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**EVERYDAY IS
A CHANGE,
TO BE
BETTER**

Melioidosis

- It is a bacterial infectious disease caused by *Burkholderia pseudomallei*.
 - *B. pseudomallei* lives in surface water (streams, rivers, lakes) and soil, mostly in tropical or subtropical areas.
 - It is endemic in Southeast Asia, northern Australia, much of the Indian subcontinent, southern China, Hong Kong, and Taiwan.
 - It is also sometimes called Whitmore's disease.
 - It has a high case fatality rate (CFR) ranging from 16% to 50% in known endemic regions.
-
- **Transmission:**
 - Both humans and animals can get melioidosis, but people can't get it from animals.
 - It's spread to people and animals through direct contact with soil, air, or water contaminated by the bacteria.
 - Cases may increase after hurricanes, heavy rain, and other severe weather events because the bacteria rise to the surface of the soil.

Melioidosis

- In areas where it's more commonly found, melioidosis usually affects adults 40 to 60 years old with certain underlying conditions. Children under 15 rarely get melioidosis.
- Symptoms:
- Melioidosis may present with localised infection (such as cutaneous abscess), pneumonia, meningoencephalitis, sepsis, or chronic suppurative infection.
- Depending on the site of infection, common symptoms include fever, headache, localised pain or swelling, ulceration, chest pain, cough, shortness of breath, haemoptysis, and swelling of regional lymph nodes.
- Treatment:
- It can be treated with antibiotics.
- Long-term treatment may be necessary for some chronic infection cases.

PM-YUVA 3.0

- The Prime Minister's Scheme for Mentoring Young Authors (PM-YUVA 3.0) aims to train young and budding authors below 30 years of age to promote reading, writing, and book culture in the country.
- The scheme will help to develop a stream of writers who can write on various facets of India, encompassing the past, present, and future.
- PM-YUVA 3.0 intends to bring to the fore the perspectives of the young generation of writers on the following themes:
- Contribution of Indian Diaspora in Nation Building;
- Indian Knowledge System; and
- Makers of Modern India (1950-2025).
- Besides, the scheme will also provide a window for the aspiring youth to articulate themselves and present a comprehensive outlook of the contribution of Indians across fields in ancient and present times.
- The National Book Trust (NBT), India, under the Ministry of Education as the Implementing Agency, will ensure phase-wise execution of the scheme under well-defined stages of mentorship.

PM-YUVA 3.0

- A total of 50 authors will be selected. The selection will be made by a committee to be constituted by NBT.
- Applicants who had qualified for the PM-YUVA Scheme 1.0 and PM-YUVA Scheme 2.0 are not eligible for the PM-YUVA 3.0 scheme.
- The selected young authors will engage with esteemed writers, participate in literary festivals, and contribute to a diverse body of work that reflects India's rich heritage and contemporary progress.
- The books prepared under this scheme will be published by National Book Trust, India, and translated into other Indian languages, fostering cultural and literary exchange while promoting 'Ek Bharat Shreshtha Bharat'.
- A consolidated scholarship of Rs. 50,000 per month for a period of six months ($50,000 \times 6 =$ Rs. 3 Lakh) per author will be paid under the Mentorship Scheme.
- A royalty of 10% will be payable to the authors on successful publications of their books at the end of the Mentorship Program.
- They will also be given a platform to promote their books and also to propagate the reading and writing culture on a national scale.

SpaceX Crew docks with ISS to reach astronauts stuck in space for 9 months

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Agence France-Presse

KENNEDY SPACE CENTER

A pair of astronauts stranded for more than nine months on the International Space Station were a step closer to returning home on Sunday after a replacement crew docked with the orbital outpost.

The astronauts were shown on live TV embracing and hugging their counterparts in zero gravity on the space station shortly after their SpaceX Crew Dragon arrived at 0545 GMT (1115 IST).

Butch Wilmore and Sunita Williams have been stuck aboard the ISS since June after the Boeing Star-



Sigh of relief: The SpaceX Dragon Crew-10 members clap after entering the International Space Station on Sunday. AFP

liner spacecraft they were testing on its maiden crewed voyage suffered propulsion issues and was deemed unfit to fly them back to Earth.

Ms. Williams said it was a “wonderful day” and “great to see our friends arrive,” speaking shortly after her colleagues emerged onto the orbital lab.

The NASA duo’s *Starliner* had returned to Earth empty, without experiencing further major issues – leaving them stuck for nine months after what was meant to have been a days-long roundtrip. Their prolonged stay was significantly longer than the standard ISS rotation for astronauts of roughly six months.

Mr. Wilmore and Ms. Williams will now begin preparing for departure and their ocean splashdown off the Florida coast, no sooner than March 19.

The replacement Crew-10 team had blasted off on Friday from the Kennedy Space Center in Florida.



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- Butch Wilmore and Sunitha Williams have been stuck aboard the ISS since June after the Boeing Starliner spacecraft they were testing on its maiden crewed voyage suffered propulsion issues and was deemed unfit to fly them back to Earth.

International Space Station

- **The International Space Station (ISS) is the largest man-made object in space launched on November 20, 1998. It serves as a habitat for astronauts in space. Since 2011, the ISS has been continuously inhabited.**
- **Participating States:** ISS is a collaborative project of the United States (NASA), Russia's (Roscosmos), Europe's (ESA), Japan's (JAXA), and Canada's (CSA) space agencies.
- **Orbit:** The International Space Station is in orbit about 400 kilometres above Earth.
- **Speed:** It travels around Earth at a speed of about 28,000 kilometres per hour. This means that it orbits Earth about every 90 minutes.
- **Objectives:** To expand our knowledge about space and microgravity and promote new scientific research. It also serves as an example of international cooperation.

Fact

- **Russia:** Salyut 1 was world's first space station launched by the Soviet Union on April 19, 1971. Then Russia launched various space stations from Salyut 2 to Salyut 7, and Mir.
- **China:** Tiangong 1 launched in 2011, Tiangong -2 launched in 2016 were test space labs and Tiangong space station was launched in 2021 (fully operational since late 2022).
- **USA:** Skylab: USA's first space station, launched by NASA in 1973.

