Nationwide programme to test all TB patients

Beginning this month, health authorities will commence a nationwide programme to test every tuberculosis (TB) patient for signs of resistance to first-line drugs. Other than providing a realistic assessment on the scale of resistance to commonly-available tuberculosis drugs, experts said this could also reveal a large number of hidden tuberculosis patients, as well greater numbers of those with multiple infections of TB and HIV.

Even as India tops the world in the number of tuberculosis cases, the WHO (World Health Organisation) estimates that possibly as many as a million Indians with TB could be outside government scrutiny. In 2015 alone, nine million Indians were tested for suspected tuberculosis and about 900,000 were confirmed to be ailing from it. Nearly 3% of new TB cases and 18% of prevalent cases are believed to be drug resistant, though independent analyses peg these numbers as much higher.

GeneXpert

The new policy, called the Universal Drug Sensitivity Test, which was formalised earlier this month, will be implemented using a molecular diagnostic test called GeneXpert, a US-developed technology tool being used worldwide since 2010. It can detect the TB bacterium as well check for resistance to rifampicin, one of the standard key TB drugs, within 90 minutes. Conventional tests take at least a day or more and require well-trained personnel for similar results.

The programme will first be implemented in the States mentioned and then expanded to rest of country. States that will first see this policy being implemented include Arunachal Pradesh, Bihar, Goa, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Sikkim, Tripura and Uttarakhand.

States will have access to more geneXpert machines but the implementation is their responsibility.These, however, are not the States with the highest tuberculosis burden. “The States are expected to implement this intervention for patients diagnosed as on 1st August or later,” says a letter signed by Sunil Khaparde, who heads India’s National TB Control Programme. The note says future stages of the programme include testing patients treated in the private sector, who, it is believed, constitute half the TB burden and receive sub-optimal care.

The WHO’s TB statistics for India for 2015 — the latest available — gives an estimated incidence figure of 2.2 million cases of TB for India out of a global incidence of 9.6 million.

An inability to rapidly diagnose multi-drug resistant tuberculosis has long been identified as among the chinks in India’s strategy to eliminate tuberculosis. There are only around 600 GeneXpert devices now in use — roughly one for each district — and this posed a stumbling block to deploying the WHO-recommended kits earlier. “We now have enough of them to implement this in a big way, as well the [necessary] funds,” Mr. Khaparde told *The Hindu* . He did not specify numbers.

Optimal output

GeneXpert kits, though one of their kind, are also known to be expensive, as well as requiring air-conditioned settings and reliable electricity access for optimal output. The Indian Council of Medical Research (ICMR) is in the process of testing a cheaper alternative to GeneXpert called Truenat MTB, which is reportedly more portable, battery-operated, and performs as well at lower costs.

“The TB burden is dramatically under-reported and, ideally, we should be moving to a system of molecular diagnostics for all TB suspects,” said Dr. Soumya Swaminathan, Director General, ICMR. “This is a significant move…we will likely find more cases and have to be prepared to treat more of them.”

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Focus on ‘Optimal Infant & Young Child feeding Practices’ during National Nutrition Week

Ministry of Health and Family Welfare is observing National Nutrition Week from 1st September to 7th September, 2017. The theme of this year’s National Nutrition Week is “Optimal Infant & Young Child feeding Practices (IYCF): Better Child Health.” During this period, a week-long campaign is also being carried out to create mass awareness about the importance of appropriate nutrition in protection and promotion of health and wellbeing of children.

For promotion of Optimum IYCF practices, MoHFW has launched “MAA- Mothers’ Absolute Affection” programme to improve breastfeeding coverage and appropriate breastfeeding practices in the country. Around 3.7 lakhs ASHAs and around 82,000 healthworkers including programme managers at district and block level, doctors (MOs), staff nurses (SNs) and ANMs have been sensitized for breastfeeding promotion strategies under MAA programme and more than 23,000 health facility staffs (MOs, SNs and ANMs) are trained in IYCF training. In addition, more than 1.49 lakh mothers’ meetings were also carried out by ASHAs at village level to sensitize mothers regarding importance of appropriate breastfeeding practices.

Community sensitization activities such as mothers’ meetings and block/ district level workshops with programme managers, services providers’ e.g MOs, SNs and ANMs along with FLWs are also planned during the National Nutrition Week (NNW). Village Health and Nutrition Days (VHNDs) will be held at village level in Anganwadi centres to increase the awareness and bring about desired changes in the IYCF practices in the community. In addition, “National Guidelines on Lactation Management Centres in Public Health Facilities” have been recently released to facilitate establishment of lactation management centres for ensuring that the sick and pre-term babies are fed with safe human breast milk.

Breastfeeding is an important, efficient and cost-effective intervention promoting child survival and health. Breastfeeding within an hour of birth could prevent 20% of the newborn deaths. Infants who are not breastfed are 15 times more likely to die from pnuemonia and 11 times more likely to die from diarrhoea than children who are exclusively breastfed, which are two leading causes of death in children under-five years of age. In addition, children who were not breastfed are at increased risk for diabetes,

obesity, allergies, asthma, childhood leukaemia, sudden infant death syndrome etc. Apart from mortality and morbidity benefits, breastfeeding also has tremendous impact on improved IQ.

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

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The climate connection to dengue

Ideal conditions: “There was a strong correlation between rainfall and dengue numbers.” Rainwater collects in a plastic tarp creating an ideal habitat for mosquitoes to lay their eggs. | Photo Credit: AwakenedEye

Given its close link with both temperature and rainfall, it is possible to forecast the outbreak of dengue. But for such forecasting to be effective, it should be based on models specific to different climatic zones in the country, a new study has shown.

Scientists have reached this conclusion after evaluating the relationship of climatic factors to the spread of dengue in different climatic zones in India — Punjab, Haryana, Rajasthan, Gujarat, and Kerala. They focussed on changes in a factor called extrinsic incubation period (EIP) of the dengue virus, by taking into account daily and monthly mean temperatures in these areas.

The EIP is the time taken for incubation of the virus in the mosquito. During this period, after the mosquito draws blood that is rich in viruses, it escapes the gut and passes through the mosquito’s body and reaches its salivary glands. Once this happens, the mosquito is infectious and capable of transmitting the virus to a human host.

However, climatic conditions play an important role in EIP, the scientists say. Lower temperatures (17-18°C) result in longer EIPs thereby leading to decreased virus transmission. With increasing temperatures, feeding increases because of the enhanced metabolism of the mosquito, leading to shorter EIPs. Even a five-day decrease in the incubation period can hike the transmission rate by three times, and with an increase in temperature from 17 to 30°C, dengue transmission increases fourfold. A further increase in temperature beyond 35°C is detrimental to the mosquito’s survival.

The study has been jointly done by the Hyderabad-based Indian Institute of Chemical Technology (IICT), the National Institute of Pharmaceutical Education and Research (NIPER), Guwahati, in collaboration with scientists at the University of Liverpool.

The researchers observed that except for Gujarat, which comprises arid regions, there was a strong correlation between rainfall and dengue numbers. They propose an increase in breeding grounds for mosquitoes as a major reason for this finding.

The study found that Kerala, which is warm (temperature ranges from 23.5 to 30°C) and wet and with short EIPs (9-14 days), experiences the highest number of dengue cases. It has been found that EIP is the shortest during the monsoon season in most States and therefore there is an enhanced risk of dengue during this time.

Researchers say it is important to take into account the dynamic EIP estimates in different regions in assessing disease burden. “This climate-based dengue forecasting model could help health authorities assess the disease intensity in a geographic region. Based on that they can plan disease-control operations well in advance and optimise the use of resources meticulously,” explained Dr. Srinivasa Rao Mutheneni of IICT, who led the study.

With changes in temperature affecting the extrinsic incubation period of the virus, future changes in the climate might have a substantial effect on dengue and other vector-borne disease burden in India. “Though such methods are in vogue for disease control operations, we are still in the initial stages of implementation of such strategic control methods,” Dr. Rao said. Factors such as population density and migration also need to be included for future risk assessment studies.

Dr. Shikha T. Malik is with India Science Wire

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

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

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A milestone in treating cancer

The United States's Food and Drug Administration (FDA) on Wednesday approved the first-ever treatment that genetically alters a patient's own cells to fight cancer, a milestone that is expected to transform treatment in the coming years.

The new therapy turns a patient's cells into a "living drug" and trains them to recognise and attack the disease. It is part of the rapidly growing field of immunotherapy that bolsters the immune system through drugs and other therapies and has, in some cases, led to long remissions and possibly even cures.

The therapy, marketed as Kymriah and made by Novartis, was approved for children and young adults for an aggressive type of leukemia — B-cell acute lymphoblastic leukemia — that has resisted standard treatment or relapsed. The FDA called the disease "devastating and deadly" and said the new treatment fills an "unmet need". Novartis and other companies have been racing to develop gene therapies for other types of cancers, and experts expect more approvals in the near future. Dr. Scott Gottlieb, the FDA commissioner, said that more than 550 types of experimental gene therapy were being studied.

Drawbacks and cost

There are drawbacks to the approach. Because Kymriah can have life-threatening side effects, including dangerous drops in blood pressure, the FDA is requiring that hospitals and doctors be specially trained and certified to administer it, and that they stock a certain drug needed to quell severe reactions.

Kymriah, which will be given to patients just once and must be made individually for each patient, will cost $475,000 (approximately 2.8 crore). Novartis said that if a patient does not respond within the first month after treatment, there will be no charge. The company also said it would provide financial help to families who were uninsured or underinsured. Discussing the high price during a telephone news conference, a Novartis official noted that bone-marrow transplants, which can cure some cases of leukemia, cost even more, from $540,000 to $800,000.

About 600 children and young adults a year in the U.S. would be candidates for the new treatment.

The approval was based largely on a trial in 63 severely ill children and young adults who had a high rhemission rate of 83% within three months. The treatment was originally developed by researchers at the University of Pennsylvania and licensed to Novartis. It was identified in previous reports as CAR-T cell therapy, CTL019 or tisagenlecleucel.

The first child to receive the therapy was Emily Whitehead, who was six and near death from leukemia in 2012 when she was treated, at the Children's Hospital of Philadelphia. Now 12, she has been free of leukemia for more than five years.

Customising Kymriah

To customise Kymriah for individual patients, white blood cells called T cells will be removed from a patient's bloodstream at an approved medical centre, frozen, shipped to Novartis in Morris Plains, New Jersey, for genetic engineering and multiplying, frozen again and shipped back to the medical centre to be dripped into the patient. That processing is expected to take 22 days. Novartis said the treatment would be available at an initial network of 20 approved medical centres

to be certified within a month, a number that would be expanded to 32 by the end of the year. Five centres will be ready to start extracting T cells from patients within three to five days, the company said.

Certification is being required because the revved-up T cells can touch off an intense reaction, sometimes called a cytokine storm, that can cause high fever, low blood pressure, lung congestion, neurological problems and other life-threatening complications. Medical staff members need training to manage these reactions, and hospitals are being told that before giving Kymriah to patients, they must be sure that they have the drug needed to treat the problems, tocilizumab, also called Actemra. NYT

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

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

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Corporal punishment is no way to treat a child in or outside the classroom

The horrific video of a teacher repeatedly slapping a Class 3 student has brought the issue of corporal punishment back to the limelight. The problem of teachers (and indeed parents) beating their children with the intention of “disciplining” them is an old one; and the law has laid down strict guidelines to discourage the practice. Under the Right of Children to Free and Compulsory Education (RTE) Act, 2009, ‘physical punishment’ and ‘mental harassment’ are prohibited under Section 17(1); and are both punishable offences under Section 17(2). In Delhi, corporal punishment in schools has been banned by the Delhi High Court since 2001 for undermining the dignity of the student. The National Commission for Protection of Child Rights (NCPCR) has issued guidelines for eliminating corporal punishment in schools.

