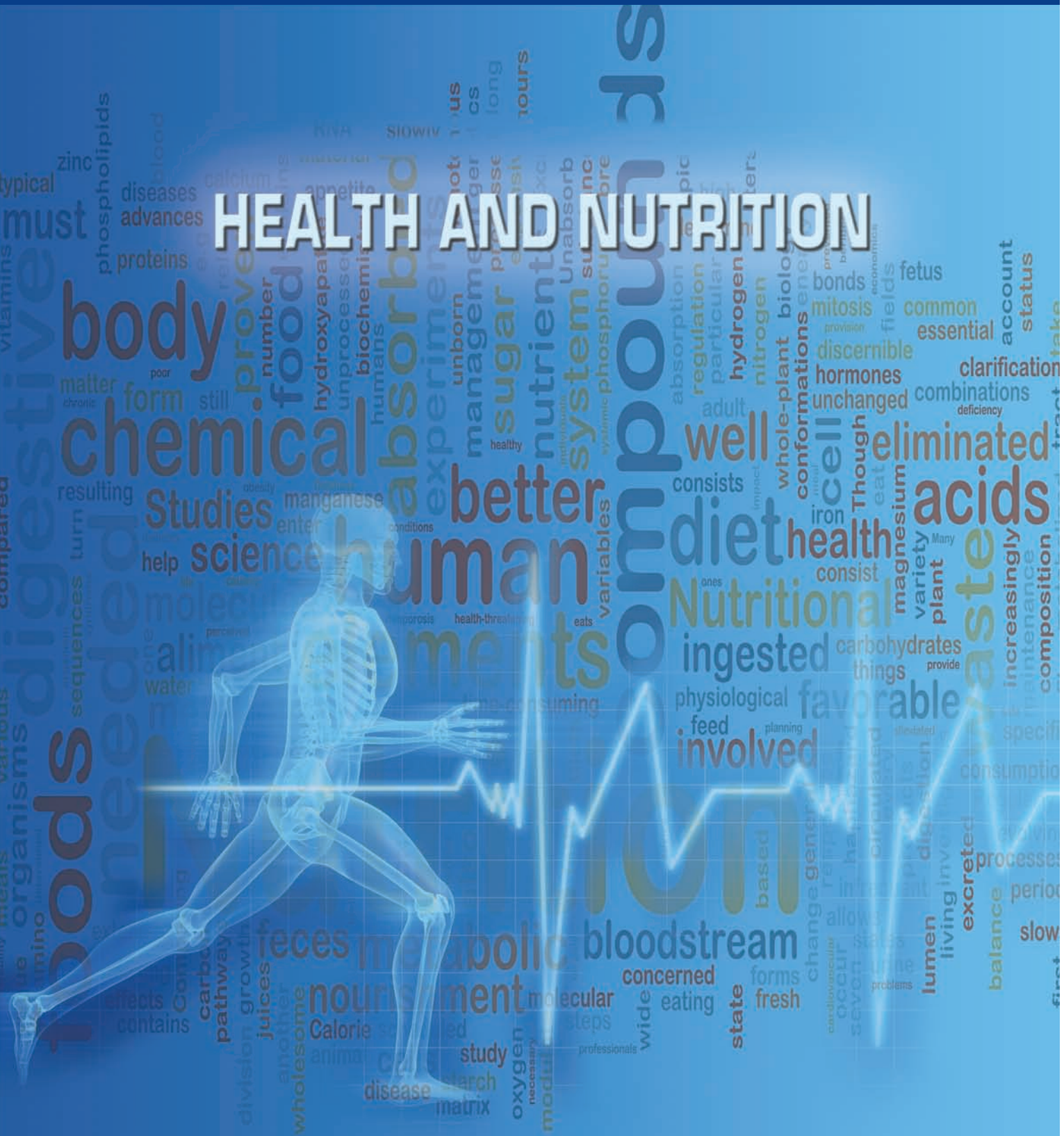


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Let noble thoughts come to us from every side
Rig Veda

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About the Issue

India's health sector is diverse and includes not just modern medicine but also a range of traditional systems like Homeopathy, Ayurveda, Unani. The overall government expenditure on health is rather low at around 1.2 percent of GDP. Communicable diseases continue to be a major public health problem in India. There is also a rising incidence of non communicable diseases, old age diseases and mental health. There is near consensus among experts that the health sector in India is plagued by acute inequity in the form of unequal access to basic health care across regions, inadequate availability of health services and acute shortage of skilled man power.



Most of the issues pertaining to public health have been acknowledged by the policy makers and have influenced the formulation process of the 12th Five Year Plan. The Approach Paper recognises the need to provide comprehensive health care with greater emphasis on communicable diseases and preventive health care, need for upgradation of rural health care services with districts as units for planning, training and service provisioning and also the need for capital investment and bridging crucial and severe human resources gaps.

The High Level Expert Group on Universal Health Care constituted by the Planning Commission has recommended that public expenditure on health should be increased from the current level of 1.1 percent of GDP to at least 2.5 percent by the end of 12th Plan and to at least 3 percent of GDP by 2022. Other recommendations are the universal entitlement to comprehensive health security; ensuring availability of free medicines by increasing public spending on drug procurement; emphasis on public health investment and addressing the problem of human resources and establishment of more medical colleges and nursing schools.

Over the years, there has been significant progress in improving life expectancy at birth, reducing mortality due to communicable diseases as well as reducing infant and maternal mortality. One of the major achievements is non-reporting of polio cases from any part of the country for more than 12 months. This is an endorsement of the effectiveness of the polio eradication strategies and their implementation in India. The NRHM launched in April 2005 was started with the stated objective to make health care universal, equitable and affordable in rural areas. The Mission was a policy response to the unequal development of health care across states and reflected the need of the centre to play a more proactive role in setting standards in public health provisioning and shaping state health systems to achieving the goals. Health care services to address the needs of the urban poor by making available essential primary health care services is also an area that requires attention.

Social and family health issues such as malnutrition of women and children, declining child sex ratio, adolescent health, care of older persons however continue to be areas of concern requiring immediate intervention.

Nutrition constitutes the foundation for human development and government has accorded the highest priority to combating malnutrition. The key issues are in preventing and reducing maternal and child under-nutrition as early as possible. To address the multi dimensional nutritional challenges being faced in the country comprehensive multi sectoral interventions and redesigned institutional arrangements are needed. The need of the hour is to review the linkages between economic growth, poverty, dietary intake and nutritional status.

This issue of Yojana deals with all these concerns and authors have outlined the challenges and the path that needs to be traversed to achieve India's goals of health care for all. □

India's Health-Issues and Challenges

Shailaja Chandra



Public health is squarely a state responsibility and particularly so in a developing country. It has to go hand-in-hand with sanitation, drinking water, health education and disease prevention

THE CHALLENGES facing India's health sector are mammoth. They will only multiply in the years ahead.

Surprisingly many of the challenges are neither a result of the paucity of resources nor of technical capacity. These hurdles exist because of a perception that the possible solutions may find disfavour with voters or influential power groups.

The first malady has been the utter neglect of population stabilisation in states where it matters the most.

The second is the monopoly that an elitist medical hierarchy has exercised for over 60 years on health manpower planning. The result has given a system where high-tech speciality services are valued and remunerated far higher than the delivery of public health services. The latter ironically touches the lives of millions.

Related to this is the third big challenge -- how to make sure that doctors serve the growing needs of the public sector when the working conditions are rotten, plagued by overcrowding, meagre infrastructure and a virtual absence

of rewards and punishments.

Divergent Attitudes to Birth Control.

In the aftermath of the 1975 Emergency and the odium of forced sterilisations, the emphasis on population control shrivelled in most of North India. While countries like Korea and Iran which then had fertility rates far higher than ours, embraced the joys of planned parenthood, India dodged the subject. In 1994 the country adopted a target free policy and the states were encouraged to implement a "cafeteria approach" while supplying contraceptives.

However the southern states of Kerala and Tamil Nadu unlike the rest of the country went full force to make family planning their top-most priority. No matter which party came to power, political support was there in abundance. In the mid-eighties the programme was spearheaded by no less than the state Chief Secretary of Tamil Nadu, Mr. T V Anthony, (nicknamed Tubectomy-Vasectomy Anthony) which speaks for itself. With enthusiastic politicians, civil servants and doctors joining hands, Kerala and Tamil Nadu reduced fertility rates to equalise European

The author was Secretary in the Ministry of Health & Family Welfare, Government of India and former Chief Secretary, Delhi.

levels. That was more than 20 years ago. Meanwhile, North India (where most of the emergency driven sterilisations had taken place) recoiled from the very mention of family planning- a mind-set that persists even to this day.

The Challenge of Reducing Maternal and Infant Mortality

There is a clear correlation between the health of the mother and maternal and infant mortality. In the northern states more than 60 percent of the girls and boys (respectively) are married well before the legal ages of 18 and 21. The repercussions of early pregnancy and child birth have not even dawned on the pair when they wed. The first child arrives within the year when most adolescent girls are malnourished, anaemic and poorly educated. With no planned spacing between the births, another

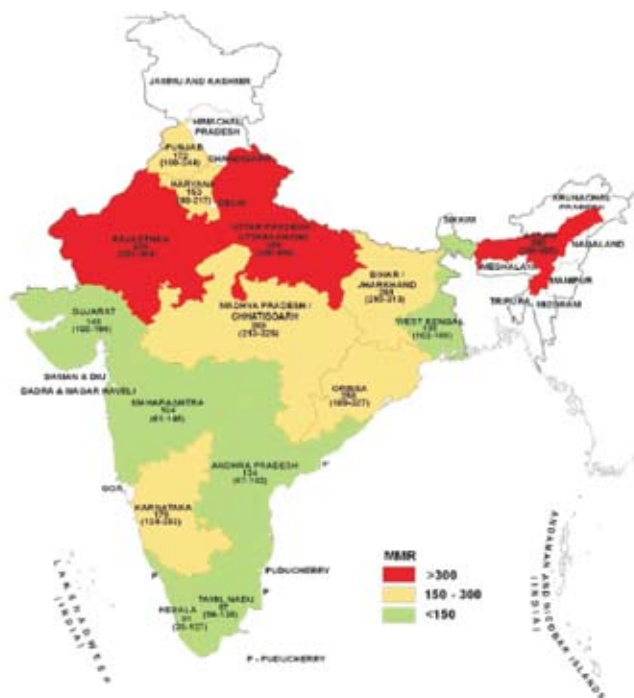
child is born before the young mother has rebuilt her strength or given sufficient nutrition and mothercare to the first born. These are among the main causes of high deaths of young women and infants. The chart and tables clearly show the regional difference in maternal, infant and child mortality. Narrowing the gaps poses one of the biggest health challenges.

The regional variations in the deaths of mothers in the states of Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Odisha, Rajasthan and Assam show that the percentage of maternal deaths is 6 times higher than in the Southern states.

Taken together the EAG States and Assam account for 62 percent of the maternal deaths. Schemes for nutrition, supplementary feeding, literacy, the right to education

and health care remain hollow expressions without any meaning as long as women (and chiefly adolescents) have no control over pregnancy. Unlike other South and South East Asian countries the use of IUD and injectibles has not taken off in India -nor are these the thrust areas for family planning anywhere in the country. Although long term, reversible methods of preventing pregnancy are available, young mothers and children continue to suffer or die. The challenge lies in bringing the issue to centre -stage and not wait for incremental improvements to take place in the fullness of time. The charts show the colossal difference that has been achieved by the southern states that invested heavily in family planning (albeit through the adoption of terminal methods like sterilisation which can be avoided today).

Regional Variations: Maternal Mortality Ratio* (MMR)



Extract from-Special Bulletin (June, 2011) on Maternal Mortality in India 2007-09 (Sample Registration System) Office of Registrar General, India

*MMR: Maternal deaths per 1,00,000 live births

Health Management and Manpower Planning

The second challenge relates to a obsession for exclusivity that has consumed the medical sector for too long. The Councils that regulate education and register the practitioners (Medical Council of India (MCI), Dental Council, Pharmacy Council, Nursing Council) were established with laudable goals- to elect a cross section of doctors and other health professionals democratically and to entrust to them the responsibility for designing and executing professional courses. It was expected that the country's needs for professional health manpower would be met both qualitatively and quantitatively. But because the Councils were constituted through a political process of elections, the baggage of money, patronage and quid pro quos became a predictable

Table 1 : Levels of MMR by Regions 2007-09

Region	MMR	% to Total Maternal Deaths
EAG* states & Assam	308	61.6
Southern states	127	11.4
Other states	149	27.0
India	212	100.0

In the Industrial countries the average MMR (adjusted 2008) is 14

EAG (Empowered Action Group) states are Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand*

Source: Special Bulletin on Maternal Mortality in India 2007-09 (SRS, 2011) Office of Registrar General, India and Unicef SOWC, 2011

accessory. Today, gaining entry to professional colleges has become highly commercialised-ultimately reflecting in the aspirations of the health fraternity to reap back benefits from huge investments incurred. As the quest to produce specialists and super specialists grows, the production of qualified technical manpower has declined severely creating a mis-match which cannot be corrected by people who work in silos and lack the understanding and vision to think of the country's health needs in totality.

The Challenge of Establishing NCHRH

The neglect of public health is one of the fallouts of the elitism that

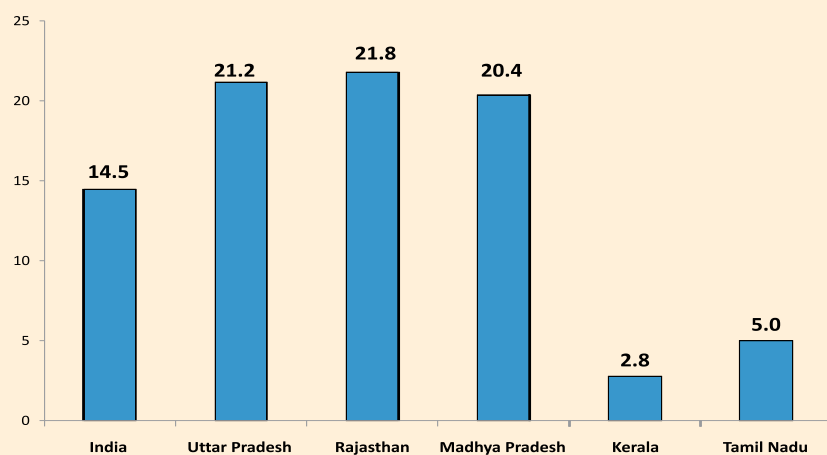
has pervaded medical education. Whereas cities and towns at least have alternatives available- at a price- epidemics and acute illnesses that occur in rural areas often leave people in the hands of fate. The erstwhile elected MCI had relegated public health to the lowest rung of the health hierarchy and the doctors that once decimated dreaded diseases like malaria and smallpox are not to be found. The complement of technical staff, nurses, pharmacists, dentists, lab technicians and operation theatre staff are all in short supply outside the urban areas as the bodies that register them do not work in tandem. More importantly no Council has a stake in health care of any particular state- leave alone the country.

