments merely address the symptoms and not the underlying biological cause of the disease. Next year, dementia is projected to become a trillion-dollar disease and Alzheimer's Disease International (ADI) recommends spending at least 1 per cent of the global cost of dementia on public funding for dementia research. In India too, Alzheimer's and Related Disorders Society of India (ARDSI) calls for the government to have its plan or policy on dementia which must be implemented in all states and funded and monitored by the health ministry.

ARDSI has been successful at in initiating a Kerala State Initiative on Dementia which is the first public-private partnership for dementia care and awareness. Kerala has the highest proportion of older persons in the country. It is also a state where many young people migrate leaving older parents behind to fend for themselves. Residential care centres for dementia-affected people are limited.

There is an urgent need to include dementia as a national health and social priority with provisions to identify dementia as early as possible and have adequate services for its treatment with sensitivity towards the care-givers, who are mostly from the family and ageing themselves.

Garnering support from the corporate sector to fund programmes, especially training of care givers and initiatives for research on the disease, is the need of the hour. Support from the Ministry of Social Justice and Empowerment becomes crucial in India as the disease has many social aspects which need awareness and service facilities at the community level.

Action on dealing with dementia calls for public health approach where social, health, legal and economic components for facing the various aspects of the disease need to be integrated. Legal provisions to safeguard and protect the rights, dignity and respect of those affected and in minimising economic costs and the burden of the disease, building public campaigns and

dementia-friendly initiatives are necessary in the next few years as the number of those affected by dementia will reach alarming proportions — from 50 million people worldwide currently to three times the number by 2050.

The Global Plan of Action on the Public Health Response to Dementia 2017-2025, adopted by 194 countries of the WHO, calls for a national dementia policy, recognition of human rights of people with dementia and the potential of dementia friendly-communities to give those rights practical effect. It is pertinent for India that the framework provided by the UN Convention of the Rights of Persons with Disabilities (CRPD) is monitored with regard to guaranteeing the rights of people with dementia. Living well with dementia is a health and social goal which should be maintained as part of the national response to the disease.

An important aspect of action in dealing with dementia is to work towards risk reduction of the disease. The non-communicable diseases plan of action should include building resources for strengthening brain health by associating it with physical and spiritual health. Above all, it is important that there be focus on supporting people with dementia to maintain their independence as much as they can and retain their inclusion in families, community and society. Stop discrimination against them.

END

Fostering Grampreneurship can transform aspirational rural India: Vice President

Addresses International Mentoring Summit

The Vice President of India, Shri M. Venkaiah Naidu has said that fostering Grampreneurship can transform aspirational rural India. He was addressing the International Mentoring Summitwith the theme 'Mentoring Young Grampreneurs for Inclusive Growth', on the occasion of Silver Jubilee of BharatiyaYuvaShakti Trust (BYST), here today. His Royal Highness Prince Charles and other dignitaries were present on the occasion.

The Vice President said that rural India is rapidly changing and the rural youth too are well informed, are eager to learn, have an entrepreneurial spirit, and quite often even global aspirations.He further said that the present Government has been tirelessly working to promote inclusive growth, to make India as one of the fastest growing economies in the world. Policies like Start-up India and Atal Innovation Mission are geared to support the start-up environment, he added.

The Vice President said that the aim of the National Urban Livelihoods Mission was to reduce poverty and vulnerability of the urban poor households by enabling them to access gainful self-employment and skilled wage employment opportunities. He further said that the core belief is that the poor are entrepreneurial and have innate desire to come out of poverty. The challenge is to unleash their capabilities to generate meaningful and sustainable livelihoods, he added.

The Vice President said that the constraints like access to credit, advantages of technology, marketing support need to be addressed and the BYST model of mentoring can play a significant role in the growth of entrepreneurial culture. He further said that the challenge is to encourage more youth to make the choice of becoming entrepreneurs, rather than be job-seekers. Many more opportunities for decent livelihoods must be created rapidly in the rural areas, he added.

Following is the text of Vice President's address:

"It is my pleasure to join youfor the International Mentoring Summiton Mentoring Young Grampreneurs™ for Inclusive Growth' on the occasion of BYST's Silver Jubilee and to address,especially, the grass root entrepreneurs who have joined us from all over the country, industry mentors and all other supporters of the entrepreneurial eco-system.

I was delighted to learn that HRH was the inspiration to Ms. Lakshmi to start the youth entrepreneurship programme in India for the underprivileged youth. This program seems to have been modelled after the Prince's Trust programme in UK. We appreciate the fact that HRH has been playing a stellar role and keeping abreast of the progress made by BYST as is evident from the fact that this is his fifth visit to BYST during the last 25 years.

I had the pleasure of attending, earlier this year, the Inaugural International Mentoring Summit

conducted by BYST at Rashtrapati Bhavan and to unveil the logo of the flagship programme of BYST – Mentoring India™.

In today's conference,it isheartening to see a "meeting of the minds" of young people, particularlythosefrom underserved communities and theexperiencedand experts in business - sharing experiences and exchanging valuablelessons.

I understand, BYST provides a facilitative environment to our rural youth, who have received limited education, have started working early in life and are struggling on the poverty line.

Rural India is rapidly changing. The rural youth too are well informed, are eager to learn, have an entrepreneurial spirit, and quite often even global aspirations.

Creating a facilitative eco-system for rural entrepreneurship is very important. Mentoring is a crucial part of this eco-system.

The present Govt. has been tirelessly working to promote inclusive growth, to make India as one of the fastest growing economies in the world. Policies like Start-up India and Atal Innovation Mission are geared to support the start-up environment.

During my earlier tenure as Minister of Urban Development, we had modified the National Urban Livelihoods Mission (NULM). The aim was to reduce poverty and vulnerability of the urban poor households by enabling them to access gainful self-employment and skilled wage employment opportunities. The core belief of National Urban Livelihoods Mission is that the poor are entrepreneurial and have innate desire to come out of poverty. The challenge is to unleash their capabilities to generate meaningful and sustainable livelihoods.

The constraints like access to credit, advantages of technology, marketing support need to be addressed and I think BYST model of mentoring can play a significant role in the growth of entrepreneurial culture.

Over the last twenty five years, BYST has given wings to rural youth and enabled them to become entrepreneurs. This is the group with greater aspirations but limited opportunities. They are a group that needs guidance and encouragement.

I am delighted to know that BYST is playing a unique and important role by providing mentoring to the entrepreneurs whether they are competing with the industry giants in the metros or difficult rural hinterland of Assam, Haryana, Maharashtra, Odisha, Telanganaand Tamil Nadu.

When I hear that BYST entrepreneurs have been winning national and international awards, I can see that they have broken through a whole range of barriers. They are making a tremendous success of theirbusinessprimarily due to the steadysupportof theirmentors.

I congratulate the winning entrepreneurs and mentors of the BYST Silver Jubilee Awards today.

These are truly excellent examples of the efficacy of mentoring.

Encouraging entrepreneurship in young people is an important way of harnessing their enthusiasm, energy and ambition to contribute to economic development. Fostering Grampreneurship can transform aspirational rural India.

The challenge is to encourage more youth to make the choice of becoming entrepreneurs, rather than be job-seekers. Bharatiya Yuva Shakti Trust (BYST) is a successful example of this paradigm. Many more opportunities for decent livelihoods must be created rapidly in the rural

areas.

Lakhs of youth emerge from various Govt. Sponsored Entrepreneurship Development Programmes or EDP. However, for them to apply their skills, develop further and fulfil their potential, they need sustained support, guidance, counselling and timely advice. In short, they require “Mentoring”.

In the absence of quality mentoring, the youth find themselves lacking focus and direction to channel their skills and become successful entrepreneurs. The nurturing and follow up support provided by mentors during the crucial first years of operation of a new business is critical. This support can often make the difference between abject failure and spectacular success.

This is whereBharatiyaYuvaShakti Trust (BYST) has excelled with its proven model of mentoring 'bottom of the pyramid' entrepreneurs, and provide the vital link in the entire chain of entrepreneur support system.The theme of today’s summit is, therefore, very aptly titled “mentoring young grampreneurs for inclusive growth”.

Both the public and private sectors have to play a catalytic role in further developing such an eco-system. I can see immense scope and possible intervention of Corporate Social Responsibility funding to support the unique mentor movement in order to create successful entrepreneurs.

Finally, I congratulate BYST for completing 25 years in the service of youth entrepreneurship development through mentoring and handholding support. I wish this organization many more years of excellent work in creating a new generation of rural entrepreneurs.

Thank you. Jai Hind.”

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KSD/BK

END

Cabinet approves Creation of National Testing Agency (NTA) to conduct entrance examinations for higher educational institutions

Cabinet approves Creation of National Testing Agency (NTA) to conduct entrance examinations for higher educational institutions

The Union Cabinet chaired by Prime Minister Shri Narendra Modi has approved creation of National Testing Agency (NTA) as a Society registered under the Indian Societies Registration Act, 1860, and as an autonomous and self-sustained premier testing organization to conduct entrance examinations for higher educational institutions.

Features:

- The NTA would initially conduct those entrance examinations which are currently being conducted by the CBSE.
- Other examinations will be taken up gradually after NTA is fully geared up.
- The entrance examinations will be conducted in online mode at least twice a year, thereby giving adequate opportunity to candidates to bring out their best.
- In order to serve the requirements of the rural students, it would locate the centres at sub-district/district level and as far as possible would undertake hands-on training to the students.

Constitution:

- NTA will be chaired by an eminent educationist appointed by MHRD.
- The CEO will be the Director General to be appointed by the Government.
- There will be a Board of Governors comprising members from user institutions.
- The Director General will be assisted by 9 verticals headed by academicians/ experts.

Finances:

NTA will be given a one-time grant of Rs.25 crore from the Government of India to start its operation in the first year. Thereafter, it will be financially self-sustainable.

Impact:

Establishment of NTA will benefit about 40 lakh students appearing in various entrance examinations. It will relieve CBSE, AICTE and other agencies from responsibility of conducting these entrance examinations, and also bring in high reliability, standardized difficulty level for assessing the aptitude, intelligence and problem solving abilities of the students.

Background:

In view of the need to have a specialized body in India like the most advanced countries,

the Finance Minister in the Budget speech of 2017-18 had announced setting up of a National Testing Agency (NTA) as an autonomous and self-sustained premier testing organization to conduct all entrance examinations for higher educational institutions.

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AKT/VBA/SH

END

Expert Advisory Group on Measles & Rubella commends India on MR vaccination progress

Significant reduction in MCV dropout rate

Expert Group advises for MR campaign to cover the country by 2018

The India Expert Advisory Group on Measles & Rubella (IEAG-MR) has commended India on the progress of the measles and rubella vaccination campaign, as it reviewed the existing strategies and efforts towards measles elimination and control of rubella during the past two days with Ministry of Health & Family Welfare. The expert member group concluded that 'the country is on the right track'. The experts commended the strong leadership of the Government of India, as well as the ownership of the state governments to ensure that every child is vaccinated against these two diseases.

The expert group consisting of national and international experts complimented India on the growing trend in MCV (measles containing vaccine) coverage, and the significant reduction in MCV-1st dose and MCV-2nd dose dropout rate which declined from 44% to 13%. There has also been a reduction of DPT booster dose and MCV2 missed opportunities from 43% to 7% . The group has advised for the MR vaccination campaign to cover the whole country by 2018. Presentably 13 states have been covered by the vaccination campaign. The most recent campaigns in Andhra Pradesh and Telangana were reviewed in detail, and the experts complimented both states for excellent performance and their innovations to achieve very high coverage. The Group has recommended to strengthen the surveillance for MR and to expand the MR laboratory network.