In spite of this, there is widespread belief among teachers and caregivers that hitting or insulting a child is the best way to ensure obedience and discipline. Several psychological studies have shown that beating or otherwise assaulting a child is extremely deleterious to their mental health, and teaches them that hitting is an acceptable means of dealing with conflict. The NCPCR draft guidelines even go so far as to say that corporal punishment can lead to several adverse physical, psychological and educational outcomes in students – including an increase in aggressive and destructive behaviour, poor attention spans, school phobia, low self esteem, anxiety, depression, and even suicide. Such abuse in early childhood has the potential to scar children for life.

That some progress in the area has been made is visible in the outrage seen on social media and news in response to the video. It is heartening to see that many people see this as unacceptable and cruel. But as is also evident from the presence of the video in the first place that there is yet a long way to go in training teachers in schools to be sensitive to the emotional and mental needs of children. Since schools are the first spaces in which children learn about power structures and social relations, society owes it to its children to provide an environment that can effectively protect and nurture them

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Health Ministry launches two new contraceptives

The Ministry of Health and Family Welfare has launched two new contraceptives, an injectable contraceptive MPA under the ‘Antara’ programme and a contraceptive pill, ‘Chhaya’, in the public health system to expand the basket of contraceptive choices to meet the emerging needs of couples. The contraceptives, which are available for free in Medical Colleges and District Hospitals at present, have so far been launched in 10 states that includes Maharashtra, Uttar Pradesh, Madhya Pradesh, Rajasthan, Karnataka, Haryana, West Bengal, Odisha, Delhi and Goa. The contraceptives are safe and highly effective, the ‘Antara’ injectable being effective for three months and the ‘Chayya’ pill for one week, and will help meet the changing needs of couples and help women plan and space their pregnancies. Training of healthcare practitioners from all the states has been completed as well, with a pool of state and district level doctors and staff nurses being trained to support the roll-out.

To help improve the supply and distribution of contraceptives, the Ministry had recently launched a new software, Family Planning Logistics Management Information System (FP-LMIS), designed to provide robust information on the demand and distribution of contraceptives to health facilities and ASHAs.

In addition, Mission Parivar Vikas, a central family planning initiative has also been launched by the Ministry. The key strategic focus of this initiative is on improving access to contraceptives through delivering assured services, ensuring commodity security and accelerating access to high quality family planning services.

• The mission is being implemented in 146 high focus districts with the highest total fertility rates in the country. These districts are in the seven high focus, high Total Fertility Rates (TFR) states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh and Assam, which constitute 44% of the country’s population.

• The main objective of the Mission Parivar Vikas family planning initiative is to bring down the Total Fertility Rate to 2.1 by the year 2025.

The Ministry of Health and Family Welfare, through its sustained family planning efforts, aims to achieve its goal of increasing modern contraceptive usage and ensure that 74% of the demand for modern contraceptives is satisfied by 2020, with continued emphasis

on delivering assured services, generating demand and bridging supply gaps. The Ministry's focus remains on increasing awareness and demand through a holistic communications campaign that has simultaneously been rolled out across all states of India.

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NITI Aayog calls renewed focus on Nutrition, launches the National Nutrition Strategy

Leader of the Green Revolution Dr. M.S Swaminathan and Padma Shri Dr. H Sudarshan, today, launched the National Nutrition Strategy, along with Vice Chairman Dr. Rajiv Kumar and Member Dr. Vinod Paul.

With a benefit to cost ratio of 16:1 for 40 low and middle-income countries, there is a well recognized rationale, globally, for investing in Nutrition. The recently published NFHS-4 results reflect some progress, with a decline in the overall levels of under nutrition in both women and children. However, the pace of decline is far below what numerous countries with similar growth trajectories to India have achieved. Moreover, India pays an income penalty of 9% to 10% due to a workforce that was stunted during their childhood.

To address this and to bring nutrition to the centre-stage ofthe National DevelopmentAgenda, NITI Aayog has drafted the National Nutrition Strategy. Formulated through an extensive consultative process, the Strategy lays down a roadmap for effective action, among both implementers and practitioners, in achieving our nutrition objectives.

The nutrition strategy envisages a framework wherein the four proximate determinants of nutrition – uptake of health services, food, drinking water & sanitation and income & livelihoods – work togetherto accelerate decline of under nutrition in India. Currently, there is also a lack of real time measurement of these determinants, which reduces our capacity for targeted action among the most vulnerable mothers and children.

Supply side challenges often overshadow the need to address behavioural change efforts to generate demand for nutrition services. This strategy, therefore, gives prominence to demand and community mobilisation as a key determinant to address India's nutritional needs.

The Nutrition Strategy framework envisages a Kuposhan Mukt Bharat - linked to Swachh Bharat and Swasth Bharat. The aim isensure that States create customized State/ District Action Plans to address local needs and challenges. This is especially relevant in view of enhanced resources available with the States, to prioritise focussed interventions with agreater role for panchayats and urban local bodies.

The strategy enables states to make strategic choices, through decentralized planning and local innovation, with accountability for nutrition outcomes.

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Indicators that matter: on the quality of public healthcare

The **deaths of more than 70 children** in one hospital in Gorakhpur and **49 in Farrukhabad**, both in Uttar Pradesh recently, reflect the appalling state of public health in India. However, it needs to be remembered that India's public health care sector has been ailing for decades. According to the latest Global Burden of Disease Study, which ranks countries on the basis of a range of health indicators, India has the 154th rank, much below China, Sri Lanka and Bangladesh.

The Gorakhpur tragedy and its aftermath

Though 'health' is a State subject, — implying that the primary responsibility of providing quality health services to the people lies with the States — States have been reducing their health-care spending efforts in relation to total government spending. In 2013-14, the per capita public expenditure on health in U.P. was 452. Such low spending cannot be expected to deliver much. The number of primary health centres, the first point of contact for patients in the rural areas of U.P. went down from 3,808 in 2002 to 3,497 in 2015. The gravity of the situation is understood better when we juxtapose this with the 25-30% increase in the State's population during the same period. These statistics show that health has never been a political priority in the State. The patterns of public expenditure on health show that the provisioning of curative care through hospitals received disproportionate policy significance, ignoring overwhelming evidence that it is preventive health care and public health actions (for example, to prevent infection by providing clean drinking water) that have brought down periodic episodes of infectious disease outbreaks or epidemics. thus, prolonging the lives of people significantly in industrialised nations and elsewhere. Scientific discoveries, technological improvements that have occurred in the last century and government efforts to improve sanitation and hygiene, not only high and middle income countries but also many low income countries have successfully controlled infectious diseases. Today, in those countries, very few parents ever experience the death of a child unlike in most Indian States where people live with the misery of seeing some of their children die due to preventable causes. The government's lack of understanding of the importance of public health has played the most important part in U.P.'s health predicament.

While the under-provisioning of health care including public health services continues in some States that were directly under the control of the British Raj, those that were once princely states such as Kerala and that had caught the attention of the world with their outstanding health achievements have not been providing enough resources to health since the late 1980s. It is no wonder then that the situation has gone from bad to worse. Health care continues to be treated like any other private good in this country, although it has certain features that make it on a par with a public good. That is why instead of leaving it to the 'invisible hand' of the market, governments around the world became deeply involved in health care. The prominent role of governments in health care goes back as far back as the 1880s when German Chancellor Otto Von Bismarck established a national health-care system to gain political advantage over the Socialist Party. After World War II, most governments in Europe became extensively involved in health care. A notable example is the National Health Service, a publicly funded health-care system in the U.K., set up in 1948. Government health spending now accounts for 80-90% of total health expenditure in most countries of the European Union and North America; public expenditure contributes to less than 30% of the total health expenditure in India.

As public health-care provisioning becomes more limited and the quality of services deteriorates, people are left with no option but to seek services from private providers, knowing well that the end result could be financially ruinous. Every year, around 60 million people become impoverished through paying health-care bills in India. Worse, more than a fifth of people do not seek health care, despite being unwell, because of their inability to pay for it.

What can we learn from the global experience? The experience from other nations that have done relatively well in health suggests that political commitment to health is a prerequisite for improving the health scenario of any country. Thailand, Cuba or Costa Rica have achieved universal health care, although they have taken different routes. While Thailandmay not be the best example to follow, it has some important lessons for India. For instance, Thailand has enacted a law to make quality health care a constitutionally guaranteed right. Unlike in India, where the Right to Education Act has been reduced to mere rhetoric, Thailand has undertaken structural reforms in the health sector to achieve the goals stated in the Health Act. Even before it started reforms to attain universal health coverage, it began massive investments to build public health facilities in rural areas. For about seven years, the Thai government channelised a greater amount of public resources to the rural areas than to in the urban places. Like Thailand, China, Ghana and other many low and middle income countries have also in recent years steadfastly augmented the public health-care system's capacity through increased funding. Cuba did the same thing many decades ago. Health care is a right there and the government assumes the fiscal and administrative responsibility of ensuring access to free health care.

The health indicators of Cuba are similar to that of developed countries. With an infant mortality rate of 4.2 per thousand births, this socialist country is among the top three performers in the world. But this was not the scenario five decades ago. In 1959, the infant mortality rate in rural areas was 100 per thousand live births and half of Cuba's doctors and hospital beds were in Havana. The rural areas had all the problems that U.P. and other underdeveloped States in India still have. Besides poverty and mass illiteracy, undernutrition was rampant and health inequalities were pervasive. However, Cuba's turn-around story is now acknowledged and its health-care system has become a model for other countries. This was made possible as the country's leadership recognised the importance of public health, which essentially means addressing the social determinants of diseases (for example, improving the living conditions of the people) and developing a health-care system based on preventive medicine and not curative care.

The tragedies in Uttar Pradesh should be a clarion call for our policy makers. If we want the people of this country to enjoy a health status that is commensurate with that of their counterparts from other middle-income countries and in the region, not only should there be more resources available for health, but also the government's approach towards health needs to be radically changed. Health needs to be integrated as a pillar of development and it must be recognised as a public good.

Soumitra Ghosh is Assistant Professor, Centre for Health Policy, Planning and Management, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai

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

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States should spend more on nutrition

Mohandas Karamchand Gandhi once said, “There are people in the world so hungry, that God cannot appear to them except in the form of bread.” Sadly, hunger and undernutrition continue to plague our country. India’s record in addressing undernutrition is abysmal. With a stunting rate of 38.4%, India accounts for about a third of the world’s stunted children. The proportion of wasted children in India increased from 19.8% in 2005-06 to 21% in 2015-16. Moreover, in states like Bihar and Madhya Pradesh, more than 40% of the children are underweight. Thus, nutrition should be high on India’s list of development priorities.

To be fair, India has a number of nutrition intervention programmes under different ministries. In absolute terms, India’s expenditure on nutrition schemes is quite high at Rs2.98 trillion but this is woefully inadequate if we take into account the level of deprivation in India.

Moreover, dramatic changes in the fiscal architecture based on the recommendations of the Fourteenth Finance Commission have raised serious concerns with regard to public spending on nutrition.

There has been a substantial decline in allocation for Central schemes. The Integrated Child Development Services Scheme (ICDS), a key scheme which provides basic education and health services to women and children below six years, suffered serious budget cuts. Allocation for ICDS declined consistently from Rs16,684 crore in 2014-15 to Rs15,489 crore in 2015-16 and Rs14,736 crore in 2016-17. Although 2017-18 saw an increase in the allocation for ICDS to Rs16,745.2 crore, this figure is only 0.5% higher than the actual expenditure incurred in 2014-15.

In the case of other schemes, like the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, also known as Sabla, and the Mid-Day Meal Scheme (MDMS), budget cuts were deeper. The outlay for Sabla declined from Rs622.4 crore in 2014-15 to Rs475.2 crore in 2015-16, and to Rs460 crore in 2016-17. In 2017-18, the allocation has been kept at the same level as 2016-17, which actually implies a decrease in allocation in real terms.