The proposal to set up a National Council for Human Resources in Health (NCHRH), far from being a bureaucratic response was a well thought out strategy having its roots in the recommendations of independent think tanks and expert committees. The rationale for setting up such an umbrella body was to see that the goals of health manpower planning, the prescription of standards, the establishment of accreditation mechanisms and preservation of ethical standards were served in a co-ordinated way, on the lines of structures that operate successfully in other countries.

The Indian Medical Association in particular and doctors in general have been arguing against the need for such a body because they perceive it as a threat to their autonomy and a camouflage for political and bureaucratic meddling. The fact that health manpower planning was simply ignored, that there was a complete lack of coordination between the councils and most important of all the fact that public health had become a low priority have been overlooked in the fire and fury of opposing the NCHRH concept tooth and nail. The challenge today is how to ensure that the health sector produces adequate professionals as required for the primary, secondary and tertiary sectors, both for the public as well as the private sector health facilities. If the NCHRH Bill before the Standing Committee of Parliament does not see light of day, the resurrection of the superseded scam-ridden MCI is a foregone conclusion.

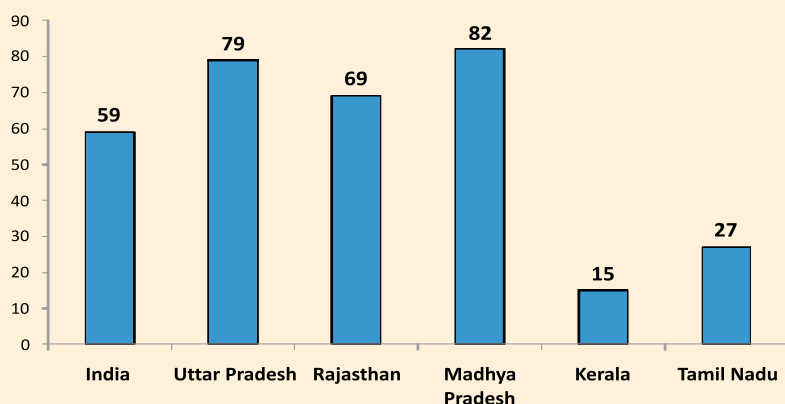
The Challenge of Allopathy and AYUSH.

Public health cannot be run on contract basis and much less be

Fig.2 : Percentage of Infant Deaths to Total Deaths 2010

Source: Registrar General of India, Ministry of Home Affairs (SRS, 2011)

Fig. 3: Under-Five Mortality Rates 2010



Source: Registrar General of India, Ministry of Home Affairs (SRS, 2011)

farmed out to private insurance companies and HMOs (Health Management Organisations) as a recent report on Universal Health Coverage seems to suggest. Public health is squarely a state responsibility and particularly so in a developing country. It has to go hand-in-hand with sanitation, drinking water, health education and disease prevention. The National Rural Health Mission (NRHM) which is a public-sector programme has registered an encouraging impact in even the most intractable regions of the country. A UNFPA study has shown that nearly three quarters of all births in Madhya Pradesh and Odisha had been conducted in a regular health facility. The percentage of institutional deliveries in Rajasthan, Bihar in Uttar Pradesh was lower but even so, accounted for almost half the deliveries conducted in those states. Indeed these achievements are immense.

Having said this, institutional deliveries alone cannot be the answer to all the problems that beset the rural health sector. A visit to any interior block or *taluka* in the Hindi belt states shows that

most primary health centres beyond urban limits are bereft of doctors, except sporadically. Some state governments have taken to posting contractual AYUSH doctors engaged under NRHM to man the primary health centres. These doctors dispense allopathic drugs, prescribe and administer IV fluids, injections and life-saving drugs, assisted by AYUSH pharmacists and nursing orderlies. This reality must be confronted. If an AYUSH doctor has been entrusted with the responsibility of running a primary health centre, and found in shape to handle the national programmes, the controversy over what AYUSH doctors can and cannot do must be settled. The trend of AYUSH doctors working in as registrars and second level physicians in private sector hospitals, clinics, and nursing homes is wide-spread in states like Uttar Pradesh, Maharashtra, and Punjab; so also in Delhi and Mumbai. The challenge lies in understanding what can be changed and what cannot be changed, without getting intimidated by protests from Medical Associations that will always protect their turf to retain primacy.

The Challenge of Retaining Doctors

The most important concern by far is to decide what kind of medical and public health cover is necessary and feasible to be given to people living beyond the bigger towns and cities. If all general duty doctors are making a beeline for post graduation- failing which opting for management, administration and even banking jobs (because cities are better places to live in,) the facts must be faced. Pursuing post-graduation, migrating abroad and prospecting for jobs outside the medical sector cannot be stopped by any Government. But fixed term requirements to stay bonded to the public sector can certainly be insisted upon for state sponsored medical graduates. But equally the working conditions, facilities and remuneration of such doctors should be respectable. In the state of Jammu & Kashmir the compensation given for working in more difficult areas has been graded. Such practical solutions can greatly bolster doctor retention.

At the end of the day, the challenges of the health sector can only be met if doctors, essential drugs and supporting staff are available in the health facilities. The biggest transformation will come if wriggling out of postings and manipulating things through political patrons stops. The doctors will fall in line only if postings are notified through a transparent and fair process and no exceptions whatsoever are allowed. Only the state Chief Ministers and Health Ministers can make this happen. But will they? □

(E-mail : chandra_shailaja@yahoo.co.in)

Better Food at Home and School

In the year 1918, a small unit for investigations on beri-beri, a disease associated with insufficient intake of Vitamin B in the diet, was started in the Pasteur Institute at Coonoor, Nilgiris District, with Sir Robert McCarrison at its head. The activities of the unit were gradually enlarged into a centre for nutrition research with the title of Nutrition Re-search Laboratories in 1928. Ever since their inception, the Laboratories and the earlier beri-beri unit have been maintained financially by the Indian Council of Medical Research (formerly known as Indian Research Fund Association).

The increasing range of nutrition problems falling within the purview of the Laboratories resulted in considerable expansion in staff, equipment and facilities and the limited accommodation at Coonoor rendered a shift of the laboratories imperative. In 1959, the institution was moved to a new, well-equipped building with-in the Osmania University Campus at Hyderabad. In its new location, the Laboratories possess ample opportunities for research in clinical nutrition in the local teaching hospitals, and for field investigations on malnutrition and for laboratory-investigations on nutrition and allied problems.

The Laboratories

The work of the Laboratories is carried in several divisions-Clinical Nutrition, Biochemistry, Pathology, Field Unit, statistics, Biophysics, Public Relations, etc. and the co-ordinate output and team work of the staff belonging to such diverse disciplines have yielded fruitful results.

Types of Activities

The Laboratories have been instrumental in initiating several surveys on the nutritional status and dietary intakes of the people in the various regions of the country. Nutrition workers under State Governments and other agencies have continued this work. These surveys have revealed that the majority of Indian diets have a basic similarity in pattern, namely, disproportionately large content of cereals and poor consumption of protective foods such as milk and leafy vegetables. Periodical repeat surveys have helped to provide information on the part played by nutrition in the economic betterment of the people. The intimate association between general malnutrition and specific diseases such as night blindness and anemia, has been brought to light.

Popular Books

Investigations on the nutritional value of several Indian foods completed by the laboratories are embodied in a booklet called "The Nutritive Value of Indian Foods and the Planning of Satisfactory Diets" (Health Bulletin No. 23). The booklet provides information of an elementary nature on foods and nutrition in general and contains data on some 300 common Indian foods in respect of minerals, vitamins and other nutritional principles. The books has proved popular and has already undergone five editions.

The Laboratories have conducted important research on rice ('Yojana', September 13, 1960). They have also thoroughly investigated the nutritional value of proteins in Indian foods and diets

and the harmful effects of lack of proteins. Mother's milk, after about six months of nursing the baby, goes down in quantity and is not able to supply the protein needs of the growing child in full. Such supplementary food is made available to the child is usually a smaller quantity of what adults take. Investigations aimed at finding suitable protein foods from local resources to treat such conditions have been successful.

Projects in Hand

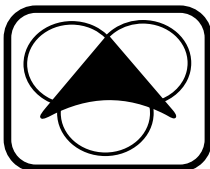
Experiments on the energy expenditures of different activities engaged in by Indians have been undertaken. This will enable formulation of calorie requirements of Indians in different walks of life.

The role of dietary factors in relation to the incidence of heart disease, the mode of action and requirement of vitamins, and various aspects of human lactation in poor Indian mothers especially the quality and quantity of milk secreted and the incidence, characteristics, cure and prevention of anaemias in Indian women, are some other activities in which the Laboratories are engaged at present.

Public Health Training

The Laboratories periodically conduct advanced training courses for public health and other personnel interested in nutrition. Research workers are trained in nutrition and allied sciences and are enabled to contributed their share in advancing the bounds of knowledge in this sphere. □

*Excerpts from the October 2, 1960 issue of
YOJANA)*



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Drug Pricing and Pharmaceutical Policy

C P Singh



***Within healthcare,
the cost of
medicine is the
major cost driver
which constitutes
nearly 60-70
percent of the total
healthcare cost***

THE DEPARTMENT of Pharmaceuticals was established on 1st July 2008 as the nodal Department for ensuring the availability of medicines at reasonable prices in the country. Availability of good quality drugs at affordable prices with a specific focus on the poor has been the constant endeavour of the Government. The Government is administering Drug Price Control through the Drug Price Control Orders issued from time to time.

Under Drug Policy 1994, DPCO 1995 was framed with the following salient features:-

- 74 Bulk Drugs and their formulations under price control
- Cost based pricing of bulk drugs
- Pricing of indigenously manufactured scheduled formulations under specified formula i.e Cost + MAPE (Maximum Allowable Post-Manufacturing Expenses) not exceeding- 100 percent
- For imported formulations : Landed Cost plus margin not exceeding 50 percent

- Control of price of any non-scheduled formulation in public interest.

The Drugs (Price Control) Order, 1995 (DPCO,95) was promulgated by the Government of India on 6th January, 1995 in exercise of the powers conferred by Section 3 of the Essential Commodities Act. Under DPCO,95, seventy six bulk drugs (subsequently reduced to 74) are included in its First Schedule. These bulk drugs are scheduled bulk drugs. The Government of India is empowered to fix and notify the price of scheduled bulk drugs and their related formulations. NPPA has been effectively performing its role of a regulator of the prices of specified drugs.

The National Pharmaceutical Pricing Authority (NPPA), an independent body of experts in the Ministry of Chemicals & Fertilizers was formed by the Government of India. The functions of NPPA, inter-alia, relates to fixation/revision of prices of scheduled bulk drugs/formulations under DPCO'1995 monitoring and enforcement of the prices.

The author is Chairman, National Pharmaceutical Pricing Authority (NPPA).

The Authority has been entrusted with the task of price fixation/ revision and other related matters such as updating the list of drugs under price control by inclusion and exclusion on the basis of the established criteria/ guidelines. The Authority is empowered to take final decisions, which is subjected to review by the Central Government as and when considered necessary. The Authority is also required to monitor the prices of decontrolled drugs and formulation and oversee the implementation of the provisions of the Drugs (Price Control) Order. NPPA also monitors the availability of drugs throughout the country and take corrective action if any shortage of medicines is noticed.

An overview of the Indian Pharma Industry is given hereunder:

NPPA while implementing DPCO,95 undertakes Pricing (Price Fixation, Review of Prices, Intervention, Check & Correction, Enforcement), Overcharging (Detect, Demand, Deposit), Monitoring (Monitor Prices, Monitor Availability, Market-Surveillance, Market-Intervention, Maintain Price Line) of Pharmaceutical Drugs. The progress made in this regard is stated below:

Monitoring of Non Scheduled Formulations

With a view to keep a close watch on price changes, monitoring mechanism is in place. The monitoring of prices of non-scheduled formulations is currently done on the basis of data from IMS Health. The ceiling for annual price increase has been reduced to 10 percent from 20 percent since 01.04.2007.

Bulk Drug Units	2389
Formulation Units	8174
Total Pharma Units	10563
No. of bulk drugs produced in the country	>600
No. of formulation packs Produced	>61325
Total Turnover	Rs.1,04,209 Crs. : 2009-2010
(i) Domestic	Rs.62,055 Crs. : 2009-2010
(ii) Exports	Rs.42,154 Crs. : 2009-2010
Global Position of Indian Pharma	3rd in Volume & 14th in Value
Average Growth of domestic market during 2006-07 to 2009-10	11.6 percent

Price Fixation/Revision Progress upto Aug., 2012

Bulk Drugs

Particular	2009-10	2010-11	2011-12	2012-13 (upto 31 st Aug., 12)	Since inception of NPPA (till 31 st Aug., 2012)
Price Increased	15	10	19	1	153
Price Decreased	10	07	01	03	346
Price fixed for First Time	02	01	0	0	17
No change In Price	01	03	1	0	10
Total	28	21	21	04	526

Formulations (Number of Packs)

Particulars	2009-10	2010-11	2011-12	2011-12 (upto 31 st Aug., 2012)	Since Inception of NPPA (till 31 st Aug., 2012)
Price Increased	184	223	257	72	1861
Price Decreased	450	60	50	83	3492
Price fixed for first time	1155	371	239	165	6227
No change in prices	35	59	61	32	432
Total	1824	713	607	352	12012

Action and Price fixation under para 10(b) of DPCO,1995

Prices of 30 non-scheduled medicines have been fixed under para 10(b) till August, 2012, the details of which are available on NPPA's website.

As a result of action under this provision, 33 manufacturers have voluntarily reduced prices of 65 packs and prices of 30 packs has been fixed by NPPA. In this way prices of 95 non-scheduled packs have been reduced so far.

Availability of Drugs

NPPA monitors the availability of drugs and identifies shortage, if any, to take remedial steps to make the drugs available. NPPA is carrying out this responsibility mainly through monthly field reports from the State Drugs Controllers and other available information. As and when the reports of shortage of particular drug(s), in any part of the country are received, the concerned company is asked to rush the stocks and to make the drugs available. Generally, shortages

reported are brand specific where alternate brands are available.

Enforcement of provisions of DPCO, 1995.

A separate enforcement division was created during the Year 2007-08 to facilitate detection of violation of DPCO 1995 with the following objectives:

Market Surveillance of prices of scheduled drugs

- (i) Purchase of samples by NPPA officers all over India to ensure compliance;
- (ii) Examine complaints by individuals / NGOs/VIP references.

