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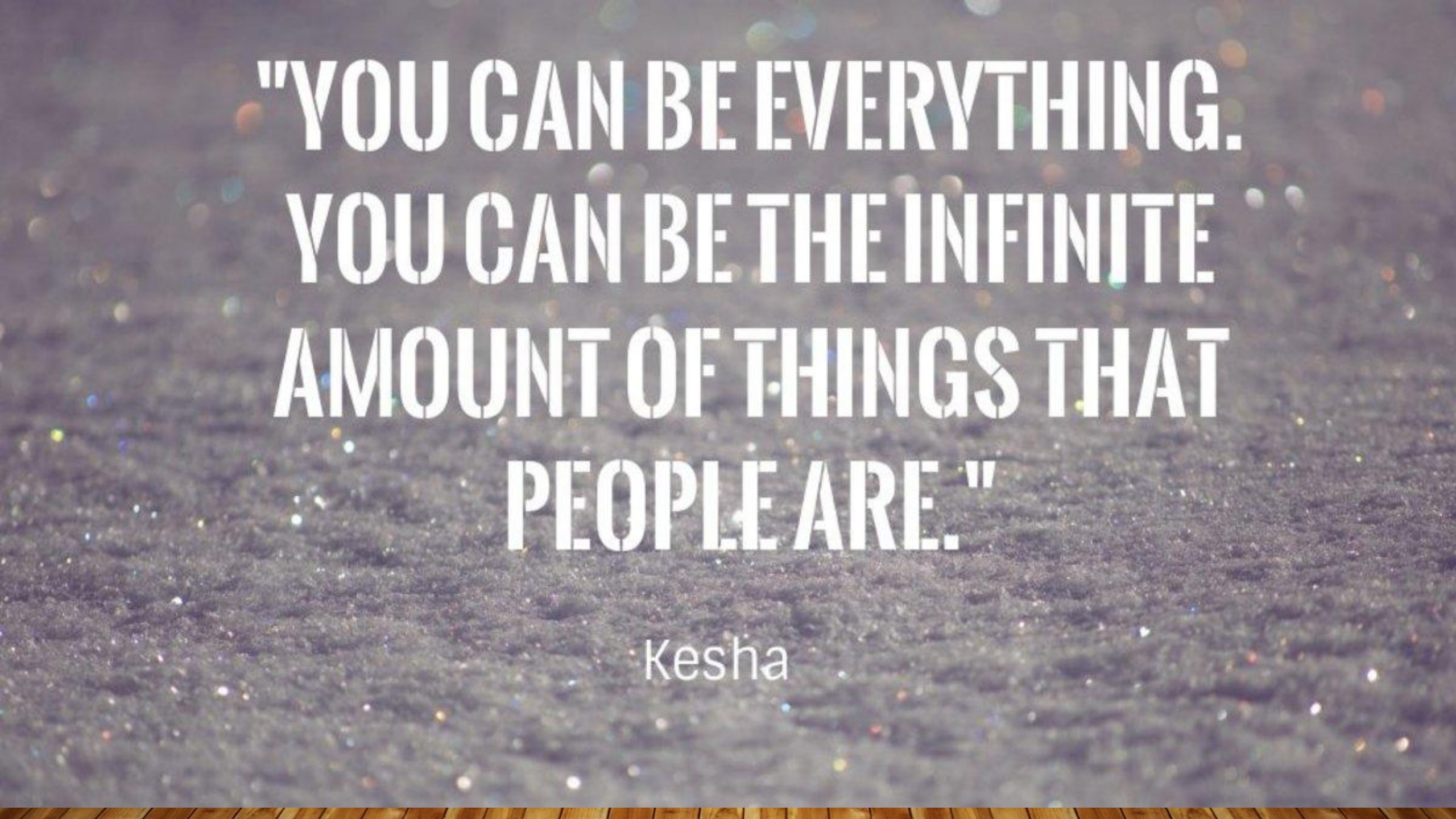
"YOU CAN BE EVERYTHING.
YOU CAN BE THE INFINITE
AMOUNT OF THINGS THAT
PEOPLE ARE."
Kesha

CJI seeks details of guards at Justice Varma's house

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Chief Justice of Delhi High Court forwards query to the police; judge asked not to dispose of his phones or delete or modify any conversation, message or data in them during the probe

Krishnadas Rajagopal
NEW DELHI

With Chief Justice of India Sanjiv Khanna seeking the ascertainment of details of security guards and personal security officers posted at the residence of Justice Yashwant Varma in the past six months, the Chief Justice of the Delhi High Court, Justice D.K. Upadhyaya, has forwarded the query to the police.

The CJI had also called for the call details and the Internet Protocol Detail Record of Justice Varma's mobile phone after the alleged discovery of "sacks" of half-burnt currency notes from a storeroom on the residential premises of the High Court judge. The call details from September 1, 2024 have been handed over to the CJI in a pen drive. Justice Varma was asked not to dispose of his phones or delete or modify any conversation, message or data from them.