In the case of MDMS, there was a persistent decline in allocation from Rs10,917.6 crore in 2013-14 to Rs10,523.4 crore in 2014-15, and further down to Rs9,144.9 crore in 2015-16. In 2017-18, there was only a 3% increase in allocation, from Rs9,700 crore in 2016-17 to Rs10,000 crore. Again, the allocation in 2017-18 is lower than the actual expenditure of Rs10,761.4 crore incurred under the scheme in 2012-13. Even the 3% increase over last year does not mean much if inflation is factored in.

However, some Central schemes did witness an increase in allocation. The Maternity Benefit Programme, a conditional cash transfer to pregnant and lactating women to provide compensation for wage loss and adequate nutrition and rest, witnessed an increase in allocation from Rs634 crore in 2016-17 to Rs2,700 crore in 2017-18. The total cost of the programme up to 2019-20 is Rs12,661 crore for 5.17 million beneficiaries. However, nutrition experts regard this as inadequate because the number of beneficiaries under other schemes, notably the Janani Suraksha Yojana, was much higher at about 7.5 million, and that too in 2015-16.

Although the whole argument behind fiscal restructuring was that with more resources at their disposal, states would step up their expenditure, data on state budget allocation for nutrition schemes is not encouraging.

In fact, 2015-16 witnessed a decline in budget allocation in many states. In Uttar Pradesh, the total budget outlays for nutrition-specific interventions declined from Rs4,358.1 crore in 2014-15 to

Rs4,054.9 crore in 2015-16, and subsequently increased to Rs4,573.3 crore in 2016-17. Budget outlays for micronutrient supplementation and deworming declined from Rs67.7 crore in 2014-15 to Rs58.9 crore in 2015-16, and Rs56.5 crore in 2016-17.

Similarly, in Odisha, the budget for nutrition-specific interventions declined from Rs1,188 crore in 2014-15 to Rs961 crore in 2015-16, and then increased to Rs1,302 crore in 2016-17.

In Bihar, there was a small increase in the allocation for nutrition-specific interventions, from Rs1,778 crore in 2014-15 to Rs1,972 crore in 2016-17. Rajasthan witnessed a modest increase in outlay for nutrition-specific schemes from Rs975 crore in 2014-15 to Rs1,022 crore in 2015-16 and Rs 1,106 crore in 2016-17. But budget allocation for nutrition-specific schemes in 2016-17 is 13% lower than the budget allocation in 2014-15.

Thus, greater fiscal autonomy has not yet translated into higher spending on nutrition by states.

Two critical questions emerge. First, can the Centre renege on its responsibility at a time when a large proportion of India's children are undernourished?

Second, given that states have a greater responsibility, what can be done to ensure that they step up their allocation for nutrition?

While the former is an ideological question, here are some recommendations for the latter. Firstly, the Centre and state should work together to set nutrition targets for every state and district. Secondly, the Centre should play a more proactive role in monitoring the nutrition programmes of every state. Lastly, effective steps need to be undertaken to upgrade capacity at the state level.

Malancha Chakrabarty is associate fellow at the Observer Research Foundation.

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Transforming health in India: Leveraging the Sustainable Development Goals

With the promise of “leaving no one behind”, the UN General Assembly adopted the universal, integrated and transformative 2030 Agenda for Sustainable Development, along with a set of 17 Sustainable Development Goals (SDGs) almost two years ago.

It is interesting that these thoughts have their roots in what was envisioned by Mahatma Gandhi. He said, “Recall the face of the poorest and weakest man you have seen, and ask yourself if this step you contemplate is going to be any use to him.” It is this thinking, which found reflection in the Millennium Development Goals (MDGs) and is now even more central in the SDGs.

Positioned as a key feature of human development, the health goal aims at “ensuring healthy lives and promote well-being for all in all ages”. It is interlinked to several other SDGs related to poverty, gender equality, education, food security, urbanization, water sanitation, etc.

The unprecedented scope of SDGs provides immense opportunity to bring health at the centre of economic growth.

Universal Health Coverage (UHC), which is an explicit target under SDG3, can anchor, guide and inform SDG goals in health. This is the only target that cuts across all of the health goals, addressing linkages with health-related targets in the other goals. It also reflects SDG’s strong focus on equity and the importance of addressing the needs of poor or disadvantaged groups.

For India to progress towards sustainable development in health, five recommendations are proposed.

First, to “promote health and well-being of all Indians”, health must be high on the national and state agenda; it is the cornerstone for economic growth of the nation.

This requires high political commitment and collective long-term efforts by ministries beyond the ministry of health to invest in health. India’s National Health Policy 2017 provides for raising public health expenditure to 2.5 % of the GDP by 2025; this is a welcome step.

Equally important is driving the convergent action of other sectors that have impact on health e.g. nutrition, water sanitation and hygiene, environment education and housing, etc.

Second, invest in public health and finish MDG agenda through further improvements in maternal and child health, confronting neglected tropical diseases, eliminating malaria, strengthening the country’s surveillance system to detect and respond to diseases and accelerating the fight against tuberculosis.

All these challenges, programmes and interventions need to be taken to scale, with an underlying emphasis on equity and quality of services.

Third, accelerate the implementation of universal health coverage. It is at the core of SDGs and in the interest of people and governments. UHC is important to prevent people slipping into poverty due to ill-health and to ensure everyone in need has access to good quality health services. To complement tax revenue based health financing, incremental expansion of prepayment and risk pooling mechanisms such as social health insurance are worth considering. The National Health Protection Scheme (NHPS), which is under consideration, would be a welcome first step to enlarge the population coverage for financial protection and access to services.

The journey toward UHC calls for defining and agreeing on vision and goals for 2030. This will serve as a national framework and roadmap that defines the roles of the centre and the states, and that of the public and private sector. The goal needs to be operationalized into well-defined 3-to-5-year plans with clear milestones, allowing for a step-by-step approach.

Health being a state subject, states should be encouraged to choose a model of their choice, develop their own path and determine the pace. The national framework will ensure convergence in the long term.

It is well recognized that while “more money for health” is necessary, obtaining “more health for money” requires that national and state plans are evidence-informed and managed in an integrated manner.

Fourth, develop a heath investment plan for each state to strengthen and build robust health systems in infrastructure and staffing with a focus on rural areas with comprehensive primary health care at its centre. The national health mission has laid an excellent foundation to further build on. The system is needed for all services—preventive, promotive, clinical, rehabilitation and palliation, and to detect and respond to health security challenges.

Given the magnitude of the private sector in India, a more effective engagement with private health care providers is vital. An appropriate contracting modality, which is an important feature under the social health insurance and NHPS, can be worked out and the private sector can be instrumental in complementing the public sector as demonstrated by different country experiences.

Finally, develop a strong and robust system for monitoring, evaluation and accountability. It is essential to regularly review and analyse the progress made for feeding into policy decisions and revising strategies based on the challenges.

In conclusion, SDGs have the potential to ensure healthy lives and promote well-being for all at all ages, to realize the right to health and leave no one behind to create the world we want. SDGs also make it possible to achieve what WHO constitution mandates: attainment by all peoples of the highest possible level of health.

Dr Henk Bekedam is the WHO representative to India

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Shri Shripad Naik inaugurates Regional Research Institute of Homoeopathy in Agartala

Strengthening health services and propagation of AYUSH systems in North-Eastern states is one of main priorities of the Government: AYUSH Minister

The Union Minister of State (Independent Charge) for AYUSH, Shri Shripad Naik has urged Homeopathic researchers to contribute and help the Government in the management of epidemics like Dengue, Chikungunya, Malaria and Swine Flu as the contribution of Homeopathy in controlling epidemics is well known in the past. Shri Naik made this appeal at the inauguration of the Regional Research Institute of Homoeopathy (RRI) in Agartala, Tripura today.

The strengthening of health services and propagation of AYUSH systems in North-Eastern states is one of the main priorities of AYUSH Ministry, Shri Shripad Naik said.

He further elaborated that we should develop indigenous technologies and drugs that are scientific, efficacious and cost effective to tackle these diseases. The Minister said that the Institute should also focus on Malaria research with Homoeopathy as this disease is endemic in the region.

The Regional Research Institute (RRI) is one of the 9 institutes functioning under CCRH. Spread over an area of 2.05 acres, it has facility of general OPD, Research OPD, pathological investigations, 30 bedded IPD. More importantly the Institute has the facility of Yoga & Naturopathy and there is a scope of future expansion also. This is the 3rd Homoeopathic regional research institute in the North Eastern states and the first with own land and building.

Shri Sankar Prasad Dutta, MP of West Tripura, Shri Monoranjan Debbarma, MLA Mandai Bazar, Director General CCRH & CCRYN Dr. Raj K. Manchanda & Dr. Iswar N. Acharya were also present on this occasion.

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India and Belarus discuss issues pertaining to collaboration in Vocational education and Skill Development

India and Belarus discuss issues pertaining to collaboration in Vocational education and Skill Development

Minister of Education, Belarus, Mr. Karpienka Ihar met the Minister of Petroleum & Natural Gas and Skill Development & Entrepreneurship, Government of India, shri Dharmendra Pradhan here today. Various issues pertaining to collaboration between the two countries in the field of vocational education and skill development were discussed. The Minister of Belarus highlighted the expertise of his country in the field of vocational training, with special reference to the manufacturing sector. He also highlighted the training institutes which have been developed to impart training for maintenance and repair of Electronic Vehicles (EVs). Minister of Petroleum & Natural Gas and Skill Development & Entrepreneurship highlighted the aspect of creating an Eco-system of trainers for which 50 existing institutes in India are being upgraded. Assistance of Belarus will be invaluable in converting such institutions into centres for global excellence. The meeting ended with the both sides promising to continue the cooperative approach in the field of vocational and technical education and leverage their areas of strength.

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AYUSH Minister inaugurates India’s first advanced Homoeopathy Virology lab in Kolkata

New drugs and technologies will be developed in Homoeopathy to combat emerging challenges of viral diseases: Shri Shripad Naik

The Union Minister of State for AYUSH (Independent Charge) Shri Shripad Yesso Naik inaugurated India’s first State of art virology laboratory at Dr. Anjali Chatterjee Regional Research Institute for Homoeopathy in Kolkata today. In his inaugural address the Minister appreciated the popularity of Homoeopathy in West Bengal. Shri Naik said that this laboratory has been established to develop new drugs and technologies in Homoeopathy to combat emerging challenges of viral diseases. In this context the Minister expressed his satisfaction of recognising this laboratory by the Calcutta University to undertake research work of the PhD students in Homoeopathy.

The laboratory, established at a cost of Rs. 8 crore is the only one in India for conducting basic and fundamental research in Homoeopathy for viral diseases like influenza, Japanese encephalitis, dengue, chickunguniya and swine flu. New drugs and technologies would also be developed here to combat emerging challenges of viral diseases.

The AYUSH Minister also appreciated efforts of the National Institute of Homoeopathy (NIH), Kolkata which is imparting higher education and training in homoeopathy under the Ministry of AYUSH and urged that both the institutes could forge an active collaboration on practical training to the students and research scholars in virus research, both in laboratory and in the field jointly.

Shri Shripad Naik expressed happiness over Council’s initiatives of establishing a Centre of Excellence in Fundamental Research in Homoeopathy at IIEST, Howrah to undertake fundamental research studies in homoeopathy with an interdisciplinary approach. This institute has undertaken several clinical research studies like autism, psoriasis, vitiligo, breast cancer, hypertension, migraine etc along with proving of new drugs in homoeopathy with their clinical validations. About 400 patients are being treated daily through OPD services and AYUSH outreach services being provided in villages too.

Dr. V.K. Gupta, Chairman Scientific Advisory Committee, CCRH, New Delhi, Prof. Ajoy Kumar Roy, Director, IIEST, Shibpur, Dr. Rathin Chakravarty, Member, Scientific Advisory Committee, CCRH, New Delhi, Dr. Raj K. Manchanda, Director General, CCRH, New Delhi among eminent scientists were also present on the occasion.