Secretary (Health) Smt. Preeti Sudan stated that 'The country is fully committed to achieving the goal of measles elimination and rubella control to protect its children from these diseases'. She commended the state governments along with partners who have supported these efforts. She also credited the concerted IEC and awareness campaign to address the barriers to the vaccination; and the appropriate programmatic and strategic modifications based on learnings during the different phases of the campaign for the success.

Dr. Robert Kezaala from UNICEF stated that "UNICEF salutes the Government of India in tackling such a major threat to children's lives and wellbeing - through a combination of campaigns and the operation Indradanush. UNICEF as a children's agency commits to walk the extra mile with the Government of India." Applauding India's efforts, WHO HQ representative Dr. Katrina Kretsinger said that "India has shown tremendous leadership on advancing measles elimination and rubella control. It sets an important example globally, demonstrating best practices."

Two doses of Measles vaccine fully protect children against measles infection. In the past while the 1st dose coverage was close to 90%, the 2nd dose lagged behind by 45%. Commending the Government efforts, Dr. Jacob John, the co-Chairman of the IEAG,

says that both the MR campaigns and IMI are dramatically reducing this gap.

Dr. Jim Goodson from Centers for Disease Control and Prevention (CDC), Atlanta said that “the Government of India has a smart plan that capitalizes on previous investments for polio eradication by re-tooling existing information systems and resources for measles elimination. Measles surveillance data should continue to be used to identify any areas with children missed by vaccination, thereby contributing to measles elimination efforts in India.”

Measles kills an estimated 49,000 children in India each year, which is about 37% of the global deaths due to this disease. India has set an ambitious goal to eliminate measles from the country. Measles Rubella vaccine has been introduced in 13 states. It is planned to expand across the country, covering 41 crore children by the end of 2018.

MV

END

New education policy draft by Dec.

In full swing:Union Minister Prakash Javadekar releases BJP pamphlets in Ahmedabad.Vijay Soneji

Union Human Resource Development Minister Prakash Javadekar said in Ahmedabad on Sunday that the Kasturirangan Committee on the new education policy was expected to submit its first draft by the end of December.

Mr. Javadekar, however, did not offer a clear date as to when the policy — expected for the past three years — would be implemented, saying this would happen well in time to ensure quality education from 2020 to 2040.

“In the leadership of Dr. Kasturirangan, an eight-member team was formed. Two days ago, they had a two-day meeting, which was their fifth meeting. They say they will give their first draft by December-end,” Mr. Javadekar said.

To the next level

“I can say with certainty that this new education policy will for the next 20 years take the country to the next level. It will offer a new vision of modern thought and growth in science, technology and human values. It will ensure that good human beings and good citizens are nurtured,” the Minister said.

Stressing that the exercise was going through wide consultations, he said, “It will ensure that the quality of education improves and research and innovation are facilitated. For this, a good policy is in the works. MPs and MLAs of all parties, educationists and teachers, those who run schools, parents and grandparents — all have offered lakhs of suggestions. Their inputs are being considered for this policy. The draft will be discussed and promptly implemented.”

Ideal policy

Asked by when this would happen, the Minister said, “The idea is to have an ideal policy effecting positive changes in education from 2020 to 2040. It will be implemented well in time for this.”

Earlier, a committee had been set up under the leadership of the former Cabinet Secretary TSR Subramanian to prepare a draft, which was eventually submitted but accepted just as “inputs” for the policy.

The Kasturirangan Committee was set up after the submission of this draft.

END

Education is a key instrument in developing social infrastructure: Vice President

Addresses East West Cultural Festival

The Vice President of India, Shri M. Venkaiah Naidu has said that education is a key instrument in developing social infrastructure - for it breaks the vicious cycle of poverty and underdevelopment. He was addressing the East West Cultural Festival in commemoration of the 121st birth anniversary of Srila Bhaktivedanta Swami Prabhupada, Founder and Acharya of ISKCON, here today.

The Vice President said that for millenniums, India has served as the seat of knowledge, combined with its deep and rich culture, it has taught countless people the righteous path of life. He further said that India has also been the land of Maha-purushas who dedicated their lives to serve humanity.

The Vice President said that due to globalization and technology, the world has become interconnected and multi-culturalism is common. He further said that much before all of these began, Swami Prabhupada had already built a bridge between the East and the West and that bridge was a cultural bridge. It allowed the west to experience the rich heritage of India, he added.

The Vice President said that we meet at a very peculiar time where on one hand the world is making rapid advancement in various fields; yet on the other hand many challenges in the form of terrorism, environmental degradation, drug addiction, hatred, hunger & poverty continue to stare at us. He further said that culture, on the other hand, is the life-sustaining force of social infrastructure. It enlivens ethical and moral values that seem to be eroding in our modern lives, he added.

Following is the text of Vice President's address:

"In many ways it is astonishing that a person who is seventy years old did all of this, sleeping just three-four hours a day and produced so many books which have been translated into 82 world languages.

But, we meet at a very peculiar time where on one hand the world is making rapid advancement in various fields; yet on the other hand many challenges in the form of terrorism, environmental degradation, drug addiction, hatred, hunger & poverty continue to stare at us.

It is in challenging times like these that I find the message of Swami Prabhupada very relevant. The beauty of his teachings lay in the fact that he united everyone under the banner of devotion and service without making any distinctions of race, gender, caste, religion or social status. He and his movement are equally accessible to anyone and everyone.

This is the teaching of this land that we see everyone as one family without any bias or distinction – *Vasudhaiva Kutumbakam*.

It is natural that when we see the world as one family, our care and concern extends to everyone. This was witnessed in the life of Swami Prabhupada. He not only provided spiritual teachings but equally cared for the wellbeing of others.

Community welfare too is at the very heart of the social infrastructure that dominated our Indian civilization for millennia. It is our great civilization that gave the world the famous slogan:

lokah samasta sukhino bhavantu
sarve janah sukhino bhavantu
sarva jiva jantu sukhino bhavantu

“May the whole world be happy and peaceful. May all the people in the world be happy and peaceful. May all forms of life be happy and peaceful.”

I’m happy to learn that the project he started as the Hare Krishna Food For Life is today the world’s largest food relief program. Under the Annamrita program, ISKCON members daily feed 12 lakh government school students free meals. Under the tribal care initiative the organization is providing education, health care in remote parts of Assam, Tripura, Jharkhand, Odisha and West Bengal. All these initiatives are highly commendable.

Education is a key instrument in developing social infrastructure - for it breaks the vicious cycle of poverty and underdevelopment.

Culture, on the other hand, is the life-sustaining force of social infrastructure. It enlivens ethical and moral values that seem to be eroding in our modern lives.

But to me – Swamy Prabhupada’s greatest achievement was that he was an exemplary ambassador of India’s ancient civilization. He carried the same traditional values that you, his followers, are now promoting from inside and outside the shores of India.

And he was so remarkably successful in doing this, that today we see hundreds of thousands of westerners who are exceptionally Indian in their outlook and remarkably Vedic in their lifestyles.

This fits in well with one of the seven purposes of ISKCON "…. to educate all people in the techniques of spiritual life in order to check the imbalance of values in life and to achieve real unity and peace in the world."

Movements like ISKCON, which celebrated its 50th anniversary last year, are helping the youth of India who are our future to lead a compassionate, service oriented life free of vices.

The 15th century saint Sri Chaitanya Mahaprabhu enjoins all Indians to do *paropakara* or welfare activity for humankind. This is what our scriptures have also said – "Paropakaararthamidam Shariram" (This body of ours becomes useful if it serves others). This is a direct order that Swami Prabhupada, who comes in the lineage of Sri Chaitanya Mahaprabhu, took to heart when he travelled worldwide and promoted the true glory of India.

He spread Krishna consciousness around the globe. It is a consciousness which promotes love, harmony and enables each human being to realize the divine forces lying latent within us.

Once again, I thank you for inviting me to be here amidst all of you for this nice festival. I wish you all success in your future endeavors to serve the society.

Thank you very much.

Jai Hind!"

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KSD/BK

END

The largest ever survey, National Achievement Survey (NAS) conducted successfully

NAS is among the largest conducted in the World

“NAS is a transparent and credible exercise done under third party verification”: Prakash Javadekar

The National Achievement Survey (NAS) is the largest ever national assessment survey in the country and is amongst the largest in the world, was conducted throughout the country today. Union HRD Minister Shri Prakash Javadekar said that the **NAS is a transparent and credible exercise done under third party verification.** It was conducted for the Classes 3, 5 and 8 in government and government aided schools. The survey tools used multiple test booklets with 45 questions in Classes III and V related to language, mathematics and 60 questions in Class VIII in Mathematics, Language, Sciences and Social Sciences. The competency based test questions developed reflected the Learning Outcomes developed by the NCERT which were recently incorporated in the Right to Education Act (RTE) by the Government of India. Along with the test items, questionnaires pertaining to students, teachers and schools were also used.

The learning levels of more than 25 lakhs students from 1,10,000 across 700 districts in all 36 States/UTs were assessed. More than 1.75 lakhs trained Field Investigators from outside the government education system were engaged to conduct the learning assessment in the country. To ensure the fairness of the survey, a monitoring team was constituted which consisted of observers from inter-ministerial departments drawn from the State Governments, National and State Observers from Education Departments and multi-lateral organizations. This monitoring team observed the implementation of the survey in all the districts, on the Day of Assessment.

The district wise learning report cards will be prepared based on a software especially designed for this. Subsequently, analytical reports will be prepared. The analysis will reflect the disaggregated and detailed learning levels. The whole process will begin immediately and will be completed within 3-5 months. The inferences will be used to design Classroom interventions percolated to all the schools in the districts for implementation. The findings of the survey, will also help in understanding the efficiency of the education system. NAS results will help guide education policy, planning and implementation at national, state, district and classroom levels for improving learning levels of children and bringing about qualitative improvements.

GG/AK

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Northeast to get India's first ever 'Air Dispensary': Dr Jitendra Singh

Northeast is all set to get India’s first-ever "Air Dispensary" based in a helicopter and the Union Ministry of Development of Northeast (DONER) has already contributed Rs. 25 crore as part of the initial funding for this initiative.

Disclosing this here yesterday after a meeting with the representatives of Aviation Sector and helicopter service/Pawan Hans, Union Minister of State (Independent Charge) for Development of North Eastern Region (DoNER), MoS PMO, Personnel, Public Grievances, Pensions, Atomic Energy and Space, Dr Jitendra Singh said, for quite a few months, the DoNER Ministry had been exploring the idea of introducing a helicopter based Dispensary/OPD service in such far flung and remote areas, where no doctor or medical facility was available and the patient, in need, also did not have any access to any medical care. The proposal put forward by the Ministry of DoNER, he said, has been accepted and is in the final stages of process in the Union Ministry of Civil Aviation.

The Union Ministry of Northeast/DoNER, Dr Jitendra Singh said, is keenly pursuing the proposal so that by the beginning of 2018, this could be the Union Government’s gift to the people of Northeast.

Dr Jitendra Singh disclosed that even today, nearly 1/3rd of India’s population did not have access to proper hospital bed care, as a result of which, poor patients living in remote areas remained deprived of crucial medical care. The experiment being introduced in the Northeast, at the behest of the Ministry of Northeast/DoNER, can also be emulated in other hill states having difficult topography like Jammu & Kashmir and Himachal Pradesh, he added.

As per the envisaged plan, Dr Jitendra Singh said, to begin with, helicopter will be based at two locations, namely Imphal in Manipur and Meghalaya in Shillong. Both of these cities have premier postgraduate medical institutes from where specialist doctors, along with the necessary equipment and paramedical staff, would be able to move into the helicopter and hold a dispensary/OPD in different locations across the eight States of North Eastern Region. On its way back, he said, the same helicopter can also transport a sick patient, requiring admission, to a city hospital. Giving an account of other new helicopter service plans for Northeast, Dr Jitendra Singh said, three twin-engine

helicopters are planned to be placed for initial operation on six routes in the region around Imphal, Guwahati and Dibrugarh.