Based on an analysis, specific cases are identified for

- (i) Recovery of overcharged amounts;
- (ii) Fixation of prices, where ever required.

Status of overcharging cases

Demand notices for overcharging have been issued from inception of NPPA.

India has some of the poorest

health indicators in the world and highest disease burden. This makes all the more important that the medicines need special priority from Government, Trade Associations, Industry and Consumer Organizations. Within healthcare, the cost of medicine is the major cost driver which constitutes nearly 60-70 percent of the total healthcare cost. 80- 90 percent of healthcare in India is out of pocket without intermediation and risk buffer of health insurance. The scenario underscores the criticality of containing drug costs for affordable healthcare. India is recognised world wide as a low cost producer of quality drugs.

Indian Pharma Industry is making all out efforts to ensure availability of medicines and taking India to a leadership position in Global Pharmaceutical Arena. Government is taking all necessary steps in supporting the Indian Pharma Industry by ensuring adequate availability of highly skilled and trained manpower, rationalising taxes, providing various fiscal and non-fiscal

Price Change - Number of Packs							
Sl.	Price Change	2011			2012		
No.		Jan	Feb	Mar	Jan	Feb	Mar
1.	Increase Percentage	181 (0.3 percent)	07 (0.01 percent)	1146 (1.89 percent)	04 (0.007 percent)	20 (0.03 percent)	62 (0.10 percent)
2.	Decrease Percentage	92 (0.15 percent)	05 (0.01 percent)	374 (0.62 percent)	02 (0.003 percent)	11 (0.02 percent)	16 (0.03 percent)
3.	No Change Percentage	60762 (99.55 percent)	60610 (99.98 percent)	58978 (97.49 percent)	61246 (99.99 percent)	61294 (99.95 percent)	60884 (99.87 percent)
	Total	61035 (100 percent)	60622 (100 percent)	60498 (100 percent)	61252 (100 percent)	61325 (100 percent)	60962 (100 percent)

Achievements

Year	No. of Samples Collected	Prima Facie Violations detected	Referred for Overcharging	Identified for Price fixation Para 8 (6) violation
2007-08	1450	840	456	384
2008-09	520	284	172	112
2009-2010	464	246	208	38
2010-2011	553	225	216	9
2011-2012	559	156	152	4
2012-2013 (upto August, 2012)*	230	41	39	2

* 35 cases are under process

The details of demand and recovery etc. till 31st August, 2012 is as follows:-

Particulars	Number of Cases	Demand Notice issued (Rs. in Crores)	Amount recovered (Rs. in Crores)	Pending Recovery (Rs. in Crores)
Total Cases	857	2574.08	234.62	2339.46
Under Litigation	113	2429.17	180.60	2248.57
Other Cases	744	144.91	54.02	90.89

incentives for R & D and minimal price control.

NPPA with the assigned mandate endeavours to maintain a balance in the conflicting interests of the consumers and producers. An effort is made to make the consumers vigilant of his rights in respect of quality of the medicines and prices charged overtime. At the same time while fixing the prices of Bulk

Drugs/ Formulations it is ensured that justice is being done with all rationality and objectivity in its approach.

Information system relating to how medicine prices change in a country reported by a national medicine price monitoring system can be a valuable tool for governments, policy makers, health professionals, civil society

and other interested local or international parties for decision making, evaluation and advocacy purposes. NPPA has increased its focus on the monitoring of prices more and has made appropriate interventions. While significant ground has been traversed, much more endeavours to be covered within the mandate of DPCO, 1995. □

Everything you want to know about nutrition

The Union Ministry of Women & Child Development's recently launched a website on Nutrition. This interactive website will offer a knowledge bank, library and e-forum to those in the business of nutrition and the ones interested in eating right to stay healthy.

Currently there is just too much information about food, nutrition and various types of diets. There are various experts in the field of food and nutrition who give out information which at times can be contradictory and even confusing for the public.

Besides working at bridging the gap of clarity on nutrition and its co-relation with health, the website will also give a bird's-eye view of what the national and international community has to say on a particular diet or issue. The site is also meant for policy-makers. The website will help the policy-makers to connect with and understand the public's nutrition concerns." Besides being of public use, the website is also expected to help the Government with real-time monitoring of the Integrated Child Development Services.

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Women and Child Health

Aarti Dhar



Unless all concerned – policy makers, civil society, communities and families and all of us – contribute in our own different ways maternal health would continue to be compromised and the human rights of women would continue to be a casualty

BY THE time one finishes reading this article, several women would have died of pregnancy related preventable causes in India! Official figures suggest one unfortunate Indian woman loses her life every eight minutes, which adds up to a loss of more than 63,000 young and productive lives every year.

All of us would agree that there can be no improvement in maternal health without eradicating extreme poverty and hunger to which women, in general, and pregnant mothers, in particular, are most vulnerable. Improved maternal health will, on its own, bring about a visible improvement in child survival and child health also.

I use the term “maternal health” in its broadest sense as the culmination of all that goes wrong with women generally and those from the poorer sections, in particular – beginning with the discrimination from the embryonic stage when detection of a female foetus leads to its elimination or termination; and if it survives, the tragedy of the infant girl whose

mortality rate is higher than that of infant boys; and growing up to face the neglect as a girl child who has to shoulder adult like responsibilities at the cost of her schooling and foregoing exposure to her other entitlements in comparison to male siblings; and then is confronted with the travails of vulnerable adolescence as she has no access to basic sanitation facilities or even a sanitary napkin or its crude substitutes become a luxury; and then she grows to assume young adulthood when sexual health is not considered a priority for her in the reproductive age, deprived as she is of sufficient nutrition, preventive health care, and denied the right to choose the timing of conception or the power to decide on which method of contraceptive to use; and then she is forced to double up as a provider of livelihood for the family; and finally, in her old age she is discarded and thrown out to beg and survive.

While approximately 10 to 15 percent of all pregnancies reportedly result in an emergency and obstetric emergencies cannot be predicted and can happen to any pregnancy, whether the woman is rich or poor, rural or urban; a woman's social

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and paying status can make all the difference and a rich woman living in Delhi will, for example, have access to a hospital. Women may need caesarean sections and/or blood transfusions, which require the complex skills, facilities and logistical support only found in a hospital. Yet for many women in our country, these services are simply not available.

One of the reasons for inaccessibility to such facilities to be the already overburdened Out Patient (OPD) load which leaves the medical staff at Primary Health Centres with little time for postpartum care. The lack of service from the public system leaves women to the care of informal and private providers, and the poorest to the care of the family itself which is ill equipped to handle complications or even basic issues like blood pressure, haemorrhage, and obstructions during labour. Studies have found that women from vulnerable sections are often not aware of many auxiliary services they are entitled to apart from the cash benefits under the Janani Suraksha Yojana, during ante-natal care. User fee for either transportation or investigations further minimises the communities' access to maternal health services. The problem is worsened when communities need to pay money for services like getting vaccinations or cutting of umbilical cord of the newly born child.

Poor functioning, poor hygiene and sanitation and unfriendly attitude on the part of the staff also render government health facilities ineffective. Will the numerous initiatives taken by the Centre and State governments to encourage institutional deliveries including the special focus on the National

Rural Health Mission, and the just launched Janani-Shishu Suraksha Karyakram, make any difference? Can the already overburdened district hospitals, Community Health Centres (CHC) and Primary Health Centres (PHC) be counted upon to deliver? My visit to Bolangir—one of the most backward regions of Orissa in the Kalahandi-Bolangir-Koraput (KBK) region – and to its District Hospital, found that against a capacity of only 25 beds, on an average 75 women are admitted and have to wait for hours before delivery because the labour room can accommodate only three patients at a time and once out of the labour room, women are kept in the leaking and damp corridors with newborns because of non-availability of bed. Women are not surprised when they are discharged from hospital within hours of delivering to accommodate new delivery cases and neither do the family members mind because they would get the money under the Janani Suraksha Yojana as would the Accredited Social Health Activist for bringing the women to the hospital. The lactating mother may die even before reaching home due to post-natal complications but it would be counted as an institutional delivery. On arrival at a health facility they are allotted a bed, without bed-sheets, and the poor families are expected to buy everything else needed for the delivery and aftercare. Sometimes, the inability to arrange vital requirements such as that of units of blood due to poverty proves fatal for the woman.

This grim scenario notwithstanding, the Centre has made some genuine efforts to improve maternal and child health in the country. Some of these

measures have already started showing results with an appreciable decline in the maternal mortality ratio and infant mortality rate, while the impact of some other schemes should be visible in the coming years.

The Ministry of Health and Family Welfare has issued operational guidelines for Home Based Newborn Care. To be implemented by Accredited Social Health Activists (ASHAs), HBNC will go a long way in ensure the safety of young mothers and infants who cannot access health facility for various reasons. For this Training of Trainers has been undertaken and translation of ASHA module in respective Regional languages and would include post partum care also. Provision of ante-natal and post natal care services for pregnant and lactating women which includes iron and folic acid supplementation for prevention and treatment of anaemia can go a long way in saving precious lives provided these are consumed regularly. Women often take the tablets but do not consume defeating the entire purpose of the scheme.

The Village Health and Sanitation Committees, set up under the NRHM, now include Nutrition in its mandate and have been renamed as Village Health, Sanitation and Nutrition committee (VHSNC). Malnutrition and anaemia are important factors for high maternal and infant mortality in India and 500,000 committees should make a difference in the health status of expecting and lactating mothers.

The NRHM seeks to bring down IMR to under 30 per 1,000 live births, MMR to 100 per 10,000 live births and total fertility rate to 2.1. To achieve this, PHCs

have been strengthened to act as First Referral Units (FRUs) with capacity to provide comprehensive obstetric emergency care. as many as 8,250 PHCs have been upgraded as 24X7 units. For the infants, 374 Special Newborn Care Units, 1638 Newborn Stabilisation Units, and 1,1432 Newborn Care Corners have already been established in addition to renovations taken up in the already existing facilities and 1,951 Mobile Medical Units provided in 442 districts for delivery of health care in difficult areas. Free transportation for shifting pregnant women to health facilities and mother and child tracking system has been set up to ensure and monitor timely health interventions.

The name based Mother and Child Tracking System established to record every pregnant woman and child and to follow up to ensure full ante natal check-ups and immunisation of children has picked up in most States. A database of more than 3.25 crore pregnant women and children has already been created. At the root of the problem of 42 percent children in India being malnourished and a substantial percent suffering from stunted growth and wastage is under-nourished and anaemic mothers.

Importantly, the government has taken a policy decision to review every maternal death both at the health facilities and in the communities, for which guidelines have been provided to the States. The purpose of the review is to find gaps in service delivery which lead to maternal deaths and take corrective action to improve the quality of service, and not for taking punitive action against service providers. All States have

institutionalised the MDR process and a preliminary study reveals what has already been in the public domain. Lack of transportation, infrastructure, privacy and behavior of the staff are the main issues that need to be addressed urgently.

A review of the NRHM, government's flagship programme by the former Union Health Secretary Javid Chowdhury suggested that it was not a grand success after all with only one third of the PHCs functioning round-the-clock. While Mr Chowdhury's report was based on official data, my field visits to remote areas also present a not so happy picture. The structures created under the NRHM are not of much use because of lack of trained human resource and supply of medicine. In a far flung village of Orissa, a PHC had not seen even a single delivery from 2007. All patients were referred to the District Hospital at Bolangir which was unable to take the burden.

A new initiative namely Janani Shishu Suraksha Karyakaram (JSSK), launched in June 2011 which guarantees free entitlements to pregnant women and sick new born till 30 days after birth, including C-Section, drugs and consumables, diagnostics, diet during stay in the health institutions, provision of blood, exemption from user charges, transport from home to health institutions, including transport between facilities in case of referral and free drop back home after 48 hrs stay, has failed to show tangible results because of lack of awareness. The benefits of the scheme are not known even at the hospitals. Expecting people to benefit from it would be rather far-fetched.

Similarly, the results of adolescent sexual reproductive health (ARSH) strategy for the promotion of menstrual hygiene among adolescent girls in the age group of 10-19 years in rural areas, is far from satisfactory. This programme is aimed at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins. Under this scheme, 1.5 crore girls across these districts will be reached with the behaviour change communication campaign and provided access to an NRHM brand of sanitary napkins that will be sold to the girls by the ASHA at subsidised costs. This is expected to prevent reproductive tract infections (RTI) and sexually transmitted infections (STIs).

Official statistics also show that 46.8 percent women in India have low body mass index and over 55 percent are anaemic. The government's initiative to provide iron and folic tablets to adolescent girls and pregnant women will need to be better monitored and implemented because women, often, chose to ignore their health. Maternal death audits have shown that women did collect the tablets but never consumed these to overcome anaemia. Strips of tablets were recovered from a young woman's house in a tribal district of Gujarat who died of excessive bleeding because the hospital asked the family to arrange for blood which it was unable to do.

Child Health and Immunisation

Over the past several years, the focus of the government has also been on child health and

immunisation that has helped in bringing down the child mortality and achieving polio free India.

Pulse Polio Immunisation

Seven million children die globally before they reach their fifth birthday. Of these, 1.7 million are in India—highest anywhere in the world. Half of these deaths occur within a month of the child being born. While India has made some progress with the under-five mortality falling from 116 per 1000 live births in 1990 to 59 per 1000 live births in 2010, this is still inadequate. These figures also mask the gross inequalities between the States and between different social, cultural, gender and economic groups within them.

India's major achievement of the recent past has been the eradication of polio. With only 42 polio cases detected in 2010 compared to 741 cases detected during 2009, the most significant progress was seen in the endemic States with no type 1 case detected in UP since November 2009 and only one type 1 case detected in 2010 in Bihar with onset of July 2010. During 2011, only a single case of wild polio virus was detected in Howrah district in West Bengal.

Earlier this year, the World Health Organisation officially removed India from the list of polio-endemic countries, as India has not had a case of polio since January 13, 2011.

Universal Immunisation Programme

Immunisation programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. In India, full

immunisation coverage is increasing but continues to be just about 60 percent and lesser in rural settings and other deprived sections not having access to pure drinking water and sanitation. Under the Universal Immunisation Programme (UIP) vaccination is carried out to prevent seven vaccine preventable diseases i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B. Since 2006, single dose of Japanese encephalitis vaccine has been introduced under routine immunisation in the high burden districts in phased manner.

Pentavalent vaccine which consists of vaccines against five diseases (Diphtheria, Pertussis Tetanus, Hepatitis B and *Haemophilus influenzae* B) has also been introduced in some States. Vaccine against Hib disease (*Haemophilus influenza* B) is a new addition to the immunisation programme. Pentavalent vaccine is administered to children at 6, 10 and 14 weeks of age and will replace the existing DPT and Hepatitis B vaccine primary dose of which is given at the same age.