Future missions:

- **NASA's Artemis Base Camp on the moon's surface and the Gateway in lunar orbit.**
- **India's Bharatiya Antariksha Station.**

Taking wing



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Nascent hope: An Indian long-billed vulture sits with its chick atop a cliff at India's only vulture sanctuary, Ramadevarabetta, near Bengaluru, on Sunday. The season marks the fourth consecutive year of successful breeding at the sanctuary, a sign of hope for the endangered species. K. MURALI KUMAR

Content.

- **India is home to 9 species of Vulture namely the Oriental white-backed, Long-billed, Slender-billed, Himalayan, Red-headed, Egyptian, Bearded, Cinereous, and the Eurasian Griffon.**
- **A significant decline in vulture populations has been observed in South Asian nations, particularly India, Pakistan, and Nepal.**
- **This decline is primarily attributed to the widespread use of diclofenac, a veterinary drug, during the late 1990s and early 2000s.**
- **This resulted in a population decline exceeding 97% in some regions, creating a consequential ecological crisis.**

Role of Vultures in Ecosystem:

- **Decomposition and Nutrient Cycling:**
- **Vultures efficiently consume carrion (dead animals), preventing carcasses from accumulating and rotting.**
- **This helps to decompose organic matter and return nutrients back into the soil, which benefits plant growth and the overall health of the ecosystem.**
- **Disease Prevention:**
- **Vultures have incredibly strong stomachs with very acidic digestive juices. This powerful acid can kill bacteria and viruses that can cause diseases like anthrax, rabies, and botulism, thus, acting as true “dead-end” for pathogens.**
- **Indicator Species:**
- **Vultures are sensitive to changes in their environment. A decline in vulture populations can be an indicator of a wider ecological problem, such as pollution or a shortage of food sources.**

1.	Oriental White-backed Vulture (<i>Gyps Bengalensis</i>)	Critically Endangered	
2.	Slender-billed Vulture (<i>Gyps Tenuirostris</i>)	Critically Endangered	
3.	Long-billed Vulture (<i>Gyps Indicus</i>)	Critically Endangered	
4.	Egyptian Vulture (<i>Neophron Percnopterus</i>)	Endangered	

5.	Red-Headed Vulture (<i>Sarcogyps Calvus</i>)	Critically Endangered	
6.	Indian Griffon Vulture (<i>Gyps Fulvus</i>)	Least Concerned	
7.	Himalayan Griffon (<i>Gyps Himalayensis</i>)	Near Threatened	
8.	Cinereous Vulture (<i>Aegypius Monachus</i>)	Near Threatened	
9.	Bearded Vulture or Lammergeier (<i>Gypaetus Barbatus</i>)	Near Threatened	

- The widespread use of veterinary drugs like diclofenac, ketoprofen, and aceclofenac in the late 20th century has had devastating consequences for vulture populations.
- These drugs, commonly used to treat pain and inflammation in livestock, are toxic to vultures when they feed on carcasses of treated animals.
- Diclofenac in particular causes fatal kidney failure in vultures, and similar effects have been documented with ketoprofen and aceclofenac.
- Urbanisation, deforestation, and agricultural expansion have led to habitat loss, destroying vulture nesting sites, roosting areas, and food sources. The lack of suitable habitat hinders their survival.
- **Collisions with Infrastructure:**
- Vultures are vulnerable to collisions with power lines, wind turbines, and other man-made structures, leading to injuries or fatalities and contributing to population decline.
- **Poaching and Hunting:**
- In some areas, vultures are targeted due to cultural beliefs or illegal wildlife trade, adding to their struggle to survive.

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- **Ban on Diclofenac:** Recognising the devastating impact of diclofenac, India banned its veterinary use in 2006.
- This was a critical step in protecting vultures from kidney failure caused by ingesting carcasses of treated livestock.
- The Ministry for Environment, Forests and Climate Change launched a Vulture Action Plan 2020-25 for the conservation of vultures in the country.
- It will ensure minimum use of Diclofenac and prevent the poisoning of the principal food of vultures, the cattle carcasses.
- **Expansion of the Ban:** In August 2023, India further banned the use of ketoprofen and aceclofenac for veterinary purposes, acknowledging their potential threat to vultures.

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- **Vulture Conservation Breeding Centres (VCBCs):** India established a network of VCBCs, the first being set up in Pinjore, Haryana in 2001.
- These centres focus on the captive breeding of endangered vulture species, providing a safe environment to raise healthy populations for reintroduction into the wild.
- Currently, there are nine Vulture Conservation and Breeding Centres (VCBC) in India, of which three are directly administered by the Bombay Natural History Society (BNHS).
- Ramadevarabetta Vulture Sanctuary is located in the Indian state of Karnataka. It is a protected area that aims to conserve and protect the vultures in the region. The sanctuary's rocky terrain and cliffs provide a suitable habitat for vultures and other avian species. It is the first Vulture Sanctuary in India.

31 killed in U.S. strikes on Yemen; Houthis hit back

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The rebels say their armed forces launched an attack on a U.S. carrier in the Red Sea; ‘hell will rain down upon’ the militant group and Iran, its main backer, Trump warns; Tehran slams America

Agence France-Presse

Associated Press

SANA'A

The first U.S. strikes against Yemen's Houthis since Donald Trump took office killed 31 people on Saturday evening, the rebels said, with the United States President warning “hell will rain down upon” the Iran-backed group if it did not stop attacking shipping.

The Houthis said they launched an attack on a U.S. carrier in the Red Sea on Sunday, hours after the deadly strikes.

Iran's Minister of Foreign Affairs Abbas Araghchi condemned the deaths, and said Washington had “no authority” to dictate Tehran's foreign policy.

The Houthis, who have



Deadly hit: Smoke rises from a location reportedly hit by U.S. air strikes in Sanaa, Yemen, on Saturday. AP

attacked Israel and Red Sea shipping throughout the Gaza war, said children were among those killed.

Attacks on Sanaa, as well as on areas in Saada, Al-Bayda and Radaa, killed at least 31 people and wounded 101, “most of

whom were children and women”, Houthi Health Ministry spokesperson Anis Al-Asbahi said.