KSD/PK/SB

END

Col. Rajyavardhan Rathore releases the India Youth Development Index and Report 2017

Union Minister of State for Youth Affairs and Sports (Independent Charge) Col. Rajyavardhan Rathore here today released the India Youth Development Index and Report 2017. The objective of constructing the India Youth Development Index (YDI) 2017 is to track the trends in Youth Development across the States. The Index enables recognizing the high and low performing states, identifies the weak domains and informs the policy makers the priority areas of intervention for youth development in the states.

The Rajiv Gandhi National Institute of Youth Development (RGNIYD), Sriperumbudur, Tamil Nadu, an Institute of National Importance has come out with Youth Development Index and Report 2017. This is a pioneering attempt made by the Institute in 2010 which it followed up with the India Youth Development Index in 2017.

Constructing Youth Development Index for the year 2017 was done using the latest definition of youth as used in National Youth Policy – 2014 (India) and World Youth Development Report of Commonwealth (15 – 29 years) as well as using the Commonwealth Indicators in order to facilitate Global comparison.

In the India Youth Development Index 2017, the first five dimensions are retained same as that of Global YDI. The indicators and weights have been modified based on the availability of data at sub-national level and the importance of the indicators in explaining Youth Development with the aim of capturing the multidimensional properties that indicate progress in youth development at the sub-national level i.e., state level. Global YDI is different from YDI constructed for India in one unique way; YDI for India adds a new domain, social inclusion, to assess the inclusiveness of societal progress as structural inequalities persist in Indian society. This construction helps to identify the gaps that require intensification of policy intervention.

This report is of immense value to enable comparisons across geographical areas and categories, as human development index has done in comparing the development situation across regions, nations and localities. The index also measures the achievements made besides serving as an advocacy tool for youth development and facilitates to identify priority areas for development of Policy and Interventions.

As an effective decision – support tool, the YDI-2017 will enable the policy makers track

the national and the regional progress as well setbacks in youth development policies, planning, priority identification and implementation strategies. Besides providing insights to suggest alternatives and options, it also aids in judicious allocation of resources.

Director, RGNIYD Prof. (Dr)Madan Mohan Goel made a presentation before the Minister of Youth Affairs and Sports Col. Rathore. Secretary, Youth Affairs Dr. A. K. Dubey was also present on the occasion.

AD

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Burden of disease shifts to non-communicable ailments

Air pollution and tobacco smoking continue to be major contributors to health loss.Getty images

The ‘India State Level Disease Burden’ report, prepared as part of the Global Burden of Disease (GBD) Study 2016, and published in *Lancet* , has found that every State in India has a higher burden from non-communicable diseases and injuries than from infectious diseases.

The study used multiple data sources to map State-level disease burden from 333 disease conditions and injuries, and 83 risk factors for each State from 1990 to 2016. It was released by Vice-President M. Venkaiah Naidu here on Tuesday.

“The contribution of non-communicable diseases to health loss — fuelled by unhealthy diets, high blood pressure, and blood sugar — has doubled in India over the past two decades. Air pollution and tobacco smoking continue to be major contributors to health loss.

“However, the extent of these risk factors varies considerably across the States of India,” said Dr. K. Srinath Reddy, president of the Public Health Foundation of India (PHFI), one of the partners of the India State-level Disease Burden Initiative (ISDBI).

Specific plans needed

“Many Indian States are bigger than most countries in the world. It is necessary to plan health interventions based on the specific disease burden situation of each State, many of which are no less than nations within a nation, if the existing major health inequalities between the States have to be reduced. This requires availability of the best possible disease burden and risk factors estimates for each state based on all available data using a standardized framework,” said Dr. Lalit Dandona, Director of the ISDBI and Distinguished Professor at PHFI and lead author of the study.

“These estimates are now provided in three complementary outputs released today: the report, the technical paper, and the open-access visualisation tool. Discussion with policy makers suggests that these findings will be useful for planning of State health budgets, prioritisation of interventions relevant to each State, informing the government’s Health Assurance Mission, monitoring of health-related Sustainable Development Goals targets in each State, assessing impact of large-scale interventions based on time trends of disease burden, and forecasting population health under various scenarios in each State,” Dr. Dandona said.

“We believe that the knowledge base developing out of the ongoing work of the State-level Disease Burden Initiative can serve as a significant public good, providing increasingly more nuanced and crucial inputs for improving health of all Indians,” he said.

The report, which provides the first comprehensive set of State-level disease burden data, risk factors estimates, and trends for each State in India, is expected to inform health planning with a view toward reducing health inequalities among States.

Dr. Soumya Swaminathan, director-general ICMR and Secretary, Health Research, Government of India, who closely guided the work of the ISDBI, said: “The effort was to produce an open-access, good knowledge base, which has the potential of making fundamental and long-term contributions to improving health in every State of the country...”

END

The Vice President of India releases the findings of 'India State Level Disease Burden' report

The findings will serve as a useful guide for fine-tuning data driven health planning: J P Nadda

The Hon'ble Vice President of India, Shri M Venkaiah Naidu today released the findings of 'India State Level Disease Burden' report of Indian Council of Medical Research (ICMR) in presence of Shri J P Nadda, Union Minister of Health and Family Welfare, Smt Anupriya Patel, Minister of State for Health and Family Welfare, Dr. Soumya Swaminathan, Secretary (DHR) and DG (ICMR) and Dr. Vinod Paul, Member, NITI Aayog, Govt. of India.

Addressing the participants, the Vice President of India stated that achieving good health for all of India's population is an important goal of the Government of India and a foundation for further social and economic development. The Vice President further stated that the health status of Indians has been improving since Independence. "The life expectancy of a person born in India in 1960 was 40 years, which has increased to about 70 years now. Of every 1000 live children born in India in 1960, about 160 died in the first year, but now this death rate of infants is about a fourth of that level," he added.

In his address, the Vice President cautioned that in order to do better, several things need to happen. These include higher priority for health in the country's policy making and enhanced resources for preventive and public health measures. "There should be adequate mechanisms at the ground level for keeping Indians healthy and for suitable healthcare when they fall sick. We should also have a solid knowledge system that enables comprehensive tracking of the health and disease burden trends in every part of the country," the Vice President elaborated.

Speaking at the function, Shri J P Nadda stated that the Health Ministry along with the state governments and other important partners in the country is making serious efforts to enunciate provision for health services that are suitable for the health situation of particular state, mainly through the public sector. "In this regard, the data and results shared by the India State-level Disease Burden Initiative today in its report, scientific paper, and the online visualization tool will serve as a useful guide for fine-tuning data driven health planning specific for health situation of each state of the country," Shri

Nadda said.

Shri Nadda further informed that the estimates released today, which are based on utilization of all available epidemiological data, show that the per person burden due to major infectious disease, that is, diarrheal diseases, lower respiratory infections, and tuberculosis is 7 to 9 times higher in the states like Bihar, Odisha, U.P, Assam, Rajasthan, M.P. and Jharkhand than in other states. “ Likewise, the burden due to the leading non-communicable diseases, that is, ischemic heart disease, stroke, diabetes, chronic obstructive lung disease is 4-9 times higher in some states than in other states,” Shri Nadda said.

Shri Nadda further said that the disease profile of each state released today showing the contribution of specific diseases and risk factors to the overall health loss can be a useful guide for states when they develop their Project Implementation Plans for health. The open-access visualization tool that is being released today shows disease and risk trends in each state 1990 to 2016 in a simple manner, which can be of much use for policy makers. I hope that the planners and experts in each state will use the findings released today and engage with the India State-level Disease Burden Initiative to further improve health in their respective states, Shri Nadda added.

Speaking at the function, Smt Anupriya Patel, MoS (HFW) said that the data and results shared by the India State-level Disease Burden Initiative today in its report, scientific paper, and the online visualization tool will serve as a useful guide for fine-tuning health planning in each state of the country. “The burden due to non-communicable disease and injuries has overtaken the burden due to infectious and maternal-child diseases in every state of India, though this happened in some states about three decades ago and in some other states more recently. This means that the more developed states that had this transition a long time ago need to go on a war footing to control the rapidly rising burden of major non-communicable diseases and injuries, Smt Anupriya Patel stated.

The India State-level Disease Burden Initiative, a joint initiative between the Indian Council of Medical Research (ICMR), Public Health Foundation of India (PHFI), and Institute for Health Metrics and Evaluation (IHME) in collaboration with the Ministry of Health and Family Welfare, Government of India along with experts and stakeholders associated with over 100 Indian institutions, released the first comprehensive set of state-level disease burden, risk factors estimates and trends for each state in India to inform health planning to reduce health inequalities amongst states in India. These estimates

are based on analysis of all identifiable epidemiological data from India over quarter of a century.

Also present at the function were Dr. Srinath Reddy, President, PHFI, Shri JVR Prasada Rao, Former Secretary, Ministry of Health & Family Welfare, Govt. of India, Dr. Chris Murray, Director, Institute of Health Metrics & Evaluation, University of Washington, Seattle, USA along with other senior officers of the Ministry and representatives of development partners.

MV/SK

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Lifestyle changes and preventive public health should be prioritized: Vice President

Releases India State-level Disease Burden Report and Technical Paper

The Vice President of India, Shri M. Venkaiah Naidu has said that the Lifestyle changes and preventive public health should be prioritized. He was addressing the gathering after releasing the 'India State-level Disease Burden Report and Technical Paper', an initiative by the Indian Council of Medical Research in collaboration with Public Health Foundation of India and Institute for Health Metrics and Evaluation (University of Washington, Seattle), here today. The Union Minister for Health and Family Welfare, Shri J.P. Nadda, the Minister of State for Health and Family Welfare, Smt. Anupriya Patel and other dignitaries were present on the occasion.

The Vice President said that achieving good health for all of India's population is an important goal of the government of India as a foundation for further social and economic development. He further said that the gap between the highest life expectancy in an Indian state and the lowest life expectancy currently is 11 years, and the difference between the state with the highest infant mortality rate and lowest rate is 4 fold.

The Vice President said that many health indicators in India continue to be poorer than some other countries at a similar level of development. He further said that this implies that while significant health improvements have happened in India, we could do better. India has had important national surveys and data from other sources that indicate significant differences in the burden of some diseases between different parts of the country, he added.

The Vice President said that the report by the India State-level Disease Burden Initiative released today provides these comprehensive estimates for each state from 1990 to 2016 for the first time in India. He further said that this report, along with the technical scientific paper and the open-access visualization tool that are also released today, together provide systematic insights in to the health status of each state and the health inequalities between the states of India. High disease burden caused by malnutrition in India must be tackled soon to enable the next generation of Indians to reach their full potential in their personal development as well as the nation's development, he added.

Following is the text of Vice President's address:

"India is home to almost one-fifth of the world's population. People living in different parts of the country and states differ in their ethnic origin, culture and in various other ways that influence their health status.

Achieving good health for all of India's population is an important goal of the government of India as a foundation for further social and economic development.

Health is wealth. If we have it, we can acquire wealth, but there is no guarantee that you can get health with health. We are living in a global village and the world has become small. We should reaffirm our commitment to give our children a healthy future and a better place to live. Medical professionals should adopt a humanitarian way in treating patients. A responsive performing healthcare delivery system with people cantered reforms can transform the health landscape of the country. Lifestyle changes and preventive public health should be prioritized.

The health status of Indians has been improving since Independence. For example, the life expectancy of a person born in India in 1960 was 40 years, which has increased to about 70years now. Of every 1000 live children born in India in 1960, about 160 died in the first year, but now this death rate of infants is about a fourth of that level.

These broad improving trends however mask major inequalities between states and between socioeconomic strata.