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Cabinet approves MoU between India and Morocco on cooperation in the field of health

Cabinet approves MoU between India and Morocco on cooperation in the field of health

The Union Cabinet chaired by the Prime Minister Shri Narendra Modi has given its approval for signing of a Memorandum of Understanding (MoU) between India and Morocco on cooperation in the field of health.

The MoU covers the following areas of cooperation:-

i) Non-communicable diseases, including child cardiovascular diseases and cancer;

ii) Drug Regulation and Pharmaceutical quality control;

iii) Communicable Diseases;

iv) Maternal, child and neonatal health;

v) Hospital twinning for exchange of good practices;

vi) Training in administration and management of health services and Hospitals;

vii) Any other area of cooperation as may be mutually decided upon.

A Working Group will be set up to further elaborate the details of cooperation and to oversee the implementation of this MoU.

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Varsities can now seek ‘eminence’ status

The University Grants Commission on Tuesday announced the beginning of a 90-day application process for universities — public and private — to seek the status of institutions of eminence, which will provide them freedom from the regular regulatory mechanisms.

Twenty institutions — 10 public and 10 private — will be given this status with the aim to give them freedom to become world-class institutions.

Global rankings

The 10 state-run institutions will have an additional benefit — provision of Rs. 10,000 crore over a period of 10 years, over and above the regular grants. The aim of the scheme is to help institutions break into the top 500 global rankings in 10 years, and then break into the top 100 over time.

By March-April 2018, the chosen institutions will be accorded the status of “Institutions of Eminence” with a mandate to achieve world-class status over 10 years.

“The institutions which can apply are divided into three categories — existing government educational institutions, existing private higher educational institutions and sponsoring organisation for setting up of private institutions,” Kewal Kumar Sharma, Secretary (Higher Education), told reporters.

Institutions in the top 50 of the National Institute Ranking Framework rankings or those who have secured ranking among top 500 of the Times Higher Education World University Rankings, QS University Rankings or Shanghai Ranking Academic Ranking of World Universities are eligible to apply. “The mission is to set up universities with all-India character and with international standards. For a large country like India the possibility of providing globally recognised best education is what we are trying to create,” said Mr. Sharma.

The HRD Ministry will set up an empowered expert committee to process the applications.

(With PTI inputs)

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Govt. puts 1,200 NGOs on notice

The Home Ministry has sent notices to over 1,200 NGOs, asking them to validate the designated bank accounts in which they receive foreign contribution, failure of which will invite punitive action, a Ministry circular said.

The list includes Sri Ramakrishna Math, Ramakrishna Mission, Indore Cancer Foundation Charitable Trust, Coimbatore Christian Charitable Trust, Delhi School Of Social Work Society, Hindu Anath Ashram and Madani Darut Tarbiyat.

In a circular, the Ministry said all NGOs registered under the Foreign Contribution Regulation Act (FCRA) should receive foreign donations in a single designated bank account.

Compliance issue

“However, it is seen that a number of such organisations have not validated their foreign contribution designated accounts, causing problems for the banks to comply with the FCRA provisions that they [banks] report to the Central government within 48 hours of such receipt or utilisation of foreign contribution,” the circular read.

These associations are required to validate their foreign designated accounts and also the utilisation accounts immediately and send the details, including the bank branch, code, account number, IFSC code and so on through FC 6 form which is available on https://fcraonline.nic.in, the circular said.

“Non-compliance may lead to penal actions as per FCRA 2010,” it said.

A few others NGOs named are Rehmat E Alam Hospital Trust Anantanag, Rotary Club of Mumbai Midwest, JK Trust, Bombay, Goonj, Madina Education and Charitable Society, Nagaland Bible College and the Indian Institute for Nature and Environment Study.

The Modi government, which has tightened the rules for NGOs, has already cancelled the registration of more than 10,000 of them in the past three years for alleged non-filing of annual returns as mandated in the FCRA. In addition, licences of more than 1,300 NGOs were not renewed or were closed in the recent past for allegedly violating various provisions of the FCRA.

Nearly 6,000 NGOs have been asked to open their accounts in banks having core banking facilities.

FCRA-registered NGOs should receive donations in a single bank account

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Tall claims on killing tuberculosis

Earlier this week, the World Health Organization (WHO) said it was ready to assist the Indian government in reaching the target of eliminating tuberculosis by 2025.

This means it will help India reduce its annual count of new infections from 2.8 million to 140,000, or by an unprecedented 95%. Not only does India shoulder the highest TB burden in the world with over two million of the 10 million cases reported here, it also accounts for the maximum drug-resistant (DR) patients — nearly 130,000 people do not respond to first-line drugs.

To call the target ambitious would incorrectly imply that India has a shot at achieving this goal, if all resources were poured into the programme. The target is not ambitious. It is either pure rhetoric or, more disturbingly, completely lacking in understanding of ground realities.

Paucity of medicines

Even if the national TB programme were modernised overnight, budgets increased and human resources and diagnostic facilities made available, there is still one massive, glaring hole in the government's strategy: there are no medicines.

According to the Health Ministry, over 100,000 patients are annually infected with DR-TB in India. In most cases, they need two drugs: delamanid and bedaquiline. Delamanid, a new class of drug to treat multidrug-resistant TB, received the Drug Controller General's approval in August. However, it is not yet available to patients in India. Further, the government has, so far, not put forward a plan to rapidly scale up production of the drug.

Bedaquiline has been available in India since February 2016, with caveats. It came as a donation from USAID (United States Agency for International Development) on behalf of the American pharmaceutical company Janssen and was limited to patients living in a five-kilometre radius of six designated hospitals.

Earlier this year, an 18-year-old from Patna, with severe DR-TB and unable to access bedaquiline, successfully sued the government in the Delhi High Court to access the medicine. While the case opened doors for other DR-TB patients not meeting domicile requirements, the government hasn't procured enough medicines to match the disease burden. As of now, India has 3,500 courses of bedaquiline and 400 courses of delaminid — both donations from USAID and Japanese pharmaceutical company Otsuka, respectively — to treat nearly 100,000 patients who are resistant to first-line medicines.

Onus on the government

This week, 69 organisations comprising affected communities wrote to Prime Minister Narendra Modi, marking the letter to officials involved in the Health Ministry's TB programme. The letter notes "with alarm" that the slow progression of delamanid roll-out was an "unconscionable delay" on the part of the government. The patient community pointed out that delamanid has been available in the European Union and Japan for over three years.

In 2015, a Joint Monitoring Mission report pointed out that India's TB targets were failing due to two key issues: the government's inability to ensure early diagnosis and provide universal access to treatment to those diagnosed.

India's response to its TB epidemic is now the world's problem after WHO had to revise global TB

estimates in 2016 to 10.4 million people infected — a jump of 500,000 from 2014 — after India informed WHO that it had been under-reporting TB cases from 2000 to 2015. While the Health Ministry is making the right noises about the urgency to respond to TB, patients and experts maintain that it is not putting its money where its mouth is. If the government is serious, it should ensure domestic production of delamanid and bedaquiline instead of running national programmes based on donations.

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

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

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The encephalitis challenge

Barely a month before the deaths of children in Gorakhpur in Uttar Pradesh, allegedly due to the disruption of oxygen supply in the BRD Medical College, the U.P. Health Minister had addressed a consultation in Lucknow organised by the Observer Research Foundation. He admitted that U.P.'s health system was in the "ICU", and said he was trying hard to fix it. Only the local media reported this. It is a fact that U.P. has a problem: many of the children who died were being treated for acute encephalitis syndrome (AES), including Japanese encephalitis (JE).

The BRD Medical College, with around 800 beds, provides tertiary health-care services to Gorakhpur and adjoining districts. It is the only tertiary hospital within a 300-km radius. On September 4, 2016, it was reported that 224 children had died of encephalitis in the hospital that year. This hardly made national news. The shocking fact is that if there was no alleged disruption of oxygen supply, the national media and policy experts would not be discussing Gorakhpur now.

In U.P., an outbreak of JE has occurred almost every year in four districts between 1978 and 2007, according to research published by the World Health Organisation. Various U.P. governments have set up special wards and set aside specialist doctors for treating the disease. Studies show that in Gorakhpur, incidence of JE has declined from 1.9 per 100,000 in 2010 to 0.5 per 100,000 in 2012, whereas the incidence of JE-negative AES, which is causing a majority of the deaths now, has remained relatively stable over the past five years.

From 2006, the Central government has been conducting vaccination drives in endemic areas of JE. In 2011, the JE vaccine was included in the universal immunisation programme (UIP). While an indigenous vaccine was licensed in India in 2013, a Chinese variant was made part of the UIP because of cost considerations. Under the UIP, two doses of JE vaccine are administered to children. However, a study published in the *Indian Journal of Medical Research* showed that only three out of four children in Gorakhpur had received at least one dose of JE vaccine. The coverage of the second dose was low. Failure to administer the vaccine simultaneously with other vaccines was the most common reason for the lack of coverage and has led to many deaths. To expand coverage, adult JE vaccination was introduced in 2014 in high-burden districts of U.P.

Mass awareness and door-to-door campaigns in districts severely affected by encephalitis, about the causes of the disease and ways of prevention, should be a priority. A study specific to Gorakhpur had suggested a possibility of faecal-oral transmission of the virus by contaminated drinking water. Sanitation, mosquito control, prevention of open defecation, and ensuring clean drinking water can help prevent an outbreak.

The State government needs to allot maximum funds to those districts most affected by encephalitis. More infrastructure is required in Gorakhpur. Perhaps cost-effective PPP models could also be explored to not just reach out, but also conduct research. Some studies suggest that scrub typhus may have some role in JE-negative AES deaths in Gorakhpur; this needs to be looked into. All this has budget implications. Unfortunately, reports indicate that the Central government released only 68% of budgeted funds for communicable diseases, and an even smaller percentage was utilised. Shockingly, the spending capacity of the health system has proven to be a major bottleneck in U.P. Research shows that in 2015-16, U.P. could spend only 58% of the approved National Rural Health Mission budget.

Encephalitis is a predictable disaster. Its transmission intensifies during the rainy season, during the pre-harvest period in paddy-cultivating regions, and in flood-prone districts. U.P. can learn from other States that have a similar risk profile and that have managed to keep JE/AES mortality in control.

Any substantial developmental goal that India has to achieve needs to be achieved by U.P. first, given the size of the State. It is important that the ruling party works towards building a multipartisan consensus around vital issues like health, so that there is policy focus and such instances of health system paralysis are minimal. Incidents like Gorakhpur are an acute manifestation of chronic, systemic problems of the health sector, and the responsibility to improve things at the earliest lies with the government.

Priyanka Chaturvedi is a national spokesperson of the Congress. Oommen C. Kurian is a Research Fellow at the Observer Research Foundation, New Delhi

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

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Restructuring the Medical Council of India to eliminate corruption

The Medical Council of India (MCI) has been repeatedly criticized for providing opaque accreditation to aspiring medical colleges in India. Many of its members have been accused of taking bribes in order to fast-track accreditation. Bribes reduce the legitimacy of all accredited colleges and thereby compromise medical college quality overall in the country. Considering India's dearth of medical professionals, quality medical colleges are needed to fill the growing healthcare shortages.

Experts at NITI Aayog have proposed replacing the compromised MCI with a new National Medical Commission (NMC), outlined in a draft Bill known as the National Medical Commission Bill of 2016. In a new research paper, we look into this proposed Bill and suggest recommendations that would raise the integrity and overall quality of accreditation of medical education in India.

According to the World Directory of Medical Schools, in 2016, India, with 343 medical colleges, had the largest number of operational allopathic medical schools in the world. Brazil, was a distant second, with 193 medical colleges, and China, with a population comparable to India's, had less than half the number. Our analysis indicates that within the next three years, 76 new medical colleges will gain the "recognized" status from the MCI. It is imperative that India ensures that all these medical colleges meet a basic minimum quality standard.