Photos published by the top court show the storeroom, firefighters, and burnt currency notes at the Delhi judge's official residence. PTI

The details of the High Court Registry staff deputed to Justice Varma were furnished to the CJI.

All these details will be placed by the Supreme Court before the probe committee. The three-member probe committee of the Chief Justices of two High Courts and a Karnataka High Court judge will take a deeper dive into the facts of the case.

The Supreme Court's publication of documents and visual material related to the inquiry into the incident is a stride towards transparency even as the records raise questions which the three-member committee may examine.

For one, the published records show that the Police Commissioner got in touch with Chief Justice Upadhyaya only around 4.50 p.m. on March 15 when the fire had broken out around 11.30 p.m. the previous night. On receiving the information, Chief Justice Upadhyaya immediately swung into action.

The Delhi Police Commissioner's report to Chief Justice Upadhyaya said a security guard at the residence of Justice Varma saw "half-burnt articles" and debris being removed in the morning after the fire.

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FIRE

Content.

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Fact

- **Constitutional Provisions: Article 124(4) and Article 218 provide the legal basis for the removal of Judges of the Supreme Court and High Court, respectively.**
- **Criteria: Removal is permitted only on grounds of proven misbehaviour or incapacity.**
- **The Constitution does not define the terms ‘proved misbehaviour’ or ‘incapacity.’**
- **The Supreme Court has opined in various cases that wilful misconduct in office, corruption, lack of integrity or any other offence involving moral turpitude would constitute misbehaviour. Incapacity here means a medical condition that may include physical or mental incapacity.**

Fact

- **The Judges Enquiry Act (1968) regulates the procedure for removing an SC judge and an HC judge.**

- **Initiation: Requires a motion signed by at least 100 MPs in Lok Sabha (LS) or 50 MPs in RS. The Chairman/Speaker may, after due consideration and consultation, admit or refuse to admit the motion. If admitted, a three-member committee (Committee of Inquiry) would be constituted.**

Committee of Inquiry:

- **Comprises the CJI or SC judge, a High Court CJ, and a distinguished jurist.**
- **Investigates charges, frames allegations, examines evidence and cross-examines witnesses.**
- **Report findings to the Speaker/Chairperson.**

Parliamentary Vote:

- **Each House must pass the motion with at least two-thirds of the members present and voting and more than 50% of the total membership in favour.**
- **If both Houses agree, the President issues the removal order.**
- **Termination of Proceedings: If the committee finds the judge not guilty, the matter is dropped.**
- **From the above, it is clear that the procedure for the impeachment of a high court judge is the same as that for a judge of the Supreme Court.**

Removal of Judges in India: Past Cases

- **Justice Ramaswami (1993): Accused of financial impropriety. Motion failed as LS abstained from voting.**
- **Justice Soumitra Sen (2011): Guilty of corruption, impeached in RS but resigned before LS discussion.**
- **Justice S. K. Gangele (2015): Cleared by a committee on sexual harassment charges.**
- **Justice Pardiwala (2015): Motion dropped after controversial remarks on reservations were expunged.**
- **Justice C. V. Nagarjuna (2017): Accused of victimising a Dalit judge and financial misconduct. The motion failed due to insufficient signatures.**
- **Justice Dipak Misra (2018): The RS chairman rejected the motion at the preliminary stage.**

Fact

- **No Success: Despite six impeachment attempts, no judge has been impeached since independence.**
- **High Bar for Removal: The stringent voting requirement makes impeachment rare.**
- **Political Nature: The process often involves political negotiations and alliances.**

- **The Collegium system refers to the mechanism for the appointment and transfer of judges in the Supreme Court and High Courts of India.**
- **It is not explicitly mentioned in the Constitution but has evolved through various Supreme Court judgments.**

Composition:

- **Supreme Court Collegium: Includes the Chief Justice of India (CJI) and the four senior-most Supreme Court judges.**
- **High Court Collegium: Led by the Chief Justice of the High Court and its two senior-most judges.**

Constitutional Provisions for Judicial Appointments

- Article 124: Supreme Court judges are appointed by the President, in consultation with the CJI and other judges as necessary.
- Article 217: High Court judges are appointed by the President, in consultation with the CJI, the Governor of the state, and the Chief Justice of the High Court.
- Government's Role: The government can raise objections or seek clarifications.
- However, if the Collegium reiterates its recommendations, the government is bound to comply.

- Evolution of the Collegium System
- First Judges Case (1981): Held that "consultation" with the CJI does not mean "concurrence."
- Gave primacy to the executive in judicial appointments.
- Second Judges Case (1993): Overturned the First Judges Case. Redefined "consultation" to mean "concurrence," giving the CJI a primary role.
- Introduced the concept of a Collegium, requiring the CJI to consult two senior-most judges.