The Government claims that Pentavalent vaccine will ensure complete immunisation against 5 diseases three injections to children and also reduces the chances of an Adverse Event Following Immunisation due to less injection load, but the claim is contested by rights-based health activists. It is estimated that 40 percent of all under-5 mortality in India is attributed to Pneumonia, Meningitis and Diarrhoea. Hib disease is estimated to cause 2.6 lakh cases of pneumonia and 52 thousand cases of meningitis every year.

In India, as in other parts of the world, the cost of healthcare is

often prohibitive for the poor and discourages the use of the services that exist. Also many States with high levels of child mortality do not spend all the resources that have been allocated. It is always the poorest and the most marginalised Indian children who are at the greatest risk.

Family Planning

Under the Family Planning programme, eligible couples are now being counseled to delay their first child and then better space their children for which contraceptives like condoms are provided by ASHAs at the doorsteps. The ASHA charges a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep.

However, there can be no improvement in maternal health, unless women are enlightened through education at least till the primary level and we cannot imagine improved maternal health in any society that does not promote gender equality or in one which does not empower its women; or in one which does not reduce child mortality rates.

It goes without saying that unless all concerned – policy makers, civil society, communities and families and all of us – contribute in our own different ways to eliminate the social, economic, cultural and political factors which reinforce discrimination, denial, deprivation and disempowerment of women in every stage of their life from the womb to the tomb, maternal health would continue to be compromised and the human rights of women would continue to be a casualty. □

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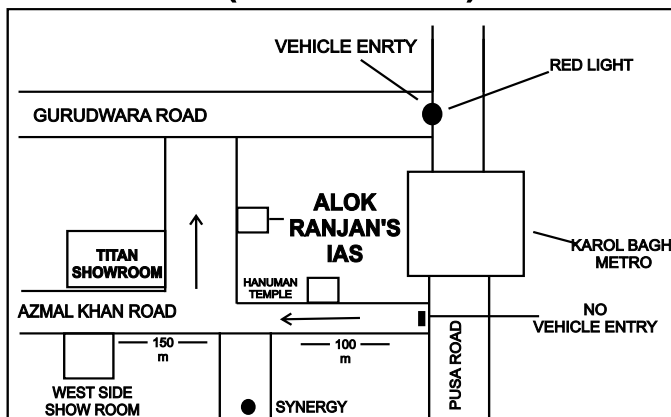
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Rediscovering the Traditional Wisdom of Nutrition

Dhananjay Kumar



A full proof nutritional regime is an ideal achieving which is easier said than done. But simple iron and folic acid and iodine supplementation or fortification can also go a long way to bring about a qualitative change in the lives of rural people

RAGI MAGGI being flaunted for calcium supplement and Ragi biscuits for diabetics speak a volume about our traditional wisdom of nutrition. These *Ragi* (a variety of coarse grain) products hog the limelight in TV commercials these days not for nothing. Not many urban folks know that this *Ragi* was once the staple of a major part of rural India but has long been banished from their plate by the trend of mono agriculture limiting farm yields only mainly to rice and wheat. Other coarse grains like sorghum or *Jowar*, *Bajra*, Maize and many others met the same fate. These coarse grains were sufficient for the nutritional requirements of the rural folks. Nutrition was thus embedded in the farm culture of rural India. Those were very easily cultivable too, even in droughts. Needless to say that these coarse grains, once looked down upon as the feed of the poor people, are key to fulfilling nutritional requirements of rural people of the country. Need of the hour thus is to rediscover the wisdom of traditional nutritional regimen. The traditional food habits favouring coarse grains and pulses were totally scientific and

customised according to the easy availability but the green revolution proved a bane in the sense that it banished those coarse grains and pulses from the community. Of course we have grown yields but in the wake of this lost the much needed protein.

With 'food security' being on the 'platter' of public discourse and high yield political agenda the nutritional needs in the rural areas of the country are a very 'tasty' food for thought. Malnutrition is very soon going to become a cause celebre with maverick Amir Khan taking up the cause with panache. Since it will be a national campaign, it is expected that, besides medicinal ways to plug the deficiency gaps, the traditional wisdom of nutrition will also get a much needed boost. All modern day diseases have percolated down to rural areas and wreaking havocs on the health of the rural populace, with even lanky ones having diseases like diabetes and coronary artery blockages. The food patterns in the rural areas are also in the cusp of a radical change. So far as deficiencies are concerned, it is uniformly almost the same throughout the rural country. Rural folks have been found famished for iron, protein and also micronutrients

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such as vitamin, zinc et el. National Nutrition Monitoring Bureau (NNMB) survey has painted a very grim picture of deficiencies in the rural populace.

It is to be understood that food security cannot be ensured simply by providing rice and wheat but it calls for a delivery of balanced diet, entailing sufficient calcium, protein, vitamin and other nutrients. Simply satiating the appetite will not materialise the food security. Food security is materialised only when all the nutritional needs are met. Deficiencies have been found to cause a number of diseases. That is why nutrition has attained the status of a component as important as medicine in the treatment of diseases. Every hospital worth its salt, governmental or corporate, has a host of dieticians because it has emerged unmistakably through many a study that the right diets facilitate a speedy recovery from illnesses and enhances the efficacy of the medicine. Diets are being customised for every illness, keeping in mind the deficiencies. District hospitals too need to have dieticians so as to complement the treatments.

So food security in rural India will need a paradigm shift and perhaps looking back to the hoary past to take a lesson or two. The modern day nutritional trend, propelled by profit making, has come to naught and even the food majors are now compelled to fall back on the traditional and time tested nutritional wisdom. Of course, iron, iodine and vitamin deficiencies particularly need to be addressed immediately but the long term nutritional strategy should be to revert back those coarse grains which are repository of substantial

nutrients. This coupled with milk, fish and green leafy vegetables will go a long way to fulfill the nutritional needs of rural folks.

In the previous budget, a very significant announcement was made so far as nutritional needs of the rural folks are concerned, though its significance was not given due importance in the media. The rationale behind announcement of Rs 400 crores for the promotion of coarse grains like *ragi*, *rai*, *bajra* was to emphasise their utmost importance in nutrition. NGOs, which are working on the nutritional needs, though give a thumbs up to its symbolic importance, consider it half hearted. They say the announcement should have been complimented with other fillips such as minimum support price and facilities for storing them. According to them only coarse grain revival will not do, efforts will have also to be made to enhance the production of pulses and oil seeds to fulfill the needs of protein and fat which are equally necessary for good health.

In the era when countryside of India was self reliant in terms of nutrition with area specific variables namely availability of fish in Odisha and other coastal areas, vegetables in Bundelkhand and milk in Punjab and Haryana, there were 160 ways to fulfill nutritional needs. That has now been reduced to barely 25 ways. *Ragi* is the repository of calcium which is a must for the formation of bones. No other source holds even a fraction of calcium compared with *Ragi*. Iron deficiency in rural areas should be a matter concern because this deficiency adversely impacts the health of the people. About 57 percents of rural populace is suffering from iron deficiency which in turn very adversely impact

the productivity of children, youths and adults alike.

Protein is the *sine qua non* of nutrition. Its deficiency has come to be established as a serious health hazards in rural areas resulting into overall depletion of immunity and thus opening the floodgates of plethora of illnesses. Hormones and enzymes, which subsist on protein, play a very crucial role in keeping people in the pink of the health. So protein deficiency in rural areas is being looked at as major crises. According to a National Sample Survey Organization (NSSO) consumption data, most northern states were diagnosed as having rural population famished in terms of consumption of calorie and protein.

Fish, a rich source of protein, came to the rescue of those who lived in coastal states. Pulses would have done this for the northern states.

All NGOs working in the area of rural nutrition advocate embedding pulses and coarse grains in the slew of measures being taken up towards the national campaign against malnutrition. It is not easily imaginable what harm deficiency of nutrients can cause. Look, how precarious a single iron deficiency can make a human being. It causes a number of medical conditions such as lethargy, poor concentration, pale skin, and shortness of breath, poor stamina, intestinal bleeding, excessive menstrual bleeding, nervousness and heart palpitation. Men, women and children are all equally pitted against this deficiency in rural areas.

According to the National Nutrition Institute, 40 percent nutrients should come from grains and the

rest should be derived from vegetables, milk, curd, spices and meat. But in rural India 72 percent nutrition come from grains. This imbalance will have to be corrected and right mix of nutrients is the need of the hour.

In the final analyses, a full proof nutritional regime is an ideal achieving which is easier said than done. But simple iron and folic acid and iodine supplementation or fortification can also go a long way to bring about a qualitative change in the lives of rural people. Midday meal programmes could have been great succor for rural and poor children. At the hand of the governments it might have gone wrong somewhere but some charitable organisations which picked up this initiative is doing exemplary nutritional supplementation. One such organisation is ISKON which is catering to about 5 lakh government school children in Delhi and NCR regions. They are giving them complete nutrition and the changes that have come over them are well documented.

Rural or urban, this supplementation work wonders. Sample this. Dr. Tripta Gupta, an activist Delhi gynecologist, Director, BT Women Hospital and part of Delhi government's anaemia initiative, has a unique story to tell. She worked on hundred maid servants, who came from rural India to work in the capital, with iron and folic acids. They were being trained by a church in Delhi to be employable as maidservants. The house ladies employing them had a lot of complaints about them, namely, they would often complain of being unwell and fatigued and were always irritable. After three months, the situation had changed. The supplementation worked wonders on them. They were quite a turned leaf after three months. They did not absent, did household chores with élan and stopped fussing. The housewives, themselves anaemic, were so impressed with this change that they themselves wanted to emulate them and, lo and behold, they were happy to get the flamboyance of their maidservants in no time.

Food patterns and habits in rural India being in a state of flux, a new danger is lurking for the children. The cold drinks are slowly but surely making a dent in rural bastion, which is recipe for disaster so far as nutrition is concerned. This empty calorie has a devastating effect on children's health as evidenced by the urban children who are being prone to all manners of medical conditions. So, rural children, to be nurtured rightly, will have to be saved from the sugary onslaughts too. □

(E-mail: dhananjay_voa@rediffmail.com)




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YE-159/2012

Responding to HIV and AIDS in India

Tapati Dutta



At one end while it is needed to step up research to understand the rural dynamics of the epidemic, at the other end HIV testing, provisioning of treatment and condoms, quality health personnel and awareness generation needs to be scaled-up as per the rural needs

TARUNI, FROM Guntur district of Andhra Pradesh recently delivered a healthy baby girl. She is an HIV positive from the district which has the highest HIV prevalence in the country and has been on Anti-retroviral Treatment (ART) since the last few years. Early screening and diagnosis of HIV, followed by the treatment regime prevented the transmission of the disease from Taruni to her child – undoubtedly good news for many in the fight to combat HIV and AIDS.

India has come a long way since 1982, when the first case of HIV was diagnosed in Mumbai and in the same year the first AIDS case reported in Chennai. Thereafter in 1986 the first HIV case through injection drug use (IDU) was diagnosed in Manipur. In India the epidemic is of concentrated nature with almost 90 percent of infections transmitted through one of the following three routes - heterosexual contact, homosexual contact and injection drug use.

The virus is concentrated mostly among sex workers, men who have sex with men, transgender, injecting drug users, and bridge populations like clients of sex workers, truckers, prison inmates, street children and migrants. At present, there is an estimated 2.39 million people living

with HIV, 39 percent of whom are women and 3.5 percent children below 15 years. Broadly, the Government's response to prevent and contain HIV and AIDS has been through awareness generation and prevention programmes; regular surveillance for HIV and AIDS related data and research focusing on epidemiology of HIV and AIDS.

Soon after the first AIDS case was diagnosed, the National AIDS Control Organization (NACO) was created in 1992 by the Government to prevent and contain HIV. Since its inception, NACO's key role has been to oversee the formulation of policies and strengthen prevention through early screening of HIV, expanding the reach of Anti-retroviral treatment, provisioning of condoms and enhance awareness for HIV prevention. These have been done through three consecutive phases of National AIDS Control Programme (NACP-I, II & III).

NACP Phase I (1992-1999) established the administrative and technical basis for Programme management and formed the State AIDS Control Societies (SACS) in 25 states and 7 union territories. The overall objective during this phase was to slow and prevent the spread of HIV with a thrust to prevent HIV transmission. The Programme also aimed at addressing the control of Sexually Transmitted Infections.

The author is working with an NGO and specialises on public Health/HIV issues.

During NACP-I, NACO provided nearly Rupees sixty crore, with 40 percent earmarked for blood safety, and 21 percent for awareness generation. "The Programme has managed to make a number of important improvements in HIV prevention such as improving blood safety," a health ministry official said.

In 1999, NACP II (1999- 2004) was launched which expanded the scope of HIV prevention activities with an increased budget of around Rupees 250 crore. The focus was to reach out to high-risk groups through targeted interventions - a package of services which entailed behaviour change communication, peer education, treatment of sexually transmitted infections, condom promotion, needle and syringe provision; creating an enabling environment and community mobilization. During the third phase of NACP from 2007-2012 the highest priority was placed on reaching to almost 80 percent of high-risk groups including sex workers, men who have sex with men, and injecting drug users. The aim of NACP III has been to reverse the epidemic through integration of prevention and treatment programmes, decentralised effort at the district level, and engage more non-governmental organisations. A new migrant strategy was launched to reach out to migrants- administered at source and destination points of the migrant populations.

Over the years, thus, there has been scaled-up coverage, decentralised management and better infrastructure and systems. Latest NACO data accomplishes providing prevention services to overall 31.32 lakh population covering 78 percent Female Sex Workers, 76 percent injection drug users, 69 percent men having sex with men, 32 percent migrants and 33 percent truckers. It has also enabled access to safe blood through a network of 1,127 Blood Banks, Syndromic Case Management

through 1,038 clinics, distribution of 25.5 crore pieces of condoms (until Jan 2011), counseling and testing through almost 7500 Integrated Counseling and Testing Centers and setting up 5.46 lakh condom outlets. Behaviour change communication, information education and communication and the much acclaimed Red Ribbon Express train (Phase II) traversing 25,000 kms and covering 152 stations across 22 states have been instrumental in awareness generation for HIV prevention.

Besides, appropriate programme planning needs data or evidence. As the National AIDS Prevention and Control Policy says "to adopt the right strategy for prevention and control of HIV/AIDS/STDs, it is necessary to build up a proper system of surveillance to assess the magnitude of HIV infections in the community." For reliable data on HIV and AIDS, thus HIV sentinel surveillance (HSS), Behavioural Sentinel Surveillance (BSS) and STD surveillance systems were initiated under the AIDS Control Program.