Structural differences between the proposed NMC and MCI are enormous. The NMC would split the selection, advising, and actual accreditation process into three separate boards. By dividing power, the hope is to create a system of checks and balances. However, as per the current Bill, all members of the accreditation board are supposed to be ex-officio members of the advisory board. This defies the logic of good governance. Instead of creating different boards to watch and observe each other, the NMC would instead create a pair of Siamese twins—two different heads, but for the most part, a single potentially corrupt body. For this reason, we recommend removing all members of the accreditation board from the advisory board.

The accreditation board is not given direct jurisdiction over the accreditation process. Rather, it is given authority over four sub-boards that look into the four core areas of accreditation: undergraduate, postgraduate (PG), registrar of medical professionals, and compliance. The compliance wing is supposed to hire a third party to check that colleges meet standards set by the other sub-boards. We believe that the monopolistic nature of this service will produce unnecessary bureaucracy, stifle smooth accreditation and possibly raise the spectre of the old MCI all over again. In its stead, we recommend the creation of four regional medical councils. Creating these regional options will lead to competition and an increase in the quality of accreditation services overall. There already exist state medical councils which can be combined for the purpose. There is a great deal of variation in the quality of state medical councils across states. Competition for the accreditation business could ignite life into these bodies.

The World Health Organization has put out several drafts on standards for basic medical education, postgraduate medical education (PME), and continuing professional development. We believe the NMC would greatly benefit from being tied to these best practices. Countries like China and Thailand have already done so to the benefit of their medical education establishment. Although the standards set by the PME call for schools to balance teaching and research, the Bill needs to incentivize research. The dean of Ganga Ram Institute of Medical Education and Research found that the faculty at over 57% of medical colleges in India have published no peer-reviewed articles. Research is fundamental to PG medical education. The PG sub-board should only accredit schools that establish a research-based hierarchy for its faculty and assess students on their research.

The current MCI rules and guidelines prohibit qualified MBBS doctors without a PG degree from performing procedures such as ultrasound and interpreting chest X-rays. The NMC should revisit these rigid regulations to raise the effective availability of qualified doctors in India.

The other factor contributing to the shortage of medical doctors is the emigration of physicians. India is the largest source of physicians in the US and the UK, and the second and third largest in Australia and Canada. This brain drain is especially expensive because many of them are trained in colleges subsidized by the government. It is within the purview of the NMC Bill to recommend a policy to limit emigration of newly graduated doctors. Thailand successfully adopted such a measure in 1972. Their policy mandates three years of government work for all post-graduates. The first year is spent in provincial hospitals, while the second and third years are spent in rural or community hospitals. Statistical evidence indicates that this policy limited brain drain, and reduced medical professional density disparity between rural and urban areas. Closer home, Kerala implemented compulsory rural service for all MBBS and PG doctors studying in government medical colleges as a part of Arogyakeralam, its version of the National Rural Health Mission.

Shamika Ravi is a senior fellow at Brookings India.

This is the first in a four-part series on reforms in the healthcare sector.

Comments are welcome at theirview@livemint.com

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First ever National Conference on “Mission Mode to address Under-Nutrition” to be held in New Delhi tomorrow

First ever National Conference on “Mission Mode to address Under-Nutrition” to be held in New Delhi tomorrow

Three States to be awarded for reducing prevalence of stunting in population

The Ministry of Women and Child Development will hold the first ever National Conference in New Delhi tomorrow on *Mission Mode to address Under-Nutrition* in the country. In his curtain raiser briefing in New Delhi today, the Secretary WCD, Shri Rakesh Srivastava said that this conference is being organized by the Ministry of Women & Child Development in collaboration with Ministry of Drinking Water and Sanitation and Ministry of Health & Family Welfare, keeping in mind the goal of **“Malnutrition Free India-2022”**.

Giving details about the conference, the Secretary WCD said that the Government has decided to lay focused attention on this issue and for this said purpose, Ministry of Women and Child Development has identified 113 districts across the States/UTs based on the composite index of NITI Ayong and prevelance of stunting from NFHS-4 data. At least one district has been selected from each State/UTs so that the action taken in the selected district can be emulated in the other districts also, he explained.

Shri Srivastava said that the National Conference, first of its kind, aims at bringing convergence at District/Block levels of the three key Departments (Health & Family Welfare, ICDS/Social Welfare and Drinking Water and Sanitation) wherein a roadmap would be drawn to evolve an appropriate strategy in tackling the problem of stunting, under-nutrition and wasting comprehensively and conclusively.

The conference would be sensitizing the District Collectors/Deputy Commissioners/District Magistrates as well as the District-level officers of Health & Family Welfare, Nutrition (ICDS/SW), Drinking Water & Sanitation Departments in the 113 High Burden Districts along with the Principal Secretaries/Secretaries, in-charge of these three Departments of all States/UTs on a multitude of topics relating to stunting, under-nutrition and wasting and the key strategic interventions which are urgently required.

The District Magistrates/District Collectors/Deputy Commissioners in these 113 high burden districts, through a dashboard, will regularly monitor and review the schemes

covering the aspects of nutrition across the line departments within their jurisdiction at least once in a three month period. Such a review and monitoring at district level would be done in an exclusively and dedicated manner (between 1st to 10th of January, April, July and October every year) to address implementation of schemes having a direct bearing on nutrition and Health.

Shri Rakesh Srivastava said that three States will be awarded at the conference tomorrow. These three states will be awarded for showing good progress in the area of reduction in stunting as measured between NFHS-3 and NFHS-4. These States are Chattisgarh, Arunachal Pradesh and Gujarat.

Joint Secretary WCD, Dr. Rajesh Kumar said that several important steps have already been taken by the WCD Ministry recently for a multipronged strategy to manage malnutrition. This includes training ICDS functionaries, developing a curriculum for ECCE, food fortification guidelines among others. He further stated that the WCD Ministry has developed a world class software 'ICDS-CAS' for real time monitoring of nutrition related parameters in 8 States. This system is one of its kind in the world and 60,000 Anganwadis have already been given tablets to report growth parameters on a daily basis with the help of this system, Dr. Rajesh Kumar explained.

The problem of malnutrition is inter-generational and is dependent on multiple factors which inter-alia, include proper Infant & Young Child Feeding (IYCF) practices, Immunization, Institutional Delivery, Early Childhood Development, Food Fortification, Deworming, access to safe drinking water & proper sanitation (WASH), Dietary diversification, full ANC checkup, early initiation of breast feeding, ICT enabled real time monitoring and implementation of Anganwadi Services, Improving infrastructure of Anganwadi Centres along with training of Anganwadi workers and other related factors. These factors can also be Area specific or dependent on particular geographical conditions. Further, it requires a convergent approach among all the three departments i.e. Health & Family Welfare, ICDS/Social Welfare and Drinking Water and Sanitation to tackle the issue of malnutrition comprehensively and conclusively.

Some of the important sessions at tomorrow's conference include efficacy of food fortification, sustainable solution through breast feeding, dietary diversification, improving maternal & child health through Mission Indradhanush, improving program delivery effectiveness, accelerating Real Time Monitoring among others.

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Singapore to set up Skill Center in Northeast: Dr Jitendra Singh

Singapore to set up Skill Center in Northeast: Dr Jitendra Singh

The Government of Singapore will set up a Skill Center at Guwahati which will cater to the entire North-Eastern region. This was stated here by Union Minister of State (Independent Charge) of the Ministry of Development of North Eastern Region (DoNER), MoS PMO, Personnel, Public Grievances & Pensions, Atomic Energy and Space, Dr Jitendra Singh after a meeting with a high-level delegation represented by the High Commissioner of Singapore, Mr Lim Thuan Kuan here yesterday. The Indian side led by Dr Jitendra Singh, consisted of senior officers from the Ministry of DoNER, Department of Space and Ministry of Personnel, Public Grievances & Pensions, which are the three main areas where Singapore has expressed its keenness to collaborate with India.

As far as Skill Centre at Guwahati, it was stated that an MoU has already been formalized between Singapore and the State Government of Assam. As a follow-up to this, a Skill Center is proposed to be set up at Guwahati by the year 2019 and the Ministry of DoNER will coordinate in this initiative.

The Singapore delegation also expressed its preference to engage with India in the area of Space Technology for collaboration in “peaceful uses of Outer Space”. To this, Dr Jitendra Singh said that the issue will be followed up in an appropriate manner.

The Singapore delegation also wanted to seek the experience and expertise of India's Ministry of Personnel, Public Grievances & Pensions to bring about value addition in public administration and governance in Singapore. Dr Jitendra Singh shared with them that there already exists an arrangement between Lal Bahadur Shastri National Academy of Administration (LBSNAA) Mussoorie with Singapore, wherein a certain number of passing out Civil Services/IAS officers, accompanied by two faculty members, regularly undertake a visit to Singapore.

Dr Jitendra Singh said, India and Singapore have always been favourably inclined towards each other and referred to the recent visit of the Deputy Prime Minister of Singapore when a stimulating lecture by him was organized under the auspices of the NITI Aayog.

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What Uttar Pradesh tells us about health infrastructure

The death of children in the recent Gorakhpur tragedy has drawn significant attention towards the state of public health institutions in Uttar Pradesh (UP). While much of the focus remained only on Gorakhpur, our analysis shows that within the state, the public health infrastructure is far worse than Gorakhpur in most districts. We have developed an index of public health infrastructure for each district of India by combining measures of quantity and quality of public health infrastructure available. According to this index, Gorakhpur ranks 19 out of 71 districts (census 2011) in Uttar Pradesh. This implies that the disease in the public health system of UP is much worse than symptoms like Gorakhpur reveal.

In our index, we combine information on quantity and quality of public health infrastructure. For measures of quantity, we use actual availability of sub-centres (SC), primary health centres (PHCs), community health centres (CHCs), sub-division hospitals and district hospitals in the district. Additionally, we also use distance to nearest SC, PHC and CHC from each village within the district. There are clear benchmarks for provision of public health infrastructure based on population. Against these benchmarks, government data shows that UP has a shortage of 33% SCs and 35% PHCs. Gorakhpur is significantly better than the state average in this regard.

In terms of CHCs, however, there is an obvious red flag that emerges for UP. The state has a suspicious surplus of 190% CHCs compared to what is required. The data shows that most of these CHCs were constructed in 2014 and 2015. Further scrutiny shows that these CHCs have a severe shortage of human resources and basic infrastructure. Less than half these CHCs have a functioning X-ray machine. Fundamentally, this suggests gross misallocation of resources and wastage of public funds.

The picture looks grimmer when we consider the drastic shortage of human resources and basic infrastructure required to run public health institutions effectively. The data from the government's Rural Health Statistics—2016 shows that there is an overall 84% shortage of specialists, 77% shortage of lab technicians and 89% shortage of radiographers in the CHCs of UP. There are similar shortages in SCs and PHCs in the state as well. Almost 91% of the PHCs do not have a lady doctor on duty and 60% do not have a functional operation theatre. Many of the PHCs and CHCs do not have regular supply of drugs for common ailments. The data shows that one of the leading causes of death in UP is diarrhoeal diseases. This raises concern about the ability of the public health institutions to treat common ailments such as diarrhoea.

UP, Bihar, and Jharkhand are the lowest ranked states in terms of overall quantity and quality of public health infrastructure in India. It is striking that the worst performing districts of Chhattisgarh, which is ranked second among the 21 big states, are comparable to the best performing districts of UP, Bihar and Jharkhand. This disparity across states might have several underlying causes but it also reflects systematic neglect of public health in some states. UP's per capita public spending on healthcare in 2015-16 was less than half of Chhattisgarh's. Moreover, within UP, some districts such as Kushinagar have hardly any rural health facilities at all. Citizens probably need to travel to nearby districts for most basic healthcare.