Fact

- **Third Judges Case (1998): Expanded the Collegium to include the CJI and four senior-most judges.**
- **Stated that dissent by even two Collegium members can halt a recommendation.**

- **National Judicial Appointments Commission (NJAC): Proposed via the 99th Constitutional Amendment Act, 2014, to replace the Collegium system.**

- **Composition included: CJI (Chairperson), two senior SC judges, Law Minister, and two eminent persons.**

- **Struck down in 2015 by the Supreme Court, citing a violation of judicial independence and the basic structure of the Constitution.**

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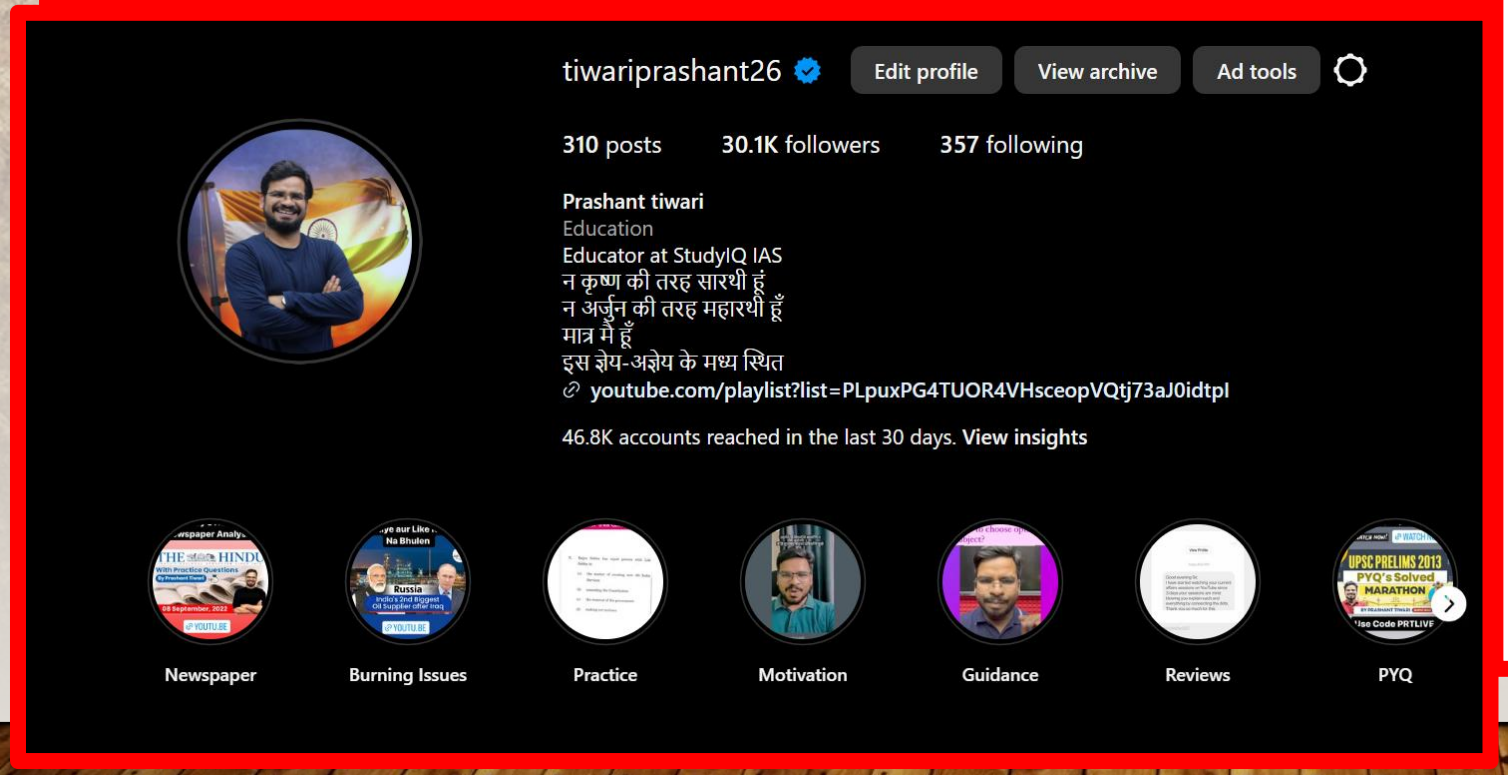

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Description

India imposes anti-dumping duty on Chinese goods for up to 5 years

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Press Trust of India
NEW DELHI

India has imposed anti-dumping duty on five Chinese goods to protect domestic players from cheap imports from the neighbouring country.

These duties were imposed as these products – Soft Ferrite Cores, a certain thickness of vacuum insulated flask, aluminium foil, Trichloro Isocyanuric Acid, and Poly Vinyl Chloride Paste Resin – were exported to India from China at below normal prices.