To highlight this, the gap between the highest life expectancy in an Indian state and the lowest life expectancy currently is 11 years, and the difference between the state with the highest infant mortality rate and lowest rate is 4 fold.

When compared internationally, many health indicators in India continue to be poorer than some other countries at a similar level of development. This implies that while significant health improvements have happened in India, we could do better.

In order to do better, several things need to happen in parallel. These include higher priority for health in the country's policy making and enhanced resources for preventive and public health measures. There should be adequate mechanisms at the ground level for keeping Indians healthy and for suitable healthcare when they fall sick. We should also have a solid knowledge system that enables comprehensive tracking of the health and disease burden trends in every part of the country.

It is on this last aspect that the work of the India State-level Disease Burden Initiative is crucial for health progress in India.

India has had important national surveys and data from other sources that indicate significant differences in the burden of some diseases between different parts of the country.

But ours is a vast and diverse country. What we require is a more detailed state wise picture for taking appropriate action. Till now, we have not had this systematic and complete compilation of the burden of all diseases and the risk factors behind them for every state of the country in a single framework. This gap is now being filled by the current initiative.

The report by the India State-level Disease Burden Initiative released today provides these comprehensive estimates for each state from 1990 to 2016 for the first time in India. This report, along with the technical scientific paper and the open-access visualization tool that are also released today, together provide systematic insights in to the health status of each state and the health inequalities between the states of India.

The findings show that the overall disease burden per person in some states of India is almost twice as much as in some other states, and the burden rate due to the leading diseases ranges five to ten times between the states. These inequalities must be addressed.

The specific disease burden trends for each state in this report provide a reference for planning interventions that are needed to address the major disease problems in each state. Such evidence-based health planning in each state would result in health improvements in every state, reduce the health inequalities between the states, and help make more rapid progress towards achieving the overall health targets for India.

One particular point in the findings released today that needs to be addressed as one of the highest priorities is the continuing very high disease burden caused by malnutrition in India. This must be tackled soon to enable the next generation of Indians to reach their full potential in their personal development as well as the nation's development. We cannot be complacent about this critical aspect of human development as we try to build a new resurgent India.

It is encouraging that the work leading to this report was done by a network of collaborators including many leading health scientists and stakeholders in India representing over one hundred institutions.

The guidance of the Director General of the Indian Council of Medical Research Dr. Soumya Swaminathan, and her close engagement with this work over the past two years has been crucial for the success of this work.

I congratulate Director General ICMR and all the collaborating individuals and institutions for completing this excellent work. You all have contributed to enhancing the knowledge base. This will be helpful in designing specific targeted approaches for improving the healthcare in our

country. I hope to see this national initiative being continued and further enriched in the years to come. I wish you all the best in your endeavours.

Jai Hind!"

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KSD/BK

END

Mapping illness

In 2013, a World Bank report, The Global Burden of Disease, Generating Evidence, Guiding Policy — South Asia, suggested that India was going through an epidemiological transition. It argued that non-communicable diseases, like heart ailments, diabetes and chronic respiratory afflictions were “increasingly causing more premature mortality and disability” in India compared to the communicable diseases. Since then, several studies have tried to understand the contours of this shift in the country’s disease burden. Major national surveys, such as the National Family Health Survey and the Annual Health Survey, have provided valuable data on key health indicators, and several states have generated data on non-communicable diseases such as diabetes and heart ailments. However, a comprehensive assessment of every major disease across all states of the country, providing estimates over an extended period, has eluded policymakers. The India State Level Disease Burden Report, released on Tuesday, fills this gap.

The report, a product of a two-year long study undertaken by the Indian Council of Medical Research, Public Health Foundation of India and the Institute for Health Metrics and Evaluation in collaboration with the Ministry of Health and Family Welfare, has some good news for the country’s policymakers and many challenges for them. Life-expectancy at birth has improved from 59.7 years in 1990 to 70.3 years in 2016 for females and from 58.3 years to 66.9 years for males. But worryingly, the study upturns the widespread perception that states performing well on economic yardsticks are also doing well on health indicators. Kerala, Tamil Nadu, Maharashtra, Gujarat, Goa and Punjab have become hubs of non-communicable diseases, while communicable diseases and malnutrition continue to dog people in most parts of the country — Jharkhand, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Odisha and Uttarakhand being the worst affected.

The report presents a two-pronged challenge for policymakers. The large-scale variation in the disease patterns across the country means that one health policy and uniform health-related schemes are unlikely to work in all the states. But at the same time, the persistence of communicable diseases and malnutrition means that efforts to tackle these maladies have to be scaled up. One nugget of information in the report throws light on the enormity of this problem: Kerala had the lowest disease burden due to malnutrition in India, but even that was 2.7 times higher per person than in China. That said, policymakers in the country should see the report as an opportunity. After all, it addresses their longstanding grievance about the paucity of data on India’s disease burden.

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About dignity

Bonanzas under the Seventh Pay Commission Recommendations are being distributed. The lucky ones are getting luckier, if not happier. We see them; for they have a knack of remaining visible and audible. It takes no greatness, Gandhiji would say, to see them or hear their clamour. What proves who we are is whether or not we have eyes to see those who otherwise go unseen. Gandhi called them God's people, Harijan, because only God sees their misery. God is the only refuge for those who are unwanted by all else.

Maybe it is not our blindness but our cowardice. We lack the gumption to look at the 500-odd million of our fellow Indians who languish in what is euphemistically called the "unorganised sector". It is not that we don't want them to eat two square meals a day. But if they do, the abundance on our banquet tables could be compromised. Will we be able to graduate from mid-segment cars to their luxury variants, if the needs of these lesser mortals are hitched on to "India Shining"? Will we imperil our dreams by providing for the bottom-line needs of our work-force, and opening the doors of the future to their children?

Euphemisms are like Madame Tussaud's wax models — they are fixed and formulated in waxen serenity. They showcase a world sans hunger and deprivation, common cold and untold suffering. So, let's ask, "What, for God's sake, is this 'unorganised sector'?"

Strange, it is made up of human beings. "Sector" could make you think otherwise. A disconcertingly large portion of our fellow citizens remains forever vulnerable to the vagaries of unemployment, exploitation, insecurity, poverty, social degradation, cultural exclusion and developmental disenfranchisement within the ambit of this sanitised expression. This "sector", by the way, is wholly human-made, though we have come to think of it as willed by fate. The lesser mortals who inhabit this no-man's land are capable of improvement, given a ghost of a chance. This should be so because they contribute 45 per cent of the wealth of our country — though we think of them as a national liability.

Look closer, if you don't mind, to the "Pay Commission". How easily we forget, in the massive consultations and microscopic fine-tuning of pay revisions in our country, that "wage" needs to be deemed as honourable and dignified as "pay" is, in a society with even a rudimentary notion of justice and fair-play. Salaries have undergone astronomical enhancements in our country. Government and private sector salaries have gone through the roof, while corporate emoluments have shot right through the sky. Wages remain, in real terms, where we left them before we began our growth story.

Wages, let us say, of the so-called "unskilled workers" vary wildly from Rs 850 per day in Kerala to a third of it in most other parts of the country. How any work done by anyone can be insulted as "unskilled" is a question that we rarely ask. Skill is involved in sweeping the floor, washing utensils, baking bricks or working in quarries. Only those who have done no manual work will continue to harbour the insensitivity of belittling the "skill" involved in doing any kind of work. Since Prime Minister Narendra Modi's Swachh Bharat Abhiyan forced soft and delicate hands to wield brooms — with what order of skills and to what effect we know — this argument need not be pressed any further.

We did hope when the PM announced his Clean India Mission, that valuing and adequately rewarding the vast army of wage-earners in India would be its most significant spin-off. PM Modi, on his part, did speak knowledgeably on the nexus between hygiene and health, with particular reference to the poor. It cannot be that the PM does not know the connection between our poverty and the systemic injustice done to those bracketed in the "un-organised" sector. Surely, health and

hygiene make no sense in the dens of destitution. It is our hope that the PM will turn his attention to bringing a modicum of justice to the long-neglected and much-wronged “unorganised sector”. Our main hope in this regard is the political acumen of the PM. He knows how grateful the poor are — or, for that matter, that only the poor are grateful.

We, therefore, await the PM to take bold steps to evolve a national and rational minimum wage policy.

What is “rational” involves a standardisation of sorts. The counterpart to those maligned as “unskilled” labour in the unorganised sector are, say, the peons/attendents in the organised sector. In the wake of the Seventh Pay Commission, they will carry home monthly salaries in excess of Rs 25,000 per month, besides enjoying 30 years of assured employment and other benefits, including medical reimbursement and life-long retirement benefits. We insult ourselves if we recompense the back-breaking, daylong work done by our fellow citizens below this level. Such a policy needs to be given effect urgently as it has a bearing on the education and health of millions of our children who, otherwise, are blighted by malnutrition and illiteracy. The correlation between the sub-human conditions under which workers in the unorganised sector live and school drop-out rates of their children is too well-known to need any argument.

We make this appeal not only to the government but also to our fellow citizens. Rather than relish the fleeting euphoria of hikes in incomes, it behooves us to embrace a voluntary salary freeze for a period, until minimum justice is done to those who toil and sweat to make the wheels of development move in this land. As the Father of the Nation said — with a larger frame of reference — we have enough to meet everyone’s needs, but not enough to quench anyone’s greed.

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Upgrading the public education system

The World Bank's recent flagship World Development Report, 2018 addressed some immediate challenges of quality education. One of the ways that it broke new ground was on the issue of provision for private education. Growing private school enrolment is a global trend and the phenomenon must be taken seriously and discussed on evidence.

Education systems in many countries are not performing up to expectation and many families have been turning to private schools since they feel that the latter deliver better education, especially when public schooling itself is not fully free. India too fails to provide free secondary public education.

However, the report highlights that research across 40 countries finds no difference in the learning outcomes of children with similar family backgrounds in both public and private schools. Private schools appear better since they enrol children from relatively advantaged backgrounds who are able to pay, not because they deliver better quality. The World Bank report thus challenges a popular perception in India and finds no consistent evidence that private schools deliver better learning outcomes than public schools. Indeed, of the 1.27 million untrained teachers teaching in India, 925,000 are in private schools, pointing to the massive historic neglect of quality. States' capacities to fully monitor and enforce adherence to quality standards, mitigate against negative equity impact and ensure contract compliance must be enhanced if justice is to be done to those who already study in private schools.

The report warned that some private schools' quest for profit "can lead them to advocate policy choices that are not in the interests of students". In some instances, private schools may indeed deliver comparable learning outcomes with lower input costs, but this is achieved largely through lower teacher salaries. The report reiterated that while this may make education cheaper, it does not make it better, and has the additional disadvantage of reducing the supply of qualified teachers over time. The quality of education can only be improved if steps are taken to ensure children come to school prepared to learn, teachers have the skills and motivation to teach effectively, inputs reach classrooms and management and governance systems are strengthened in schools that serve the poorest. Other research on the issue, such as the recent report by the Global Campaign for Education, suggests that learning outcomes are poor in both.

There are also clear risks as private schools skim off higher-income students that are easiest and most profitable to teach, leaving the most disadvantaged within the public system. The reliance on private schools risks segregating the education system on family income and deepening existing social cleavages; it also undermines the political constituency for effective public schooling in the long run. This has particularly dangerous outcomes in India where caste, gender and class inequalities dominate. Indeed, recent research from India suggests that the gender gap in private enrolment may be on the rise, even as it is reducing in government schools. Data for relatively richer countries also shows that systems with low levels of competition have higher social inclusion and that upward social mobility is higher in government systems.