The HIV Sentinel Surveillance System covers all the districts of the country and gives HIV related data for Pregnant women attending Antenatal clinics, Patients attending STI Clinics, Female Sex Workers, Injecting Drug Users, Men who have Sex with Men, Migrant Population, Long distance Truckers, Eunuchs and Fisher folk as well as all the high risk population groups, comments NACO. Based on the data, all the districts in the country are categorized as A, B, C and D. Category A refers to high prevalence of HIV and D with lower prevalence rates. Likewise the Behavioural Surveillance Surveys (BSS) have information on knowledge, awareness and behaviors related to HIV and AIDS among general population, youth and different high risk groups. It also throws light on impact of the intervention efforts being undertaken by NACP.

India's HIV surveillance system has evolved over the years and has fulfilled several important programme needs ranging from estimating the number of people affected with HIV, targeting the highly affected geographic areas and vulnerable population groups, identifying new sub-epidemics, and evaluating the impact of interventions, reports NACO. NACO has also recently initiated a computerised management information system and a computerised project financial management system, for strengthened tracking and programme monitoring.

Realising that interventions for control of HIV infection need to be backed and synergised with quality research, the National AIDS Research Institute was set up by the Indian Council of Medical Research in 1992 simultaneously with the formation of NACO. The Institute is located at Pune, Maharashtra and carries out multi-disciplinary research on HIV and AIDS in different parts of the country. In similar lines, towards invigorating research for HIV prevention, the Translational Health Sciences and Technology Institute (THSTI) was recently launched by Former President of India, A.P.J. Abdul Kalam. This surely showcases the vision of the Government for an integrated and interdisciplinary approach. It also reinforces the importance for research-based and evidence informed programming, to address HIV and AIDS.

Such multifaceted and concerted efforts by Government and other stakeholders has shown positive results over the years. There has been decline of adult HIV prevalence at the national level from 0.41 percent in 2000 to 0.31 percent in 2009 and among Antenatal Care clinic attendees. Azad recently stated a 56 per cent drop in HIV-related cases in India and duly credited the strong prevention programme which goes hand in hand with care, support and treatment.

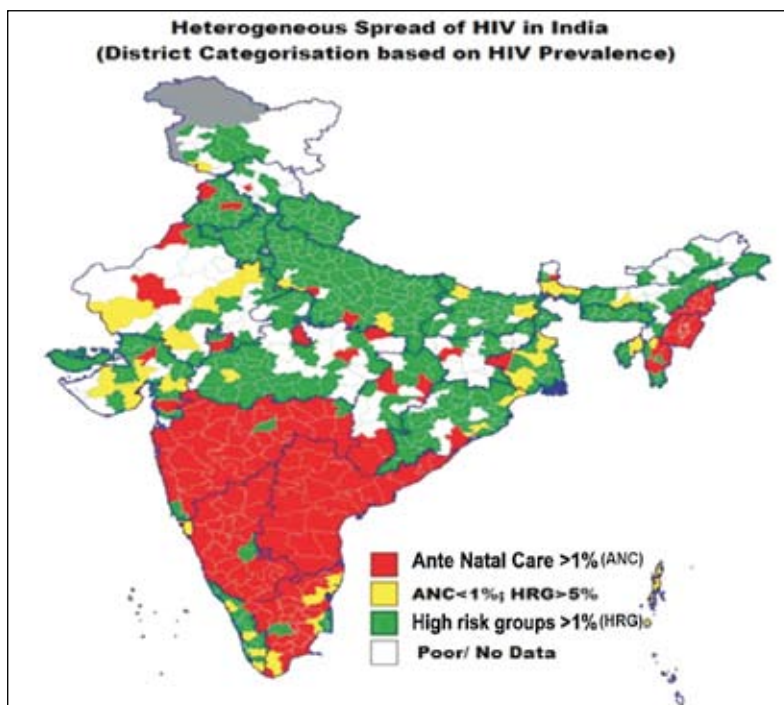
Meanwhile it's not a very happy state for Rameshwari, an Auxillary Nurse Midwife (ANM). She is expecting her second child, and during her routine Antenatal Care checkup it was revealed that she is HIV positive. Monogamous in practice, the detection came as a mix of extreme shock and resentment to her, more so when she was told that she contracted the infection from her husband, who was subsequently diagnosed HIV positive. Rameshwari is not a singulate voice, but representing many such men and women, especially in remote rural locations, many of whom are unaware of their own HIV status and often unknowingly infect their intimate partners/spouses.

Recent surveillance data shows that the epidemic is spreading from urban to rural areas, and from individuals practising risk behaviour to the general population, mentions the National AIDS Prevention and Control Policy. Acknowledging their surge in commercial sex-work, NACP, gearing up for its fourth phase (2013 onwards) calls for evidence generation and interventions for hard to reach populations in the non-brothel, non-street-based and home-based settings, especially in rural areas.

Rural population, particularly those along truck routes, migrant labour from rural to urban areas and wives/partners of male migrants are the most vulnerable groups to contract and transmit HIV. Problems compound with poor health infrastructure, restricted access to health facilities, inadequate surveillance, dearth of knowledge of HIV transmission and perception on prevention among the rural populace.

National Family Health Survey, Phase III (2006-07), the most comprehensive household level survey on health issues reveals 'poor knowledge' of HIV transmission and prevention

Map highlighting HIV prevalence in the country: Source NACO



among the rural masses than the urban. While 57.7 percent urban women knew that HIV cannot be transmitted by mosquito bite, only 28.3 percent rural women had the same information, the survey noted. Similar is the trend among rural male, wherein 67.3 percent urban men were aware that HIV could not be transmitted through mosquito bite, only 44.7 percent rural men know about the same. NFHS III also notes that young women living in urban areas were more than twice as likely as those in rural areas to have comprehensive knowledge of HIV/AIDS. A scanty 1.8 percent in the rural areas as against three times- 5.4 percent in the urban areas, were tested of HIV and received results. Utilisation of barrier/prevention methods is equally bleak, with condom use almost half (29.7 percent) among rural men as compared to the urban counterparts (52.9 percent).

Thus, with some evidence, much concern, yet little known about the dynamics, context and social impact on people living with HIV and AIDS in rural areas,

HIV in rural areas often remains silent and invisible. Discourses are beginning to highlight the need for adequate surveillance and systematic data on HIV and AIDS related deaths among the rural populations. Stakeholders are also concerned in 'how to' translate scientific breakthroughs into affordable, accessible and available interventions, customised for the rural poor.

'Combination Approach', addressing all the aspects- Prevention, Care, Treatment and Support, tailored for rural areas, could help in addressing the same. At one end while it is needed to step up research to understand the rural dynamics of the epidemic, at the other end HIV testing, provisioning of treatment and condoms, quality health personnel and awareness generation needs to be scaled-up as per the rural needs. This can surely lead to an AIDS free country- with zero incidence of HIV, zero AIDS related deaths and no stigma and discrimination. □

(E-mail: dutta1108@gmail.com)

DO YOU KNOW?

NATIONAL MISSION FOR JUSTICE DELIVERY AND LEGAL REFORMS

What is National Mission for Justice Delivery and Legal Reforms?

The National Mission for Justice Delivery and Legal Reforms was set up in June, 2011 to achieve the twin goals of increasing access by reducing delays and arrears; and enhancing accountability through structural changes and by setting performance standards and capacities. The Mission has become fully functional from 2012-13 and is pursuing strategic initiatives: outlining policy and legislative changes; re-engineering of procedures and court processes; focussing on Human Resource Development; and leveraging Information and Communication Technology & tools for better justice delivery.

What are the policy and legislative changes the Mission has undertaken?

The Mission has taken several steps in each of the strategic areas towards fulfillment of its objectives. Judicial Standards and Accountability Bill has been prepared. The Bill has already been passed by the Lok Sabha and is now before the Rajya Sabha for consideration. Constitution amendment bill for raising the retirement age of High Court Judges is also before the Parliament.

A comprehensive proposal has been formulated for constitution of All India Judicial Service and the 25 States have formulated their Litigation Policies.

What are the changes proposed for Court Procedures and Court Processes?

An important aspect of the

judicial reforms relates to re-engineering court procedures and court processes for early disposal of cases. A National Court Management System has been recently notified by the Supreme Court for addressing the issues of case management, court management, setting measurable standards for performance of the courts and the National System of Judicial Statistics in the country. The National Mission would coordinate with NCMS and would render necessary assistance in achieving the goal of reducing pendency in courts.

What is the impact on Infrastructure Development?

Infrastructure development for the subordinate judiciary is a major thrust area of the National Mission. With a view to enhancing the resources of the State Governments, the Government has increased the central share by revising the funding pattern from 50:50 to 75:25 (for States other than North Eastern States) under modified Centrally Sponsored Scheme for development of infrastructure facilities for the judiciary from the year 2011-12 onwards. The funding pattern for North-Eastern States has been kept as 90:10 from 2010-11.

What is the Gram Nyayalayas Act 2008?

The Gram Nyayalayas Act, 2008 has been enacted for establishment of Gram Nyayalayas at the grass roots level for providing access to justice to citizens at their doorstep. The Central Government provides assistance to States for

non-recurring expenses for setting up of Gram Nyayalayas and for meeting the cost of recurring expenses for running these Gram Nyayalayas for the first three years. At the time of enactment of Gram Nyayalayas Act it was envisaged that 5067 Gram Nyayalayas would be set up throughout the country for which Central Government would provide recurring and non-recurring assistance to States as per prescribed norms.

What is the Pendency Reduction Drive launched by the Government?

The Government had launched a pendency reduction drive from July 2011 to December, 2011. High Courts were requested by the Minister of Law and Justice to initiate a campaign mode approach towards clearing long pending cases and cases relating to marginalised sections of the society. As per feedback received from them, total pendency was reduced by over 6 lakh cases out of which about 1.36 lakh cases belonged to targeted groups such as senior citizens, disabled, minors and marginalised sections of society.

One of the important components of pendency reduction drive related to release of under-trial prisoners from jail. Around 3.16 lakh under-trial prisoners were released from the prisons during the campaign period.

A similar drive has been launched this year as well from July, 2012 to December, 2012. □



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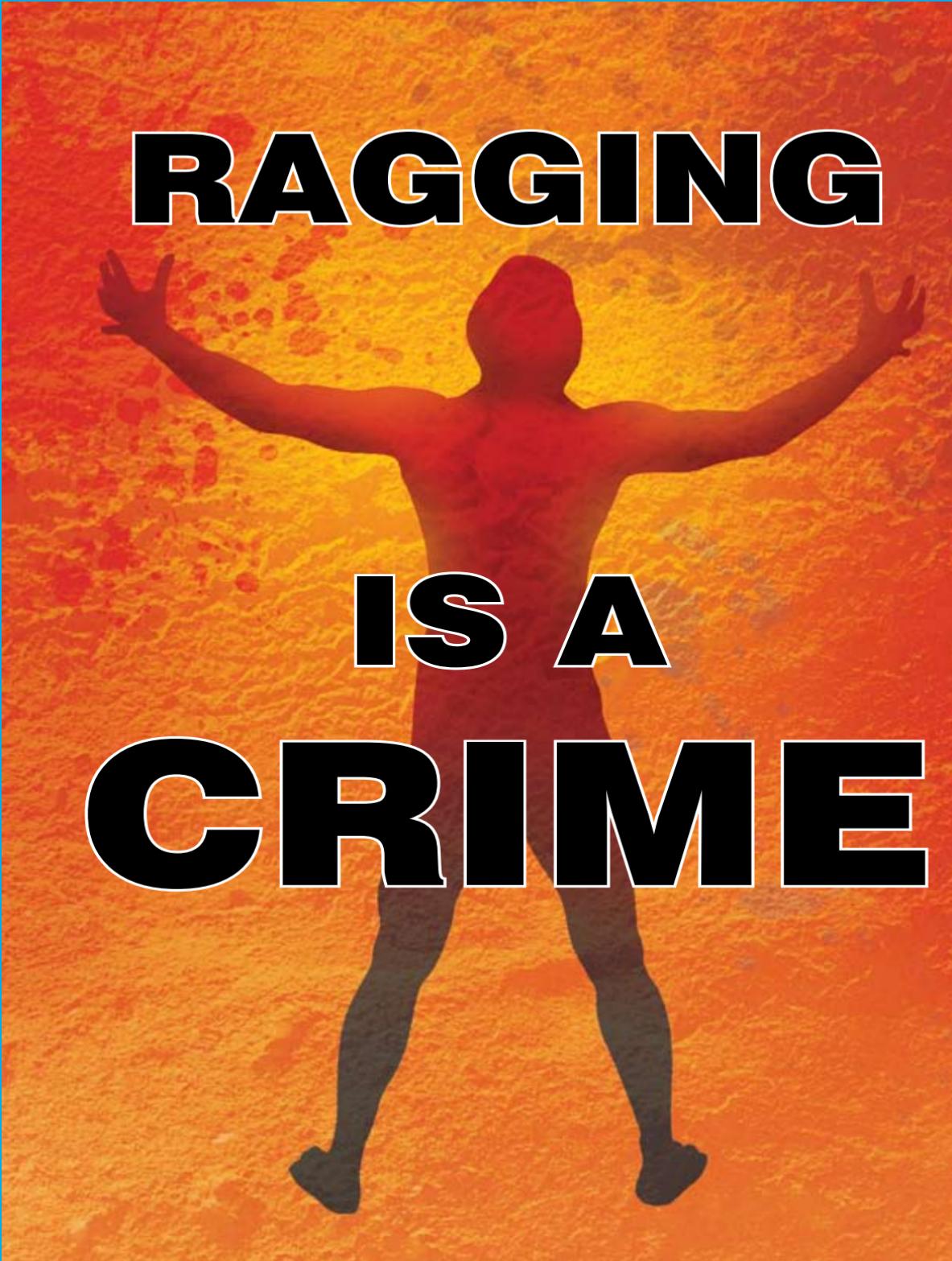
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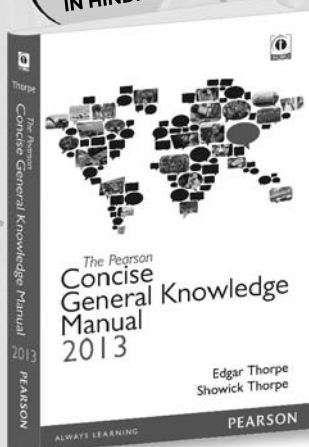
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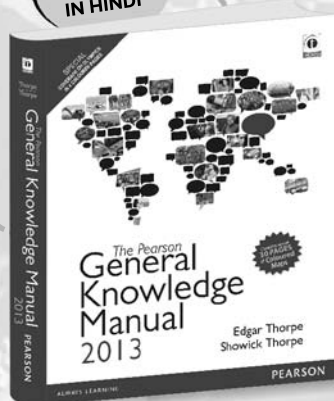
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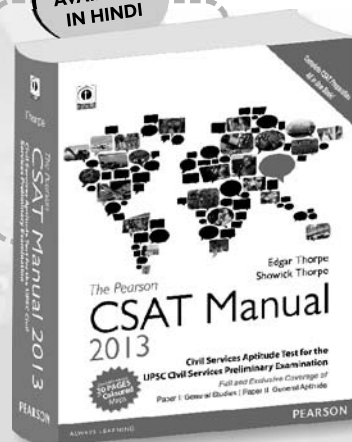


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YE-148/2012

Micronutrient Malnutrition – Ending 'Hidden Hunger'

Melanie Galvin



The prevention of maternal and child under-nutrition is a long term investment that will benefit the present generation, and their future generations too

VITAMINS AND minerals are vital components of good nutrition and human health, advancing physical and intellectual development in many important ways. And yet, around the world, billions of people live with vitamin and mineral deficiencies, quite pertinently termed as 'Hidden Hunger'. One in three people in the world suffers from hidden hunger. Women and children from the lower income groups in developing countries are often the most affected.