In the overall ranking, the top 5 states are Jammu and Kashmir, Chhattisgarh, Gujarat, Karnataka and Rajasthan, while the worst six states are Bihar, Jharkhand, UP, West Bengal, Odisha and Haryana. Disaggregating the data further shows that while Gujarat has relatively lesser quantity of public health infrastructure than Kerala, it has significantly higher quality as measured by availability of doctors, nurses, supply of drugs, etc. This makes the overall condition of public health infrastructure of Gujarat superior to Kerala. Similarly, Delhi has more public health infrastructure than most states, but the relative quality is poorer than several large states.

The lesson of the story is that healthcare cannot be about real estate and construction alone. While there has been a massive drive to expand the quantity of public health infrastructure in India, particularly in rural areas, the focus must urgently shift to staffing of doctors, nurses, technicians, availability and maintenance of equipment and supply of drugs. The long-term quality of local public health infrastructure will also be fundamentally determined by the governance reforms that we introduce in this sector.

Health being a state subject offers great opportunities for experimentation in this regard. For instance, some states have chosen to empower their medical officers. These states, for example Kerala, have given greater authority for decision-making to their medical officers and also, therefore, hold them more accountable. In many parts of India, however, most local decisions are routed through the district magistrate's office. This is inefficient and undesirable for sustained improvement of public health institutions in these states. There are several such examples of good governance and best practices available within the country and that could be adopted by the states that are struggling with the knotty problem of poor public health systems.

Shamika Ravi and Mudit Kapoor are, respectively, senior fellow at Brookings India and associate professor of economics at the Indian Statistical Institute in New Delhi.

This is the second in a four-part series on reforms in the healthcare sector. To read the first part, 'Restructuring the Medical Council of India to eliminate corruption', click here.

Comments are welcome at theirview@livemint.com

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Cabinet approves increase of cost norms for Supplementary Nutrition provided in Anganwadis and in the Scheme for Adolescent Girls

Cabinet approves increase of cost norms for Supplementary Nutrition provided in Anganwadis and in the Scheme for Adolescent Girls

Cabinet also approves annual cost indexation for increase in rates in future

Government will, over the next three years, invest an additional Rs. 12,000 crore for the nutrition of pregnant and lactating women, children in the age group of 0-6 years, and out of school adolescent girls

The Cabinet Committee on Economic Affairs chaired by the Prime Minister Shri Narendra Modi, has approved the proposal for revision of cost norms with annual cost indexation for Supplementary Nutrition (SN) for the beneficiaries of Anganwadi Services and Adolescent Girls (out of school 11-14 years) under the Umbrella ICDS Scheme. This addresses a long standing anomaly and ensures that the changes in norms keeps pace with changes in costs on an annual basis.

This follows the decision by the Government to provide cash benefits to pregnant and lactating mothers under the Pradhan Mantri Matru Vandana Yojana, and is part of an intensive effort to improve the nutritional status of women and children.

The revised Supplementary Nutrition cost norms for the beneficiaries of Anganwadi Services and for Adolescent Girls (11-14 years out of school) under the Umbrella ICDS Scheme, as approved by the Government are as under:

S.No.	Category	Existing Rate Rs./day/beneficiary	Revised Rates Rs./day/beneficiary
1	Children (6-72 months)	Rs.6.00	Rs.8.00
2	Pregnant Women & Lactating Mothers (PW&LM)	Rs.7.00	Rs.9.50
3	Severely Malnourished	Rs.9.00	Rs.12.00
4	Adolescent Girls (11-14 years out of school)	Rs.5.00	Rs.9.50

The revision of cost norms for SN for beneficiaries of Aanganwadi Services would cost additional expenditure of Rs.9,900 crore and for beneficiaries of Adolescent Girls, it would cost Rs.2,267.18 crore as GoI share for a period from 2017-18 to 2019-20.

The revision in the cost norms of SN for the beneficiaries of Anganwadi Services and Adolescent Girls would impact the health and nutritional status of about 11 crore beneficiaries per annum.

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Who knew healthcare was so complex

The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design.” —F.A. Hayek, *The Fatal Conceit: The Errors Of Socialism*.

NITI Aayog’s recommendation to improve access, reduce out-of-pocket expenditure, create infrastructure and augment capacity at district hospitals for non-communicable diseases (NCDs), is urgent and necessary. It deserves credit for recognizing that the public sector does not have the wherewithal to meet the NCD challenge and that the private sector is needed to address this gap. We highlight some remaining concerns.

The NITI Aayog’s solution is to incentivize the private sector via public private partnerships (PPPs), wherein the government provides land, infrastructure, capital for viability gap funding, and patients via referrals from public screening programmes. In return, the government fixes the price of basic services to ensure a reasonable rate of return. The delivery, quality and governance of the PPPs is monitored by the project steering committee, contracts management cell and project coordination committee, etc.

The first assumption here is that if sufficient incentive were provided to the private sector, through land and capital, then it would earn a reasonable return on equity and decide to enter. If so, then why not have a simpler policy: Earmark some land (within district hospital or outside) and provide subsidized capital to anyone who wants to enter these markets, and let market forces determine winners.

There are large fixed costs (and regulatory requirements), which are entry barriers, but provide reasonable returns to those who choose to enter. Here, patients will have choice, and competition will ensure that the most efficient players survive. Under the existing proposal, the selection, monitoring, evaluation, and governance of private players is done by the government.

Such a system suffers from two challenges: (1) It creates rent-seeking opportunities, which will adversely affect quality and quantity of care. It will attract private players with the greatest capacity to manipulate the system and not necessarily the most efficient ones. (2) In a competitive environment, performance of a firm changes over time depending on new and better management practices and technology. Firms with dynamic efficiency survive, while others stagnate. Under this proposal, however, the Herculean task of collecting continuous information on best practices, latest technology, quality of care improvements and cost reduction is left to government representatives. This is an impossible task.

The second challenge relates to tariff, which is non-negotiable and fixed by government. The biggest constraint in expanding health services is shortage of qualified human resources like onco-surgeon, clinical cardiologist and specialized nurses. These services are in high demand in big cities. In addition to higher salaries, there are large differences in quality of life between tier 1 and smaller cities. To induce migration from metros to smaller cities, private players will have to pay higher compensation. With fixed tariffs, this lowers profitability of the venture. For viability, there will be cost-cutting, potentially lowering the quality and quantity of care.

The third challenge relates to key performance indicators (KPIs), in particular, quality of care. Unfortunately, riskiness of patients is not considered while assessing quality of care. This will create two tiers of patients: (a) risky patients who are economically costlier than (b) non-risky patients who have fewer unscheduled visits and returns to operation theatre, etc. If payment is linked to KPIs, which are not adjusted for risk, then private players are disincentivized from treating risky patients while over-treating safer patients. There are also agency problems where

the doctor's interest is not aligned with that of the patient. Due to lower profits, doctors avoid treating riskier patients while over-treating safer patients by performing unnecessary procedures. This is a serious concern; for example, the latest National Family Health Survey shows that private hospitals carried out 41% caesarian sections as compared to 12% in government hospitals.

The fourth challenge relates to payments, which creates three types of patients: government-sponsored, self-paying, and patients insured under government schemes. Tariff for each patient is uniform and fixed but the economic cost varies. Government-sponsored patients are more expensive because 70% of their payment is released within 30 days while 30% is released within 45 days after "due diligence". There are several ways for government representatives, with no skin in the game, to hold up payments. For self-paying patients, funds are transferred within 15 days of receipt. Facilities, therefore, prefer self-paying patients and are reluctant to provide the same level of services to government-sponsored patients who are typically poorer. Private hospitals in Delhi have reserved beds for poor patients in lieu of subsidized land given by government. What is the evidence from this earlier version of PPP? We must check occupancy rates of reserved beds and the poor's access to these facilities. The NITI Aayog has made a promising start, but must address these challenges. It would be *fatal conceit* to believe in simple solutions to complex problems.

This is the third article in a four-part series on reforms in the healthcare sector.

Part 1: Restructuring the Medical Council of India to eliminate corruption

Part 2: What Uttar Pradesh tells us about health infrastructure

Mudit Kapoor and Shamika Ravi are, respectively, associate professor of economics at the Indian Statistical Institute in New Delhi, and senior fellow at Brookings India.

Comments are welcome at theirview@livemint.com

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The need for reforms in healthcare finance

The Centre and state governments are experimenting with several new and exciting ideas in healthcare reforms. What is missing, however, is a serious reform agenda for health financing. The last big reform was expanding the coverage of the Rashtriya Swasthya Bima Yojana (RSBY) from Rs30,000 to Rs1 lakh, reinforcing insurance as the long-term strategy for health financing. However, the experience of several countries has revealed that this is a perilous path—taking India towards a bad equilibrium. Depending on the route, India could end up spending either 18% of its gross domestic product (GDP) on health like the US or just 4% like Singapore to achieve similar outcomes.

The current “system” of health financing is largely out-of-pocket payments, with tax breaks provided for health insurance. The National Sample Survey data shows that Indian households are increasingly relying on their own income and drawing down their savings to finance healthcare expenses. This holds true for both rural and urban households.

Between 2007 and 2010, several state governments in south India adopted publicly funded insurance models for secondary and tertiary care for the poor, and the national government followed with the RSBY in 2008. Data for health insurance coverage shows that while private health insurance is largely limited to the richer urban households, in contrast, public insurance coverage is evenly distributed across all quintile groups of the population.

However, these public health insurance schemes have not been associated with lower health burden for the average household as measured by total real out-of-pocket health expenditure, catastrophic health expenditure or impoverishment caused by health expenses.

The overall out-of-pocket spending for households has risen significantly since 2005. This is mostly from a rise in inpatient department expenses because outpatient department spending has not changed much since then. The data also shows a significant increase in use of services associated with insurance, and in particular a significant increase in hospitalization. While this could mean that people suffering from ailments are more likely to be treated if they are covered by insurance, it could also mean that insurance schemes are being designed to incentivise hospitalization. This could potentially explain the massive increase in Caesarean section deliveries in India over the last 15 years.

An added concern is that the extreme poor households do not use their health insurance coverage given their low financial literacy and awareness. This is reflected in the low claims to coverage ratio for extreme poor households. This is ironic because most government-funded health insurance schemes are aimed at these groups.

Insurance is widely recognized as a poor model for healthcare financing because it suffers from serious information asymmetries. In a voluntary insurance market, there is an adverse selection problem where people who buy insurance on average are sicker than the average population. This makes the pool of insured more risky and thereby makes pricing of insurance difficult. Most developed countries have, therefore, made health insurance mandatory.

The other big worry is a moral hazard. Clients and doctors are incentivized to over-use facilities, thereby driving up health costs. Neither have the incentives to control costs, making the insurance system unsustainable. This is not to say that the problem is insurmountable. There are developed countries which have tax-funded, pay-as-you-go, single-payer systems where governments pay citizens’ healthcare costs. While most of these countries have well-run government systems, they are currently facing a sustainability crisis.

India’s poor record in healthcare governance inspires less confidence in its ability to successfully pull off a universal healthcare system with the government as the single payer. But this deserves a serious thought, given the transformational mood in the nation.

India must also be open to experimentation with newer products of healthcare financing. Medical savings accounts (MSAs) is one such product. Singapore adopted MSAs in 1984, and presents a success story. Its healthcare outcomes are comparable to most developed countries, while its spending is significantly lower. Following Singapore’s success, China has also adopted MSAs for urban areas. These are complemented by high deductible insurance (after a large amount has already been paid from the MSA) and a government fund to pay for those who cannot pay for themselves. Given India’s large population below and around the poverty line, it could do the same.

In healthcare, it is important to recognize that, even if one gets the financing model right, the sector remains labour-intensive with lower productivity growth. This means that when other sectors experience higher productivity growth, they can offer more competitive prices for land and human capital, which can be offset by productivity gains. In healthcare, there are no offsetting productivity gains. As a result, either the price of healthcare delivery goes up or quality falls. This is a long-term problem which the private sector and the government will have to grapple with perennially.

Shamika Ravi is senior fellow at Brookings India.