The Houthis had said earlier that the strikes “will not pass without response”. “In response to this (U.S.) aggression, the

armed forces conducted a military operation... targeting the US aircraft carrier USS Harry Truman and its accompanying warships,” the group said in a statement, adding it had launched 18 missiles and a drone.

Mr. Trump, in a post on social media, vowed to “use overwhelming lethal force” to end the Houthi attacks, which the rebels say are in solidarity with Palestinians amid the Gaza war.

Mr. Trump also issued a stern warning to the group's main backer. “To Iran: Support for the Houthi terrorists must end IMMEDIATELY!” he said, adding it would be held “fully accountable” for any continued threats.

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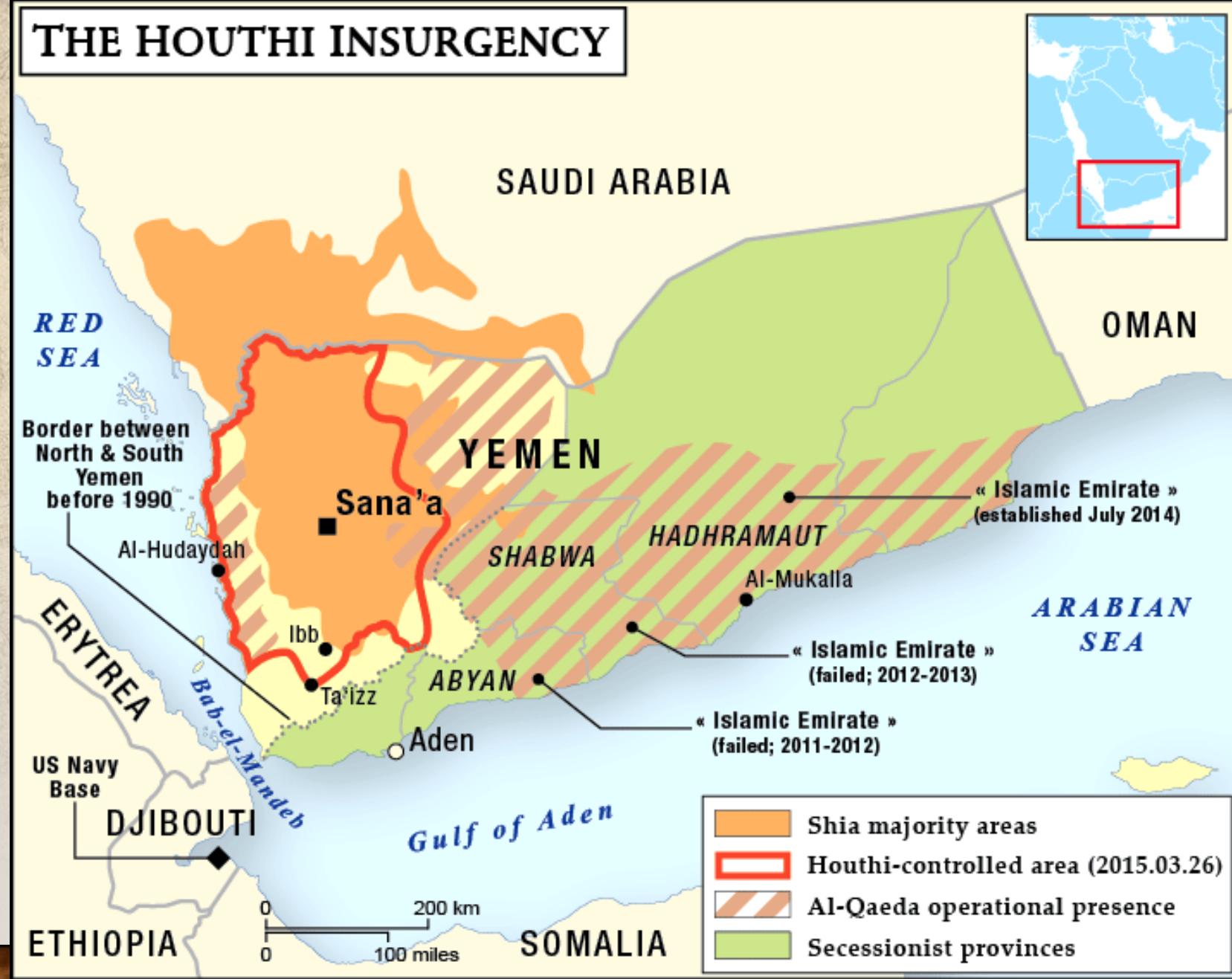
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Suez Canal and SUMED Pipeline chokepoints





THE HOUTHI INSURGENCY



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- The Houthis said they launched an attack on a U.S. carrier in the Red Sea on Sunday, hours after the deadly strikes.
- The Houthis, officially known as Ansar Allah (Partisans of God), are an Iranian-backed Shiite Muslim military and political movement in Yemen.
- Its members, who subscribe to the minority Zaidi sect of Shiite Islam, advocate regional autonomy for Zaidis in northern Yemen.

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- They are a minority in Yemen, which is predominantly Sunni Muslim, but they are a significant one, numbering in the hundreds of thousands and making up as much as a third of the overall population.
- The group emerged in the 1990s and takes its name from the movement's late founder, Hussein al-Houthi.
- The Houthi movement began as an effort to maintain tribal autonomy in northern Yemen and protest Western influence in the Middle East.
- They have been fighting Yemen's Sunni-majority government since 2004.
- The Houthis took over the Yemeni capital Sanaa in September 2014 and seized control over much of north Yemen by 2016. Currently, Houthis controls approximately one-third of Yemen's territory.
- Today, the Houthis seek a greater role in the Yemeni government and continue to advocate for Zaidi minority interests.