Despite this evidence, and given the scale of the challenge of delivering quality education for all, governments have progressively looked to the private sector for support. However, mechanisms to track the quality of education in private schools have historically tended to be weak or absent, even in developed countries. Building this regulatory capacity requires significant financial and human resource investments. The report concluded that "overseeing private schools may be no easier than providing quality schooling" and that "governments may deem it more straightforward to provide quality education than to regulate a disparate collection that may not have the same objectives".

India has taken some steps in the direction of developing regulatory frameworks for private schools, with several states enacting fee-regulation legislation and the courts intervening to challenge private sector failures. Last month, the Supreme Court intervened to direct states to enforce guidelines on safety in schools; in January, it had to enforce fee regulation. Building regulatory capacities, however, is only one solution. The long-term solution lies in strengthening the public education system in its complexity and ensuring that all of India's children receive quality education.

The government is set to unveil the first New Education Policy in 25 years in December 2017. It needs to address the key concerns and should focus on equity in quality—ensuring universal access to free, quality, equitable and safe public education for all of India's young citizens. This alone would help achieve India's aspirations of global leadership by tapping into the demographic dividend that India still enjoys. This must be backed by adequate resources. India is committed to the global and domestic benchmark of allotting 6% of gross domestic product to education, but has never crossed the 4% threshold. Failing to invest in the best education for the poor will only widen the social inequalities that exist in India today. The road to reform is fraught with challenges but the cost of inaction will be much higher.

Anjela Taneja is director, education, CARE India.

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Ministry of Health organizes National Workshop on Promotion of Male Participation in Family Planning

Ministry of Health organizes National Workshop on Promotion of Male Participation in Family Planning

Spreads awareness about Vasectomy Fortnight

Ministry of Health and Family Welfare organized a one-day national workshop on the promotion of male participation in family planning, here today. Smt. Vandana Gurnani, Jt. Secretary inaugurated the workshop, which highlighted concrete strategies to understand and incorporate the male perspective and male needs in the same way as attention is given to women's perspectives and needs. The Health Ministry through its sustained family planning efforts, aims to increase male participation in family planning, with continued emphasis on delivering assured services, generating demand and bridging supply gaps.

The workshop also saw the launch of the Family Planning Logistics Management Information System (FP-LMIS) manual. The FP-LMIS software was developed to facilitate the management and distribution of contraceptives and is designed to provide robust information on the demand and distribution of contraceptives to health facilities and ASHAs and strengthen supply chain management. It is intended to be a decision-making tool for policy makers, program managers and logistics personnel to monitor and manage the flow of contraceptive supplies, in order to reduce stockouts and overstocks, and improve the program's effectiveness and contraceptive security.

Male participation in improving the reproductive health of couples is crucial. While the permanent methods of contraception have traditionally found more acceptance in India, the maximum number of acceptors are women. The World Vasectomy Day is an event intended to raise global awareness on Vasectomy. The National Workshop today is also a precursor and curtain raiser to the upcoming Vasectomy Fortnight across States. All states/UTs across India will observe a dedicated 'Vasectomy Fortnight' from **21st November to 4th December 2017** with commensurate publicity whereby quality male sterilization services would be provided to clients at public health facilities.

The observation of a dedicated fortnight is intended to galvanize awareness on male sterilization and thereby improve its acceptance in the community. The Vasectomy Fortnight will be observed up to the block level with focus on Family Planning service delivery along with IEC & advocacy.

The theme of the workshop and the 'Vasectomy Fortnight 2017' is:

"जिम्मेदार पुरुष की यही है पहचान, परिवार नियोजन में जो दे योगदान"

"Zimmedar Purush ki yehi hai Pehchan, Parivar Niyojan mein jo de Yogdaan"

The observation of the Vasectomy Fortnight 2017 will be conducted in two phases:

1. **Mobilization phase (21st Nov – 27th Nov)** - This fortnight is utilised for awareness generation on the benefits of male contraception. IEC, especially on male participation in Family Planning and addressing various myths associated with it, will be available across public and accredited health care facilities.

2. **Service delivery phase (28th Nov – 4th Dec)** - In addition to awareness generation, all districts and blocks will organise for provision of male sterilization services in this dedicated fortnight.

Male participation in adoption of family planning has been a challenge along with other numerous challenges that must still be overcome, particularly in terms of raising public awareness around promoting and male engagement in family planning services. The promotion of male participation is vital to the success of the Family Planning programme. The theme of the workshop was in alignment with the theme of the Vasectomy Fortnight and discussions during the workshop revolved around a variety of topics such as:

- Concerted efforts to promote male involvement in Family Planning
- Bolstering young men's engagement in adopting reproductive decisions
- Bridging the gender gap
- Addressing the sexual and reproductive health needs of adolescents

The eminent speakers at the workshop also included the pioneers of NSV in India who addressed the gathering on the global scenario and the role of technical agencies in promoting male participation. The state representatives highlighted the respective strategies for improving the uptake and arresting the decline of vasectomy services.

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Shri J P Nadda represents India at ‘1st WHO Global Ministerial Conference on Ending TB in Sustainable Development Era’ in Russia

Shri J P Nadda represents India at ‘1st WHO Global Ministerial Conference on Ending TB in Sustainable Development Era’ in Russia

Reaffirms India’s commitment to eliminating TB by 2025

Shri J P Nadda, Union Minister of Health and Family Welfare, today reaffirmed India’s commitment to eliminating TB by 2025 at 1st WHO Global Ministerial Conference on Ending TB in Sustainable Development Era’ at Moscow, Russia. The Ministerial and High-Level meetings offer participating nations the potential to strengthen and energize the discourse on TB and are perhaps the biggest window for global action on TB in the foreseeable future. Ministry of Health and Family Welfare is also organizing a side event at the conference on ‘Ending TB: Our Promise to Our People’ assisted by Global Coalition against TB to be attended by 7 MPs and other world leaders.

Speaking at the first high level plenary, Shri Nadda said that India has ended polio and will use a similar intensified effort to end TB also. The National Strategic Plan for TB elimination in India has essentially four pillars to address the major challenges for TB control, namely- “Detect, Treat, Build and Prevent”. “This plan requires a significant increase in the budget compared to previous NSP and I am happy to share with you that this plan is fully funded and most of this is through domestic resources,” Shri Nadda elaborated.

The Union Health Minister pointed out that since the major challenges for TB control in India are many; the government’s first priority is reaching the unreached. “The government will ensure access to care for some vulnerable populations such as tribals, people in urban slums etc. Early diagnosis of all patients and putting them on the right treatment and ensuring their complete treatment is crucial” Shri Nadda emphasized.

Shri Nadda informed the participants that the Indian government has given top priority to addressing the quality of care for patient’s. 25% of the budget is earmarked for direct interventions in this area. This include free diagnosis with rapid molecular tests, free treatment with best quality drugs and regimens, financial and nutritional support to patients, online TB notification systems, mobile technology based adherence monitoring system, interphase agencies for better private sector engagements, policy for transparent service purchase schemes, stronger community engagements, communication campaigns, regulatory systems to capture information on all those consuming anti-TB drugs etc.

Highlighting India’s commitment further, Shri Nadda stated that to provide access to patients in difficult to reach areas, both socially and geographically, the government has started active TB case finding campaigns in selected areas. “We have already completed two such campaigns covering 257 districts and screened over 30 million vulnerable persons and detected over 15,000 additional TB cases. We are planning the next campaign in December this year. We will now be mounting interventions for TB in urban slum areas through the urban health mission,” Shri Nadda said.

Shri Nadda also said that India is a major manufacturer of anti-TB drugs for the world having almost an 80% global market share. “We give only the best quality drugs to our patients, whether within the country or abroad. There is a wide scope for us to sit together and discuss seriously about promoting generic drugs for TB patients all over the world, I have no doubt that together we can make TB treatment affordable to all in the world. We owe it to the millions of TB patients and we owe it to ourselves,” Shri Nadda stated.

The top thematic priorities of this conference based on the SDGs and the UNGA high level health themes include Universal Health Coverage, Increased and Sustainable Financing and Scientific Research and Innovation.

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Cabinet approves Continuation of sub-schemes under Umbrella Scheme “Integrated Child Development Services (ICDS)” for the period till November, 2018

Cabinet approves Continuation of sub-schemes under Umbrella Scheme “Integrated Child Development Services (ICDS)” for the period till November, 2018

The Cabinet Committee on Economic Affairs chaired by the Prime Minister Shri Narendra Modi has given its approval for continuation of Anganwadi Services, Scheme for Adolescent Girls, Child Protection Services and National Crèche Scheme from 1.4.2017 to 30.11.2018 with an outlay of over Rs.41,000 crore. These are the sub-schemes under Umbrella Scheme “Integrated Child Development Services (ICDS)”

Features:

- The approved Schemes include:

  i. Anganwadi Services
  ii. Scheme for Adolescent Girls
  iii. Child Protection Services
  iv. National Crèche Scheme

- The Cabinet has also approved:
  i. implementation of Scheme for Adolescent Girls for out of school girls in the age group of 11-14 years, its phased expansion
  ii. phasing out of the on–going Kishori Shakti Yojana for out of school girls in the age group of 11-14 years.

- The decision also provides for conversion of National Crèche Scheme from Central Sector to Centrally Sponsored Scheme with the revised cost sharing between Centre and States as 60:40 for all States and UTs with legislature, 90:10 for NER and Himalayan States and 100% for UTs without legislature and implementation of the Scheme through States/UTs instead of existing implementation agencies.

Impact:

The sub-schemes listed above are not new schemes but are continuing from the XII Five Year Plan. The programme through targeted interventions will strive to reduce the level of malnutrition, anaemia and low birth weight babies, ensure empowerment of adolescent girls, provide protection to the children who are in conflict with law, provide safe place for day-care to the children of working mothers, create synergy, ensure better monitoring, issue negative alerts for timely action, encourage States/UTs to perform, guide and supervise the line Ministries and States/UTs to achieve the targeted goals and bring more transparency.

Beneficiaries:

More than 11 crore children, pregnant women & Lactating Mothers and the Adolescent Girls will be benefited through this scheme.

Financial Outlay:

The details of expenditure for the period from 01.04.2017 to 30.11.2018 for various sub-schemes are as follows:

(Rupees in crore)

Name of the sub-scheme	**Amount approved**
Anganwadi Services	34441.34
National Nutrition Mission (proposed)	4241.33
Scheme for Adolescent Girls	1238.37
Child Protection Services	1083.33
National Crèche Scheme	349.33
Total	41353.70

Implementation Strategy and Targets:

Anganwadi Services (ICDS) and Child Protection Services are already in operation in the entire country. The Scheme for Adolescent Girls will be expanded in a phased manner. National Creche Scheme will continue to be implemented in 23,555 creches. Approval for National Nutrition Mission shall be obtained separately.

States/districts covered:

Anganwadi Services (ICDS) and Child Protection Services are already in operation in the entire country. National Nutrition Mission will be rolled out in a phased manner. Similarly, Scheme for Adolescent Girls will be expanded in a phased manner.

Background:

The ongoing schemes have been rationalized by the Government in financial year 2016-17 and have been brought under Umbrella ICDS as its sub-schemes. These sub-schemes need to be continued for delivering the child related services to the intended beneficiaries. The aims of these schemes are as under:

a. **Anganwadi Services** (ICDS) aims at holistic development of children under the age of six years and its beneficiaries are children of this age group and Pregnant Women & Lactating Mothers.

b. The objective of the **Scheme for Adolescent Girls** is to facilitate, educate and empower Adolescent Girls so as to enable them to become self-reliant and aware citizens through improved nutrition and health status, promoting awareness about health, hygiene, nutrition, mainstreaming out of school AGs into formal/non formal

education and providing information/guidance about existing public services.

c. The objectives of **Child Protection Services** are to provide safe and secure environment for children in conflict with law and children in need of care and protection, reduce vulnerabilities through a wide range of social protection measures, prevent actions that lead to abuse, neglect, exploitation, abandonment and separation of children from families etc., bring focus on non-institutional care, develop a platform for partnership between Government & Civil Society and establish convergence of child related social protection services.

d. **National Creche Scheme** aims at providing a safe place for mothers to leave their children while they are at work, and thus, is a measure for empowering women as it enables them to take up employment. At the same time, it is also an intervention towards protection and development of children in the age group of 6 months to 6 years.