This is the last article in a four-part series on reforms in the healthcare sector.

Comments are welcome at theirview@livemint.com

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Government provides additional Rs.12000 Crores to tackle malnutrition

The Government has provided an additional Rs.12000 Crores to fight malnutrition over next three years in the country by revising cost norms for supplementary nutrition provided in anganwadis and in the scheme for adolescent girls. Briefing media persons in New Delhi today, Secretary, WCD Shri Rakesh Srivastava said that the government has effected a quantum increase of about 33% in cost norms, which have been revised for the first time since 2011 in the case of ICDS. In the case of Scheme for Adolescent Girls, cost norms have been increased first time since 2010. With this, an additional Rs.9900 Crore have been given for supplementary nutrition in anganwadis over the next three years and Rs.2276 Crores in the scheme for adolescent girls over the next three years, he explained. This reflects commitment of the government to tackle malnutrition on a war footing as reflected in Prime Minister Narendra Modi Ji's vision, Shri Srivastava said.

The cost norms have now also been linked to the Food Price Index which will enable the government to increase the cost norms annually without any hindrance. Shri Srivastava disclosed that in the recently held national conference on malnutrition, the district collectors and district magistrates have been asked to take responsibility for eliminating malnutrition in their districts. They have been asked to review comprehensively the nutrition/helath status of children and women once in three months and also ensure 2% to 3% decline in malnutrition/stunting per year.

The WCD Secretary announced that a separate policy/protocol for Severly Acute Malnourished Children will be released at the earliest to enable States to deal with this problem effectively.

The revised Supplementary Nutrition cost norms for the beneficiaries of Anganwadi Services and for Adolescent Girls (11-14 years out of school) under the Umbrella ICDS Scheme, as approved by the Government are as under:

S.No.	Category	Existing Rate Rs./day/beneficiary	Revised Rates Rs./day/beneficiary
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3	Severely Malnourished	Rs.9.00	Rs.12.00
4	Adolescent Girls (11-14 years out of school)	Rs.5.00	Rs.9.50

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NITI Aayog and Govt. of Assam organizes workshop on health sector reforms in Guwahati; launches SATH- Sustainable Action for Transforming Human Capital

The Department of Health and Family Welfare, Government of Assam and NITI Aayog organized a state consultative workshop today (September 22) in Guwahati. The consultation marked the launch of program called SATH- Sustainable Action for Transforming Human Capital, a joint initiative of Government of Assam and NITI Aayog, which aims to provide structured support to Assam in identifying key health priorities and implement the solutions towards transforming the health and improving the well-being of people of Assam.

The SATH program embodies the philosophy of co-operative federalism. NITI Aayog selected the three states through a three stage challenge-process – expression of interest, presentations by the states and assessment of commitment to health sector reforms. Finally, three states: Assam, Uttar Pradesh and Karnataka were chosen based on objective assessment criteria affecting the potential for impact and likelihood of success. A consortium of reputed technical consultants are closely working with NITI Aayog and the states to conceptualize the initiatives and provide support in the implementation process.

The reforms suggested through this workshop and the SATH program overall will follow a systems approach, rather than a systematic approach, and there will be focus on improving infrastructure and strengthening human resources to achieve our health objectives. This workshop was key to developing partnerships and bringing convergence among different stakeholders working towards the same goal of transforming health outcomes. The event saw participation of over 100 people including experts from development organizations such as World Bank, World Health Organization, UNDP, UNICEF and World Health Partners, officials, stakeholders and private partners from Assam's public health system, and healthcare representatives from several districts of Assam. While NITI will be an enabler, leaders from within the state system will be created. These leaders can be from any designation or position, but will be those who are committed to tangible change. The prosperity of Assam is key to a prosperous India in 2022, a critical milestone for achieving progress towards the United Nation's Sustainable Development Goals.

The workshop helped identify and build consensus on the priorities, which included strengthening of human resources, improving governance and performance management of the healthcare system, reducing maternal and child mortality especially in remote areas such as tea plantations, improving nutritional status to tackle preventable causes of morbidity and mortality and using health care technology for end-to-end strengthening of the health system. The action plans that were created on the priority themes in this workshop will be further detailed, planned implemented in the coming months as part of the SATH initiative.

The inaugural session included special addresses by senior dignitaries from the Government of Assam and NITI Aayog including: Shri Dr. Vinod Paul, Member, NITI Aayog, Shri Alok Kumar, Advisor, NITI Aayog, Shri Manoj Jhalani, Additional Secretary & Mission Director (NHM), Ministry of Health and Family Welfare and Shri V. B. Pyarelal, Additional Chief Secretary to the Government of Assam (Finance Department). The welcome note, agenda setting and vote of thanks were delivered by Shri Samir Kumar Sinha, Principal Secretary Health & Family Welfare, Government of Assam, Dr. R. Bhuyan, Director, Directorate of Health Services Assam and Shri

J.V.N. Subramanyam, IAS, Mission Director, National Health Mission Assam.

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Child mortality on the decline, says study

India's child mortality rate has always been a cause for concern, but a recent study published in the medical journal *Lancet* suggests that the situation may be changing for the better.

The study shows a significant decline in cause-specific child mortality rates between 2000 and 2015 in the country.

The faster declines in child mortality after 2005 (average annual decline of 3.4% for neonatal mortality and 5.9% for 1 to 59-month mortality) suggest that the country has avoided about one million more child deaths compared to the rates of progress in 2000–2005.

Premature births

However, on a sobering note, in the same period, deaths due to premature births or low birth weight rose from 12.3 per 1000 live births in 2000 to 14.3 per 1000 live births in 2015. The increase was driven mostly by more term births with low birth weight in poorer States and rural areas.

The Million Death Study titled "Changes in cause-specific neonatal and 1–59 month child mortality in India from 2000 to 2015: a nationally representative survey' was published online by the *Lancet* on September 19. The survey was led by Prof. Prabhat Jha from the Centre for Global Health Research at St Michael's Hospital in Toronto.

Taking note of the progress in three States during this period, the study says that "if all States of India had achieved the declines seen in Tamil Nadu, Karnataka, and Maharashtra, nearly all States of India would have met the 2015 Millennium Development Goals."

India's child mortality rate per thousand live births has fallen by 62% from 125 per thousand live births in 1990 to 47 per thousand live births in 2015. This is slightly less than the 2015 Millennium Development Goal of a 66% reduction.

Interpreting the outcome, the *Lancet* report said: "To meet the 2030 Sustainable Development Goals for child mortality, India will need to maintain the current trajectory of 1–59-month mortality and accelerate declines in neonatal mortality (to >5% annually) from 2015 onwards. Continued progress in reduction of child mortality due to pneumonia, diarrhoea, malaria, and measles at 1–59 months is feasible. Additional attention to low birth weight is required."

The study tracking 52,252 deaths in neonates and 42,057 deaths at 1–59 months has been funded by National Institutes of Health, Disease Control Priorities Network, Maternal and Child Epidemiology Estimation Group, and the University of Toronto.

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Drug-resistant bacteria emerge from drug companies' untreated effluents

Thanks to discharge of untreated effluents from pharmaceutical companies in Hyderabad, water bodies in and around the Patencheru-Bollaram Industrial area are contaminated with antibiotics and antifungal agents leading to the emergence of multidrug-resistant bacteria.

The bacteria from these water bodies have been found to produce enzymes such as extended spectrum beta-lactamases and carbapenemases which can protect them from antibiotics such as penicillin, cephalosporins, cephamycins, and carbapenems. The study was carried out by scientists from Leipzig University, Germany along with a Hyderabad-based NGO Gamana. The results were published in the journal *Infection*.

Polluted Patancheru

The Patencheru-Bollaram Industrial area, 32 km outside Hyderabad is a growing hub with over 100 industries and more than 30 pharmaceutical manufacturing companies.

Samples were collected from different water bodies — rivers, lakes, ground water, and water from sewage treatment plant to name a few — in the vicinity of the companies as well as from locations far away from the industrial area. All the 16 samples collected from the vicinity of the industrial area and 10 of 12 samples collected from distant locations were contaminated with antifungals and/or antibiotics.

The antifungal agent fluconazole was detected in 13 samples and one particular sewer in the vicinity of the industrial area showed levels as high as 20 times greater than therapeutically desired levels in blood in patients. According to the scientists, this is the highest concentration of any drug ever measured in the environment.

The other antiinfectives found in the waters included antifungal medicine voriconazole, medications for bacterial infections such as moxifloxacin, linezolid, levofloxacin, clarithromycin, ciprofloxacin, ampicillin, doxycycline, trimethoprim and sulfamethoxazole.

Monster microbes

The bacterial isolates from the different samples were tested for drug resistance. Except two samples taken from tap water away from the industrial area, the remaining samples showed bacteria containing drug-resistant genes.

Carbapenemase-producing enterobacteria and non-fermenting bacteria such as Acinetobacter and *Pseudomonas* species were found in more than 95% of all water samples collected. This finding further confirms previous studies that there is a strong association between drug pollution and presence of multidrug-resistant bacteria.

"The sewage treatment plant at Patancheru is ill equipped to treat pharmaceutical wastewater containing effluents with different chemical compositions. So it simply discharges it into the river. There have been complaints that they just mix household waste water from BHEL Township with these industrial effluents and discharge it into the river. As a result, the water in the Musi river has started to turn foamy," Mr. Anil Dayakar from Gamana NGO and one of the authors of the paper.

Despite the Supreme Court demanding last year that the industries in the Patencheru-Bollaram area should treat wastewater and reuse it, "massive violations" have been the norm.

“The ground water in this area is yellow. The villagers who live around this estate have many skin problems. Though there is a water treatment plant nearby, it is not really of use. Despite decades of campaigning by local NGOs the pollution has not been reduced. In 2009, the national pollution index classified this industrial area as ‘critically polluted,’” says Mr. Dayakar.

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

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

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Centre to fund social audit units under MGNREGA Scheme

NEW DELHI: The Centre has decided to bypass states and directly fund the social audit units under the MGNREGA, a first of its kind move aimed at securing an independent view on the implementation of its flagship rural employment guarantee scheme.

All states except Rajasthan, Maharashtra, Haryana, Goa and Jammu & Kashmir—where there is a BJP government or where the party is part of the ruling coalition— have set up social audit units.

"The social audit has to be done independent of the implementing authority. It goes beyond financial audit and brings greater transparency to the scheme," a senior government official said.

The rural development ministry has also informed the Supreme Court that the above mentioned states have not complied with the social audit requirements.

So far, Rs 118 crore has been released by the ministry to 24 states and union territories which have set up these centres and got the required personnel on board.

The Centre is also taking up the matter of social audit with the chief secretaries of the five states, which are yet to comply and put systems for proper evaluation and monitoring of the scheme.

Social audit is mandatory under the Mahatma Gandhi National Rural Employment Gurantee Act (MGNREGA). It involves a review of all official records of expenditure and an assessment of whether the states have reported all transactions correctly.

It is then followed by a public hearing where all findings are shared by the gram sabha.

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India and the United States Renew Commitment to Joint Collaboration on Health

Collaboration on research, global health security and access to medicines will benefit both countries

The second India-U.S. Health Dialogue (September 26-27, 2017) concluded in New Delhi today. The bilateral dialogue was jointly inaugurated by Shri C K Mishra, Secretary (MoHFW), Dr. Soumya Swaminathan, Secretary (DHR) and DG (ICMR), Mr. Garrett Grigsby, Director of Global Affairs at U.S. Department of Health and Human Services (HHS), and Mr. Mark Anthony White, Mission Director, India, U.S. Agency for International Development (USAID).

Representatives from the U.S. Department of Health and Human Services Office of Global Affairs (OGA/HHS), Centers for Disease Control and Prevention (CDC/HHS), Food and Drug Administration (FDA/HHS), National Institutes of Health (NIH/HHS) and USAID interacted with their counterparts from the Ministry of Health and Family Welfare (MoHFW), Ministry of Science and Technology (MoST), and Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) to encourage bilateral collaboration across several aspects of health pertinent to both nations.