Rare success

ICC is still dependent on political interests to pursue its work

The arrest of former President of the Philippines Rodrigo Duterte on a warrant issued by the International Criminal Court (ICC) marks a rare success in the ICC's attempts to make senior political figures, especially those who have held or still hold public office, accountable for their crimes. However, it has to be acknowledged that only a set of favourable circumstances led to Mr. Duterte's arrest, and his being flown to The Hague: the warrant was executed by the government headed by President Ferdinand Marcos Jr., and the decision may have been the fallout of his differences with Vice-President Sara Duterte, Mr. Duterte's daughter who is embroiled in impeachment proceedings. ICC warrants invariably remain unexecuted, unless national governments cooperate with the ICC, a feature that often delays and stymies most ICC prosecutions. Mr. Duterte has been accused of "the crime against humanity of murder". The reference is to his 'war on drugs', a campaign of state-backed killing when he was Mayor of Davao City, and later President. The ICC is investigating the situation between 2011 and 2019, as he formally pulled his country out of ICC membership. However, the Pre-Trial Chamber has determined that despite the country not being a state-party now, it has jurisdiction to try crimes committed by individuals during the time the Philippines was a party.

The ICC was created by the Rome Statute in response to a need to have a permanent court, instead of ad hoc tribunals, for war crimes and crimes against humanity. It has no power of enforcement and is dependent on the national interests of big powers. It has often been accused of focusing on Africa, moving mainly against warlords and leaders in conflict zones. Warrants against leaders such as Vladimir Putin and Benjamin Netanyahu are seldom executed. In addition, some member-states have also expressed an inability to execute arrest warrants when those individuals visit their countries, while some leaders avoid visiting countries of state-parties. Added to this is the open hostility of the United States that frequently threatens the ICC with punitive measures if it moves against its nationals or allies. Fortunately, the ICC still exists as an international judicial institution mainly because it tries only individuals and not states. It has also rendered some significant verdicts on its own jurisdiction, the most important being the ruling in respect of Palestine that it can order investigations into crimes committed by nationals of both state-parties and non-state-parties on the territory of a state-party. Thus, a mere refusal by a country to ratify the Rome Statute or not being a party to it may not be relevant to any decision by the ICC to investigate and prosecute any individual.

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Content.

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ICJ vs. ICC



	International Court of Justice (ICJ) La Cour Internationale de Justice (CIJ)	International Criminal Court (ICC) La Cour pénale internationale (CPI)
Year Court Established	1946	2002
UN-Relationship	Official court of the U.N., commonly referred to as the "World Court."	Independent. May receive case referrals from the UN Security Council.
Location	The Hague, The Netherlands	The Hague, The Netherlands
Types of Cases	Contentious between parties & Advisory opinions	Criminal prosecution of individuals
Subject Matter	Sovereignty, boundary, & maritime disputes, trade, natural resources, human rights, treaty violations, treaty interpretation, and more.	Genocide, crimes against humanity, war crimes, crimes of aggression
Funding	UN-funded.	Assessed contribution from state parties to the Rome Statute; voluntary contributions from the U.N.; voluntary contributions from governments, international organizations, individuals, corporations and other entities.

4 Categories of crimes under ICC

 Genocide	 Crimes against humanity	 War crimes	 Crime of aggression
<ul style="list-style-type: none">● Specific intent to destroy a national, ethnic, racial or religious group by killing its members or by other means.	<ul style="list-style-type: none">● Serious violations committed through large-scale attack against civilian population● 5 forms listed in the Rome Statute includes offences like murder, rape, imprisonment, enforced disappearances, enslavement, torture, apartheid etc.	<ul style="list-style-type: none">● Grave breaches of the Geneva conventions in the context of armed conflict<ul style="list-style-type: none">● Includes use of child soldiers; killing or torture of civilians/prisoners of war; intentional attacks against hospitals, historic monuments etc.	<ul style="list-style-type: none">● Use of armed force by a State against the sovereignty, integrity or independence of another State.

The challenges of public health education in India

The decision by the United States to withdraw from the World Health Organization (WHO) and drastically reduce the scale of the United States Agency for International Development (USAID) is one that has sent shock waves through the aid and public health world. This move has disrupted essential health-care services in many low- and middle-income countries. However, India has been largely unaffected, as international aid accounts for just 1% of its total health expenditure. Nevertheless, the cessation of such funding threatens to further shrink an already constrained public health development sector, which relies heavily on international support. More importantly, this development directly impacts the public health job market, reducing opportunities for thousands who are pursuing their Master of Public Health (MPH) and similar postgraduate courses.

Public health plays a critical role in shaping a nation's well-being and health-care delivery. The Constitution of India, through Article 47, underlines the state's responsibility to improve public health care. Public health is a specialised field that requires specific knowledge and skills to effectively address people's health needs. There is an urgent need for a dedicated workforce in India trained in public health, a fact that was very starkly realised during the COVID-19 pandemic. Beyond government systems, such a workforce is essential for civil society organisations, academic institutions, and research organisations engaged in public health.

The evolution of training and jobs in India
Though the surge in public health education in India is relatively recent, its history dates to the colonial era. In the early days, public health was largely embedded within medical teaching. This narrow approach persisted despite the establishment of the All India Institute of Hygiene and Public Health, Kolkata in 1932 and the subsequent inclusion of preventive and social medicine – later known as community medicine – as an essential part of medical education. Specialists in community medicine, well-trained in public health provided public health services and met human resource needs in this field. However, their numbers were limited, and they were often engaged in medical teaching. Many students pursued MPH courses abroad in countries such as Australia, the European Union, the United Kingdom and the U.S. Yet, the supply of public health professionals remained constrained. Recognising the growing need and demand, MPH institutions and teaching expanded in India.

The number of institutions offering MPH and related courses in India has grown rapidly. Currently, over 100 institutions offer master's



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level courses in public health, whereas in 2000, there was only one. This expansion coincided with the launch of the National Rural Health Mission (NRHM) in 2005, which opened public health system roles to non-medical public health specialists. A wide range of institutions, from social science faculties to community medicine departments within medical institutions, have begun offering MPH courses. However, after an initial surge in demand, government recruitment for public health specialists plateaued, while the number of schools, programmes, and graduates continued to rise. As a result, securing jobs has become increasingly difficult for graduates.

Compounding this issue are challenges such as the lack of standardised training, insufficient practical learning opportunities, faculty shortages, and varied curricula that inadequately prepare students for real-world public health challenges. In addition, institutions offering public health courses are unevenly distributed, with large and populous States such as Assam, Bihar and Jharkhand, and many smaller and hilly States, having none or only a limited number of seats.