In separate notifications, the Central Board of Indirect Taxes and Customs, Department of Revenue, said that the duty imposed "shall be levied for a period of five years" on imports of Soft Ferrite Cores, vacuum insulated flasks, and Trichloro Isocyanuric Acid. The anti-dumping duty of up to $873 per tonne was imposed provisionally on aluminium foil for six months.

The duties were imposed as products were exported from China at below normal prices.

The government has imposed a duty in the range of $276 per tonne to $986 per tonne on imports of the acid (a water treatment chemical) from China and Japan.

On imports of Soft Ferrite Cores (used in electric vehicles, chargers, and telecom devices), up to 35% duty was imposed on CIF (cost, insurance freight) value.

Similarly, on a vacuum-insulated flask, $1,732 per tonne anti-dumping duty was levied. The levy, which ranges from $89 per tonne to $707 per tonne, on Poly Vinyl Chloride Paste Resin was slapped on the imports from China, Korea RP, Malaysia, Norway, Taiwan and Thailand for five years.

These duties are imposed after recommendations for the same were made by the Directorate General of Trade Remedies (DGTR).

Anti-dumping probes are conducted by countries to determine whether domestic industries have been hurt due to a surge in cheap imports.

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- **Anti-dumping probes are conducted by countries to determine whether domestic industries have been hurt due to a surge in cheap imports.**

Anti-Dumping Duty:

- **It is a protectionist tariff that a domestic government imposes on foreign imports that it believes are priced below fair market value.**

- **Dumping is a process wherein a company exports a product at a price that is significantly lower than the price it normally charges in its home (or its domestic) market.**

- **The duty is priced in an amount that equals the difference between the normal costs of the products in the importing country and the market value of similar goods in the exporting country or other countries that produce similar products.**
- **It is imposed to protect local businesses and markets from unfair competition by foreign imports.**
- **Thus, the purpose of anti-dumping duty is to rectify the trade distortive effect of dumping and re-establish fair trade.**

Content.

- **The use of anti-dumping measures as an instrument of fair competition is permitted by the World Trade Organization (WTO).**
- **The WTO allows the government of the affected country to take legal action against the dumping country as long as there is evidence of genuine material injury to industries in the domestic market.**
- **The government must show that dumping took place, the extent of the dumping in terms of costs, and the injury or threat to cause injury to the domestic market.**
- **While the intention of anti-dumping duties is to protect local businesses and markets, these tariffs can also lead to higher prices for domestic consumers.**

Petty politics

Delaying the Census aids politicisation of delimitation issue

The impressive gathering in Chennai, on March 22, which brought together leaders from several States – including four Chief Ministers – for the inaugural meeting of the Joint Action Committee (JAC) on Fair Delimitation, sent a clear message: any delimitation exercise based solely on the current population figures is unacceptable. The meeting's primary demand – to extend the freeze on the number of parliamentary constituencies based on the 1971 Census for another 25 years – echoes a similar resolution passed at a recent meeting of parties in Tamil Nadu, which proposed a 30-year extension. This concept of a freeze is not new; it was implemented through the 42nd Amendment (until 2000) and extended again via the 84th Amendment (until 2026). Rightly, the JAC emphasised that States which have successfully implemented family planning should not be penalised with reduced parliamentary representation. This concern, which is particularly prominent in the South, should not be dismissed as a regional issue, despite the strong southern presence at the meeting, which was hosted by Tamil Nadu Chief Minister M.K. Stalin and attended by Kerala Chief Minister Pinarayi Vijayan, Telangana Chief Minister Revanth Reddy, and Karnataka Deputy Chief Minister D.K. Shivakumar. The meeting also saw participation from outside the South, including Punjab Chief Minister Bhagwant Mann and Odisha's former Chief Minister Naveen Patnaik, who, in an online address, reinforced the message against punishing States for effective population control measures. It is after a long time that parties across regions and ideologies are uniting on a substantive issue – representative democracy –rather than forming opportunistic electoral coalitions that lack policy coherence.

The Bharat Rashtra Samithi's working president, K.T. Rama Rao, proposed considering a State's fiscal contribution as a parameter in the delimitation process – an idea that may help address the concerns of the southern States. But it might not make sense to predicate decisions with long-term consequences such as delimitation on factors that change from one year to another. In any case, the Union government must act without delay to begin nationwide consultations involving a wide range of parties. Before initiating the Delimitation Commission, it should facilitate inclusive dialogue, regardless of when the next Census – an essential prerequisite – is conducted. So far, statements from Union Ministers have failed to provide clarity. The Centre must recognise the importance of transparency and consultation on this inexplicable delay. Inexplicable, unless petty political calculations are factored in.