Hidden hunger is unlike the hunger that comes from a lack of food or calories. It is a chronic lack of vitamins and minerals that is often not evident and has no visible warning signs; therefore people who suffer from it may not even be aware of it. The consequences are nevertheless disastrous - it can increase child and maternal mortality, cause birth defects and developmental disabilities, contributes to and exacerbates global poverty, constrains women's empowerment and limits the productivity and economic growth of nations.

Fast Facts for India

Slowly and insidiously, 'the hidden hunger' of micronutrient malnutrition is sapping away the vitality of entire nations, including India. Consider these facts:

- Child under-nutrition and micronutrient deficiencies in India are among the highest in the world, -worse than many much poorer countries.
- 62 percent of pre-school children are deficient in vitamin A, leading to an estimated annual 330,000 child deaths.
- 9 percent of children under five are affected by diarrhoeal diseases, one of the two biggest killers of children.
- up to 60 percent of pregnant women, 63 percent breastfeeding mothers and 70 percent of pre-school children are anaemic.
- Only 71 percent of households currently consume adequately iodised salt, an ingredient absolutely vital for brain development.

It is a shocking state of affairs, especially when you consider that we have the means and know-

The author is Asia Regional Director, Micronutrient Initiative.

how to prevent it – and the cost is insignificant! Today, India is on the threshold of superpower status but it cannot be sustained without ensuring a certain basic standard quality of life to its citizens. It is no longer simply food security; rather, it is comprehensive nutrition security that we need to win the battle faster, and more efficiently.

There are several strategies to combat micronutrient malnutrition – dietary diversification, supplementation and food fortification to name a few. Of these, food fortification, or adding essential vitamin and minerals to foods that are consumed daily by a significant proportion of the population (such as flour, salt, sugar and oil) can cost as little as a few rupees per person per year and supplementation has been named by a panel of Nobel prize winning economists as the “best buy” in development, meaning it has the most benefits at a low cost.

The Micronutrient Initiative (MI), an international not-for-profit development organisation formed in 1992 by a group of like-minded donors, UN agencies and the World Bank to address the issue of micronutrient malnutrition, has been working in India since 1997 to support the provision of vitamins and minerals through the existing health systems in a number of states of India.

Priorities in India

Child Survival: Reducing under-five mortality

A child's growth curve is set for life in the first few years of life starting with its mothers pregnancy; not having adequate nutrition during this critical time has lifelong consequences on health, productivity

and economic growth. Poverty can lead to undernourishment and because of the harm it does to children's survival and potential, it locks people into poverty for current and future generations. Improving nutrition throughout the life is important; however, nutrition and health interventions during the critical first few days and years of a child's life can be particularly effective at improving a child's chance at survival, provide them with an increased learning ability over a lifetime, and can improve outcomes and maternal health.

Vitamin A

It is an alarming fact that 62 percent of pre-school children in India are deficient in vitamin A, leading to an annual 330,000 child deaths. Adequate Vitamin A supplementation amongst children helps drop the child mortality rate by as much as 23 percent amongst vitamin A deficient populations. It also reduces child blindness by up to 70 percent. For this reason, provision of high-strength vitamin A supplements is recognised as one the most cost-effective ways to improve child survival. Vitamin A supplements are an important part of an integrated package of essential services that promote child health and stop preventable deaths.

Zinc

No life-threatening childhood illness affects more children than diarrhoeal disease. Where it doesn't kill, it wreaks havoc on young bodies and lives - leading to millions of hospitalisations, weakening immune systems, holding children back from school and play, and contributing to long-term nutritional consequences. Zinc - one of the more abundant elements on earth - has quickly emerged as

an exciting new opportunity in the urgent quest to drastically reduce the number of global child deaths by the 2015 target for the Millennium Development Goals. When administered in conjunction with oral rehydration therapy, zinc has proven to be the most powerful tool to help children combat and recover from diarrheal disease. India has led the way globally on introducing programmes to scale up zinc, coupled with oral rehydration salts, to treat and prevent diarrhoea episodes.

Child Health, Growth and Development: Enhancing cognitive growth of young minds

Iodine is a vital element for early brain development in a fetus. Mild-to-moderate iodine deficiency impairs cognitive and motor function and severe iodine deficiency causes hypothyroidism with marked mental and growth retardation. Iron is essential for maternal and foetal health, learning and productivity. Iron deficiency can result in poor memory or poor cognitive skills and can result in poor performance in school, and at work.

Salt Iodisation

In order to achieve improvement in the status of iron and iodine, it is critical to reach women in their childbearing age and young children. Given how difficult it is to target these two groups, the global strategy of choice for preventing Iodine Deficiency Disorders (IDD) is universal salt iodisation (USI). Because salt is commonly consumed, even in impoverished areas, it is an ideal vehicle to carry iodine. Adding iodine to salt provides protection from brain damage due to iodine deficiency for whole populations, helping

people and countries reach their full potential.

Double Fortified Salt

In its efforts to reduce iron and iodine deficiency, MI has developed a new way to combine iron and iodine in salt. Using the momentum of the iodized salt programme, double fortified salt (DFS) could provide iron on a regular basis as well. As part of its efforts to reduce iron and iodine deficiencies in children, MI provided technical support to the Tamil Nadu Salt Corporation (TNSC), to start producing DFS. Through DFS programming in Tamil Nadu, MI has acquired considerable programme experience and is eager to partner with the government in scaling up of the DFS programme in the country.

Women's and Newborn Survival and Health: Empowering women by improving survival and health

Providing adequate iron to women of child bearing age and early in pregnancy is essential for their health and the health of their children. Folate promotes healthy foetal development of the spine, spinal cord, skull and the brain. Women need to have adequate folate levels in the earliest days of conception, when the nervous system is beginning to develop. Iron, folic acid and other essential micronutrients can be added to regularly consumed foods like wheat flour, rice and salt as they have been added in many parts of the world – virtually eliminating most birth defects.. These nutrients also help improve the quality of life for women. A strong and healthy woman can better provide for her family and her community. Iron supplementation and flour

fortification are two cost-effective ways to reach out to these women.

Policy environment for micronutrients in India and the Gaps

India realised the need to have nation-wide programmes to combat micronutrient deficiencies long before the rest of the world did and programmes such as the ones to address vitamin A deficiency (through the provision of high dose supplements to children 6-59 months), iodine deficiency (through universal salt iodisation) and iron deficiency (through the provision of iron supplements to pregnant women and children) were started as early as the 1970s.

Until the end of the 4th Five Year Plan (1969-1974), India's main emphasis was on the aggregate growth of the economy and reliance was placed on the percolation effects of growth. In the face of continuing poverty and malnutrition, an alternative strategy of development comprising frontal attack on poverty, unemployment and malnutrition became a national priority from the beginning of the 5th plan (1974-1979). This shift in strategy gave rise to a number of interventions to increase the purchasing power of the poor, to improve the provision of basic services to the poor and to devise a security system through which the most vulnerable sections of the poor (i.e. women and children) can be protected. In 1993, India developed a National Nutrition Policy, which proposed to tackle nutrition as a multi-sectoral issue which is to be tackled at various levels through direct short term interventions and indirect long term instruments which focus on institutional and structural changes. Several policy guidelines, such as the revisions to the national policy on iron and

folic acid supplementation, vitamin A supplementation, therapeutic zinc supplementation along with ORS for childhood diarrhoea and the revised nutritional and feeding norms for supplementary nutrition in Integrated Child Development Services (ICDS) have been issued by various ministries which have focused on what needs to be done to address micronutrient deficiencies in the country and how they should be implemented.

The country has taken many steps to address micronutrient deficiencies through national programs such as National Programme for Control of Blindness, National Iodine Deficiency Disorders Control Programme and National Anaemia Control programme through its various ministries. Programmes such as the Integrated Child Development Services scheme, Mid-Day Meal scheme and the Targeted Public Distribution System are meant to address malnutrition and while they have not yet had the desired outcome, these systems offer a natural platform to rapidly increase access to essential vitamins and minerals for vulnerable groups. The National Rural Health Mission through its architectural correction of the public health delivery systems and increased budgetary allocations has also provided an opportunity to address micronutrient deficiencies with renewed vigour. In addition, a number of UN and International agencies and private sector are involved in programme implementation and advocacy.

The Eleventh Five year plan (2007-2012) set clear goals to reduce malnutrition among children aged 0-3 years and anaemia among women and children by half by the end of the plan period. The Twelfth Plan proposes to break the vicious cycle of multiple deprivations faced

by girls and women because of gender discrimination and under nutrition. This cycle is epitomised by high maternal and child mortality and morbidity, and by the fact that every third woman in India is undernourished (36 percent per cent have low Body Mass Index) and every second woman is anaemic (55 percent per cent). Ending gender based inequities is proposed to be accorded high priority and these needs to be done in several ways such as achievement of optimal learning outcomes in primary education, interventions for reducing under nutrition and anemia in adolescent girls and providing maternity support.

Existing gaps identified in each of the micronutrient programmes include:

- 1) Vitamin A supplementation –there is a need to scale-up to improve coverage and strategies for hard to reach population
- 2) Zinc therapy: there is a requirement for programme scale-up in many States and developing and disseminating strong evidence on zinc treatment
- 3) USI: need for more focus on strengthening monitoring system and enforcement
- 4) Anaemia: strengthening programme implementation of iron and folic acid (IFA) and iron syrup administration for women and children, advocacy for innovative approaches to address anaemia among 6-24 month olds and evidence generation and consensus building on various fortification approaches.

Conclusions and Way Forward

One of the causes of poverty, and its perpetuation from one generation

to the next, is the fact that a large number of children across the world do not have the kind of start in life that allows them to fulfill the potential with which they were born. After years of spectacular developments, the facts are known, solutions are available and the cause is one in which many individuals and organizations, national and local governments, private sector, scientific community and civil society can become involved.

Children have the right to a healthy start in life and should grow up free from the preventable impairment of hidden hunger. Women have the right to the vitamins and minerals that enable their full economic and social participation in society. The prevention of maternal and child under-nutrition is a long term investment that will benefit the present generation, and their future generations too. □

(E-mail:mgalvin@micronutrient.org)

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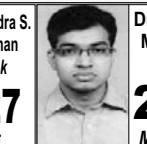

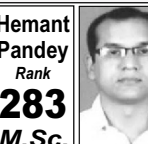












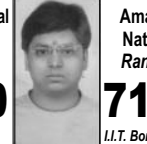


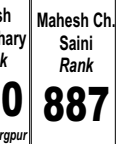
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YE-165/2012

WOODWORK : A RENOWNED KASHMIRI HANDICRAFT

Since Kashmir has a climate with months of snow and long winters, wood is a favoured medium for constructing homes, places of worship, even its famous houseboats and smaller ‘*shikaras*’, Kashmir’s answer to the gondolas of Venice. Kashmiri woodwork and carving is very famous, and workshops or ateliers take orders for furniture like beds and dressers, dining tables, chairs and buffets, living room sofas, tables, and chests, or tall folding screens, decorated with fine carvings of Kashmir’s signature *chinar* leaves, fruits and flowers, even dragons, most made to order for a discerning, often international clientele. Most carved pieces are made from walnut wood, a type of tree found all over the Kashmir valley.

Less well-known outside Kashmir are the ‘*khatamband*’ ceilings, a very special craft, and the ‘*pinjrakari*’ or ‘lattice’ work done on wood for Sufi places of worship, or house fronts, or even as lace-like trims on balconies, as well as on houseboats, those floating ‘luxury hotels’ from old times.



It is believed that in the 14th century a famous Persian Sufi from the ancient city of Hamadan, Sayyid Ali Hamadani arrived in Kashmir with a band of about 700 followers. The valley, convincing a large numbers of people, including the king, to convert to moderate Sufi Islam, and leaving a lasting imprint on the culture of the valley. With him came a number of Hamadan’s famous artisans who brought many new handicrafts to Kashmir, including the art of wood carving and ‘*Khatamband*’, plus fine shawl making. The Kashmiris proved to be apt pupils, and have practiced and refined those skills till today.

Once the skilled artisans from Persia and other places settled down in Kashmir from the 14th century onwards, they also started building Sufi shrines and mosques. A number of these structures are famous for their use of wood, for both building and decoration. One can find delicately carved balconies in Shah-e-Hamdan and in Naqshband Sahib. The walls and ceiling of the latter’s main prayer hall especially are decorated with ‘*Khatarnband*’ (Persian word) work, and its sanctum sanctorum contains a very intricately carved wooden screen.

In more recent times, this technique has been used especially for making ceilings with relief patterns in wood. The relief is usually made from thin panels of pine wood, and cut into geometrical designs, using hardly any nails in the process. This traditional skill was passed down from generation to generation, but is losing favour now, due to the high costs involved, and the difficulty in getting timber at affordable rates. It is done entirely by hand. It takes four people roughly 15 days of work to complete a 100 square foot ceiling. Many of the people involved in making such ceilings live in the Safakadal neighbourhood of Srinagar.

Traditionally, many Srinagar houses were made built mainly of wood. Wooden ceilings were suitable for a region with snow-bound, long winters, for they kept the houses warm in winter and cool in summer. These relief patterns added a touch of beauty and glamour. Such ceilings are highly prized, and adorn the houses of the rich as well as places of worship, and many houseboats. A beautiful example of it can still be seen in the old wing of the Maharaja’s former places, now the Lalit Grand Hotel.