Hurdles graduates face, issues in education
The foremost challenge is the mismatch between supply and demand, with limited and shrinking job opportunities for graduates. Today, entry-level positions in public health, such as research or programme assistants, attract a very high number of applications, with a significant proportion of candidates being eligible. The success rate remains exceptionally low, with only a few positions available. Moreover, the shrinking of public health roles and institutions within the public system has further limited job prospects. Efforts to establish public health management cadres in States have been hindered by multiple factors.

In recent times, the changing landscape of health care, marked by the growing dominance of the private sector in public health, further restricts employment opportunities. The private sector prioritises hospital and business management professionals over public health specialists. With limited opportunities in both the public and private sectors, the research and development sectors remain the primary employers for graduates. However, these sectors rely largely on foreign grants, and India is no longer one of the priority countries for such international funders. Similarly, the development sector is constrained by limited funding, which is expected to worsen further due to recent decisions in the U.S. The national research and health development funding remains in its early

The key issue is the mismatch between supply and demand, with shrinking job opportunities and the dominance of the private sector

development and is significantly underfunded. Thus, the job scarcity for public health professionals continues and can exacerbate further.

Beyond job scarcity, there are concerns about the quality of MPH education. The rapid spread of public health schools has led to intense competition to attract students, often at the expense of compromising admission standards.

Many students enrol in these courses without a clear understanding of the field or passion needed to thrive in this field. Further, public health faculty often lack adequate training and real-world experience. The absence of a standardised curriculum and clear outcome measures, despite the Health Ministry's model course framework further exacerbates

concerns. In India, MPH courses are currently not mandatorily regulated by any regulatory body. Neither the National Medical Commission (NMC) nor umbrella organisations such as the University Grants Commission (UGC) oversee MPH training. In the absence of these quality measures, the overall quality of graduates is also impacted.

Approaches to consider

To address these challenges, a multi-pronged approach is required. The most urgent priority is to create public health jobs at all levels, from primary care to State and national health systems. In most developed countries with established public health education systems, governments are the largest employers of public health professionals. Similarly, establishing a dedicated public health cadre within State governments would be a significant step. This would not only create employment but also strengthen public health systems.

Next, a robust regulatory mechanism must be introduced by constituting a dedicated regulatory body or a specialised public health education division within existing regulatory agencies such as the NMC or UGC. This department, led by public health experts, should be responsible for setting curriculum standards and minimum training requirements while allowing room for institutional innovation, given that public health is a dynamic and evolving discipline. Moreover, public health training in all institutions must be closely integrated with practical learning opportunities within public health systems. There is a need to foster the growth of public health institutions in States where there are none or only a limited number. The emerging global situation calls for more national action and the building of local ecosystems for sustainable development in health.

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- However, India has been largely unaffected, as international aid accounts for just 1% of its total health expenditure.
- Nevertheless, the cessation of such funding threatens to further shrink an already constrained public health development sector, which relies heavily on international support.
- Public health plays a critical role in shaping a nation's well-being and health-care delivery.
- The Constitution of India, through Article 47, underlines the state's responsibility to improve public health care.

Fact

- There is an urgent need for a dedicated workforce in India trained in public health, a fact that was very starkly realised during the COVID-19 pandemic.
- In the early days, public health was largely embedded within medical teaching. This narrow approach persisted despite the establishment of the All India Institute of Hygiene and Public Health, Kolkata in 1932 and the subsequent inclusion of preventive and social medicine — later known as community medicine — as an essential part of medical education. Specialists in community medicine, well-trained in public health provided public health services and met human resource needs in this field.
- Currently, over 100 institutions offer master's level courses in public health, whereas in 2000, there was only one. This expansion coincided with the launch of the National Rural Health Mission (NRHM) in 2005, which opened public health system roles to non-medical public health specialists.

Fact

- The foremost challenge is the mismatch between supply and demand, with limited and shrinking job opportunities for graduates. Today, entry-level positions in public health, such as research or programme assistants, attract a very high number of applications, with a significant proportion of candidates being eligible.
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- To address these challenges, a multi-pronged approach is required. The most urgent priority is to create public health jobs at all levels, from primary care to State and national health systems.
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From insurance-driven private health care to equity

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As the world's largest democracy, India has long been committed to 'Health for All' under the World Health Organization's Universal Health Coverage (UHC) framework, which prioritises primary health care (PHC) and to reduce out-of-pocket expenditure (OOPE). India's evolving health policies have shaped Budget allocations and influenced health-care service and delivery. With the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) addressing OOPE, there is now greater scope to strengthen public health systems, especially primary health care. This insurance-based programme reduces OOPE by covering hospitalisation, surgeries, and procedures at the tertiary level, but sidelines the UHC principle of primary health care. Despite improving financial protection, it discourages primary health-care use, weakens public health infrastructure, and strengthens market-driven private health care.

Neglect of primary health-care systems
A robust PHC system reduces the burden on secondary and tertiary care, and ensures cost-effective health care. When health is recognised as a citizen's right, the state must ensure accessible and affordable PHC, whether publicly provided or well-supported. However, AB-PMJAY's hospitalisation-based reimbursement shifts the focus away from preventive and community-based health care, increases long-term costs and reliance on private hospitals, and fails to reduce OOPE. This contradicts the Bhore Committee's vision of strong primary health care, with a pyramid-shaped health system tapering to secondary and tertiary care.

Since its launch in 2018, the Ayushman Bharat Digital Mission dashboard reports the issuance of over 36 crore Ayushman cards and the empanelment of more than 31,000 hospitals. Although health is a state subject, PM-JAY reroutes funds to private insurance players, limiting state control. The 2025 Budget allocates ₹9,406 crore to AB-PMJAY, which is ₹2,000 crore more than the previous year, boosting privatisation and insurance-based financing. It



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The government must invest in preventive, community-based care that is accessible to all

remains unclear how much it will help reduce health expenditures for marginalised groups or support primary health care to lower out-of-pocket expenses for Below Poverty Line cardholders.