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- **Before initiating the Delimitation Commission, it should facilitate inclusive dialogue, regardless of when the next Census — an essential prerequisite — is conducted.**

- **Delaying the Census aids politicisation of delimitation issue**

The need for universal and equitable health coverage

Dr. Soumya Swaminathan

is Chairperson, M.S. Swaminathan Research Foundation (MSSRF)

India has made substantial and tangible progress in Tuberculosis (TB) care, adopting new strategies to detect, treat and prevent TB. Some key areas of progress include the expansion of molecular testing for rapid detection of TB and drug-resistance; the introduction of the shorter, all-oral BPaLM regimen (a combination of four drugs Bedaquiline (B), Pretomanid (Pa), Linezolid (L), and Moxifloxacin (M)); doubling of the entitlement under the Ni-kshay Poshan Yojana (NPY) for nutrition support to ₹1,000 a month; roll-out of TB preventive therapy; and an expanded role for communities through the involvement of TB survivors and Champions. The impact of the roll-out of these strategies can be seen in the 17.7% decline in TB incidence in India, from 237 per 1,00,000 population in 2015 to 195 per 1,00,000 population in 2023, in tandem with a 21.4% reduction in TB-related deaths.

Since Independence, India's public health system has delivered disease control services through primarily vertical health programmes, such as the National Tuberculosis Elimination Programme (NTEP). While this vertical nature has allowed for concentrated focus and brought benefits in many ways, it has also been limiting. Integration of TB services within the broader public health system is key to India's pursuit of equitable, universal health coverage (UHC) for all.

Decentralising TB care for all

The ambitious Ayushman Bharat National Health Protection Scheme was launched in India in 2018 to provide UHC for the Indian population. Today, TB has been integrated within both key components of Ayushman Bharat: the Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), considered the world's largest insurance scheme, and the Ayushman Arogya Mandirs (AAMs, formerly known as Health and Wellness Centres), which provide a comprehensive basket of primary health-care services in rural and urban India.

From the perspective of a person with TB symptoms, the best experience would be accessing consistently high-quality services at the first point of contact. The integration of TB services at the AAM primary care level is designed to meet this need, bringing together diagnostic, treatment and preventive care under one umbrella. AAMs serve as sputum collection centres, where people with TB symptoms can give samples for testing. The NTEP has also been optimising sample collection and transportation methods through a diagnostics network optimisation exercise. A person diagnosed with TB at a secondary or tertiary care facility can undergo treatment at the health centre closest to their residence, again minimising time and costs. In the first two months when people with TB are weak and drop outs as well as mortality is highest, community health officers positioned at the AAMs and their teams must be trained to identify and refer such patients for admission.

Integration of TB services within the broader public health system is key to India's pursuit of equitable, universal health coverage for all

While TB services have been free within the public health system, over 50% of all people with TB symptoms continue to seek care in the private sector. Uneven standards of care across the vastly heterogeneous private health sector has led to delays in diagnosis and contributed to poor outcomes as well as significant out-of-pocket expenditure (OOPE) for families. It is imperative to strengthen referrals from the private to the public health system, particularly for those who cannot afford to incur substantial expenditure on health and who may not be aware that TB services are freely available in the public health system. It is equally essential to ensure that the AB-PMJAY provides full insurance coverage for those who seek care for TB in the private or public sector, particularly those who are severely ill.

Equitable and decentralised care for all

What does the road to equitable TB care look like? There are five key steps we can take to accelerate our progress towards TB elimination and universal health coverage (UHC).

First, while we work to achieve decentralisation, we must strengthen person-centred care approaches, and deliver them at scale. There have been model interventions in several States that have assessed people with TB for social and clinical vulnerabilities and linked them to care. In Tamil Nadu, the Tamil Nadu Kasanoi Erappila Thittam (TN-KET), or "TB death-free project", has been successful in achieving reduced TB mortality through a robust system of identifying those most vulnerable or sick, and referring them for a brief period of admission. Similarly, there have been other interventions focusing on tribal communities, migrants, and homeless populations. One clear pathway to achieving UHC and increased utilisation of the public health system is by strengthening investment in the traditional 'inputs' for health and streamlining their functioning – human resources, supplies and infrastructure.

Second, we must develop mechanisms to recognise intersectionalities. Multiple factors such as gender, age, caste, disability, socio-economic status, and occupation determine health seeking intent and access to health and TB services. The intersection of these aspects of identity can both positively and adversely impact TB outcomes. The NTEP has adopted the national framework for a gender-responsive approach to TB, recognising that women, men, and LGBTQIA persons experience TB differently. Improving understanding of gender will take time, and inevitably challenge personal behaviours and norms, but is essential to equitable care. Similarly, there has been some early work to better understand TB and disability, which must be built upon.

Third, integrated care remains a challenge for India's health system, as we continue to build our primary care services. How do we ensure that someone who comes with TB symptoms is tested for Chronic obstructive pulmonary disease (COPD) or asthma? How can a person with TB be screened for depression or hypertension and linked to appropriate services and counselling? We must adopt models of integrated general health screening in community settings, for example, test for TB and COPD through validated Artificial Intelligence (AI)-enabled chest x-rays and upfront molecular testing, along with screening of common non-communicable diseases through blood pressure, blood glucose, and body mass index (BMI) monitoring.