Another prized technique is the delicate trellis or lattice work, to be found on wooden balconies that often jut out from the main structure, or it may cover the entire front of a house. The art of making *khatamband* ceilings and the trellis/lace woodwork, whether on balconies or on houseboats, is likely to die out, unless concerted efforts is made to keep it going, and make it worthwhile for the skilled craftspersons to devote the time and effort required to carve pieces of such intricate beauty. □

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YE-156/2012

Janani-Shishu Suraksha Karyakram

H Bhushan



JSSK has been launched, to ensure that each and every pregnant woman and sick neonates upto one month gets timely access to health care services free of cost and without any out of pocket expenses

IN JUNE 2011, Ministry of Health and Family Welfare, Government of India launched the Janani-Shishu Suraksha Karyakram (JSSK), a national initiative which entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.

The scheme emphasises utmost importance on “Free Entitlements”. The idea is to eliminate out-of-pocket expenses for both pregnant women and sick neonates. Under this scheme, pregnant women are entitled for free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for Caesarian section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth.

The JSSK initiative is estimated to benefit more than one crore pregnant women and newborns who access public health institutions every year in both urban and rural areas.

Why JSSK?

India has made considerable progress in reduction of Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR), but the pace

at which these health indicators are declining needs acceleration. The number of institutional deliveries has increased significantly, after the launch of Janani Suraksha Yojna (JSY) in the year 2005 but many of those who opted for institutional deliveries were not willing to stay for 48 hrs, hampering the provision of essential services both to the mother and neonate. Moreover, the first 48 hours after delivery are critical as complications like haemorrhage, infection, high blood pressure, etc are more likely to develop during this period and unsafe deliveries may result in maternal and infant morbidity or mortality.

Access to mother and child health care services were also hindered by high out of pocket expenses on user charges for OPD, drugs and consumables, diagnostic tests etc. In some cases such as severe anaemia or haemorrhage requiring blood transfusion can also increase immediate expenses. The same becomes still higher in case C section is being done. So, JSSK has been launched, to ensure that each and every pregnant woman and sick neonates upto one month gets timely access to health care services free of cost and without any out of pocket expenses.

Entitlements

Entitlements for Pregnant Women

Under JSSK, free Institutional Delivery services (including

The author is Deputy Commissioner, Maternal Health, Ministry of Health and Family Welfare, Government of India.

Caesarean operation) are provided in government health facilities. Also, medicines including supplements such as Iron Folic Acid are to be given free of cost to pregnant women. Further, pregnant women are entitled to both essential and desirable investigations like Blood, Urine tests and Ultra-Sonography etc. Furthermore, they are to be provided with free Diet during their stay in the health institutions (up to 3 days for normal delivery and 7 days for caesarean section). Not only this, there is a provision of free blood transfusion if the need arises. A significant number of maternal and neonatal deaths can be saved by providing timely referral transport facility to the pregnant women. Pregnant women are entitled to free transport from home to health centre, referral to higher facility in case of need and drop back from the facility to home. Besides, under JSSK there is exemption from all kinds of user charges including OPD fees and admission charges.

Entitlements for Sick Newborn

Free treatment is also provided to the sick Newborn upto 30 days after birth and all drugs and consumables required are provided free of cost in public health facilities. As in the case of the mother, the new born too is provided with free diagnostic services and there is a provision of free blood transfusion if the need arises. The facility of free transport from home to health institutions and back is also available.

Implementation of JSSK

All the States and Union Territories are implementing free entitlements under JSSK both to the pregnant women and sick neonate's upto one month of age. In brief, institutional deliveries are a key determinant of maternal mortality and quality provision of ante-natal and post-natal services can reduce infant as well as maternal mortality. Janani-Shishu Suraksha Karyakram supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant women and sick newborns.

Besides it would be a major factor in enhancing access to public health institutions and help bring down the Maternal Mortality ratio and Infant mortality rates.

However, the actual implementation of the scheme hinges on the proactive role played by state governments. The degree to which the scheme is successful would be determined by the extent to which the programme implementation is carried out by the State functionaries.

Brief Status of JSSK programme in the Country

Government of India has launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011. The initiative has been rolled out in all States and Union Territories under the overall umbrella of National Rural Health Mission (NRHM). The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries.

In the year 2012-13, a sum of Rs 2082.47 crores have been allocated to the States for the implementation of free entitlements under JSSK. A quick review was undertaken by the Ministry in select health facilities in 1 to 2 districts of 13 States between April to June, 2012 (6 EAG States and 7 others). The States included in the field visits are Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, HP, Karnataka, Maharashtra, M.P, Odisha, Punjab, Rajasthan and UP. The information provided in this report is based on the interaction with the pregnant women and mothers in OPD and IPD, service providers in the facilities and district level health administrators. The report has highlighted certain significant progress in JSSK programme which are as under.

Key Positives

User Charges in OPD and IPD for Pregnant women and sick children exempted in 10 out of the 13 States visited except Bihar, Chhattisgarh and Odisha.

Drugs and consumables

Availability of drugs in the facilities have improved. Out of the 13 states, 8 states are giving free drugs from within the facility. Situation of drugs in Madhya Pradesh, Bihar, Chhattisgarh, Odisha and Himachal is still far from adequate

Diagnostics

Availability of diagnostic facilities are better at the District Hospitals and even at CHCs and the routine tests for pregnancy wherever available (urine and blood) are being provided free of cost to pregnant women in the facilities.

Diet

Provision of diet in IPD for pregnant women has been started in 12 states at the District Hospital and CHC levels.

Referral transport

Out of the 13 states, in 10 states – Andhra Pradesh, Bihar, Himachal Pradesh, Punjab, Haryana, Rajasthan, Chhattisgarh, Madhya Pradesh, Gujarat, Karnataka national level emergency referral transport model is operational under PPP except for Haryana. Drop back has recently been started and is slowly picking up.

Display of entitlement and awareness of community

Health facilities in Andhra Pradesh, Maharashtra, Madhya Pradesh, Chhattisgarh and Gujarat had displayed the entitlements prominently. In the other states, display was sporadic, generally available in DHs and SDHs and partial at the PHC and SC levels.

Grievance redressal mechanism

Grievance Redressal Mechanism has been set up in some districts of Maharashtra, Madhya Pradesh and Chhattisgarh, however in rest of the states it is yet to set up a system for addressing grievances from patients with regard to JSSK entitlements. The review in 13 states also highlight some of the gaps in Referral Transport (specially drop back), grievance redressal, Display of entitlements and IEC which are being addressed. □

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YE-155/2012

Guarding Precious Lives: 108 Ambulance Service of Kerala

Ram Krishna Pillai

DESPITE MOUNTING pressures of fast growing population on the pace of socio-economic development, noteworthy achievements made by India in the health sector continue to receive international recognition and acclaim. In the recent decades overall living standard index and life expectancy have improved considerably in almost all states of our vast sub-continent. Deserving special mention, in health care initiatives the southern state of Kerala continues to be in the forefront. A number of health care indicators of Kerala is often comparable to European standards. In terms of social welfare and quality of life, Kerala is one of the most progressive states in the country. The state is credited with the highest life expectancy, lowest infant mortality and best sex ratio in the country. Innovative initiatives of the National Rural Health Mission (NRHM) have provided further boost to God's own country's strides in health sector.

NRHM activities have provided further fillip to Kerala's vibrant health care sector raising it to the level of international standard. Of all the health care initiatives of

NRHM in Kerala, "108 Ambulance Service" operated by Kerala Emergency Medical Service Project (KEMP) has become a huge success receiving wide admiration from the general public and media. Within just two years of launch "108 Ambulance Service" has saved fifty thousand precious lives in the two districts of Thiruvananthapuram and Alappuzha. The fact that in two years as many as 47 successful



deliveries have taken place inside these ambulances speak volumes about the reliability of the vehicle and the care extended by the para medical staff in these life saving vehicles. This round the clock service is indeed a boon both to the less privileged and well-to-do sections in rural and urban areas. Considering the very high rate of road accidents and related deaths in Kerala the service of 108 ambulance is all the more praise-worthy. Overall, 30 percent of the cases attended by 108 ambulance service is connected to road accidents.

Each ambulance, at par with European standards, costing Rs. 35 lakh is equipped with state-of-the-art life saving facilities and para medical staff and reaches the needy within minutes of dialing the emergency toll free number 108. Totally free service ensures that the patient is taken to the nearest well-equipped hospital of his or relatives' choice without wasting a single minute. In fact, KEMP is a network of most modern ambulance service interlinked with computer network. Voice logger, Geographical Positioning System (GPS), automatic vehicle trafficking system and mobile communication ensure hassle-free functioning. As of now, Thiruvananthapuram district has 25 and Alappuzha has 18 such ambulances in operation saving many a precious lives in emergency including fatal road accidents.

One of the beneficiaries, Prasad aged 52 hailing from Chirayinkeesh in Thiruvananthapuram told Yojana that he is still alive thanks to the prompt and efficient service rendered by 108 ambulance in March this year. Already confronted with multiple ailments like high blood pressure and diabetes he suffered a cardiac arrest around midnight and the nearby health centre indicated that chances of

The author is Editor of Yojana, Malayalam, Thiruvananthapuram.


his survival are remote. However, on request, the 108 ambulance reached the spot within no time and Emergency Medical Team (EMT) revived the patient on their way to a better equipped hospital a few kilometres away. Prasad pointed out that during his 33 years of employment in Dubai he has never come across such an effective medical help that too at very short notice.

A young mother Priya aged 22 gave birth to her child inside the ambulance safely on its way from her residence in Kilimanoor to a private hospital in the state capital. She too is all praise for the prompt service extended by the trained and compassionate medical team of the vehicle. Another beneficiary, 81 year old V Alexander from Mavelikkara in Alappuzha also mince no words in saluting the service. His son, working in USA, who happened to be with his father when they received the service said that team of paramedical staff reached the spot very quickly despite torrential rain at midnight.

Highlighting the success story of KEMP-108 ambulance service and the change in attitude of people towards accident victims the state coordinator of the service Rajeev Shekhar, "Till a few years ago people were either frightened of legal implications or just indifferent to help road accident victims. Now the attitude especially of young people is fast changing. On an average we get eight calls about a particular road accident case from different people. People take pride in rescuing life by informing 108 ambulance services. A very welcome change in a densely populated state like Kerala with unusually high road accident rates".

The on-going operating expenses of the ambulance service is met by the state health department. With funds to be provided by the Centre under NRHM, 283 number of ambulances are likely to join the fleet by the New Year spreading the sought after service to all fourteen districts of Kerala. Apart from this, since the state government is in the process of finalising setting up of dedicated trauma care hospitals in every district, 198 number of additional ambulances are also to be pressed into service in the near future. All put together, in minimising deaths from non-communicable diseases, road accidents and other exigencies like natural and manmade disasters, the role played by 108 ambulance service will be growing from strength to strength in coming years. Hats off to the meticulous service of a dedicated team of para medics, technicians and drivers for their success saga of saving precious lives. □

(E-mail: yojanamal50@yahoo.co.in)


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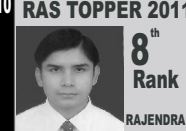
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YE-158/2012

Occupational Lifestyle Diseases in India

Jomon Mathew



The emerging lifestyle diseases not only affect the economic conditions of the individuals but also the productivity of the economy which is going to be threatened dangerously in the near future

LIFESTYLE DISEASE is one associated with the way a person or group of people lives. In other words, lifestyle diseases characterise those diseases whose occurrence is primarily based on the daily habits of people and are a result of an inappropriate relationship of people with their environment. These diseases include hypertension, heart diseases, stroke, diabetes, obesity, diseases associated with smoking and alcohol and drug abuse, cancer, chronic bronchitis, premature mortality etc. Lifestyle diseases which are also called diseases of longevity or diseases of civilisation interchangeably are diseases that appear to increase in frequency as countries become more industrialised and people live longer. There are several factors leading to the occurrence of lifestyle diseases including factors like bad food habits, physical inactivity, wrong body posture, and disturbed biological clock. However, the significant factor contributing to lifestyle diseases of the present day may be regarded as the occupational nature of the people. The occupational pattern in India has undergone drastic

changes in recent decades giving priority to IT and other similar services neglecting the very base of the agrarian culture. Along with these changes in occupation, the food habits of the society too changed that gradually caused the spread of several lifestyle diseases in our society.

Mounting figures of lifestyle disorders

Several studies have been conducted by different organisations to identify the magnitude of lifestyle diseases in India. According to a survey conducted by the *Associated Chamber of Commerce and Industry (ASSOCHAM)*, 68 percent of working women in the age bracket of 21-52 years were found to be afflicted with lifestyle disorders such as obesity, depression, chronic backache, diabetes and hypertension. Another study by *Preventive Healthcare and Corporate Female Workforce* summarised that long hours of work under strict deadlines cause up to 75 percent of working women to suffer from depression or general anxiety disorder, compared to women with lesser levels of psychological demand at work. Women employed in sectors that demand more time like those in media, knowledge

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process outsourcing and touring jobs are unable to take leave when they are unwell. These tensed and continuous working conditions force themselves to work mainly due to job insecurity, especially during the current financial meltdown. In India, around 10 percent of adults suffer from hypertension while the country is home to 25-30 million diabetics. Three out of every 1,000 people suffer a stroke.

IT sector has been playing dominant role in Indian economy both in terms of contribution to GDP and its employment generation capability. It was estimated that this sector has increased its contribution to India's GDP from 1.2 percent in FY 1998 to 7.5 percent in FY 2012. Moreover, this sector has also led to massive employment generation. The industry continues to be a net employment generator - expected to add 230,000 jobs in FY 2012, thus providing direct employment to about 2.8 million, and indirectly employing 8.9 million people. Generally being a dominant player in the global outsourcing sector Indian IT sector has emerged to be a key development strategy. Due to the above factors, majority of Indian youth depend directly or indirectly on this priority sector. However, according to the findings of the study by ASSOCHAM, around 55 percent of young workforce engaged in India's IT and ITES sector are stricken with lifestyle disorders due to factors like hectic work schedules, unhealthy eating habits, tight deadlines, irregular and associated stress. More than half of the respondents participated in the survey said that due to 24 x 7 working environment and irregular food timings they directly place orders to fast food outlets, street food vendors and roadside eateries operating outside their offices serving ready to eat high calorie

processed food items like noodles, burgers, pizza, and fried stuff like samosas along with aerated drinks, and coffee, etc.