Budget, privatisation, insurance overhaul

The health budget allocates ₹95,957.87 crore to the Department of Health and Family Welfare and ₹3,900.69 crore to the Department of Health Research. The Budget prioritises medical digital infrastructure and medical education expansion over PHC. The National Health Mission, vital for grass-root health care, receives a declining share, signalling the state's gradual retreat from its universal health-care responsibility and shifting the burden onto private players. This affects citizens, as insurance schemes merely consolidate capital at the public's expense.

Additionally, significant changes in the insurance sector include raising the foreign direct investment (FDI) cap in the insurance sector from 74% to 100%, following a previous increase from 49% to 74% in 2021. This aims to improve India's low insurance penetration, especially in rural areas, attract more players into the insurance market, and achieve "Insurance for All" by 2047. The Insurance Regulatory and Development Authority of India (IRDAI) expects this to bring capital and expand coverage.

Policy changes raise concerns for India's informal workforce and marginalised urban populations. With the informal sector comprising a significant portion of the workforce, the lack of universal health coverage leaves millions without health security. The government has yet to outline how it will protect these vulnerable populations. Insurance illiteracy further complicates access, forcing many migrant and non-literate working classes to rely on middlemen. Without strict private sector regulation, OOPE is likely to increase due to inflated medical costs and uncovered

consumables. Coverage for Accredited Social Health Activist (ASHA) workers and grass-root health-care providers remains uncertain.

Compounding these issues is outdated data – the last Census was in 2011, and the Periodic Labour Force Survey was in 2020-21 – hindering efficient allocation and utilisation of social protection schemes.

Lessons from global models

Global experiences warn against an over-reliance on private insurance. In the U.S., insurance-driven pricing has led to skyrocketing health-care costs, widening inequalities, and limiting access for uninsured individuals. Public outcry over claim denials highlights the risks of corporate control over health care.



India can learn from countries such as Thailand (tax funded universal coverage scheme) and Costa Rica's Mandatory insurance scheme (Caja Costarricense de Seguro Social). Both rely on general tax revenue, strong public health investments, and regulated private insurance, prioritising primary care and community-based services.

As India navigates urban and health-care transitions shaped by the Budget and policy, it must reassess priorities. Instead of disproportionately favouring tertiary private health care through insurance models, the government must invest in preventive, community-based care that is accessible to all. Policies must address the health-care needs of informal workers, the unemployed, migrants, and vulnerable populations, especially with rising climate-related health risks.

Comprehensive public health benefit packages, cost-control mechanisms, and programmes to reduce OOPE are essential for achieving UHC. Safeguards must be in place to prevent private insurance from driving up health-care costs, ensuring India's commitment to 'Health for All' remains more than just a slogan.

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- As the world's largest democracy, India has long been committed to 'Health for All' under the World Health Organization's Universal Health Coverage (UHC) framework, which prioritises primary health care (PHC) and to reduce out-of-pocket expenditure (OOPE). India's evolving health policies have shaped Budget allocations and influenced health-care service and delivery.
- With the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) addressing OOPE, there is now greater scope to strengthen public health systems, especially primary health care.
- This insurance-based programme reduces OOPE by covering hospitalisation, surgeries, and procedures at the tertiary level, but sidelines the UHC principle of primary health care.
- Despite improving financial protection, it discourages primary health-care use, weakens public health infrastructure, and strengthens market-driven private health care.

- A robust PHC system reduces the burden on secondary and tertiary care, and ensures cost-effective health care. When health is recognised as a citizen's right, the state must ensure accessible and affordable PHC, whether publicly provided or well-supported.
- However, AB-PMJAY's hospitalisation-based reimbursement shifts the focus away from preventive and community-based health care, increases long-term costs and reliance on private hospitals, and fails to reduce OOPE.
- Since its launch in 2018, the Ayushman Bharat Digital Mission dashboard reports the issuance of over 36 crore Ayushman cards and the empanelment of more than 31,000 hospitals. Although health is a state subject, PM-JAY reroutes funds to private insurance players, limiting state control.
- It remains unclear how much it will help reduce health expenditures for marginalised groups or support primary health care to lower out-of-pocket expenses for Below Poverty Line cardholders.

Fact

- The National Health Mission, vital for grass-root health care, receives a declining share, signalling the state's gradual retreat from its universal health-care responsibility and shifting the burden onto private players. This affects citizens, as insurance schemes merely consolidate capital at the public's expense.
- Additionally, significant changes in the insurance sector include raising the foreign direct investment (FDI) cap in the insurance sector from 74% to 100%, following a previous increase from 49% to 74% in 2021.
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Tackling the problem of nutrition

While health was not a priority for Budget 2025, it seems that nutrition is. In the coming financial year, two Union government schemes will receive higher allocations – Saksham Anganwadi and Poshan 2.0. But will this fix India's nutrition challenge?

Nutrition in India is not just about food insecurity, but also about dietary habits shaped by culture, caste, and gender relations. Only one aspect of the nutrition challenge receives most of the policy focus – malnutrition among women and children. Women outside of the reproductive age, men, and senior citizens rarely figure in national nutrition policy discussions. More importantly, we ignore diabetes, hypertension, and other lifestyle-induced non-communicable diseases which are really another manifestation of under nutrition. One type of nutrition deficiency is because some people just don't have enough to eat and the other type is because people are not eating sufficient nutritionally rich food. The outcomes are damning in unique ways.

India has among the world's highest share of malnourished children and anaemic women. According to the National Family Health Survey-5, 36% of children under five are stunted and a meagre 11% who are breastfed between the ages of 6 months and 23 months receive an adequate diet. Fifty-seven percent of women in the 15-49 age group are anaemic. There is a rise in the share of those with diabetes, hypertension, and other such lifestyle-diet induced non-communicable diseases (NCDs). 24% of women and 23% men in India are overweight or obese and 14% take medicines for diabetes.