Fourth, UHC approaches are centred around minimising OOPE, thereby eliminating health-related debt. Schemes such as the NPY have helped alleviate the financial burden on families, by providing monetary support for access to nutritious food. Case-finding approaches, such as the ongoing '100 Days' campaign, can help reduce OOPE prior to diagnosis. However, there are still several significant indirect costs that remain. Expanding social protection by extending nutrition support to the family, piloting wage-loss schemes to offset a loss of income during TB treatment and introducing livelihood programmes for TB survivors are potential future actions.

Lessons from COVID-19, communication

Finally, equity in terms of access to information and knowledge is critical. TB remains severely misunderstood. Recall how swiftly we were able to ensure public understanding of COVID-19, through a flood of science-based information using a multitude of platforms. We need similar approaches for TB, to encourage people to seek care and adopt simple measures to reduce transmission within homes and communities. Promoting knowledge about drug-resistant TB, in the context of growing anti-microbial resistance (AMR) is vital. Decimating TB stigma is critical to ensuring early detection and successful treatment outcomes for people with TB.

An equitable TB programme is one where every individual receives the highest quality of person-centred care that takes into account individual needs. Equity is a cornerstone of health care, and is essential to achieving TB elimination and universal health coverage. India's TB response is well poised to define global standards and benchmarks. Applying the equity lens will only accelerate our progress.

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Content.

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Content.

- **It is celebrated to raise awareness around the disease, increase efforts to eradicate the disease, and mobilise support for those affected by TB.**

Background

- **March 24, 1882 is considered a significant date in the battle against tuberculosis as it is on this day that Dr Robert Koch discovered the bacteria that causes TB.**

- **This groundbreaking announcement led to better understanding, diagnosis, and eventual treatment of the disease.**

- **It was not before the year 1982, on the centenary of Dr. Koch's discovery that the International Union Against Tuberculosis and Lung Disease (IUATLD) proposed observing March 24 as World TB Day to raise awareness about TB and its global impact.**
- **The first World TB Day was officially observed in 1983, and since then, it has become an annual event.**

Imagining a 360° and comprehensive TB care response

Page No. 6, GS 2

Rani had had a cough for over 10 days. Cough syrups and antibiotics had not made her feel any better. Her doctor advised her to test for Tuberculosis (TB). A shocked Rani reluctantly gave her sputum sample for testing, which confirmed that it was drug-sensitive TB.

Her doctor assured her that TB was curable and advised Rani to eat a protein-rich diet, test for diabetes and HIV and get her family tested for TB. Rani informed her supervisor at work, who gave her time off work. She began a medicine regimen every day until she was cured. Later, she met several TB survivors who had inspired her, and she also chose to speak about her own TB experience.

Every segment must work

Rani's journey is what the ideal care pathway for TB care can and ought to look like in India. But for Rani to have this seamless experience, the complex machinery that works behind the scenes must be efficient. Every piece has to be in place, as in the case of Rani, even one missing element could have changed the course of her life.

What if her doctor had not suggested that she test for TB? She might have gone from one doctor to another awaiting diagnosis. She could have been too terrified to inform her family – when she did, they blamed her and were unwilling to begin any preventive therapy. Rani's supervisor was understanding, but what if the person had turned hostile and fired her?

Rani could have also stopped taking her medicines when she developed side effects. The medicines were in short supply, so she would have had to travel over 20 kilometres every few days to replenish the supply. As this was strenuous, she may have had to approach a local pharmacy, but this would have mean running out of money soon. Rani could have been shunned by her neighbours, or she may have been malnourished, an elderly person or had a disability, all of which could have worsened her TB experience.

Dr. Ramya Ananthakrishnan

is the Director of the Resource Group for Education and Advocacy for Community Health (REACH), a non-profit organisation working on tuberculosis for over 25 years

Anupama Srinivasan

is Deputy Director, REACH and a member of the 2024-25 India WomenLift Health cohort

There needs to be a tapestry of system and community-level actions with a focus on people with TB

TB is a simple, yet complex, disease impacting a person's physical and mental health. Stigma, loneliness and self-blame are common factors that people with TB face and experience. TB is a disease that dismantles social networks and disrupts economic progress, but cannot be cured by medicines alone, however essential. This is the single biggest lesson that TB survivors have taught the world.

At a macro level, there are issues about TB. Despite it being an airborne disease, there is a larger problem of insularity and persistent apathy, driven by the notion that it is a disease of the poor. Those of us who work deeply with TB care, know this well. There are too few of us and inadequate to tackle the scale of the crisis. How do we get everyone to care about TB and convince them that they have a stake in this fight?