Sleeping disorders are alarmingly growing among the employees in the corporate work field. ASSOCHAM records that 78 percent of corporate employees suffer from sleeping disorders leading to *Impact of Insomnia on Health and Productivity*. Due to demanding schedules and high stress levels, nearly 78 percent of the corporate employees sleep less than 6 hours in a day which leads to sleep disorders amongst them. The report is based on the survey conducted in the major cities like Delhi, Mumbai, Kolkata, Chennai, Ahmedabad, Hyderabad, Pune, Chandigarh, Dehradun etc. As per ASSOCHAM'S corporate employees' survey result, 36 percent of the sample population are also suffering from obesity. It can be logically summarised that obesity alone can modify occupational morbidity, mortality and injury risks that can further affect workplace absence, disability, productivity and healthcare costs. Almost 21 percent of the sample corporate employees suffer from another serious lifestyle disease called depression. High blood pressure and diabetes are the fourth and fifth largest diseases with a share of 12 percent and 8 percent respectively as suffered among the corporate employees.

A striking case of life style disorders found in the India's most developed state, Kerala which is almost on par with some of the European countries and America in terms of development indicators. The state is fast emerging as the lifestyle diseases capital of India with the prevalence of hypertension, diabetes, obesity and other risk factors for heart disease reaching levels comparable to those in America, as revealed in a recent

study done by Dr K R Thankappan and his colleagues at the Achutha Menon Centre for Health Science Studies. It was found that overall prevalence of diabetes in Kerala is about 16.2 percent. This is estimated to be 50 percent higher than in the US, according to the results of the study published in the *Indian Journal of Medical Research*. High blood pressure is present in 32 percent people, comparable to recent estimates in the US. Close to 57 percent people studied had abnormal levels of cholesterol, while 39.5 percent had low HDL cholesterol. The prevalence of smoking in men and use of alcohol are dangerously growing in the state. This transition of the state to an era of life style diseases is driven by economic growth, urbanization and our changing food habits.

Economic and productivity impact

It is predicted that globally, deaths from non communicable diseases (NCD) will increase by 77 percent between 1990 and 2020 and that most of these deaths will occur in the developing regions of the world including India. These conditions not only cause enormous human suffering, they also threaten the economies of many countries as they impact on the older and experienced members of the workforce. In India alone, heart ailments, stroke and diabetes are the most demanding ones which are expected to take away the country's gross national income to a huge extent by the year 2015.

As per the report, jointly prepared by the *World Health Organization and the World Economic Forum*, India will incur an accumulated loss of \$236.6 billion by 2015 on account of unhealthy lifestyles and faulty diet. The resultant chronic diseases like heart disease, stroke, cancer, diabetes and respiratory

infections which are ailments of long duration and slow progression, will severely affect people's earnings. The income loss to Indians because of these diseases, which was \$8.7 billion in 2005, is projected to rise to \$54 billion in 2015.

ASSOCHAM's healthcare survey further reveals that 41 percent of employees spend in the range of Rs.500-5000 on health care in a financial year. Over 36 percent of the survey respondents say that they spend less than Rs. 500 on their health expenditure in a year. 21 percent of the employee's health expenditure ranged between Rs. 5,000-50000, as they suffered from diabetes, acute liver disease, kidney disease, high blood pressure and stroke. Merely 2 percent of the employees spend more than Rs. 50,000 due to heart disease, paralytic attack, surgery etc.

India's rapid economic growth could be slowed by a sharp rise in the prevalence of heart disease, stroke and diabetes, and the successful information technology industry is likely to be the hardest hit. So-called lifestyle diseases are estimated to have wiped \$ 9 billion off the country's national income in 2005, but the cost could reach more than £ 100 billion over the next 10 years if corrective action is not taken soon. The study by the

Indian Council for Research on International Economic Relations says that although India's boom has brought spiralling corporate profits and higher incomes for employees, it has also led to a surge in workplace stress and lifestyle diseases.

The emerging lifestyle diseases not only affect the economic conditions of the individuals but also the productivity of the economy which is going to be threatened dangerously in the near future. As majority of employees especially those in the IT sector suffer from different types of health disorders and obesity, the productivity that depends on the efficiency and enthusiastic involvement of youth may in all way have to be compromised. The wrong choice of occupation in the blind run for higher salaries and the resultant developing food habits generate all kinds of evil effects to the health of our youth. Over exploitation of the potentials of our youth particularly those in the IT sector may in course of time depreciate their efficiency and productivity leading to poor economic performance of the economy.

Concluding remarks

A healthy lifestyle must be adopted to combat these diseases

with a proper balanced diet, physical activity and by giving due respect to biological clock. To decrease the ailments caused by occupational postures, one should avoid long sitting hours and should take frequent breaks for stretching or for other works involving physical movements. In this revolutionised era we cannot stop doing the developmental work, but we can certainly reduce our ailments by incorporating these simple and effective measures to our lives. The working conditions especially in the IT sector should be properly monitored assuring that the potentials of our youth are not overexploited by the corporate profit motive employers. Moreover, the consumption pattern giving priority to fast food culture has to be effectively controlled. Even though, consumerism increases spending and boosts a country's economy therefore increases its status around the globe, the evidence presented demonstrates the effects of unregulated consumption in modern society. Here is the role the media, marketers and social class play in moulding an individuals' identity, protecting their good health and the efficiency and productivity of nation's huge human resources. □

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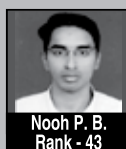
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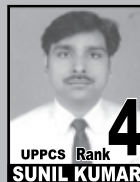


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Reaper Windrower



The novelty of the innovation lies in the design and spatial arrangement of the windrowing attachment, which achieves minimal grain loss. The gathered crop drops inline between the tyres in a neat row for collection and facilitates the next parallel run

AN AGRICULTURIST from Sojanawale, Bhagwan Singh Dangi (55) has made a front-mounted, self-propelled reaper cum windrower, which reduces shattering losses to the minimum.

Sojanawale is 37 km from the district head quarter Vidisha where Bhagwan Singh was born to Preetam, a farmer and Saraswati, a home-maker. The village, with a population of about 1200, is predominantly based on agriculture. In his family, Bhagwan Singh has his wife, two sons and three daughters. All his children are graduates. His elder son helps in his farm while the younger one is pursuing his diploma in computers and preparing for competitive exams. He owns about 12 hectares of tube well irrigated land where he grows soybean, black gram, green gram in *kharif* and wheat, gram, *masoor*, pea nut in *rabi*.

Though his brothers completed their graduation but the charm of agriculture bit Bhagwan and he left studies after class twelve in 1973. He turned his attention to farming, simultaneously, pursuing his aptitude of building and repairing farm implements. Being creative since childhood, he had always enjoyed tinkering with farm implements and building them in novel and customized ways.

One of his first designs was a front mounted blade for the tractors made in 1985, which could be employed for land leveling and bunding. Next, in 1995 he developed a rubber accessory for increasing the discharge of borewells by over 40 per cent. He continued mending small gadgets and the farm implements for years before he came up with the idea of making a reaper cum windrower, which unlike the conventional ones could reduce the shattering loss.

Genesis of innovation

Soya bean is a major crop in his village. With labour shortage, harvesting becomes a great challenge, and often results in repeated opportunity losses during the peak season. Bhagwan Singh started exploring the market for machines, which would harvest quickly and with minimal grain loss. He needed a machine to execute two main functions- reaping and windrowing. Reaping involves cutting the crops systematically where as windrowing involves laying the cut stalks in windrows for easy bundling and post harvesting processes.

Some of the machines he came across were self-propelled reapers placing the harvested crop on one side of the machine, which lead to high shattering losses. Moreover, large portions of the stalks were left in the fields, which required manual clearance before the next run. This

arrangement was not feasible for small fields with frequent turns as it damaged the standing crop. The reaped crop was carried all along the row, which was dropped only at the turns. This created an unnecessary load on the engine and hence added to fuel consumption

He conceptualized building a light, agile vehicle with a front mounted hexagonal rotating reel, with mechanism for cutting and dropping the crops. Working with the available resources, he came out with the first prototype using 2 hp motor in 2001. Inspired he decided to start his own workshop where he could give shape to his imagination and creativity. He took a loan against his property and opened the workshop in 2004. All this while he continuously worked on his design and improved his idea. The modified prime mover had 18 hp engine instead of the earlier 2 hp one and a centrally placed reaping and windrowing machine. It took him over a year and 10 lakh rupees to develop, test and modify the individual components and assemblies.

The reaper cum windrower

The unit is an improved reaper cum windrower comprising an engine, power transmission system, cutter blade, reel, conveyor, steering system and four pneumatic wheels.

As the unit moves forward, the rotating hexagonal reel equipped with crop collectors in the front pushes the standing crop towards the cutter bar. The windrower unit, consisting of two conveyor belts with iron lugs mounted on rollers and moving in opposite direction, drops the crop in the space between the tyres.

This configuration overcomes the shattering loss as in the subsequent turn; the tyres do not run over the harvested crop.

In the present prototype the prime mover for the reaper is an 18

hp 4 cylinder water cooled engine, with a rated speed of 4000 rpm. The unit is fitted with four wheels sourced from the Jeep vehicle. The cutter bar height can also be adjusted between 90 cm and 10 cm using a hydraulic system.

The machine requires only one person to drive the unit and two persons at the rear to collect the produce. Apart from rice, it can be used to harvest wheat, pulse and soybean. It is capable of working in small fields, taking sharp turns and not damaging the standing crops. It has a field capacity of 0.6 hectares per hour and saves more than 70 per cent of the labour costs achieving timely harvesting.

Bhagwan Singh has recently come up with a reaper windrower as an attachment for mounting in the front of a tractor. It takes drive from the engine crankshaft directly. A gearbox has been incorporated for aligning the driving and driven shafts. The attachment seems to have a huge potential but is yet to be adequately tested in the field.

The prior art reveals two types of reapers. The first one is the rotating blade type for ratings below 6 hp and the reciprocating blade type for higher ratings. In these conventional units, the harvested crop is dropped perpendicular to the travel of the prime mover causing a lot of grain loss.

The novelty of the innovation lies in the design and spatial arrangement of the windrowing attachment, which achieves minimal grain loss. The gathered crop drops inline between the tyres in a neat row for collection and facilitates the next parallel run.

The toughest part in the fields is harvesting as for most of the other activities, machines are available. But, only wealthy farmers can afford a harvester, I want to bring this reaper cum windrower in the market so that it brings respite marginal farmers who can also afford it owing to its lower cost.

Considering the fact that in Bhagwan Singh's, it takes 25 farmhands to do manual harvesting of one hectare. At the rate of Rs. 100 per labour Rs. 2500 are spend per hectare.

Using this machine only three people are required and 15 litres of diesel is consumed for completing 5 hectares in a day. This means an expenditure of only Rs. 825 and an average cost of Rs. 200 per hectare.

Apart from reaping, the machine can do weeding and drilling operation after attaching a separate accessory. The chain and socket drive gains power from the engine and drives the seeding mechanism, which can do seeding at desired depth and plant spacing. The weeding arrangement is provided in front of the seeding mechanism so that, so that the weeds are removed from the field before the seeds are sown.

Considering its applications, NIF facilitated its value addition by developing it as attachment for tractor at CMERI Durgapur under the NIF-CSIR Fellowship Scheme, which is underway. The innovation has also received local media coverage. This has resulted in over 150 enquiries from various districts. Patent was filed by NIF in the name of the innovator in 2007.

Apart from his works in agriculture sector, he also has conceived an idea about generating electricity from the road transport. He also wants to continue developing new farm implements, agricultural practices and seed varieties. He dreams of the day when his reaper unit would be used in large numbers and help large number of marginal farmers across the nation. About common practices employed by an average farmer, he remarks that a lot of improvement is needed for optimal growth. □

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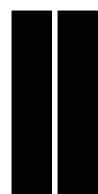
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NORTH EAST DIARY

WORLD WAR II MUSEUM COMING UP IN ARUNACHAL

The tourism industry in Arunachal Pradesh has received a shot in the arm with the Union Ministry of Culture sanctioning funds for construction of a museum in memory of those who laid down their lives in World War II at Nampong in Changlang district. The Second World War Memorial Museum, which will come up adjacent to the historic Stilwell Road, is expected to boost tourist inflow from South East Asian countries.

The museum, to be constructed with a sanctioned amount of Rs 2.25 crore, will also be in honour of the Arunachalees who laid down their lives fighting under the British. The sanctioned fund had already been released in the current fiscal and the department was undertaking the site selection job for the proposed museum. The museum would not only preserve the remnants of the War, but also personal belongings of the soldiers and other persons involved. The Stilwell Road, near which the museum will be set up, is part of a tourist circuit where there already exists a World War II cemetery near Jairampur, Hell Gate and the Iron Bridge, the last two being the living testimonies to the WW II. The National Highway Authority has been undertaking renovation and construction of the Stilwell Road up to Pangsau Pass, the last Indian post. The NHA has been asked to re-align the road near the Hell Gate and the Iron Bridge so that both structures could be preserved as historical evidences of the War.

Not long after the construction of the Stilwell Road was completed and the first convoy of Allied supplies reached China in February, 1945, the Second World War ended. The Stilwell Road's construction and the airlift of supplies from Assam to Yunnan in China across mountains exceeding 10,000 feet are considered to be one of the most remarkable chapters of World War II. It was necessitated following the Japanese invasion of China and the consequent inability of the Allied Forces to reach supplies to China by sea. To make matters worse, the Japanese land thrust towards India from South East Asia cut off access to the Burma Road once Myanmar fell.

The airlift from Assam, called "Flying the Hump", became a legend in aviation history. Flown by American and Chinese pilots, several aircraft were lost on the way. Lobbying to re-open the Stilwell Road, much of which lay in Myanmar, has been on for some time. Nampong, where the museum is proposed to be built, is a town where unofficial trade between Myanmar and India is carried out. Trade articles on offer include packaged food items, garments, toiletry, cosmetics, porcelain and small gadgets. Border policing in these parts works on the principle that people residing in the neighbourhood of the international divide be allowed to cross. There are specific days for visits by either side. Soon the region will gain the official status of a tourist circuit. □



GREEN INDIA MISSION IN NAGALAND

Entire Nagaland is vulnerable to climate changes as per studies conducted by the Indian Institute of Science, Bangalore, even as the Composite Forest Vulnerability Index (CFVI) shows that significant proportions of the forests in Nagaland are vulnerable to climate change risks. In this regard, two most vulnerable districts in Nagaland – Mon and Mokokchung – have been identified for implementation of the Green India Mission (GIM) project covering 12 villages. The mission aims at responding to climate change in the forest sector, namely adaptation, mitigation, vulnerability and ecosystem services, and further aims to take a broader approach to address the drivers of forest degradation while supporting communities meet their basic necessities of fodder, fuel-wood and livelihood.

Nagaland has sufficient forest area but the need here is to improve the quality of the forest, which is as important as expanding areas under forest. The objectives are to improve the income of the forest dependent villagers also. In this regard, the need to work with the people to harness and improve the quality at one go by simultaneously providing scientific knowledge to the villagers is important. □

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