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Health Ministry introduces Daily Drug Regimen for treatment of Tuberculosis

The Ministry of Health & Family Welfare has recently announced the launch of daily regimen for TB patients across the country under The Revised National TB Control Programme (RNTCP). The Health Ministry has been providing the thrice weekly regimen for the treatment of tuberculosis (TB), however it has now decided to change the treatment strategy for TB patients from thrice weekly to daily drug regimen using fixed dose combinations (FDC) for treatment. This change will bring transformation in the approach and the intensity to deal with this disease which accounts for about 4.2 lakh deaths every year.

The daily FDC anti-TB drugs will be made available to private pharmacy or at private practitioners to dispense to TB patients who seek care in private sector, depending upon the convenience of patient and practitioner free of cost. The Health Ministry will take this forward with all major hospitals, IMA, IAP and other professional medical associations to expand the access to daily FDC to all TB patients.

The salient features of this treatment strategy are use of Ethambutol in continuation phase for all patients, drugs to be given daily (as against only 3 times weekly previously), fixed dose combination (FDC) tablets to be used which will reduce pill burden (as against separate 7 tablets previously), for children, child friendly formulations as dispersible tablets and use of Information Technology (IT) enabled treatment adherence support system.

Current WHO Global TB Report, 2017 has reported that incidence of TB has reduced from 28.2 lakh to 27 lakh and mortality by 60 thousand over the last one year, which is a testimony of anti TB drive by Government of India.

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The lowdown on the dengue epidemic

The National Vector Borne Disease Control Programme (NVBDCP) records show that 1,29,329 people fell sick with dengue this year, while 200 died. India's official numbers are well known to be gross underestimates, with private hospitals often not reporting the disease.

In fact, a 2014 study calculated that the actual number of cases between 2006 and 2012 was 282 times the NVBDCP number.

But even if one were to factor in the undercounting, 2017 is an extraordinary year. This is due to three reasons. First, India is getting better each year at reporting dengue, leading to more cases being counted. Second, dengue itself is becoming more endemic due to urbanisation.

The dengue mosquito thrives in urban habitats, in water pooled under a flower pot for example. As population explodes in rural areas, what was initially an urban disease has moved to these regions too, says Arunkumar Govindakarnavar, a virologist at the Manipal Centre for Virus Research who runs a surveillance project for febrile illnesses in 10 States. Third, dengue epidemics follow a natural cycle as population immunity waxes and wanes. But given our patchy data collection, it has been hard to glean out such cycles.

As dengue burden rises in the country, says Mr. Arunkumar, the likelihood of more people becoming severely ill grows.

This is because more infections raise the chances of the virus mutating to a more virulent form. It also raises the risk of a phenomenon called antibody-dependent enhancement.

The dengue virus has four serotypes, or types that are classified by the type of antigen (a molecule on the viral surface which human antibodies recognise) they have.

These serotypes are DENV-1, DENV2, DENV-3 and DENV-4. When a person is affected by one dengue serotype, she develops antibodies against it, which protect her for the rest of her life. If the same person is then infected by a different serotype, she is likely to develop severe disease.

This is because, in some cases, antibodies against the first serotype worsen the second infection, instead of protecting against it.

This phenomenon is called antibody-dependent enhancement (ADE) and results in a more dangerous illness called dengue haemorrhagic fever (DHF).

Severe dengue haemorrhagic fever causes blood vessels to leak, which leads to a loss of blood pressure. If this isn't treated quickly by replacing bodily fluids, the person can go into shock and can die. But treating a patient of DHF is a delicate balance, and hard to do in the high-pressure environment of an outbreak, says Mr Arunkumar. First, doctors must learn to spot severe cases and avoid indiscriminate admission of mild cases. For this, they need to look beyond easily-measured parameters like platelet counts, to symptoms that need careful observation. Haemorrhagic fever shows up as a puffy face, loss of blood pressure, low pulse rate and a range of other symptoms. Once it develops, fluids need to be given with care. It often happens, says Mr Arunkumar,that doctors give patients too much fluid, which too has dangerous consequences.

Given the burden of dengue, the economic cost for India is huge. One calculation based on data from Madurai estimated the 2012 medical cost of dengue for India to be $548 million. According to the study, a hospitalised person spent an average of $235.20, usually out of her own pocket.

Costs like this are a blow to daily-wage earners, because hospitalisation also means a loss of income. The good news is that, across the world, early treatment keeps mortality levels as low as 2%. India is still pondering over introducing the world's first dengue vaccine, Dengvaxia, and for good reason. Studies show that people who have never been exposed to dengue can develop severe disease if they get dengue a few years after vaccination. This is thought to be due to ADE. So, for vaccination to be helpful, between 50 and 70% of the population needs to have been exposed to the virus. India is conducting seroprevalence studies to calculate exposure rates before it takes a call.

Priyanka Pulla

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In Asia, a path to cleaner air

Cancer. Stroke. Heart Disease. Asthma.

These are some of the life-threatening diseases caused by air pollution, a problem that kills more than six million people worldwide every year, and also the most pressing environmental health risk humanity faces. In 98% of cities in low- and middle-income countries, air quality exceeds World Health Organisation safe levels and is having a severe impact on peoples' health. The youngest, the oldest and the poorest among them are most affected.

For urban residents across the South-East Asia region, the situation is dire. As urbanisation proceeds, inadequate planning is compounding an already fraught scenario. Every day, more and more people are exposed to the deadly particulate matter from motor vehicles, diesel generators, smokestacks and power plants. And every day, those particulates are having a devastating impact on our immediate and long-term health.

Small but key steps

Despite the magnitude of the problem, change is possible. Each one of us can do our part.

Choosing to use public transport over driving a private vehicle is a good way to make an immediate difference that not only decreases emissions but also saves money and encourages physical activity. Similarly, if and when we do use a private vehicle, we can ensure that its engine is well-tuned and running efficiently, thereby decreasing emissions and maximising fuel mileage. Though these steps are simple, they can have a wide-ranging impact. Private vehicle use remains a significant contributor to urban air pollution across the region. In and around the house we can also make small but important changes. For example, instead of burning wood and other biomass fuels for cooking or heating, we can switch to using natural gas or liquefied petroleum gas (LPG). The household use of wood and other biomass fuels (including kerosene) is the cause of approximately 1.69 million deaths in the region every year — each one of them preventable. Importantly, we can also make concerted efforts to cut down on and have better disposal of waste, including ending open burning.

From the top

In aiding private citizens' actions, government interventions can be of crucial importance.

It is now being seen across the region that from the municipal level up, governments are aiming to provide the infrastructure needed to provide healthier environments and taking steps to encourage public forms of transport. This is being done by building quality bus and rail systems, and making cities pedestrian- and bicycle-friendly through the provision of footpaths and bicycle lanes. Schemes are being implemented to provide incentives for households to switch to cleaner energy sources that are benefiting the poor and the vulnerable. Biomass continues to be burned largely as a result of cost incentives and there is a realisation now that demand can be shifted to other forms of household energy through subsidies and other innovative pricing mechanisms.

Empowering and engaging the health sector is also important. Not only can the health sector identify and assist vulnerable groups to prevent exposure to air pollution, thereby mitigating its effects but it can also provide critical support to the society-wide struggle for clean air. Health institutions and workers have the power to raise awareness and promote change at the personal and policy levels — a role that should be encouraged and, where possible, supported. As a part of this wider push, city administrators ought to mobilise individuals and the cities they live in to take

action against air pollution. Though air pollution represents a massive moral and practical challenge, it also represents a chance to chart a bold new path — one where clean air is an integral part of healthy economic development and growth. Indeed, as countries across the South-East Asia region develop and prosper, they needn't repeat the development tropes of a bygone era. They can and must write a different history.

Dr. Poonam Khetrapal Singh is Director, WHO- South East Asia Region (SEAR)

World Diabetes Day highlights the implications of neglecting women's health

The Cardiff University professor, who reported on the enzyme called New Delhi metallo beta lactamase, says China and Pakistan are more serious about anti-microbial resistance genes than India.

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Health Ministry notifies amendment to Food Safety & Standards (Contaminants, Toxins & Residues) Regulations, 2011

Health Ministry notifies amendment to Food Safety & Standards (Contaminants, Toxins & Residues) Regulations, 2011

Ministry of Health and Family Welfare, through FSSAI, has notified amendment to Food Safety & Standards (Contaminants, Toxins & Residues) Regulations, 2011 on 7th November, 2017. This notification contains maximum permissible limits of various antibiotics in meat and meat products including chicken. Maximum permissible limits of 37 antibiotics and 67 other veterinary drugs are prescribed for chicken.

Through this notification, objections and suggestions have been invited from all the stakeholders including general public within 30 days of the notification i.e. by 6th December, 2017. The objections & suggestions received will be placed before the Scientific Panel of FSSAI on Residues of Pesticides and Antibiotics for consideration. The recommendations of the Scientific Panel will be considered by the Scientific Committee and then the Food Authority for approval after which it will be notified in the Gazette of India with the approval of the Hon'ble Minister.

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India’s first health atlas mirror’s a health emergency

The India State-level Disease Burden Initiative released last week was at once both revealing and frightening. For the first time, it comprehensively identified the disease burden of the country; at the same time though, it revealed the extent of disease burden, which if unaddressed on a war footing as it were could nix the country’s enormous growth potential.

This is something that Bill Gates, who coincidentally was in town last week, captured in a wide-ranging interview unrelated to the health study published in *The Times of India* on 18 November. “Every other country that moved to middle-income status spends over 3% (of its gross domestic product, or GDP) on public health. If you are (paying) out of your pocket (for healthcare) it can bankrupt your family,” he said, before highlighting the consequences of not prioritizing spending on healthcare: “Most countries that moved to middle-income status, provide insurance—either through the private sector, through government or some weird mix.” In short, Gates is laying down the red line: spend on healthcare or stay stuck as a low-income nation.

In a nutshell the health study, conducted jointly by the Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation, revealed that between 1990 and 2016 the life expectancy improved significantly.

But the disease burden underwent a structural shift: six out of 10 Indians now die due to non-communicable diseases (like a heart attack), even while child and maternal malnutrition continue to cause premature deaths (an estimated six million children die before they are five years old) and tuberculosis, with the highest incidence in the world, continues to be a threat.

The study captures the disease burden expressed as the number of years lost due to ill-health, disability or early death—it was nine-fold for diarrhoeal diseases and tuberculosis, and seven-fold for lower respiratory infections in 2016. Lest we forget, not too long ago, the epidemic of AIDS all but destroyed a generation of South Africa’s workforce.

Ideally, this health atlas (because that is what it is doing by drilling down to the state level with such detail) should have been published decades ago. It would have helped policy planners immensely in customizing curative solutions, instead of universalizing the strategy as there was rarely any big data to fall back upon. As the cliche goes, better late than never.

While this is indeed the case, it does not in any way absolve regimes over the last seven decades, including the present one, for their failure to prioritize health—it averages a little over 1% of GDP. Part of the problem, like in the case of pollution, is that this falls in the realm of the Union government and the states. And unless it is in your face, politicians seldom find it worthwhile to react.

But the health atlas reveals that this is a luxury politicians may not have for too long. While it shows a dismal national picture, the regional story is even more depressing. The inequalities in the disease burden suggest that regional growth disparities will only widen. It’s only a matter of time before people start checking off their aspirations against those in better off regions and start asking politically uncomfortable questions—the 2014 general election is a great example of how aspirations can trigger structural political change.