What is needed

Most critical in all this is a resilient public health system, with dedicated human resources in place, an uninterrupted supply of commodities and drugs and the ability to transition from 'one-size-fits-all' care to person-centred care that is responsive to clinical, social and economic vulnerabilities. We need well-trained and compensated health workers to deliver care, which includes treatment literacy and psychosocial support (underestimated but critical). We need empowered communities, that are led by TB survivors, to advocate on behalf of people with TB and tackle discrimination. We need feedback loops to improve the quality of care. We need newer tools for point-of-care testing. Within the private health care system, better quality of care is key. To prevent TB, we need to improve airborne infection control, improve nutritional status and make available an effective vaccine for all.

Our responsibilities do not end at cure. We must understand the needs of TB survivors and provide follow-up care. All of this must be backed by gender-responsive, data-driven planning and decision-making.

What needs to be done

The most efficient health sector cannot end TB by itself. We need multisectoral action. We need more Champions who are able to say they had TB and motivate other people with TB. TB needs to be integrated within social and private insurance schemes. Our elected representatives must include TB on their agendas. We need an 'aware media' which is willing to spotlight TB.

Corporate India must prioritise TB control and be more open to investing corporate social responsibility resources. In the long run, we need viable social business models for TB care that transcend public-private partnerships.

In India, many of these aspects are part of the National Strategic Plan and operational to varying degrees. But if we are serious about ending TB, we cannot afford to pick and choose. Every single element is essential and can directly determine whether Rani, and others like her, are able to get a quick diagnosis and get cured. Every actor has a specific role in this ecosystem and must work in synergy to dismantle apathy. We will not reduce suffering and deaths due to TB if we do not build this tapestry of system and community-level actions that firmly place the needs of people with TB in the front and centre.

Content.

- **TB is a simple, yet complex, disease impacting a person's physical and mental health.**
- **Stigma, loneliness and self-blame are common factors that people with TB face and experience.**
- **TB is a disease that dismantles social networks and disrupts economic progress, but cannot be cured by medicines alone, however essential. This is the single biggest lesson that TB survivors have taught the world.**
- **At a macro level, there are issues about TB.**
- **Despite it being an airborne disease, there is a larger problem of insularity and persistent apathy, driven by the notion that it is a disease of the poor.**

Fact

- **‘Social stigma is a reality even today’**
- **With an estimated 2.8 million new cases a year, India contributes to more than 25% of the world’s Tuberculosis (TB) burden. More than half the TB patients in India seek private medical care.**
- **The current system of treatment of TB is confined to either public hospitals where treatment is given free but in an ambience which may not be welcoming, or in private hospitals where affordability is a major concern but the ambience is more welcoming.**
- **Government hospitals can offer a standardised clinical algorithm and facilities for contact tracing. Yet, the patients feel that free treatments may not be of optimal quality both with regard to the drug bio-availability and the testing processes.**

Fact

- **On the other hand, private practitioners may offer a better ambience and better comforts during treatment, but may not adhere to standardised protocols for treatment. Also, patient monitoring may also be compromised in private hospitals, which do not have the bandwidth to ensure compliance and follow-up.**

- **As we stride towards the World Health Organization's goals of ending TB, we need to think of innovations in TB care — that is, with regard to diagnosis as well as treatment. To balance the faults of the system, we need a strong and sustained drive to encourage public-private partnerships in the management of TB patients.**

- **Certain anti-TB medicines for drug-resistant TB are available only in government hospitals, to limit misuse and prevent resistance development to these novel drugs. To ensure strict adherence to treatment protocols, public health policies insist on admission to hospitals for two weeks at initiation of this regimen for drug-resistant cases.**

Fact

- **Tuberculosis (TB) is an infectious disease caused by Mycobacterium tuberculosis.**
- **TB commonly affects the lungs (pulmonary TB) but can also affect other parts (extrapulmonary TB).**

- **Transmission: It spreads from person to person through the air when people infected with TB cough, sneeze or otherwise transmit respiratory fluids through the air. However, people with latent TB (when the infections do not show any symptoms) do not spread the disease.**

- **Common symptoms include:**
- **Chronic cough with blood-tinged sputum**
- **Loss of weight**
- **Loss of appetite**
- **Fever and night sweats**
- **Fatigue are common symptoms of tuberculosis, etc.**

Fact

- **For new TB cases, the treatment in the intensive phase (IP) consists of four drugs:**
- **Isoniazid (INH)**
- **Rifampicin**
- **Pyrazinamide**
- **Ethambutol**
- **For previously treated cases of TB, the intensive phase is 12 weeks, where an injection of streptomycin is given for eight weeks along with four drugs.**
- **A strictly followed 6-month drug regimen cures most people with TB.**

- **BPaLM Regimen**
- **It consists of four drugs — Bedaquiline, Pretomanid, Linezolid, and Moxifloxacin.**
- **It offers a more effective, faster, and safer alternative to traditional treatments.**
- **The BPaLM regimen is being introduced as part of the National TB Elimination Programme.**
- **Key Benefits of the BPaLM Regimen**
- **It cures MDR-TB in six months, compared to the 20-month traditional treatment.**
- **It improves recovery chances (higher treatment success rate) for drug-resistant TB.**