A comprehensive agenda
Poshan 2.0 and Saksham Anganwadi offer more of the same solutions – take-home rations, supplementary foods, tracking of



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severe and acute malnutrition cases, iron and folic acid tablets etc. With Poshan 2.0, there is additional focus on aspirational districts and the north-eastern region. But these schemes reinforce the idea that malnutrition is a problem only in certain parts of India and only in certain segments of the population. Instead, what we need is a comprehensive nutrition agenda in which nutrition is identified as a public health problem that impacts people across the social strata.

A comprehensive agenda would recognise the nutrition needs of different segments of the society. It must consist of: first, a clear identification of nutrition needs beyond reproductive and child health; second, a broad set of solutions, particularly rooted in the local food systems; and third, a clear identification of locally embedded facilities to deliver nutrition services. We need most work in identifying local institutional linkage for the agenda. Who will implement this in our neighbourhoods every day? The clear answer is: the health and wellness centres (HWCs).

At present, we provide supplementary nutrition for pregnant and lactating mothers and young children through take-home rations, iron and folic acid tablets for adolescent girls at Anganwadi centres (AWCs); and mid-day meals for children in schools. We need to systematically expand the nutrition-focused activities to other segments of the population and involve HCWs and ACWs. The mix of nutrients which goes in the take-home ration for poor women is relevant for pregnant women from all strata of society. Food items which use locally available low-cost, nutrient-dense produce need to be emphasised for the middle classes too, which consume sugar-laden, fibre-poor packaged goods.

For HWCs to implement this agenda, they need to be in

sufficient numbers to cover the entire population. Each of them has to have a detailed set of nutrition services covering the entire catchment population. At present, the spread of HWCs is lopsided. Rural areas seem to have

them in excess when compared to urban ones. And within rural areas, some areas have a higher concentration of HWCs.

Nutrition services in HWCs are limited. HWCs are supposed

to provide nutrition advice to pregnant women and lactating women, adolescents and children, the elderly population, and those recuperating from disease, disaster and trauma. But these are not implemented consistently or systematically.

We also need dedicated staff to provide nutrition services at the HWCs. In the existing design, nutrition is a tiny part of the responsibilities of the multi-purpose worker.

Factors for success

The success of the nutrition agenda will depend on two factors: engaging with local elites; and linking nutrition practices with local cuisines. Professor Prerna Singh at Brown University demonstrates in her research on small pox vaccination that there was significant variation in the uptake of vaccination during the 1950s among equally placed countries such as India and China. Some got their population vaccinated earlier and faster than others. Those that did were countries where the vaccination interventions were publicly owned by local elites and connected with local health practices and ideas.

India is a rapidly transforming society. We have to push further with the HWC approach of imagining health as wellbeing and not just an absence of illness. A locally owned, comprehensive nutrition agenda for all strata of society delivered by the primary health system is a first step in this direction.

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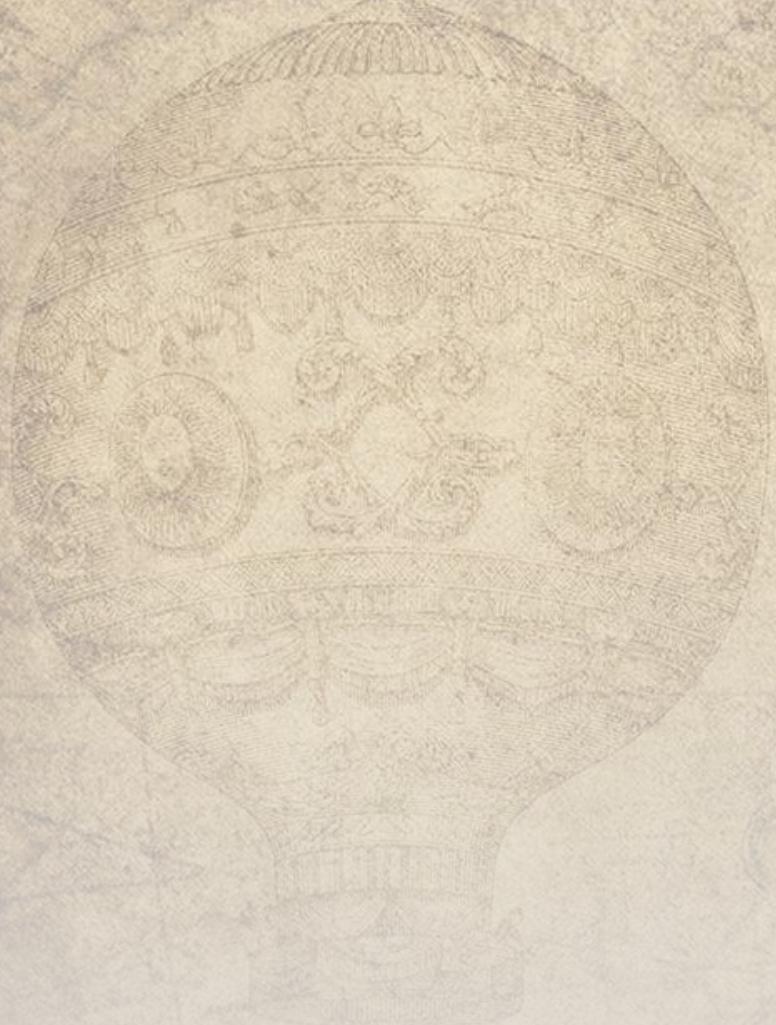
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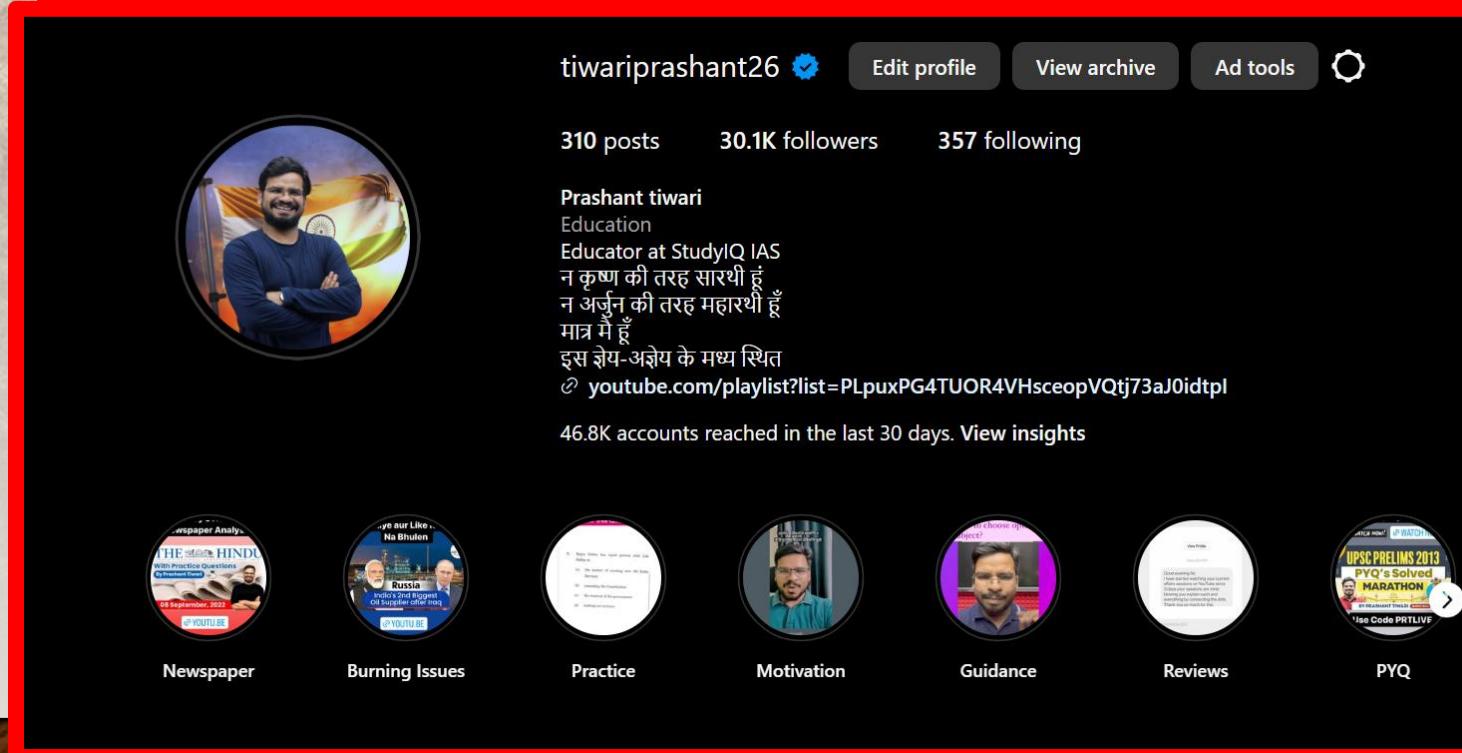
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Fact