The writing is on the wall as it were for the country. Heed the message captured in the study or rue a missed opportunity.

Anil Padmanabhan is executive editor of Mint *and writes every week on the intersection of politics*

and economics.

His Twitter handle is @capitalcalculus.

Respond to this column at anil.p@livemint.com.

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Fighting tomorrow’s public health battle

The “India: Health Of The Nation’s States” report, released last week, makes two things abundantly clear. The first is that the lack of such a granular, state-wise assessment of India’s public health scenario and trends in a common framework until now has been an inexplicable failure on the part of previous governments. The Narendra Modi government has done well to rectify the lack. The second is that the nature of the country’s health challenges has changed sharply over the past couple of decades and is going to continue changing.

The latter should not come as a surprise. Global precedent shows that a country’s health profile changes as its economy and level of urbanization grow. The threat posed by communicable diseases such as tuberculosis and malaria, maternal, neonatal and nutritional diseases—collectively termed infectious and associated diseases in the report—declines, and the burden of non-communicable diseases (NCDs) grows. India is no different, even if the rapidity and extent of the change are startling.

In 1990, the total disease burden of infectious and associated diseases in the country, measured using the metric of disability-adjusted life years (DALYs), was 61%. The burden of NCDs at the time was 30%. Cut to 2016 and those numbers have just about flipped: infectious and associated diseases account for 33% of the disease burden while NCDs account for 55%. This trend is going to continue to play out as India’s socio-economic contours change. In roughly the same period that the report covers—the past quarter century—two thirds of the deaths globally have been because of NCDs. The World Health Organization predicts that over the next decade, NCD deaths will increase by 17% globally. And in high-income countries, generally speaking, they account for 80% or more of deaths. All of this leads to two conclusions.

The first is the need for decentralized health policymaking. There is wide divergence between the health profiles of various regions and states in India. While infectious and associated diseases now account for less than half of the disease burden in all the states, the transition happened as early as 1986 and as late as 2010 depending on the state in question. Likewise, the NCDs burden covers a substantial range—from 48% of the state disease burden to 75%. Drill deeper and it gets even more complicated. The burden due to specific diseases within the NCDs and the infectious and other diseases groups differs substantially. This is true not just between groupings of economically similar states—say, industrialized states like Maharashtra and Gujarat, and Empowered Action Group states like Uttar Pradesh and Madhya Pradesh—but between similar states as well. This divergence, naturally, extends to the risk factors that cause various diseases. In the face of this reality, Centre-dominated health policymaking—save in its broadest contours such as increasing insurance coverage, setting standards for public sector health institutions and deciding drug policy—must inevitably diminish the effectiveness of state response.

The second takeaway is the nature of state response will have to enter relatively new territory. According to the report, “The leading individual cause of death in India in 2016 was ischaemic heart disease... The other NCDs in the top 10 individual causes of death included chronic obstructive pulmonary disease, stroke, diabetes, and chronic kidney disease.” Risk factors such as dietary risks, high blood pressure, high blood sugar and tobacco use rank correspondingly high.

In a journal article *Beyond Carrots And Sticks: Europeans Support Health Nudges*, Lucia A. Reisch, Cass R. Sunstein and Wencke Gwozdz note that tools such as nutritional standards, fiscal measures and hard regulation such as banning advertisements for certain products have been less effective globally than hoped for in addressing such risk factors. Instead, they note: “Increasing research evidence suggests that a key to changing nutritional and activity patterns is the purposeful design of living and consumption environments—the so-called choice architecture.”

In other words, nudges, brought into prominence in recent years by the work of Nobel Prize winning economists like Daniel Kahneman and Richard H. Thaler. An increasingly large number of countries are incorporating this in policymaking; the UK's Behavioural Insights Team is perhaps one of the most well-known attempts.

Building an effective choice architecture can require direct government action. Urban planning is perhaps the best example of this. Ensuring that citizens lead a more physically active life would directly address a number of risk factors for NCDs. That means ensuring ease of access from everything to pedestrian access to public transport and communal green spaces. Effective architecture will require bringing private enterprises on board in other instances—from displaying health information and advice in stores to appropriate food labelling, high salt warnings and product placement in stores.

This sort of broad and diffuse response will not be easy to implement. And certainly, addressing the weak fundamentals of India's health system is critical. But NCDs are called lifestyle diseases for a reason. Evidence from developed economies shows that addressing them requires inducing basic changes in the manner citizens live their lives, effective health systems notwithstanding. Achieving this without straying into state paternalism and heavy-handed regulation—an ever present risk in India—is going to be tricky but essential for fighting tomorrow's health battle.

Can nudges effectively address India's growing NCD burden? Tell us at views@livemint.com

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Pill talk — On antibiotic resistance

Around the time the UN Climate Change Conference drew to a close in Bonn last week, so did the World Antibiotic Awareness Week, a World Health Organisation campaign to focus attention on antibiotic resistance. The global threats of climate change and antibiotic resistance have much in common. In both cases, the actions of people in one region have consequences across the globe. Also, tackling both requires collective action across multiple focus areas. For resistance, this means cutting the misuse of antibiotics in humans and farm animals, fighting environmental pollution, improving infection control in hospitals, and boosting surveillance. While most of these goals need government intervention, individuals have a critical part to play too. This is especially true for India, which faces a unique predicament when it comes to restricting the sale of antibiotics — some Indians use too few antibiotics, while others use too many. Many of the 410,000 Indian children who die of pneumonia each year do not get the antibiotics they need, while others misuse drugs, buying them without prescription and taking them for viral illnesses like influenza. Sometimes this irrational use is driven by quacks. But just as often, qualified doctors add to the problem by yielding to pressure from patients or drug-makers. This tussle — between increasing antibiotic use among those who really need them, and decreasing misuse among the irresponsible — has kept India from imposing blanket bans on the non-prescription sale of these drugs.

When policymakers did propose such a ban in 2011, it was met with strong opposition. Instead, India turned to fine-edged tools such as the Schedule H1, a list of 24 critical antibiotics such as cephalosporins and carbapenems, whose sale is tightly controlled. But even Schedule H1 hasn't accomplished much: pharmacists often flout rules, and drug controllers are unable to monitor them. Thus, the power to purchase antibiotics still remains in the hands of the consumer. It is up to consumers now to appreciate the threat of antibiotic resistance and exercise this power with care. These miracle drugs form the bedrock of modern medicine today, and are needed for everything from prophylaxis for a complicated hip surgery to treatment for an infected knee scrape. Losing these drugs would mean that even minor illnesses could become killers, and the cost of health care will soar. Consumers need to remember that not all illnesses need antibiotics, and the decision on when to take them and for how long is best left to a doctor. Multi-resistance in some tertiary-care hospitals to bugs like *Staphylococcus aureus* has grown to dangerous levels. But the experience of countries like Australia shows that cutting down on antibiotics can reverse such trends. The National Action Plan on Antimicrobial Resistance aims to repeat such successes in India. Meanwhile, awareness must be built among consumers so that they see the coming crisis and take up the baton.

Revving up infrastructure spending is necessary, but not sufficient

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Going universal — On Karnataka's universal health coverage

Karnataka’s move to amend the law governing private medical establishments is a logical step in its plan to provide universal health coverage in the State. There can be a debate on how individual aspects of medical services are best regulated, but laying down standards, containing treatment costs, mandating transparency and creating a binding charter that empowers patients are all basic components of healthcare reform. The State government has wisely dropped the clause on imprisonment for medical negligence in the final draft of the amendment Bill, avoiding a possible delay in broadening the scope of the Karnataka Private Medical Establishments Act, 2007. There is a need, of course, to ensure parity in services offered by government and private institutions, and end the neglect of public facilities especially in rural areas. The transition to universal health access, provided free at the point of delivery, must be a national priority as it is the key Sustainable Development Goal relating to health to be achieved by 2030. The UPA government dropped the ball midway, although it had a report from an expert group of the Planning Commission in 2011 proposing a road map for universal coverage. Karnataka is pursuing needed reform in some of the areas covered by the expert panel, notably on containing the cost curve in establishments that operate for profit and where patients with state-supported insurance get treated.

The task before Karnataka now is to come up with an essential health package consisting of treatments available to all and to devise ways to charge users based on the ability to pay. Capping costs for those who use such facilities is important, given that out-of-pocket expenditure on health in India is extremely high. Regulation of prices for some drugs may have had a moderating effect, but much work remains to be done to streamline processes to achieve centralised procurement and free distribution of essential medicines to all. Karnataka’s decision to set up a regulator for government hospitals is a response to the criticism that nothing is being done to raise standards in these institutions and bring in accountability. Ideally, all health institutions participating in a universal access programme should be governed by common regulations, for which national, State and district-level authorities are the answer. Such a comprehensive approach can eliminate fragmentation of functions. Also, the public health approach at the primary level should not be lost sight of, while focussing on reform of hospital-based care. National schemes aimed at reducing the burden of infectious and non-communicable diseases, and improving the health of women and children, should continue to receive top priority.

Revving up infrastructure spending is necessary, but not sufficient

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States of healthcare

Health status of populations across the world changes over time in response to socio-economic, demographic, nutritional, scientific, technological, environmental and cultural shifts. Such health transitions have been especially profound in the past half-century due to sweeping industrialisation, rapid urbanisation and relentless globalisation in most parts of the world. It is necessary to understand, and even predict, the patterns and dynamics of health transition so that multi-sectoral actions can be taken to protect and promote the health of populations.

The Global Burden of Disease study was initiated 26 years ago to chart the changing patterns of disease-related death and disability from 1990 onwards. Since then, estimates are periodically provided for years of life lost to premature mortality as well as for years of disease-related disability that is weighted for severity. A combined measure of these two metrics is expressed as the loss of Disability Adjusted Life Years (DALYs) attributable to any disease or risk factor. In recent years, national and sub-national estimates are emerging to provide greater focus to action within countries.

The first-of-its-kind Indian effort to map state-level disease burdens was undertaken by over 1,000 experts led by Lalit Dandona of the Public Health Foundation of India, in partnership with the Indian Council of Medical Research and the team that leads the global study. The results, reported last week, highlight significant trends common to all states as well as important differences between them.

Life expectancy at birth improved in India from 59.7 years in 1990 to 70.3 years in 2016 for females, and from 58.3 years to 66.9 years for males. However, life expectancy of women in Uttar Pradesh is 12 years lower than that of women in Kerala, while the life expectancy of men in Assam is 10 years lower than that of men in Kerala. The per person disease burden, from all causes, dropped by 36 per cent in the same period. However, there was an almost two-fold difference between the states in 2016, with Assam, Uttar Pradesh, and Chhattisgarh having the highest rates, and Kerala and Goa the lowest rates.

The under-five mortality rate has reduced substantially in all states in these 25 years. But there was a four-fold difference in this rate between the highest, in Assam and Uttar Pradesh, as compared with the lowest in Kerala in 2016. Despite a decline from 1990 levels, child and maternal malnutrition remains the single largest risk factor, contributing to 15 per cent of the disease burden in 2016. With its under-five mortality six times higher than Sri Lanka and burden of child and maternal malnutrition 12 times higher than in China, India has wide gaps to bridge.

Communicable, maternal, neonatal, and nutritional diseases contributed to 61 per cent of India’s disease burden in 1990. This dropped to 33 per cent in 2016. But the share of non-communicable diseases in the disease burden increased from 30 per cent in 1990 to 55 per cent in 2016, and that of injuries increased from 9 per cent to 12 per cent. While all states show this trend, Kerala, Goa, and Tamil Nadu have the largest dominance of non-communicable diseases and injuries over infectious and associated diseases, whereas this ratio is much lower in Bihar, Jharkhand, Uttar Pradesh, and Rajasthan. Five of the 10 individual leading causes of the disease burden in India in 2016 are a carry-over of past threats: Diarrhoeal diseases, lower respiratory infections, iron-deficiency anaemia, neonatal pre-term birth, and tuberculosis. Though the disease burden due to poor water and sanitation decreased in these 25 years, the per capita burden due to these factors is 40 times that in China.