Fact

- **In MDR-TB, the bacteria develop resistance to antimicrobial drugs used to cure the disease.**
- **MDR-TB does not respond to at least isoniazid and rifampicin, the 2 most powerful anti-TB drugs.**

- **XDR-TB is a form of multidrug-resistant TB with additional resistance to more anti-TB drugs.**
- **People who are resistant to isoniazid and rifampicin, plus any fluoroquinolone and at least one of three injectable second-line drugs (amikacin, kanamycin, capreomycin) are said to have XDR-TB.**

- **The UN aims to end the TB epidemic by 2030.**
- **The Indian Prime Minister expressed India's goal of eliminating TB five years earlier, by 2025.**

- **Revised National TB Control Programme was renamed the National TB Elimination Programme.**
- **The name change aligns with the larger goal of eliminating the disease by 2025, five years ahead of the SDG 3.3 target.**

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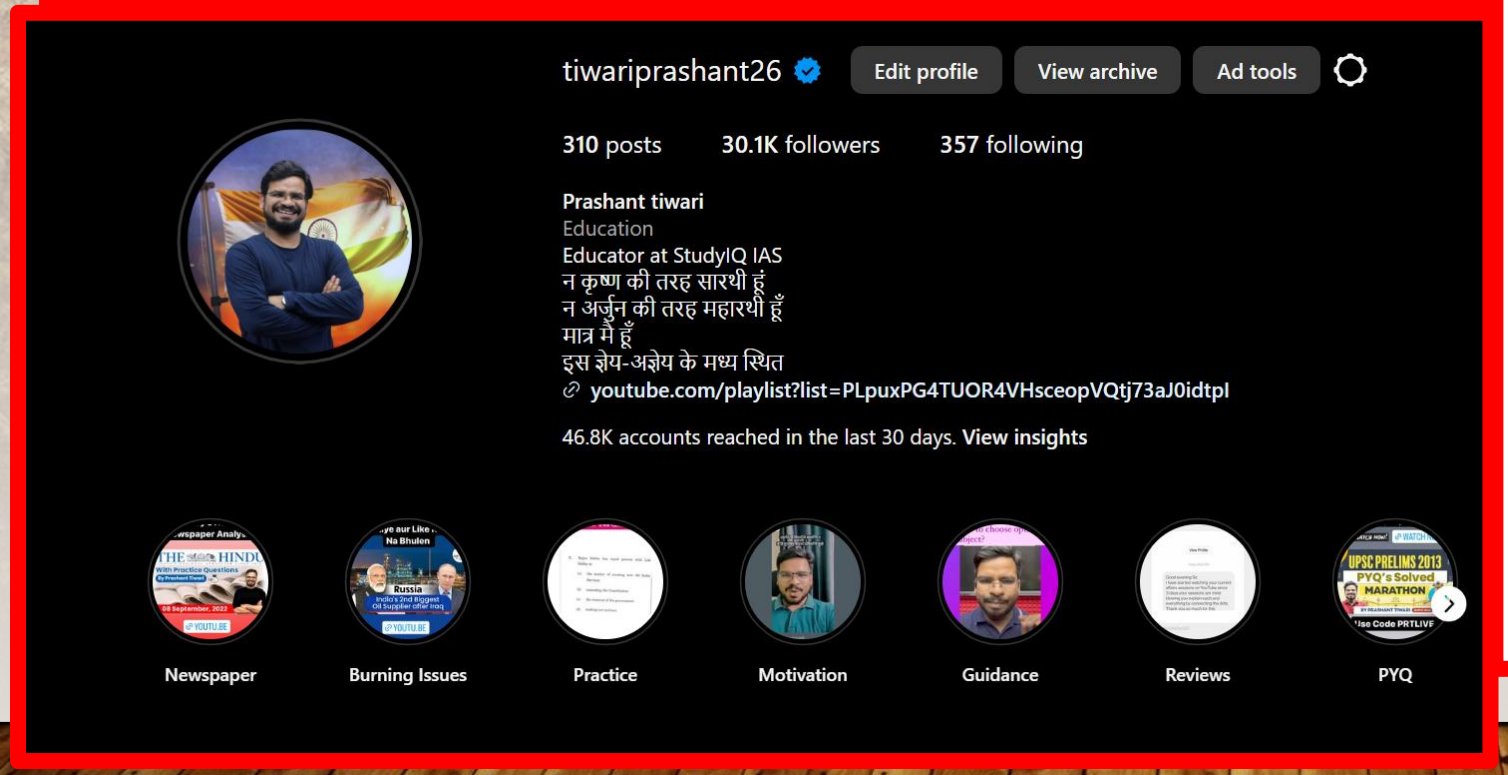

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Description

Thank You!