Addressing the participants, Shri CK Mishra, Secretary (H&FW) said that "India and U.S. have a long history of health cooperation which has now started converging on the platform of the India-U.S. Health Dialogue. By institutionalizing the dialogue, we have reaffirmed our commitment to work together in the areas of health, for better addressing the health challenges faced by our people in both countries, such as cancer, R&D, communicable and non-communicable diseases, traditional medicines, access to medicines, food and drug regulation, antimicrobial resistance, etc. It is mutually beneficial for us to continue to engage on these and other health issues, to not only address our health challenges but to also, in the process, contribute to global health objectives and outcomes.” In its most comprehensive iteration yet, the 2nd Health Dialogue touched upon several issues of bilateral importance - communicable and non-communicable diseases, health systems, biomedical research and low-cost innovations, science and health data, food and drug regulations, traditional medicine and access to medicines. Participants reaffirmed the commitment to strengthen scientific, regulatory, and health cooperation between the two nations and the global community; highlight priorities and ongoing activities, and exchange information on policies, regulations, research, technologies, programs, activities, and practices. The final goal is to identify emerging areas of mutual interest and facilitate the development of new collaborations.

“Today’s India-U.S. Health Dialogue highlights the many areas of ongoing co-operation between India and the United States. These collaborations form a key part of our larger Strategic and Commercial Dialogue. Working together, we can tackle problems relevant to both our nations, such as global health security, research on understudied diseases, and access to medicines” said Mr. Garrett Grigsby, Director of Global Affairs at HHS.

In addition to the discussions at the Health Dialogue, the U.S. delegation visited several Indian institutes in New Delhi, Mumbai, and Bengaluru to highlight collaborations to control and manage HIV/AIDS, tuberculosis, antimicrobial resistance, cancer, acute encephalitis syndrome, mental health, vision and traditional medicine. The Health Dialogue's closing ceremony was attended by U.S. Charge D'Affaires Ms. Mary Kay Carlson, who said, "The strong showing from ministries and agencies on both the U.S. and Indian sides shows the level of commitment to this relationship. We look forward to continued strong cooperation in the scientific, regulatory, and health sectors – not only between our two nations, but with the global community." Discussions will be strengthened at the next U.S.-India Health Dialogue in Washington, DC.

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Falling off the health-care radar

The National Health Policy (NHP), 2017 is unable to see the wood for the trees. Life and death questions are dealt with perfunctorily or simply overlooked. For example, it overlooks the rapid rise in the share of the old (60 years or more), and associated morbidities, especially sharply rising non-communicable diseases (NCDs) and disabilities. With rising age, numerous physiological changes occur and the risk of chronic diseases rises. The co-occurrence of chronic diseases and disability elevates the risk of mortality.

Another, more recent report, “Caring for Our Elders: Early Responses, India Ageing Report – 2017 (UNFPA)”, complements the NHP by focussing on the vulnerability of the aged to NCDs, recent policy initiatives and the role of non-governmental organisations in building self-help groups and other community networks. While all this is valuable, it fails to make a distinction between the aged in general and those suffering from chronic conditions. It matters as many suffering from chronic conditions and disabilities may find it harder to participate in such networks. Nor are the important questions of the impact of these networks and their replicability discussed except in a piece-meal manner.

The health system is ill-equipped to deal with surging NCDs; nor is the staff well trained to treat/advise the aged suffering from dementia or frailty, and for early diagnosis and management of conditions such as hypertension. The quality of medical care is abysmal, and hospitalisation costs are exorbitant and impoverishing. Health insurance covers a fraction of medical expenses incurred. However, many of these chronic conditions such as hypertension can be prevented or delayed by engaging in healthy behaviours. Physical activity and healthy diets can mitigate these conditions. Others could be managed effectively if detected early such as diabetes. Some of course can’t be treated but rendered less painful and debilitating through assistive devices such as stroke). Supportive families and community networks often make a significant difference.

Based on the India Human Development Survey (IHDS) 2015, among aged males and females (over 60 years), the proportions of those suffering from NCDs nearly doubled during 2005-12, accounting for about a third of the respective populations in 2012. More females than males suffered from these diseases. The proportions were higher among those over 70, and these doubled in the age groups 60-70 years and over 70.

A vast majority of those with NCDs had access to medical advice and treatment and the proportion remained unchanged during 2005-12. As there is considerable heterogeneity in providers of medical help — from qualified doctors to faith healers and quacks — and a sharp deterioration in the quality of medical services, it is not surprising that the proportions suffering from NCDs have shot up despite high access. Access to government health insurance nearly doubled but remained low as barriers for the aged remain pervasive such as fulfilling eligibility criteria, slow reimbursement and a lack of awareness of procedures. In any case, the proportion of medical expenses covered was measly.

Loneliness and immunity

Loneliness is a perceived isolation that manifests in the distressing feeling that accompanies discrepancies between one’s desired and actual social relationships. The link between loneliness and mortality is mediated by unhealthy behaviours and morbidity. The fact that loneliness predicts health outcomes even if health behaviours are unchanged suggests that loneliness alters physiology at a more fundamental level. Research shows that loneliness increases vascular resistance and diminishes immunity.

We have used two proxies for loneliness: one is single-member households and the other is whether one is married or widowed. Snapping of the spousal bond in old age poses serious health risks. In 2005, old females with NCDs were twice as likely to live in single member households than the corresponding males. In 2012, while the females were two and a half times more likely to be living in single member households, the share of males rose more than moderately. In effect, old females with NCDs became much lonelier.

Whether related to or unrelated to loneliness, a high risk factor for NCDs is daily consumption of alcohol, especially local brews. Daily consumption of alcohol among the aged with NCDs rose more than twice over the period 2005-2012. Banning of liquor sales in a few States hasn't helped because of strong resistance from vested interests including politicians and expansion of illicit sales.

Networking as support

Another measure is the proportion of those married and widowed. More females were married than males while the widowed were much higher among the females in 2005. Both male and female proportions of those married doubled in 2012 but the latter remained larger. While widowed males tripled, widowed females rose just under twice. However, children often play an important role in elderly support with the caveat that filial piety shows signs of diminishing. So if we look at households with 2-4 members, we find that the proportion of aged females with NCDs living in them was much higher than that of males in 2005, and both rose rapidly, especially the latter. So it is arguable that family support more than compensated for the sharp rise in loneliness. An important point is that today, 'women are increasingly filling other roles, which provides them with greater security in older age. But these shifts also limit the capacity of women and families to provide care for older people who need it'.

That social networks are effective in providing support to the aged is far from axiomatic as there are questions of size of a network, whether it is proximal or non-proximal and whether there is social harmony. If social networks are instrumental in bonding together in periods of personal crises, this could compensate for a lack of family support, e.g. widows living alone, and help alleviate morbidity. We find that bonding rose sharply among both aged males and females suffering from NCDs during 2005-12.

The IHDS also provides data on inter-caste and village conflicts, with the proportion of those suffering from NCDs living in villages that experienced inter-caste or other conflicts more than doubling during 2005-2012. Lack of social harmony induces helplessness, disruption of medical supplies and network support.

The World Report on Ageing and Health 2015 (WHO) is emphatic about what is known as ageing in place, that is the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity. Ageing in place can be further enhanced by creating age-friendly environments that enable mobility and allow them to engage in basic activities. This reinforces the case that solutions to those with chronic diseases lie within but also outside health systems.

From a policy perspective, health systems have to be configured to deal with not one NCD but multiple NCDs to manage them better. The impact of multi-morbidity on an old person's capacity, health-care utilisation and the costs of care are significantly larger than the summed effects of each. Besides, the reconfigured medical system must be complemented by stronger family ties and social networks. This is not as Utopian as it may seem as examples of such complementarities abound.

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

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India and Norway sign Letter of Intent to extend health cooperation

Ministry of Health and Family Welfare, Government of India signed a Letter of Intent with the Norwegian Ministry of Foreign Affairs, Government of Norway to extend the cooperation within health sector through the Norway India Partnership Initiative (NIPI) for a period of three years starting from 2018, here today. Shri C K Mishra, Secretary (HFW) and His Excellency, Mr. Nils Ragnar Kamsvag, Ambassador of Norway signed this Letter of Intent. Shri Manoj Jhalani, Additional Secretary & Mission Director (AS&MD), Ms. Vandana Gurnani, JS (RCH), Dr. Tore Godal, Special Adviser to Prime Minister of Norway, Dr Maha-noor Khan, Ministry of Foreign Affairs, Norway were also present during the signing ceremony.

Through this letter, the cooperation between India and Norway will continue to be aligned with the development goals of the Indian Government as outlined in its National Health Policy 2017 for achievement of Sustainable Development Goals (SDGs). The cooperation shall focus on global health issues of common interest.

The partnership shall also include areas related to reproductive, maternal, new-born, child, adolescent health and health system strengthening, and shall build on experiences from NIPI phase I and II. The cooperation will continue to focus on innovative, catalytic and strategic support, taking the Indian Government’s Intensification Plan for Accelerated Maternal and Child Survival in India as the starting point.

The Governments of Norway and India had agreed in 2006 to collaborate towards achieving MDG 4 to reduce child mortality based on commitments made by the two Prime Ministers. The partnership was based on India's health initiative, the National Health Mission (NHM), and aimed at facilitating rapid scale-up of quality child and maternal health services in four high focus states - Bihar, Odisha, Madhya Pradesh and Rajasthan. The main activities in Phase I (2006-2012) were home-based new born care (HBNC), Yashoda through State health system, establishing Sick Newborn Care Units (SNCU), techno managerial support, and providing strategic support for immunization and Public Private Partnership (PPP) initiatives.

The Governments of India and Norway decided to extend the partnership to coincide with the second phase of National Health Mission plan (NHM) for a period of five years (2013-

17). Besides the four states already supported by NIPI, Jammu & Kashmir was added as a fifth state with NIPI being the lead partner for RMNCH+A activities.

Norway India Partnership Initiative (NIPI) through its work in the last ten years (2007-2017) has resulted in newer initiatives. In addition to trying out innovations, NIPI has also supported NHM by providing credible technical support in the five states and at national level. This has resulted in development and release of multiple policies and guidelines for the NHM.

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India registers significant decline in Infant Mortality Rate (IMR)

Major drop in birth cohort and infant deaths

Gender gap reducing: Big boost to ‘Beti Bachao Beti Padhao’

India has registered a significant decline in Infant Mortality Rate (IMR). According to the just released SRS bulletin, IMR of India has declined by three points (8% decline), from 37 per 1000 live births in 2015 to 34 per 1000 live births in 2016, compared to two points decline last year. Not only this, India also recorded a major drop in birth cohort, which has for the first time come down to below 25 million. India has registered 90000 fewer infant deaths in 2016 as compared to 2015. The total number of estimated infant deaths have come down from 930000 (9.3 Lakhs) in 2015 to 840000 (8.4 lakhs) in 2016.

According to the SRS Bulletin the gender gap in India for child survival is reducing steadily. The gender difference between female and male IMR has now reduced to <10%, giving a major boost to the ‘Beti Bachao Beti Padhao’ scheme of the Government.

The results signify that the strategic approach of the Ministry has started yielding dividends and the efforts of focusing on low performing States is paying off. Among the EAG States and Assam, all States except Uttarakhand have reported decline in IMR in comparison to 2015. The decline is reported as 4 points in Bihar, 3 points in Assam, Madhya Pradesh, Uttar Pradesh and Jharkhand and two points decline in Chhattisgarh, Odisha and Rajasthan.

These remarkable achievements in merely one year is also the result of a countrywide efforts to increase the health service coverage through various initiatives of the Government that includes strengthening of service delivery; quality assurance; RMNCH+A; human resources, community processes; information and knowledge; drugs and diagnostics, and supply chain management, etc.

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