In 2016, three of the five leading individual causes of disease burden in India were non-communicable, with ischaemic heart disease and chronic obstructive pulmonary disease being the

top two causes and stroke the fifth leading cause.

A group of risks including unhealthy diet, high blood pressure, high blood sugar, high cholesterol, and overweight, which mainly contribute to ischaemic heart disease, stroke and diabetes, caused about 25 per cent of the total disease burden in India in 2016, up from about 10 per cent in 1990. Ambient air pollution and household air pollution both rank high as risk factors in 2016, the former rising and the latter declining in the past 25 years.

There were large variations between states in the degree to which these risks are rising. States in early stages of the health transition were coping with both the persisting challenge of infectious, nutritional and pregnancy-related health threats and the rising magnitude of non-communicable diseases. States in the advanced stage of the transition were grappling largely with non-communicable disorders.

These data, of time trends and inter- state variations, highlight the need to develop specific strategies to address the major contributors to disease burden within each state. Disaggregated data, as provided in the recent report, will help to tailor customised state-level responses while summated time trends will help the National Health Policy to set and track the progress towards country-level targets. Since the present report provides modelled estimates derived from multiple and often limited data sets, it is imperative to strengthen vital registration mechanisms and beef up disease and risk factor surveillance systems in every state.

The broad national agenda should be elimination of malnutrition, reduction of child and maternal mortality, control of infectious diseases and containment of risk factors contributing to non-communicable diseases. This report provides each state the GPS to chart their individual journeys towards those goals, from different starting points.

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A toolkit to think local: on decentralised health planning

Policymakers in India need reliable disease burden data at subnational levels. Planning based on local trends can improve the health of populations more effectively. Till now, a comprehensive assessment of the diseases causing the most premature deaths and ill health in each State, the risk factors responsible for this burden and their time trends have not been available. To address this crucial knowledge gap, a team of over 250 scientists and others from around 100 institutions who are part of the India State-Level Disease Burden Initiative has analysed and described these trends for every State from 1990 to 2016. Its report was released by the Vice President of India, and a technical paper published in the journal Lancet recently.

The findings of the study are based on analysis of data from all available sources. This includes vital registration, the sample registration system, large-scale national household surveys, other population-level surveys and cohort studies, disease surveillance data, disease programme data, administrative records of health services, disease registries, among others. The estimates were produced as part of the Global Burden of Disease Study 2016, which uses standardised methods in a unified framework. The key metric used to assess burden is disability-adjusted life years (DALY), which is the sum of the number of years of life lost due to premature death and a weighted measure of the years lived with disability due to a disease or an injury. This allows comparisons of health loss between diseases, risk factors, States, sexes, age groups, and over time.

The per person disease burden, measured as DALY rate, has dropped in India by 36% from 1990 to 2016, but there are major inequalities among States with the per person DALY rate varying almost twofold between them. The burden of most infectious and childhood diseases has fallen, but the extent of this varies substantially across India. Diarrhoeal diseases, lower respiratory infections, iron-deficiency anaemia, neonatal disorders, and tuberculosis still continue to be major public health problems in many poorer northern States.

The contribution of most major non-communicable disease categories to the total disease burden has increased in all States since 1990. These include cardiovascular diseases, diabetes, chronic respiratory diseases, mental health and neurological disorders, musculoskeletal disorders, cancers, and chronic kidney disease. The contribution of injuries — the leading ones being road injuries, suicides, and falls — to the total disease burden has also increased in most States since 1990.

The continuing high burden of infectious and childhood diseases in poorer States along with the rising tide of non-communicable diseases and injuries poses a particularly ominous challenge for these States. Substantial increases in health spending by the government and expansion of suitable preventive and curative health services are necessary to prevent this potentially explosive situation. It is important to note that the State-specific DALY rates for many leading individual diseases varies five- to tenfold between States. Major differences are also observed for individual diseases between neighbouring States that are at similar levels of development. This points to the need for State-specific health planning instead of generic planning.

Disease burden can be reduced by addressing the risk factors for major diseases. The findings of the study reveal that three types of risks – undernutrition, air pollution, and a group of risks causing cardiovascular disease and diabetes – are akin to national emergencies as these have the potential to significantly blunt the rapid social and economic progress to which India aspires.

First, it is remarkable that even though there is a declining trend in child and maternal undernutrition, this is still the single largest risk factor in India, responsible for 15% of the total

disease burden in 2016. Undernutrition increases the risk of neonatal disorders, nutritional deficiencies, diarrhoeal diseases, and lower respiratory and other common infections. This burden is 12 times higher per person in India than in China. While this risk factor is relatively worse in the major northern poor States and Assam, it is amazingly the leading risk in over three-fourths of the States across India.

Second, air pollution levels in India are among the highest in the world, making it the second leading risk factor in 2016, responsible for 10% of the total disease burden in the country. Air pollution increases the risk of cardiovascular diseases, chronic respiratory diseases, respiratory infections, and cancer. The burden of outdoor air pollution has increased in every part of India since 1990 because of pollutants from power production, industry, vehicles, construction, dust and waste burning. Air pollution is higher in the northern States, but is considerable even in the southern States. The unacceptably high disease burden due to undernutrition and air pollution in most of India must be brought to an end through systematic large-scale interventions with robust short- and long-term goals.

Third, a group of risks that include unhealthy diet, high blood pressure, high blood sugar, high cholesterol and overweight, which increase the risk of ischaemic heart disease, stroke and diabetes, contributed a tenth of the total disease burden in India in 1990, but increased to a quarter of the total burden in 2016. While these risks are currently higher in the relatively more developed States, their phenomenal increase in every State over the past quarter of a century poses a grave threat. Unless serious attempts are made soon to address this surge through massive upscaling of interventions in the health, food, agriculture, housing and urban development sectors, these risks can result in major deterioration in the health status across all States, rich and poor. An important point to note related to undernutrition, air pollution, and the risks causing cardiovascular disease and diabetes is that the interventions needed to address them have to involve extensive collaborations between the health sector and other relevant sectors.

These findings reported by the India State-Level Disease Burden Initiative provide the most comprehensive mapping so far of the magnitude of diseases and risk factors in every State, their age and sex distributions, and trends over a quarter century — all in a single standardised framework. The chances of achieving the overall health targets for India and of reducing health inequalities among States would be higher now if the biggest health problems and risks identified for each State are tackled on priority basis rather than with a more generic approach that does not take into account these State-specific trends. This new knowledge base and the annual updates planned by the India State-Level Disease Burden Initiative will provide important inputs for the data-driven and decentralised health planning and monitoring recommended by the National Health Policy 2017 and the NITI Aayog Action Agenda 2017-2020.

Lalit Dandona is Director of the India State-Level Disease Burden Initiative, Distinguished Research Professor at the Public Health Foundation of India, and Professor of Global Health at the University of Washington. Soumya Swaminathan is Secretary, Department of Health Research, Ministry of Health and Family Welfare, and Director-General of the ICMR

The definition of harassment needs to be constantly updated, and the process for justice made more robust

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Balancing patents and drug prices

A debate on drug policy is vital in light of growing concerns about access to medicines and apprehensions about the financial sustainability of healthcare systems around the world. Affordable drugs are indeed necessary. But what happens when there are no drugs to treat the new diseases that continue to confound pathologists? What happens when new drugs are not created to treat existing diseases more effectively due to increasing resistance to antibiotics? The question of affordability, then, becomes moot.

India's health sector, until last year, was allocated only a little over 1% of our nation's gross domestic product (GDP) compared to the world average of 6%. There is a need to better understand determinants of drug prices, in order to identify exactly which measures can be most effective in terms of affordability and access.

Why Indian patients wait longer for treatment

A general scepticism and gloom-ridden predictions based on an incomplete understanding of intellectual property rights (IPRs) often obfuscate the real issues facing India's drug industry. Patents are critical in innovative sectors, because they provide incentives for companies to invest in the creation of new solutions.

Currently, only 5% of medicines used in India are said to be patent-protected. What must link medical innovation and affordable treatment is a supportive role of the state. India has over three million cancer patients, which means one in every 13 of the world's cancer patients is Indian. Then why only seven new cancer drugs were introduced in India in the last few years, despite the fact that over 50 breakthrough therapies were made available in other countries? Scholars Iain Cockburn and Ernst Berndt of Boston University and the Massachusetts Institute of Technology provide an answer. They examined 184 US Food and Drug Administration-approved innovative drugs sold in India and found that 50% of these drugs encountered delays in marketing approval of more than five years after their global launch.

Even once approved for marketing, over 50% that became newly available in India was produced and sold as generic versions by multiple follow-on Indian manufacturers within one year of their introduction. The scholars claim that such delays combined with rapid appearance of generic versions of innovator drugs in India could be an indication of a lack of faith in the patent regime and enforcement environment. If their findings are to be believed, it is bad news not just for manufacturers facing uncertainty, but, more importantly, for our patients.

The World Health Organization (WHO) announced earlier this year that the world is running out of antibiotics in the face of multi-drug-resistant infections, and that the speed of increasing resistance will outpace the slow drug development process. Major drug companies are closing their labs dedicated to antibiotics research, perhaps to pursue research on drugs for diseases, including diabetes, hypertension and cancer. But why are they closing antibiotic research labs when bacterial resistance is increasingly rendering the current stock of antibiotics ineffective and the pipeline of backup drugs is running dry?

Academicians from the University of British Columbia addressed this important question in their research. Combining theoretical economics and molecular biology, they find that the problem of cross-molecular resistance may necessitate stronger intellectual property protection with broader and longer patents. This may sound odd to some but governments must not erode incentives to innovation and fight the very real threat of humankind returning to pre-penicillin days.

How do medicine prices build up?

According to WHO and Health Action International, more than 50% of the end price of medicine is contributed by components other than the manufacturer's selling price.

Drug price regulation, such as the one instituted by the National Pharmaceutical Pricing Authority (NPAA) recently, is ineffective if the design of the price-control mechanism is detached from all the other components identified by WHO and implementation is poor. Scholars have empirically established that Eastern Europe countries should focus more on containing the distribution costs, which form an integral part in the medicine value chain. Economic theory tells us that price controls may deter entry into the market, resulting in perverse welfare effects. China followed a different strategy to tackle the issue of affordability of patented drugs.

Earlier this year, China slashed prices of patented drugs by 70% as a precondition for eligibility for government insurance schemes, but without tampering with grant of patents. This made the drugs eligible for state co-payment, making them affordable to patients while protecting the revenue stream of pharmaceutical companies.

Policy re-routing can bring rewards

Based on 2015 *Bloomberg* data, it was found that the monthly unit drug prices in India for hepatitis C, asthma and diabetes were 2%, 3% and 4%, respectively, of prevailing US prices. In terms of comparison, patients in China and Brazil pay substantially more for the same drugs. However, this lowered price has come at the cost of time, with excessive delay in the availability of essential medicines in India and weak incentives for our own industry to innovate. Along with reducing uncertainty in IPR, India can also deploy policy tools to strengthen its fragile health sector. India needs to follow-up on the commitments it laid down in the National IPR Policy to bring about a congenial environment for innovation to take place. The bright promise of a forward-looking bio-pharmaceutical industry in India will only be fulfilled if we work to build an ecosystem that promotes medical innovation. I hope this was one of the outcomes of the recently concluded world conference on medicines held in New Delhi. Our government needs to actively create an enabling environment for this to happen. We must achieve a balance between the current and future needs of patients and the timely introduction of existing and new pharmaceutical drugs.

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