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- India is a rapidly transforming society.
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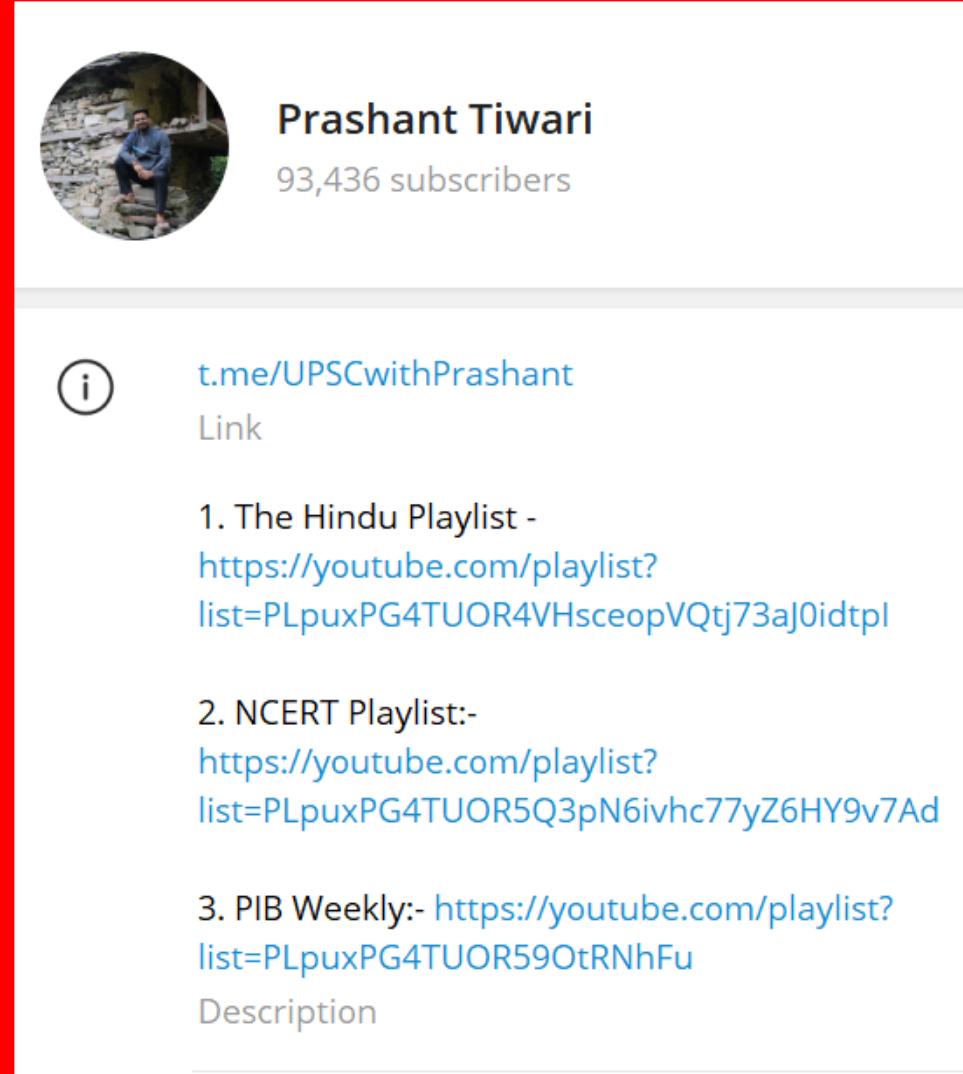
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